AN EXPLORATION OF THE PERCEPTIONS OF STUDENT NURSES ON THEIR DEVELOPING SENSE OF PROFESSIONAL AUTONOMY

By

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A thesis submitted to the University of Birmingham for the degree of

DOCTOR OF EDUCATION

School of Education
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University of Birmingham
August 2023

Abstract

An important aspect of nurse education is the achievement of professional autonomy; however, to date, there has been little research into how student nurses conceive of their developing sense of professional autonomy as they work towards becoming Registered Nurses. This study aimed to explore student nurses' perspectives on the factors that influence its development and how nurse education might support the development of professional autonomy.

In depth, semi-structured interviews, with eleven student nurses in their second and third years of education, generated data that were analysed and interpreted. The applicability of situated learning (Lave and Wenger, 1991) and liminality (van Gennep *et al.,* 2019) were reflected upon in data analysis.

The study revealed that professional autonomy development was conceived as an individual and liminal, transitional experience which continued throughout the student nurses' education and into their professional practice as Registered Nurses. Professional autonomy development appeared to be influenced by the extent of familiarity, confidence and experience that each student nurse brings to a clinical practice situation, through engaging in authentic nursing tasks or being involved in decisions about aspects of patients' care. However, it was apparent that transitions, such as starting a new placement, may impede the smooth development of a sense of professional autonomy and as such, it should not be regarded as necessarily a linear or consistent process of progression.

This study highlights the importance of educating student nurses and nurse educators about the relationships between familiarity, confidence and professional autonomy. The findings also offer practical and policy insights for the process of placing student nurses in practice settings, in order that they can recognise their liminal experiences and, thereby, more easily deal with the sense of uncertainty and lapses in confidence which are likely to accompany the process of moving towards registered status. This study offers potential wider applicability to situations in which multiple practical placements form an integral part of professional training.

Acknowledgements

I give thanks to Professor Marion Bowl, who has expertly guided and supported me through this study. Her commitment and time, given so generously, have enabled me to navigate the requirements of this thesis and the unpredictable nature of work, life and study.

I thank all the participants who willingly gave up their time. Without their commitment this study would not be possible. I am eternally grateful and humbled that they felt they could share their experiences of nurse education with me.

I also thank all my friends and work colleagues who have helped and supported me to manage undertaking this study whilst in full time employment. In particular, for their endless encouragement that helped me to continue and author this thesis.

Finally, a special thanks to my family; my husband and best friend, Stuart, our sons, Paul and Dominic and our daughter, Catherine, who have been there for me, are my inspiration and of whom I am immensely proud.

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List of abbreviations

AEI Approved Education Institution (by NMC)

CoDH Council of Deans of Health

CoC Chief Organising Concept

CoP Community of Practice

HCA Healthcare Assistant

HEE Health Education England

ICoN International Council of Nurses

IPA Interpretative Phenomenological Analysis

LPP Legitimate Peripheral Participation

NHS National Health Service

NMC Nursing and Midwifery Council

PSA Professional Standards Authority

RCN Royal College of Nursing

RN Registered Nurse with Nursing and Midwifery Council

RTA Reflexive Thematic Analysis

SLT Situated Learning Theory

Chapter One
The Genesis of this Study

Introduction

In this chapter, I introduce this study which aimed to explore perceptions of student nurses on their sense of developing professional autonomy. Professional autonomy in nursing is the ability to act on professional knowledge and to exercise professional judgement over patient care and clinical decision-making (Holland Wade, 1999; Kramer and Schmalenberg, 2008; Skår, 2010; Traynor, Boland and Buus, 2010; Pursio *et al.*, 2021; Rouhi Balasi *et al.*, 2022). My interest in professional autonomy arose as a student nurse in the 1980's and particularly as I made the transition to qualification as a Registered Nurse (RN). I questioned the respective roles of RNs and of healthcare managers and queried the extent to where my authority to make autonomous decisions rested; the extent to which autonomy was mine simply because I was a RN and the extent to which my autonomy was a result of the authority given to me at the discretion of my managers. This is a question I have continued to grapple with as a RN, nurse educator and now as a novice researcher.

I introduce this chapter by presenting aspects of myself which are relevant to this research; as a nurse and as a nurse educator. In the first section, I explain why the notion of professional autonomy was relevant to me because, in the past, I have had cause to question whether I had the autonomy to make decisions about patients' needs. In the second section I explain why I, as an educator, questioned

the extent to which nursing is an autonomous profession. This led me to consider the importance of autonomy in nursing and in the role of the RN. Having professional autonomy as an RN is important because it has been associated with increased job satisfaction (Kramer, Maguire and Schmalenberg, 2006; Rafferty, Ball and Aiken, 2010; Mastekaasa, 2011; Labrague, McEnroe-Petitte and Tsaras, 2018), in that it enables RNs to establish effective and respectful, professional relationships with other healthcare workers and patients (Kramer and Schmalenberg, 2008) which, it is argued, can benefit the quality of patient care and patients' experiences of healthcare (Rafferty *et al*., 2010). From my own perspective, having professional autonomy is essential if nurses are to advance their practice and implement high quality patient care. Exercising professional autonomy enables RNs to have responsibility to make reflective, evidence-based decisions (Varjus, Leino-Kilpi and Suominen, 2011) and to enhance nursing's practices (Watkins, Hart and Mareno, 2016) thus improving their job satisfaction (Finn, 2001) and the quality of patient care through shared leadership (Pursio *et al.*, 2021). This study is important because to facilitate student nurses' development of professional autonomy, nurse educators need to understand how student nurses themselves conceive of professional autonomy and what factors influence the development of this. In the last section, I outline the structure of this thesis.

My sense of professional autonomy as a Registered Nurse

I have been an RN and worked in roles requiring professional registration for over 35 years. This has involved me in working with students, other RNs,

interprofessional teams and patients and their families. I recall a particular occasion when, as a senior RN, based on completion of an extensive training programme, I perceived that my team and I had knowledge, skills, and ability necessary for providing nursing care for a child with a life-limiting condition. However, I was told by a hospital accountant that the nursing care that I deemed appropriate would be too expensive. I was advised to instigate what I considered a lesser quality care experience for the child and family. I had to advocate for the child and family, a process which resulted in significant delay. This experience caused me to question the extent of my professional autonomy and authority to act and to consider what being autonomous as an RN meant.

To maintain my registration as a RN, I am accountable to the regulator for nursing – the Nursing and Midwifery Council (NMC) in that I am required to adhere to the Code of practice entitled: *Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates* (NMC, 2018d). The Code states;

> *'The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work'. (NMC, 2018d, Pg 4).*

The Code does not offer a definition of autonomy or state what these *'different levels of autonomy'* are for those who practice in accordance with it. On the particular occasion described above, I perceived that I did not have the authority to

make an autonomous decision (Cassidy and McIntosh, 2014; Snelling, 2017) regarding the nursing care I considered that this particular child required and I did not have the freedom to act in accordance with my professional knowledge base (Skår, 2010). This, and other similar incidents, caused me to reflect on my own nursing practice, and the practices of nursing more broadly, and question whether as a RN, I was an autonomous professional.

My sense of professional autonomy as a nurse educator

After approximately 20 years working as a RN in different hospitals, I moved into nurse education based in a university. My role was to teach student nurses during their pre-registration nursing programme and RNs on post-registration courses. During this time, new regulations imposed the expectation that RNs be educated to degree level (NMC, 2010). My belief was that degree level education would put RNs on an equal educational footing with other healthcare professionals and provide career pathways toward higher level study and further professional development.

Degree level nurse education has reportedly offered enhanced patients' outcomes, including shorter in-patient stays, reduced incidence of medical complications and reduced patient mortality rates in hospital settings (Blegen *et al.*, 2013, Aiken *et al.*, 2014, and Liao *et al.*, 2016). Claims for such improvements in patient outcomes have been based on an increased ability of degree level educated nurses to apply critical thinking to their practice (Clark, Casey, and Morris, 2015;

Smith, 2012; Wynd, 2003), defined as problem-solving, decision-making, inference and evaluation (Clark *et al.,* 2015), and their enhanced capacity to access and apply research evidence to improve care (Wallin, Gustavsson, Ehrenberg, and Rudman, 2012) and an increase in technical competence (Royal College of Nursing (RCN), 2021; Scott, 2008; Smith, 2012). However, I questioned how, based on my own clinical experiences, these perceived developments in nurses' critical thinking, application of evidence and technical competence could provide benefits to patient care unless RNs had autonomy, the ability to apply their professional knowledge, to their nursing practice (Rouhi-Balasi *et al.*, 2020). This caused me to think about how student nurses develop a sense of professional autonomy.

My attention was again drawn to professional autonomy in nursing following the publication of a series of reports on the role and work of RNs (Cavendish, 2013; Department of Health, 2013; Francis, 2013; Transforming Care and Commissioning and Steering Group, 2014). These reports were commissioned by the then Secretary of State for Health or by NHS England following allegations of severe failing in patient care across multiple English NHS Trusts and other organisations. These reports asserted that a culture of poor leadership and a widespread lack of decision-making by RNs resulted in poor patient care. Such assertions made me question whether RNs lacked knowledge and skill to provide leadership and high-quality patient care or whether in fact, as I had perceived happened in my own clinical practice, RNs did not feel they had the autonomy to make decisions or the freedom to act in accordance with their professional

knowledge base (Skår, 2010). As a nurse educator, I wanted to understand more about how student nurses saw themselves developing a sense of professional autonomy.

The achievements of this study

My analysis and interpretation of the data leads me to conclude that professional autonomy development is an individual, liminal, and transitional experience. Its development continues throughout nurse education and into professional practice as a Registered Nurse.

Since student nurses develop professional autonomy as temporary, transient, and peripheral members of the practice team, I have drawn on Situated Learning Theory (Lave and Wenger, 1991), most notably the notion of legitimate peripheral participation, to claim that professional autonomy is developed through engagement in authentic nursing tasks and involvement in decision-making about nursing care. The study throws light on the nature of legitimate peripheral participation in nurse education and reveals the importance of developing a sense of belonging within the practice team. Engagement in the social processes of communities of practice (CoP) (Lave and Wenger, 1991) is what enables student nurses to move towards professional autonomy development.

The study also reveals that transitions such as those entailed in moving to a new practice learning placement, may impede the smooth development of professional autonomy. Professional autonomy development, as described in this study, appears to be influenced by the degree of familiarity, confidence, and experience that each student nurse brings to a new placement situation. Thus, I claim its development should not be regarded as a linear or predictable process. I draw on the work of van Gennep *et al* (2019) to highlight the potential for liminal experiences within nurse education and assert that these may provoke feelings of ambiguity among student nurses as they move through their practical education (Turner, 1969). Finally, I emphasise the importance of the role of nurse educators in supporting student nurses to understand the concept of liminality, enabling them to consider how liminal experiences may influence their sense of confidence and helping them to manage feelings of ambiguity which may arise.

Aims for this study

My aims for this study were to investigate the following questions:

- How do student nurses conceive of their developing professional autonomy in the context of their nurse education?
- What factors do student nurses perceive as influencing the development of professional autonomy?
- How can nurse educators further support the development of a sense of professional autonomy among student nurses?

Thesis structure

This thesis is presented in six chapters, which include this introductory chapter. In the section below I present an outline of each chapter. Here, I aim to help my readers navigate this thesis and to supply a brief overview of how this study has addressed the aims articulated.

Chapter Two: The contexts in which student nurses learn

I set out the relevant policies and practices that inform nurse education in England. I explain the importance of the time student nurses spend in practice settings because it is here that student nurses may have opportunities to develop their professional autonomy. I explain the role and function of the NMC, as the regulatory body for nurses, midwives, and nursing associates and the guardian of standards for nurse education. I problematise the concept of professional autonomy within nursing. I also give an overview of the recent changes to nurse education policy and explain how these changes may influence supervision of students' learning in practice settings (NMC, 2018a).

Chapter Three: Literature review

The literature review draws on theoretical perspectives, concepts, and research in reference to three aspects which conceptualise this study within what is already known in relation to notions of professional autonomy, and which have relevance for this study: First, professional autonomy as a common aspect of

professionalism. Here, I draw on theoretical frameworks to show that whilst different perspectives of professionalism exist, professional autonomy is a key aspect of professionalism (Hall, 1968; Etzioni, 1969; Abbott, 1988; Freidson, 2001). Second, I draw on key literature to analyse professional autonomy in the context of nursing. Specifically, I consider how nurses' experiences in healthcare, the relationships formed with other nurses and healthcare professionals and nurses perceptions of their professional autonomy inform the current evidence related to professional autonomy in nursing (Wynd, 2003; Wade, 2004; Mrayyan, 2004, 2005; Karagözoğlu, 2009; Iliopoulou and While, 2010; Skår, 2010; Baykara and Sahinoglu, 2014; Shohani and Zamanzadeh, 2017; Labrague, McEnroe-Petitte and Tsaras, 2018; Arreciado Marañón and Isla Pera, 2019; Oshodi *et al.*, 2019). In the third aspect of this literature review, I draw on theoretical frameworks of Situated Learning Theory (Lave and Wenger, 1998) and liminality (van Gennep *et al.,* 2019) to consider how student nurses might learn to develop their professional autonomy within their nurse education. This review shapes the research questions that this study looks to answer and identifies gaps within the literature.

Chapter Four: Methodological approach, research design and research procedures

Herein, I present my ontological and epistemological approaches which justified a qualitative approach to the research undertaken. I explain my interpretivist approach by consideration of how aspects of Heideggerian Hermeneutic Phenomenology (Heidegger *et al.,* 2010), provided a guiding research design. I

then justify my research procedures, including recruitment of participants and data generation using semi-structured interviews. I detail ethical concerns in the research process and the steps I took to mitigate these. I explain my approach to data analysis using Reflexive Thematic Analysis (Braun and Clarke, 2006) to describe how I arrived at my analysis and interpretation of the data and how I have presented my findings.

Chapter Five: Participants' perceptions on their developing professional autonomy

I present my interpretation of the four key themes arising from the participants' accounts:

- ***Familiarity as a precursor to developing confidence***: the data show that developing familiarity within a practice situation appeared to facilitate the development of a sense of confidence. This, in turn, seemed to enable autonomous practice.
- ***The student-mentor relationship***: I explore participants' differing perspectives on the opportunities that facilitated participants' autonomous practice. These included the availability of support to engage in authentic nursing tasks, and when participants perceived their mentors took an interest in their learning. I also show participants' perceptions of those factors they perceived to hinder opportunities to develop professional autonomy. Notable here, were perceptions that participants' views related to patient care needs were not sought or valued.
- ***Establishing a sense of belonging as a member of the team:*** I show that becoming part of the team was perceived as salient to professional

autonomy development. Participants' perspectives show that opportunities for professional autonomy development were enabled through sharing in the decision-making of the team. However, when a sense of belonging was absent, participants seemed to question their ability to develop professional autonomy.

- ***Transitions towards professional autonomy***: The data suggest, first, that the trajectory to a sense of professional autonomy was different for each individual. Second, it suggests that, as participants considered they were transitioning towards professional autonomy, they also perceived this entailed a process of increasing independence with complex decision-making. Participants' perspectives also showed that at transition points, such as starting a new placement or moving from being a student nurse to becoming a RN, the perception of one's ability to practice autonomously may fluctuate or decline.

Chapter Six: Discussion and conclusions

I draw on the works of van Gennep (van Gennep *et al.,* 2019) and Lave and Wenger (1991) to show what the findings of this study add to the academic and professional understanding of professional autonomy development in these student nurses. Here, I assert that because perceptions of confidence are likely to fluctuate, these student nurses may develop their professional autonomy through liminal experiences as temporary, transient and peripheral members of the practice team. I also discuss the diversity of liminal experiences which student nurses may encounter; often, repeatedly and perhaps persistently during their

nurse education. I show that ‘legitimate peripheral participation’ (Lave and Wenger, 1991) was a means of developing professional autonomy. I then illuminate factors found in this study to influence professional autonomy development, such as time, space and participants’ relationships with mentors and the practice team. I then discuss the implications of my findings for nurse educators which include consistency of opportunity for all student nurses to benefit from individualised, mentor-led support within practice settings. I present my dissemination strategy and offer my personal reflections on my experiences during this study.

Chapter Two
The Contexts for Student Nurse Education

Introduction

In this chapter I set out my understanding of the context for nursing in England. This forms an important aspect of the circumstances in which this study is set; those practices, and the assumptions which underpin them, give meaning to the context in which the data was generated. Such circumstances are also those in which Registered Nurses (RNs) are educated and student nurses develop their sense of professional autonomy. I also present the context of practice settings in which a shortage of RNs has implications for mentorship of student nurses as they work toward becoming professionally autonomous.

I focus on the role of the NMC as the regulator for nurses, midwives, and nursing associates. Here, I consider differing perspectives on *The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates* (NMC, 2018d) for the autonomy of RNs. I then provide an overview of the standards for nurse education laid down by the NMC that articulate the requirements against which RNs are educated and approved as autonomous practitioners. To give context to how student nurses may develop professional autonomy, I then discuss how student nurses' learning is supported and assessed within practice settings. I also introduce the role of the mentor who is responsible for supporting these student nurses' learning within practice settings, which includes assessing their development of professional autonomy.

Nursing in England

In this section, I set out the context for nurse education in England. In so doing, I begin to problematise the concept of professional autonomy of RNs. I also introduce the breadth of practice settings in which student nurses may be placed and where they may learn to apply theory to practice as they transition towards autonomous RNs. I also explain the differing ways in which the number of RNs are presented and suggest that these differing methods cause some complexity in understanding the availability of RNs to support student nurses in practice settings.

Professional autonomy of RNs

The professionalism and autonomy of nursing in England has been challenged because historically the level of knowledge and skill required of RNs has been less than that required by some other regulated allied health professions, for example Physiotherapists (Evetts, 2011; Krautscheid, 2014). Additionally, as RNs draw on knowledge from a range of disciplines, for example, medicine, biology and psychology, claims of a non-specific knowledge base also questioned the professional status of RNs (Adams and Miller, 2001; Scanlon, 2011).

Questions regarding nursing's professionalism and its professional autonomy also stem from how it has developed its identity (Roberts, 2000). Nurses' work has tended to be regarded as synonymous with 'caring' (Peplau, 1988) and 'female' work (Girvin *et al,*. 2016), viewed as practical, altruistic and presented as a

vocation (Clayton-Hathway, Griffiths, Schutz, Humbert, and Mcilroy, 2020; Dahlborg-Lyckhage and Pilhammar, 2008). This has served to continue the debate as to whether nursing has a status of a vocation or a profession (Andrew, 2012; Ayala, Vanderstraeten, & Bracke, 2014; Keogh, 1997; Thomas, 2016; Holland Wade, 1999).

Nursing in England remains female dominated with the proportion of males in the nursing workforce staying constant over the last decade at approximately 10% (Clayton-Hathway *et al.,* 2020). Whilst females represent approximately three quarters of all NHS staff, they account for around a third of all senior roles (Girvin *et al.,* 2016; NHS Digital, 2018). This has led to claims of gender discrimination and bias (Kouta and Kaite, 2011; Girvin *et al.,* 2016; Clayton-Hathway *et al.,* 2020) which have been exacerbated by the documented dominance of medicine over nursing (Scanlon, 2011; Pursio *et al.*, 2021). These issues, accompanied by concerns related to inconsistencies in nurse education and the mandatory nature of The Code (NMC, 2018d) have manifested as a lack of organisational power, autonomy, and control (Group and Roberts, 2001; Evetts, 2006a; Matheson and Bobay, 2007; Evans, 2008; Scanlon, 2011) which have resulted in devaluation of nursing's professionalism and, as such, continues to complicate nursing's claims to be professionally autonomous. To try to challenge these debates nurse education in the UK has moved from a wholly apprentice style education in schools of nursing located in hospitals, to degree level nurse education based in universities, with practical experience gained in practice settings.

Learning in practice settings

Practice settings may include hospital wards and departments, community nursing teams, general practice surgeries, nursing homes and private and voluntary sector healthcare providers, for example, hospices. In these practice settings student nurses are expected to apply and develop their nursing knowledge, skills, and competence and develop professional autonomy. The number of student nurses who can be accommodated in practice settings is based on the mentorship capacity of that setting. This is determined by the availability of RNs to support, supervise, and assess student nurses' competence to register with the NMC (NHS Confederation, 2021). Therefore, a barrier to increasing the number of student nurses is limited placement capacity (CoDH Shape of Caring Advisory Group, 2016). However, when increasing the number of student nurses in practice settings, the quality of the student nurses' learning experiences, their opportunities to develop knowledge, skills and competencies required for them to become autonomous RNs must also be considered.

At the time this study was conducted, there was a reported shortage of RNs (HM Treasury, 2015; CoDH Shape of Caring Advisory Group, 2016; Bungeroth and Fennell, 2018). However, reporting the exact number of RNs can seem contradictory depending on the focus; the number of nurses registered with NMC, the number of RNs in employment, or the number of RNs being educated. The NMC reported that in September 2018 there were 3880 more RNs and midwives registered than at the end of September 2017 (NMC, 2018e). This suggests an

increase in RNs. However, the RCN reported that between 2016 and 2018 there was a 5.3% reduction in the number of RNs in employment (RCN, 2018) with increasing numbers of RNs retiring or leaving the profession. During the same time period, NHS England reported that there were approximately 40,000 vacancies in substantive nursing posts and that insufficient RNs were being educated to meet patients' needs (NHS England, 2019). There was also a reported 1.3% reduction in the number of student nurses in nurse education between 2017 and 2018 (RCN, 2018). Therefore, a potential shortage of RNs will be a long-term concern. As such, nursing numbers in the NHS in England had not changed markedly between 2010 and 2017 and the UK continues to produce fewer new RNs in comparison with other Organisation for Economic Co-operation and Development countries (OECD) (Buchan *et al.,* 2019).

More recent data suggests between 2017 and 2020, there was a 4.8% increase in the number of RNs (Buchan *et al.,* 2020). However, the increasing number of patients and complexity of healthcare needs, combined with an aging nursing workforce and increasing numbers of RNs choosing to work part-time or to leave the profession widened the gap between nursing numbers and the requirements for RNs (Buchan, Gershlick, *et al.*, 2019; Crane and Abbott, 2021).

The shortage of RNs can, in part, be attributed to the historical commissioning process. Until 2016/ 2017, Health Education England (HEE) was responsible for setting the number of nurse education places available across England. In 2011/ 2012 the number of commissioned places for nurses was reduced by 10% and by

a further 3% in 2012/ 2013 (HEE, 2016). The number of commissioned places only exceeded 2010/ 2011 numbers in 2015/ 2016 (RCN, 2018). Given that the duration of nurse education is normally expected to be three years, those students starting education in 2015/ 2016 graduated as RNs in 2018/ 2019 suggesting that there was no perceived increase in the number of newly qualified RNs until after 2018.

From September 2017, the HEE cap on student numbers was abolished and training grants were replaced with student loans and the requirement for student nurses to pay higher education tuition fees (HM Treasury, 2015). However, practice settings continued to be commissioned and funded by HEE (Bungeroth and Fennell, 2018) and therefore HEE maintain some oversight of student nurse numbers. In 2019, Department of Health and Social Care announced its intention to recruit an additional five thousand student nurses and NHS England made a commitment to increase placement capacity by providing an additional five thousand placements for student nurses (NHS England, 2020).

The role of the Nursing and Midwifery Council in regulation and education

The NMC was established as the professional, statutory regulator for nurses by the *Nursing and Midwifery Order 2001.* Its function is to protect the public by maintaining a register of nurses, midwives and, more recently, nursing associates, by setting the educational requirements for registrants and by putting in place arrangements to manage concerns regarding registrants' fitness to practise (NMC,

2015). The *National Health Service Reform and Health Care Professions Act*, (2002) gave the Professional Standards Authority for Health and Social Care (PSA) a legal mandate to ensure public protection by regulating healthcare regulators, such as the NMC. The PSA therefore supervises the work of the NMC, and whilst not accountable for the performance of the NMC (Pickett, 2017), the PSA is accountable to the UK Government's Health Select Committee. In turn, PSA can appeal against decisions made by NMC and has power to impose regulatory reform (Pickett, 2017) and therefore this raises questions about the extent of autonomy enjoyed by the NMC.

To gain employment and to practice, it is a legal requirement for nurses to be registered with NMC. This statutory registration enables RNs to conduct their professional activities without direct supervision (McLaughlin, Leigh, and Worsley, 2016). The NMC set the standards of practice for RNs in The Code (NMC, 2018d).

Nursing in UK has had a published code of conduct since 1983 (Pattison and Wainwright, 2010). The Code was last updated in 2018 (NMC, 2018d). In order to keep their registration a RN must make a commitment to adhere to the Code. Whilst the Code recognises that nurses, midwives and nursing associates, the professions regulated by NMC, have *'different levels of autonomy'* (NMC, 2018d, Pg.4), the Code does not include standards specifically relevant to the exercise of these differing levels of autonomy.

Regulation via the Code has been discussed from differing perspectives. First, of the Code being *'there to empower, not to prohibit or to restrict'* (Finch, 2019, Pg.454) by articulating the professional standards expected of RNs and how to recognise *'good nursing'* (NMC, 2018, Pg.5). A differing perspective criticised the language used within the Code as being prescriptive, telling RNs what they *'must'* do rather than showing how to meet and maintain its requirements (Pattison and Wainwright, 2010; Snelling, 2017). This prescriptive, managerial stance questions whether RNs can exercise their professional autonomy by acting on their professional knowledge over patient care and clinical decision-making (Johnstone, 2016). A further perspective criticises the disciplinary agenda of the Code in that failure to follow its requirements may result in the potential for disciplinary sanctions against one's practise (Snelling, 2016). These criticisms have been argued to indicate a lack of organisational power and autonomy (Group and Roberts, 2001; Evetts, 2006a; Matheson and Bobay, 2007; Evans, 2008; Snelling, 2016) which have resulted in devaluation of nursing's professionalism and, as such, complicates nursing's claims to be professionally autonomous.

Standards of nurse education in England

The NMC is responsible for approving universities, or Approved Educational Institutions (AEI), to offer nurse education programmes which confer eligibility to register with the NMC and employment as a RN. Since 2013, nurse education in

the UK has stipulated a minimum of degree level education as a requirement for entry onto the professional register (NMC, 2010).

At the time of this study, approval to deliver nurse education was granted to AEIs under the NMC (2010) *Standards for Pre-registration Nurse Education.* To show the competence required to register as RNs, student nurses were required to:

> *…practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing' (Pg.13)*

Within these standards autonomy was defined as:

> *'The freedom to make binding decisions, within the scope of practice, that are based on professional ethics, expertise and clinical knowledge' (NMC, 2010, Pg.144)*

Under these standards (NMC 2010, 2018) student nurses must complete fifty percent of their time in education in an AEI and fifty percent in a range of nursing practice settings. Learning during time spent in practice settings has been identified as influencing professional identity development (CoDH Shape of Caring Advisory Group, 2016) including developing attitudes, values and behaviours that inform the practice of student nurses as they qualify as autonomous RNs (Walker *et al.*, 2014). It is through learning in practice settings that the student nurses in this study may have had opportunities to consider their professional autonomy development.

Supporting student nurses' learning in practice settings

The support, supervision and assessment of these student nurses' learning in practice settings is provided against specified competency and assessment requirements in accordance with the document: *Standards to Support Learning and Assessment in Practice* (NMC, 2008). Until 2020-2021, it was specified that this task be conducted by a 'mentor', defined as a RN who: *'facilitates learning and supervises and assesses students in a practice setting'*, (NMC, 2008, Pg.56). Mentors had to undergo a period of degree-level, university-based preparation for this role. Student nurses were required to spend a minimum of forty percent of their time in the practice setting working with their mentor, who was expected to assess the student's competence and ability to progress to complete their programme (NMC, 2008). The mentor: student relationship was normally expected to last throughout the duration of the student's practice placement; this period was typically between four and twelve weeks. This relationship was conceptualised as a formal relationship in that each student had to have a designated mentor within each practice setting (NMC, 2008).

Mentors were expected to balance the competing responsibilities of delivering patient care against supervising student nurses' learning and assessing their competence (Morley, 2016; O'Driscoll, Allan, and Smith, 2010). However, the effectiveness of mentoring in practice settings in nurse education has been called into question (Willis, 2012). Such questions relate to first, potential conflicts between the mentor's role as supervisor, supporter, coach, assessor and,

sometimes, confidante (Duffy, 2003) which manifested in concerns of mentors' 'failure to fail' students who did not meet the standards of competence required of autonomous RNs (Holland Wade, 1999; Duffy, 2003; Black, Curzio and Terry, 2014; Pennycook *et al.*, 2017). Second, the shortage of RNs called some to question whether there were sufficient mentors to appropriately supervise and assess the required number of student nurses (Levett-Jones and Lathlean, 2008; Molesworth, 2017; Buchan *et al.,* 2019; Buchan *et al.*, 2020; Crane and Abbott, 2021) and so provide appropriate learning opportunities in which student nurses could develop professional autonomy.

As a result, following a review of nurse education commissioned by Health Education England (HEE) in partnership with the NMC, the report, *Raising the bar: Shape of caring: A review of the future education and training of registered nurses and care assistants* (Willis, 2015) called for;

> '*higher quality learning experiences in practice settings, high-quality mentorship and increased opportunities for student nurses to develop their autonomy and confidence' (Pg.29).*

Whilst this report did not provide definitions of either autonomy or confidence, it resulted in the NMC (2008, 2010) standards being replaced by (NMC, 2018a) *Realising professionalism: Standards for education and training.* In place of mentors, student nurses were to be supervised and assessed in practice settings by practice supervisors and practice assessors; two different but complementary roles. Practice supervision was intended to enable students to learn and safely

achieve both competence and autonomy in their professional role (NMC, 2018b, Pg.6) and could be conducted by any registered healthcare professional. Practice assessors were to be responsible for conducting assessments to confirm students' achievement of competencies and certify that students have met the requirements of autonomous RNs (NMC, 2018b). Rather than achieving degree-level, university-based preparation for the role of mentor, practice supervisors were not required to receive degree-level preparation for their role (NMC, 2018).

Unlike in the NMC (2010) *Standards for Education,* the NMC (2018) *Realising Professionalism: Standards Framework for Nursing and Midwifery Education* do not supply a definition of autonomy. All universities and AEIs providing nurse education had to deliver nurse education against the NMC (2018b) standards by September 2021 and therefore further reference to the NMC (2018b) standards will be made in the discussion chapter.

Chapter summary

The NMC is the professional, statutory, regulatory body for nursing in the UK. As such, the NMC sets the standards for nurse education against which student nurses may develop their professional autonomy. The NMC also sets the standards for professional conduct, articulated in the Code (NMC, 2018d) against which the autonomous practice of RNs is communicated. The Code has been viewed from differing perspectives of being empowering, managerial and disciplinary, which may call into question how the professional autonomy of RNs is

considered. I have provided an overview of nurse education in England and some of the roles and terminology that will be used within my study. Notably here is the importance of practice settings, in which student nurses spend fifty percent of their nurse education and in which they may develop their sense of professional autonomy and are assessed against the standards and requirements to become autonomous RNs. I have also presented the NMC definition of autonomy as presented within the NMC (2010) *Standards for education* and against which the student nurses within this study are educated.

Healthcare policies govern the number of RNs to be trained and educated to meet healthcare requirements in the UK. I have presented data related to the number of nurses registered with the NMC, those in employment and the numbers of student nurses in training. To address the shortages of RNs an increase in the numbers of student nurses is needed which will increase the numbers of student nurses learning within practice settings. Increasing student nurse numbers places more pressures on the capacity to support, supervise, and meet assessment requirements on RNs whose primary role is the provision of patient care, in addition to supporting student learning. It is in these practice settings, that student nurses may develop their sense of professional autonomy.

Chapter Three
Literature Review

Introduction

In this literature review I present theoretical concepts and research about professional autonomy in general, professional autonomy in the context of nursing and how student nurses develop professional autonomy. In Section One, I show that professional autonomy is a key aspect of professionalism (Hall, 1968; Etzioni, 1969; Abbott, 1988; Freidson, 2001). Through my review of relevant literature, I argue that different perspectives on professionalism exist, and that this implies that the notion of professional autonomy, as an aspect of professionalism, may be subject to differing interpretations.

In Section Two, I evaluate what is already known about professional autonomy in the context of nursing. The literature shows that nurses' perceptions of autonomy are influenced by the context within which it is exercised. These contexts include the type of practice setting and extent of practitioners' experience (Wynd, 2003; Karagözoğlu, 2009; Baykara and Sahinoglu, 2014; Shohani and Zamanzadeh, 2017). I then present evidence which confirms the relational nature of professional autonomy in nursing as the literature states that nurses' perceptions of professional autonomy are influenced by relationships with other nurses, professionals, and patients (Holland Wade, 2004; Skår, 2010; Oshodi *et al.*, 2019). Finally, I argue that nurses' sense of professional autonomy appears to be

influenced by their perceptions of their own authority which ranged from having no authority to having independent authority (Mrayyan, 2004, 2005; Iliopoulou and While, 2010; Labrague, McEnroe-Petitte and Tsaras, 2018; Arreciado Marañón and Isla Pera, 2019). Drawing on literature, I present the challenges to, and facilitators of, the development of professional autonomy. Significantly, facilitators appear to relate to the context in which experience was gained and the relationships formed with others within the practice setting. Challenges appear to arise when there are perceived relational and operational concerns.

In Section Three, I present aspects of Situated Learning Theory (SLT) which may help to explain how student nurses learn to develop professional autonomy within the practice setting (Lave and Wenger, 1991; Wenger, 1998; Wenger-Trayner, Fenton-O'Creevy, Hutchinson, Kubiak, Wenger-Trayner, 2015). I first argue that there are parallels between Lave and Wenger's descriptions of communities of practice (CoPs) and the research evidence on how student nurses learn in practice settings. I then present van Gennep's work on the concept of liminality (van Gennep, *et al.,* 2019) and show that existing research suggests that student nurses may navigate transitions as they develop towards professional autonomy. I conclude that, together, the theoretical concepts of SLT (Lave and Wenger, 1991) and liminality (van Gennep, *et al.,* 2019) may help to throw light on how student nurses make the transition to RN.

Professional autonomy as an aspect of professionalism

Professionalism is a complex concept because multiple perspectives on professionalism co-exist and are subject to differing interpretations. However, the notion of professional autonomy is common to the differing perspectives on professionalism. These perspectives range from those that define professionalism according to specific traits and functions, (Flexner, 1915; Carr-Saunders and Wilson, 1933; Durkheim, 1957; Barber, 1963; Wilensky, 1964; Eraut, 1994), to those which regard it as occupational and organisational control and so question the function of professional autonomy (Wilensky, 1964; Larson, 1977; Abbott, 1988; Freidson, 2001; Noordegraaf, 2011; Evetts, 2013). More recently, perspectives on professionalism have located professional autonomy within organisational contexts of interdisciplinary working and interdependency (Evetts, 2013; Noordegraaf, 2016) and as an individual, iterative process of learning. Whilst I will conclude there is little consensus between writers holding different perspectives on the nature of professionalism, I show that professional autonomy is held to be an important aspect across these perspectives.

20th Century authors on professionalism focused on two distinct approaches. First, a traits approach which considered the values held by professionals. Second, a functionalist approach which considered professionals' roles. Advocates of a traits approach defined a profession according to the degree to which it manifested five dimensions, or hallmarks, of professionalism, viz:

- The existence of a professional organisation,
- A belief in public service,
- A sense of occupational autonomy,

- A belief in self-regulation,
- A sense of ‘calling,’ or vocation.

(Hall, 1968).

Traits approaches were predicated on assumptions about professionals’ unique knowledge, skills, expertise and ethical standards (Eraut, 1994; Freidson, 2001; Caspersen, 2007; Saks, 2012; Bowl, 2014) gained through formal education (Goode, 1957; Saks, 2012). In contrast, a functionalist viewpoint reflected a theoretical perspective based on roles performed by professionals within society rather than the values denoted by a traits approach (Barber, 1963). A functionalist viewpoint situates professionals’ autonomy in accordance with the benefits they perform for community and society (Durkheim, 1957; Barber, 1963; Evetts, 2013; Noordegraaf, 2016) and emphasise the public value of professionals’ work.

Whilst providing different perspectives on professionalism, both trait and functionalist approaches have been criticised. First, due to a lack of consensus about the core traits and roles required of professions (Johnson, Larkin, and Saks, 1995). Second, as they bestowed the individual, and the community of professionals, the prestige of status, income, autonomy and power (Goode,1957) this conferred a position of privilege (Freidson, 1994). These approaches were also criticised because professionalism and the status of professionals were exclusive (Evans, 2015) and often unachievable for most members of society (Evetts, 2006b; Saks, 2016).

Whilst being applied to the values and roles held by professionals, perspectives on professionalism have also been applied in a variety of occupational and organisational contexts, as well as in a range of professions and occupations (Evetts, 2006b). This variety of contexts appears to have blurred boundaries or even raised questions as to whether boundaries exist across professional and occupational groups that may share similar characteristics (Evans, 2015; Evetts, 2013). As my discussion below shows this blurring has created complexity in the meaning of professionalism and in conceptions on professional autonomy.

The discourse of occupational professionalism centres on the occupational control of the work conducted by the professionals. As such, occupational professionalism is controlled by professional organisations and operationalised by members of those organisations. It has been described from two contrasting perspectives – as a values system (Noordegraaf, 2007) and as a *'controlling ideology'* (Evetts, 2003, Pg.399). As a values system in which a group of professionals share common values and beliefs, occupational professionalism is perceived to confer positive perspectives on professional autonomy of the professional. Here, through collegial authority members of the profession have a shared understanding of their autonomy within that system (Evetts, 2006). This perspective offers that through collegial authority social influence was enabled (Carr-Saunders and Wilson, 1933; Dingwall and Lewis, 2014) which facilitated patient/ client trust and autonomy of the members of the profession (Evetts, 2006) and perpetuated the values of the social system (Durkheim, 1957). In turn, this created a shared professional identity for members of a profession (see Hughes, 1981). However, when occupational

professionalism is considered from the perspective of a *'controlling ideology'* (Evetts, 2003) professional autonomy provides a position of influence in which professionals and occupations demonstrate autonomy as power, derived from their specialist knowledge and expert status, to control the values, expectations, and behaviour of members (Larson, 1977; Abbott, 1988; Noordegraaf, 2016).

Perspectives reflected in the work of a number of writers on organisational professionalism consider how the work of professionals was managed within organisational hierarchies (Evetts, 2006, 2009, 2013; Evans, 2008; Noordegraaf, 2011; Saks, 2012; Adams, 2012). Within these perspectives, the place of policy and the context in which policy is operationalised seem to have influence on conceptions of professional autonomy. For example, within the UK National Health Service (NHS) the influence of New Public Management (NPM) (Hannigan,1998) resulted in both structural and governmental transformations, through a series of reforms, offered as a way of promoting organisational professionalism (Hanlon, 1999). NPM was characterised on the one hand, by decentralisation through which government services were subjected to market-based competition and management systems (Leicht, Walter, Sainsaulieu, and Davies, 2009). This enabled the setting of performance standards (Carter, 2000) as methods of assuring sound governance (Simonet, 2015) through greater accountability and efficiency (Leicht *et al.*, 2009). On the other hand, decentralisation resulted in greater regulation through increased monitoring and audit measures, for example, by the Care Quality Commission (Bergh, Friberg, Persson, and Dahlborg-Lyckhage, 2015; Evetts, 2009). Organisational professionalism was therefore,

perceived as a means of controlling professionals (Engel, 1970; Fournier, 1999) and so called into question their sense of autonomy. This resulted in perceptions of a loss of professional autonomy and to claims of proletarianisation through a de-valuing of professional status (McKinlay and Arches, 1985; Coburn, 1994; Harrison and Dowswell, 2002).

My discussion has presented differing perspectives on professionalism relevant to the occupational and organisational contexts in which professionals work. These contrasting perspectives suggest that professional autonomy may be viewed from conceptions of collegial authority, power and influence or organisational hierarchies which suggest the concept of professional autonomy is complicated. Additionally, role diversification (Kirkpatrick, Dent, and Jespersen, 2011), national and transnational changes to the education of professionals (Faulconbridge and Muzio, 2011), and the impact of international mobility for employment (Allsop *et al.*, 2009) contribute to the changing way in which professionals work. Furthermore, professions have adapted to function across organisations and boundaries and so professionals and professions have become interdependent (Noordegraaf, 2011). This means that professionalism and the professional autonomy of the members of a profession is situated within occupational and organisational contexts that require *'interdisciplinary knowledge and interactive skills'* (Noordegraaf, 2007. Pg.775) that are continuously changing and evolving as new knowledge and new ways of working are found. This suggests that occupational and organisational perspectives of professional autonomy are also subject to change.

A further perspective on professionalism offers a *'process approach'* (Bowl, 2014, Pg.52) in which professionals develop their professional autonomy and *'sense of professional self'* through continuing professional development (Scanlon, 2011, Pg.16). This perspective considers professionalism of individuals rather than of occupations or organisations. As such, professional autonomy is also positioned as a moral, political and social ideal (Dworkin, 1988). Developing professional autonomy is therefore seen as an individual, process of professional *'becoming'* rather than having a fixed end point of being an expert (Dreyfus and Dreyfus, 1980; Benner, 1982, Scanlon 2011).

In conclusion, professionalism is a complex concept with many differing perspectives on it, yet the concept of professional autonomy is a key common aspect central to all perspectives on professionalism and underpins how professionals conduct their work. These differing perspectives on professionalism have been re-shaped through occupational and organisational contexts that are themselves subject to national and global changes, and policy developments (Eraut, 1994; Abbott, 1988; Freidson, 2001; Noordegraaf, 2011; Evetts, 2013). Therefore, as perspectives on professionalism change so does the context of professional autonomy.

Definitions of professional autonomy

Professional autonomy has been identified as something to be striven for because it is associated with freedom to control decision-making within an area of expertise (Wilensky, 1964; Eraut, 1994; Holland Wade, 1999; Mastekaasa, 2011; Funck, 2012) and so confers privilege (Freidson, 1994). Molander, Grimen and Eriksen (2012) go as far as to suggest that, without autonomy, it would be impossible to conduct professional work. Indeed, Freidson's (1988) work in relation to medicine cited autonomy as the *'most strategic and treasured characteristic of the profession*' (Pg.23).

Freidson (1994) defined professional autonomy as the degree of freedom, discretion, and independence that an individual can exercise to decide the kind of work s/he does and to do that work as s/he sees fit, based on a *'sense of knowing'* how to do it (Pg.23). Professional autonomy enables workers to exercise discretion, to act on their judgements and to take responsibility for their actions (Freidson, 1994). The NMC (2010) definition presented in chapter 2, whilst having some similarity with Freidson's definition, recognises limiters (e.g. one's scope of practice) to professional autonomy:

> *'The freedom to make binding decisions, within the scope of practice, that are based on professional ethics, expertise and clinical knowledge'. (NMC, 2010, Pg.144)*

With autonomy comes the responsibility to exercise it according to the standards, values, and behaviour expected of a profession (Evetts, 2013; Freidson, 2001; Hall, 1968; MacDonald, 2002). The imposition of accountability through

professional ethics, and professional regulation (Evetts, 2006; Asprzak, 2013; Adams and Saks, 2018) is designed to maintain professional standards, values and behaviour with the aim of enabling patients, employers, and the public, to trust in the work of the profession (Evetts, 2013; Freidson, 2001; Hall, 1968; MacDonald, 2002). Freidson (1978) argued that complete professional autonomy would require an *'occupational monopoly'* with exclusive control over economic, political, and administrative matters of the profession (Pg.163) which would be unrealistic. Therefore, professional autonomy must be viewed from the perspective that it is discretionary (Evans, 2008; Evetts, 2003, 2011; Freidson, 1988). The discretionary nature of professional autonomy in nursing can be explained in that RNs must work within the requirements of the *Code* (NMC, 2018d). Whilst the Code does not define autonomy, it recognises that the professions bound to the Code have distinct levels of autonomy based on their *'knowledge and skills'* (Pg.4). In addition, RNs as employees, must follow the terms and conditions of their employment, including applying employer's policies, procedures and processes. Therefore, the autonomy enjoyed by RNs is, in this sense, discretionary.

Autonomy as an aspect of professionalism within nursing is further complicated because the NMC position the importance of autonomy as being central to professionalism;

> *'Professionalism is characterised by the autonomous evidence-based decision-making by members of an occupation who share the same values and education'.* (NMC, 2017. Pg.3)

However, within nursing there is no consensus on its definition (Ballou, 1998; Keenan, 1999; Varjus, Leino-Kilpi and Suominen, 2011; Traynor, 2019; Rouhi-Balasi *et al.*, 2020; Pursio *et al.*, 2021). Varjus *et al* (2011) conducted a review of 36 research studies with the aim of clarifying the concept of autonomy within nursing. These authors concluded definitions of autonomy applied within the reviewed studies differed based on their aims and focus, and on their theoretical perspectives, e.g., feminist theory, social psychological theory or organisation theory (Pg.205). Varjus *et al* identified similarities in definitions related to *'ability, independence, control, responsibility, accountability, authority and one's own practice.'* (Pg.202). More recently, Pursio *et al* (2021) completed a literature-based review using 27 studies conducted in 17 countries with the aim of summarising knowledge of professional autonomy in nursing. They identified two themes that they indicated describe professional autonomy of nurses; '*independence in decision-making and ability to utilize one's own competence'*, (Pg.1573). However, these authors noted that the differing views on professional autonomy, including the variety of methods used to assess or measure an individual's professional autonomy make defining and understanding it complex.

Section summary

Within this section I have positioned professional autonomy within differing perspectives of professionalism. It is these differing perspectives of professionalism that on reflection, I recognise in myself as nurse, educator and novice researcher and that caused me to question my sense of professional autonomy (see chapter one). In understanding how student nurses conceive their sense of professional autonomy and the factors that influence its development, I look to raise awareness of these perspectives. I have considered Freidson's (1994) definition of professional autonomy and from this, indicated that professional autonomy is discretionary and with it comes an accountability to keep the standards and values expected of a profession. In the absence of a definitive definition of professional autonomy in nursing, in this study, the NMC (2010) definition will be applied.

Professional autonomy in the context of nursing

Having established professional autonomy as a key aspect common to a number of perspectives on professionalism, I now explore literature on professional autonomy in nursing. In the three sub-sections which follow, I begin by exploring the contextual nature of professional autonomy in nursing. I conclude that the available evidence suggests that historically, nurses report a lesser sense of autonomy than workers in other professions, for example, medicine, social work and teaching (Hall, 1968). Furthermore, I delineate some of the factors that may influence nurses' perspectives on their professional autonomy – such as the particular setting in which they work and their level of education. These factors

suggest a contextual nature to professional autonomy (Baykara and Sahinoglu, 2014; Karagözoğlu, 2009; Shohani and Zamanzadeh, 2017; Wynd, 2003).

In the second sub-section, I argue that evidence suggests that perceptions on professional autonomy are affected by the relationships formed with other professionals and patients with whom nurses and student nurses work (Holland Wade, 2004; Skår, 2010; Oshodi, Bruneau, Crockett, Kinchington, Natar, West, 2019). Finally, I consider what the literature tells us about how nurses perceive their professional autonomy in relation to their understanding of the scope of their role. The evidence suggests that nurses perceive that they have greater professional autonomy in decision-making related to patient care than in relation to the organisation and management of nursing (Iliopoulou and While, 2010; Labrague *et al.*, 2018; Mrayyan, 2004, 2005; Arreciado Marañón and Isla Pera, 2019). I highlight facilitators and barriers shown in the literature as impacting on the development of a sense of professional autonomy.

The contextual nature of professional autonomy in nursing

Research evidence suggests a sense that professional autonomy in nursing is dependent on contextual factors. By contextual, I am referring to the length and type of experiences a nurse accumulates and the environments in which they work (Baykara and Sahinoglu, 2014; Shohani and Zamanzadeh, 2017; Wynd, 2003; Karagözoğlu, 2009). Quantitative studies by Hall (1968), Wynd (2003), Shohani

and Zamanzadah, (2017) used Hall's (1968) professional inventory scale (PIS) to measure nurses' and other groups of professional workers' sense of professional autonomy. Hall's study is now dated; however, it is included within this review because the PIS tool was validated in this original study and application of the PIS as a common measurement tool facilitates comparison between this and more recent studies. Hall's study also provides an historic context to the perspectives of nurses on their professional autonomy.

The PIS is a 25-item instrument that incorporates a 5-point Likert scale to measure a total score for sense of professionalism and sub-scores for Hall's (1968) five dimensions of professionalism (membership of a professional organisation, commitment to public service, sense of autonomy, belief in self-regulation and a sense of 'calling'). In the reporting of their studies, Hall (1968), Wynd (2003), Shohani and Zamanzadah, (2017) articulated study aims that were clear and focussed and the findings were discussed in relation to the set aims, thus aiding validity (Polit and Beck, 2016).

Baykara and Sahinoglu (2014) conducted a mixed methods study using a different measurement tool called the Sociotropy Autonomy Scale (SAS) to measure autonomy and social dependency (sociotropy). The SAS was previously implemented by Beck *et al*., in 1983 and adapted by Sahin and Ulusoy in 1993 (Baykara and Sahinoglu, 2014). The authors indicated the SAS assessed perceptions on professional autonomy by measuring dependency and autonomy, independent decision-making, and the ability to be independent and self-sufficient.

Baykara and Sahinoglu's (2014) study also had a qualitative part consisting of individual semi-structured interviews using seven questions. These questions were aimed to explore concepts such as perceptions of autonomy and factors perceived to affect it and aligned with the topics covered within the questionnaire. This mixed methods approach enabled comparison between results from quantitative and qualitative data. The qualitative element also ensured that the findings were grounded in participants' reported experiences conferring credibility of the study's findings (Moule *et al.***,** 2017).

Few recent studies have focussed on professional autonomy among student nurses, as distinct from more experienced nurses. However, Karagözoğlu (2009) conducted a cross-sectional study aimed to find the level of autonomy of nursing students, which also used the SAS. The calculated Cronbach's alpha coefficient in these studies was greater than 0.70, which suggests there was good internal consistency and hence reliability of the findings (Heale and Twycross, 2015).

Hall's (1968) study accessed 328 participants - teachers, nurses, social workers, physicians, lawyers, accountants, and advertising executives to measure their perspectives on their professional autonomy. Wynd's (2003) study drew on a random sample of 774 RNs, of which ninety-five percent were female, with a mean age of 45 years. Shohani and Zamanzadah (2017) had a sample size of 185, seventy-four percent of the participants were female with an average age of 33.4 years. Baykara and Sahinoglu (2014) conducted their mixed-methods study with thirty nurses. Karagözoğlu's (2009) study had 326 student nurse respondents.

With the exception of Hall's (1968) study, the reports of these studies confirm that respondents were recruited ethically, with processes for gaining consent and maintaining confidentiality (Moule *et al,.* 2017). Hall (1968), Wynd (2003), Shohani and Zamanzadah (2017), Karagözoğlu (2009) recruited their participants through probability sampling based on a clearly identified sampling frame suggesting generalisability of findings (Parahoo, 2014). Furthermore, the specific research aims and key variables reported in each study informed the allocation of cases to strata which enabled the authors to present findings about specific population subgroups. E.g. gender, age, and to make inferences about these specific subgroups (Gerrish and Lathlean, 2015). Baykara and Sahinoglu (2017) used a non-probability, maximum variety method and purposive sampling with clearly documented inclusion and exclusion criteria to ensure participants who were recruited had specialist knowledge to address the research questions (Thomas, 2013). In the reporting of these studies descriptive and inferential statistics were reported clearly and precisely to enable the reader to determine the accuracy of results (Gerrish and Lathlean, 2015).

Hall's (1968) and Wynd's (2003) studies were conducted in the USA, while Shohani and Zamanzadah's (2017) research was conducted in Iran. Baykara and Sahinoglu (2014) and Karagözoğlu (2009) conducted their studies in Turkey. Whilst this speaks to a lack of UK research in this subject, the consistency across the findings of these studies contributes to the strength of the evidence (Moule *et al.,* 2017). Additionally, these countries are members of the International Council

of Nurses (ICoN) which suggests some shared values and practices in nursing (ICoN, 2021).

Hall's (1968), Wynd's (2003) and Shohani and Zamanzadah's (2017) studies found that nurses' perceptions on their sense of professional autonomy is relatively lower than the other key aspects of professionalism as defined by Hall (1968). Similarly, Baykara and Sahinoglu (2014) found that nurses considered the nursing profession to be either not autonomous or only partially autonomous. These studies show that nurses with the most years of experience had the highest mean score for their sense of their professional autonomy as scored by themselves (Wynd, 2003; Shohani and Zamanzadah, 2017). Additionally, the type of experience and the environment in which nursing experience was gained is a consideration, as nurses working in university hospitals (Wynd, 2003), school health settings (Shohani and Zamanzadah. 2017) and intensive care settings (Baykara and Sahinoglu, 2014) had higher mean scores for sense of autonomy than those of nurses working in general hospitals (Wynd, 2003; Baykara and Sahinoglu, 2014) and nursing homes (Shohani and Zamanzadah, 2017). These findings would have been more informative if the authors had considered whether scores for sense of autonomy were impacted by the length of experience within a particular sub-speciality, rather than length of experience in nursing. However, they are helpful in showing how the context in which nurses practice can inform perceptions on professional autonomy.

These studies also add to what is understood about facilitators and barriers to a sense of professional autonomy in nursing. Wynd's (2003), and Shohani and Zamanzadah's (2017) studies found that nurses educated to degree level were found to have higher scores for their sense of professionalism and a greater sense of autonomy, whilst Baykara and Sahinoglu (2014) concluded that nurses perceived that degree level education enabled an *'increase in professional knowledge,'* (Pg.451) which enhanced perceptions on professional autonomy. However, Karagözoğlu (2009) found that first-year students reported the highest level of autonomy followed by the second, third and then fourth-year students (Pg.181). The author explained the decreasing perceptions on autonomy as students transitioned through their education showed that final-year students were more dissatisfied with the quality of their nurse education in supporting their development of autonomy than more junior students. These findings suggests that the level and quality of education and a sense of having the ability and permission to act independently is also important for the development of professional autonomy.

Barriers to professional autonomy included limited resources, identified as insufficient nursing staff, were perceived as resulting in inferior quality of nursing care also negatively affecting conceptions on professional autonomy (Baykara and Sahinoglu, 2014; Karagözoğlu, 2009).

These studies highlight that how nurses feel about their ability to be professionally autonomous is contextual to their environment, length of experience as a nurse

and helped by having a good quality higher education. However, most of these studies looked to quantify participants' perspectives on autonomy. It is questionable whether it is possible to self-report on a phenomenon which is affected by various aspects related to the context in which nurses practice. These studies do supply insight into the causal relationships between variables, such as length of experience as a nurse and higher education. However, these studies are unable to give insight into why respondents self-assessed as they did or which aspects of their experience and/ or education contributed to their perceptions and why. A more in-depth, qualitative research approach may increase understanding of how student nurses perceive their professional autonomy and why the context of their situation may impact these perceptions.

The relational nature of professional autonomy in nursing

In this section I present three research studies that offer evidence that perceptions on professional autonomy are influenced by the relationships formed by nurses and student nurses with their educators, the teams in which they work, and the patients with whom they work (Holland Wade, 2004; Skår, 2010; Oshodi *et al.*, 2019).

Holland Wade (2004) aimed to measure respondents' self-scored attitudinal part of professional autonomy, using the Autonomy Caring Perspective instrument (ACP). Holland Wade defined professional autonomy as a set of attributes, *'affiliative relationships with clients; responsible, discretionary decision making; collegial*

interdependence; and proactive advocacy for clients' (Pg.116), The ACP consists of a 45-item questionnaire scored using a 5-point Likert scale with 317 female nursing students across 20 degree nursing programmes in the USA, recruited via convenience sampling. This tool had been validated in previous research studies (Boughn, 1988, 1995) and the tool had been previously standardised by the study authors, thus confirming consistency in that the tool measured what was intended (Suresh, 2017). The Cronbach's alpha coefficient was 0.79 which showed internal consistency of the instrument in measuring what it set out to measure (Thomas, 2013). Whilst this correlational study was able to report on complex relationships between variables (Gerrish and Lathlean, 2015) such as participants characteristics and their perceptions on their professional autonomy (self-scored by the participants), the results do not consider why, for example, respondents perceived the length of nursing experience caused an increase or decrease in scores for professional autonomy (Polit and Beck, 2016) .

The study conducted by Oshodi *et al* (2019) used semi-structured interviews to explore how 48 RNs from two English NHS Trusts perceived autonomy in their nursing practice. Skår (2010) conducted in-depth individual and focus group interviews with eleven Norwegian nurses to explore their perspectives on their sense of autonomy. Skår's (2010) use of two methods of data collection, enabled triangulation of data. Each participant was interviewed individually and as a member of one of two focus groups. Whilst the report does indicate data was triangulated across the individual interviews and focus groups, asserting that the focus groups enriched discussions, the author does not report if participants'

perspectives remained the same or changed during the focus group interviews. Oshodi *et al., (*2019) engaged all the co-researchers in independently reviewing the transcripts in order to agree and confirm the accuracy of the analysis thus reducing potential researcher bias (Noble and Smith, 2015). The interviews were conducted by Skår (2010) and Oshodi *et al.*, (2019) respectively to ensure consistency of results within each study, and the detailed descriptions of data analysis suggested trustworthiness of the findings (Braun & Clarke, 2019). Both studies detailed appropriate ethical considerations, including consent, confidentiality and voluntary participation (Gerrish and Lathlean, 2015).

These researchers found that relationships nurses have with other nurses and other members of their team contribute to their participants' perceptions on their professional autonomy. These studies offer insights into the types of relationships that may enhance individuals' perceptions on their professional autonomy. Holland Wade's (2004) study found that reciprocal relationships that were perceived by participants to be based on trust between team members generated positive self-beliefs of self-esteem and a sense of competence which enhanced their sense of professional autonomy.

Similarly, Skår (2010) found that through developing positive relationships with patients, other nurses and professionals, nurses in her study perceived that they had confidence *'to know that you know'* (Pg.2230) in relation to patients' diagnoses and treatment, and competence which gave them the capacity and *'ability to dare'* (Pg.2231) to provide nursing care in new or complicated nursing

situations. Skår (2010) also found that participants emphasised that professional autonomy was helped through collaboration between senior nurses, working with and supporting more junior nurses (Pg.2311), sharing skills which could, in turn, enhance individual competence (Pg.2232). For Skar (2010), positive relationships were those based on trust developed through nurses communicating with and taking time to get to know each other. Therefore, Skår's (2010) findings show that positive relationships seemed to enable confidence in understanding the culture of the practice setting that facilitates professional autonomy development.

Whilst Oshodi *et al.,* (2019) found that participants in their study understood professional autonomy as the ability to work independently, which required a willingness to act on their own initiative, these participants perceived that professional autonomy was demonstrated through decision-making in the context of a team. Shared decision-making appeared to increase perceptions on a sense of competence which Oshodi *et al.,* (2019) reported was conceptualised by participants as the application of knowledge and skills in new, complex, and emergency situations, thereby aligning with Skår's (2010) findings.

These studies suggest a connection between a sense of professional autonomy and relationships with others in the practice setting (Holland Wade, 2004; Skår, 2010; Oshodi *et al.,* 2019). Relationships, defined by these writers as being reciprocal and based on trust and caring, appeared to positively influence perceptions of self-esteem and confidence which also seemed to contribute to feelings on a sense of autonomy. However, it would have been helpful if these

studies had defined ‘confidence’ or considered how the participants in these studies may have perceived on it. These studies considered perspectives of qualified nurses. My study might contribute to what is known about how the relationships student nurses form with their mentors and other members of the team in practice settings might influence student nurses’ developing sense of professional autonomy.

The relationship between perceptions of autonomy and authority

In this section, I explore five research studies which suggest a relationship between perceptions of autonomy and perceptions of authority. Here authority is defined as the ability to make decisions related to patient care. The evidence indicates that nurses perceive that they have greater autonomy about aspects of their role in which they perceive they have authority, such as patient care, than about aspects of the organisation and management of nursing practice (Iliopoulou and While, 2010; Mrayyan, 2004, 2005; Labrague, McEnroe-Petitte and Tsaras, 2018). The literature also suggests some confusion among student nurses about the meaning of autonomy and authority (Arreciado Marañón and Isla Pera, 2019).

Four of these studies used quantitative methods. Iliopoulou and While (2010) conducted a study with 202 nurses working in critical care units in Greece (CCUs). They looked to quantify nurses’ views on professional autonomy and its relationship with job satisfaction, role conflict and role ambiguity. Mrayyan’s (2004) study focussed on the role of nurse managers in enhancing hospital staff nurses’

sense of autonomy, with 264 respondents from the United States (83.3%) and Canada and the United Kingdom (16.7% combined). A further study by Mrayyan (2005) considered 300 USA nurses' perceptions on their professional autonomy about their own work and perceptions on their autonomy over how their unit operated. Labrague *et al*'s (2018) study explored perceived levels of professional autonomy among 166 nurses in the Philippines. Mrayyan's (2004, 2005) and Labrague ***et al's*** (2018) studies used Blegen *et al*'s (1993) Preferences for Decision Making Autonomy Scale. This is composed of two sub-scales: decisions related to patient care, and decisions related to unit operations and control over nursing practice. Blegen et al's., (1993) original study defined autonomy as the authority and accountability for patient care and for unit operation (1993, Pg.340) and this definition was applied within these studies. Reliability of the measurement tools used in all four studies was shown as Cronbach's Alpha coefficients of 0.70, or higher, were reported.

A fifth study within this area is a qualitative study conducted in Spain by Arreciado Marañón and Isla Pera (2019). This study aimed to gain an understanding of how student nurses understood their professional autonomy. Data were collected through three focus groups with a total of twenty-three final-year students. Credibility was enhanced by the detailed application of Lincoln and Guba's (1985) criteria for demonstrating trustworthiness. Participants were recruited through purposive sampling, with clear inclusion criteria (Parahoo, 2014). The focus groups generated data on participants' perspectives related to the study's aim and therefore was trustworthy (Gerrish and Lathlean, 2015). However, as data related

to individual's experiences was sought, focus groups may be unsuitable because of the risk of individual's dominating the group (Parahoo, 2014) or individual participants being shy or reluctant to participate (Aveyard, 2019) which can result in obtaining the groups shared beliefs (Morse, 2015).

The four quantitative studies reported similar findings in that their respondents reported that to practice autonomously, they needed to perceive that they had authority to make decisions. Thus, suggesting a causal relationship between perceptions of authority and autonomy (Iliopoulou and While, 2010; Mrayyan, 2004, 2005; Labrague *et al.,* 2018).

Mrayyan (2004, 2005) and Labrague *et al*., (2018) found that respondents reported greater professional autonomy in respect of patient care decisions, for example, acting as patient advocates, questioning physicians' instructions, informing patients about their medication and consulting with other professionals. Lowest professional autonomy scores were reported in relation to control over nursing practice, for example, planning and managing budgets and recruitment of staff. Therefore, nurses in these studies perceived that they had greater autonomy and authority in making decisions related to patient care than in deciding how nursing was managed and operationalised. However, the quantitative nature of these studies means that whilst self-reported scores show a relationship between autonomy and authority, these studies do not report on why these respondents perceived such a relationship or how their experiences contributed to the scores they awarded.

Iliopoulou and While (2010), Mrayyan, (2004, 2005) and Labrague *et al.,* (2018) suggested that more experienced nurses self-reported high scores for their perceptions of their authority and for autonomy than less experienced nurses. In these studies, more experience meant having degree level education, holding managerial positions and ten years or more experience as a nurse. Labrague *et al.,* (2018) also found that nurses who scored themselves as perceiving they had control and authority over their nursing practice, also scored themselves as having elevated levels of autonomy. Therefore, perceptions of experience and authority seem to align with perceptions of autonomy. However, Iliopoulou and While (2010) reported that positive feelings of autonomy decreased as perceptions of role conflict and role ambiguity increased. When the nurses in their study indicated that they were confused about their level of authority or whether they had authority to make decisions, they self-reported lower scores for their sense of autonomy. Here, the authors reported professional autonomy had a moderate positive correlation ($P<0.001$) with reported role conflict and role ambiguity (Pg.2525). This suggests that lack of clarity about role and authority over decision-making and nursing practice may impact on these nurses' perceptions on their professional autonomy.

Arreciado Marañón and Isla Pera (2019) found that student nurses in their study articulated two separate aspects of autonomy. First, it was perceived as the authority to make decisions about patient care which required making clinical judgements. Through this authority, control was perceived to be exercised over their nursing practice. Second, autonomy was perceived to mean the power to

influence the decision-making of other healthcare professionals. Whilst the first perspective confirms that the participants in this particular study perceived a relationship between authority and autonomy, the second suggested that they appeared to see autonomy as being able to influence decisions in areas outside of nursing practice. As professional autonomy relates to control over one's own practice (Skår, 2010) and within one's scope of practice (NMC, 2018d) this may suggest a lack of understanding about the meaning of autonomy.

In summary, these studies show a relationship between autonomy and authority showing that, in order to be autonomous, nurses need to perceive that they have the authority to act and make decisions (Iliopoulou and While, 2010; Labrague *et al*., 2018; Mrayyan, 2004, 2005). Therefore, a sense of autonomy seems to be related to a sense of authority. Authority was reported to be derived from having degree level education, experience in nursing and having a managerial role. However, it is unclear from these studies whether all of these factors needed to be present. This raises questions as to how student nurses can develop their autonomy without having such derived authority.

Section summary

In this section I have presented research and scholarship in respect of three themes concerning professional autonomy in the context of nursing. These findings are relevant to my study in that perceptions on professional autonomy in nursing may be different than in other professions (Hall 1968). Moreover, perceptions of professional autonomy may be influenced by contextual factors,

such as the environment in which nurses gain experience (Wynd, 2003; Karagözoğlu, 2009; Baykara and Sahinoglu, 2014), the length of their experience and their level of education (Wynd, 2003; Karagözoğlu, 2009; Baykara and Sahinoglu, 2014; Shohani and Zamanzadeh, 2017). Therefore, the type of practice setting student nurses experience during their nurse education may influence their perceptions on their professional autonomy. My study looks to add to understanding of how aspects of the practice context e.g., the relationships student nurses form with mentors and the practice team might be perceived to shape how they learn to develop their sense of professional autonomy.

The existing literature suggests a relational nature to professional autonomy in nursing because perceptions on one's professional autonomy are influenced by the relationships nurses form with others with whom they work (Holland Wade, 2004; Skår, 2010; Oshodi *et al.,* 2019). My study will look to explore student nurses' perceptions of how these relationships influence development of professional autonomy.

The evidence from the literature suggests that nurses perceive that they have greater professional autonomy related to decisions about patient care, than in relation to organisational decision-making (Mrayyan, 2004, 2005; Iliopoulou and While, 2010; Labrague *et al*., 2018). Furthermore, the existence of a relationship between autonomy and authority implies that, to be autonomous, nurses need to perceive that they have the authority to act and make decisions (Mrayyan, 2004, 2005; Labrague *et al.,* 2018; Arreciado Marañón, and Isla Pera, 2019).

I have highlighted factors that, according to the literature, challenge or facilitate the development of professional autonomy. Significantly, challenges appear to arise when participants perceived relationships between them and other professionals are ineffective (Holland Wade, 2004; Skår, 2010; Oshodi *et al*., 2019) and when authority is questioned or unclear (Iliopoulou and While, 2010; Mrayyan, 2004, 2005; Labrague *et al.,* 2018; Arreciado Marañón, and Isla Pera, 2019). Skår, (2010) and Oshodi *et al.*, (2019) point to the importance of confidence for having a sense of professional autonomy. Further consideration of how developing a sense of confidence can be supported may enable opportunities to facilitate professional autonomy development. My study will add to what is known about factors that student nurses perceive might influence their sense of developing professional autonomy and the implications of these factors for nurse educators.

Theoretical perspectives on learning in practice settings

Situated Learning Theory (SLT) is cited widely in nursing literature as a theory underpinning how students learn in practice settings (Andrew *et al.,* 2008; 2009) Birks, Bagley, Park, Burkot, and Mills, 2017; Choi and Ahn, 2021; Field, 2004; Grealish and Ranse, 2009; Hughes, Kenmir, Innis, O'Connell, and Henry, 2020; Molesworth, 2017; Morley, 2016; Stoffels, Peerdeman, Daelmans, Ket, and Kusurkar, 2019; Terry, Nguyen, Peck, Smith, and Phan, 2020; Thrysoe, Hounsgaard, Dohn, and Wagner, 2010). I draw on Lave and Wenger's (1991)

work to consider whether student nurses' learning in practice settings aligns with learning within communities of practice (CoPs).

I also discuss the concept of liminality (van Gennep *et al.*, 2019) and argue that it offers insights into how students make transitions. I conclude that this may inform understanding of how student nurses conceive of their developing professional autonomy as they progress towards becoming RNs (Holland Wade, 1999; Barton, 2007; Andrew *et al.*, 2009; Billay, Myrick and Yonge, 2015; Evans and Kevern, 2015; Cantlay *et al.*, 2017; Fredholm *et al.*, 2020; Crane and Abbott, 2021).

The processes of learning in practice settings

Based on their empirical study of how apprentices learn in the work environment, Lave and Wenger (1991, Pg.35) concluded that:

> *'...learning is not merely situated in practice. …Learning is an integral part of generative social practice in the lived-in world.'*

This view presents learning as a social and relational process embedded in practice (Fuller *et al.*, 2005; Arnseth, 2008). Lave and Wenger (1991) developed SLT by focusing on the processes of learning in five seemingly disparate groups, one of which was midwives. Furthermore, practice settings in which student nurses are placed have been identified as environments in which learning is an integral aspect of that environment (Hughes *et al.,* 2020; Molesworth, 2017;

Stoffels *et al.*, 2019; Thrysoe *et al*., 2010). Engagement within such environments is said to offer students opportunities to apply theoretical knowledge while giving nursing care (Grealish and Ranse, 2009). The social interactions, and the opportunities student nurses have to extend their knowledge and practical skills during placements in practice settings, are presented as the means through which learning may occur (Labrague *et al.,* 2018; Shivers, Hasson, and Slater, 2017; Fuller *et al*., 2005). Therefore, this theoretical perspective has application to my study as it may offer a means for considering how student nurses develop their sense of professional autonomy.

Learning in communities of practice

Lave and Wenger (1991) introduced the idea of 'communities of practice' (CoPs) to help articulate the processes of learning that take place in *'lived-in world'* environments, as opposed to classroom-based learning. They presented a CoP as being formed by people who engage in a process of collective learning towards a shared goal. As such, learning takes place within a social context (Wenger, 1998). Lave and Wenger focused on learning that occurs in CoPs between novices (or newcomers) and experts and the processes with which newcomers might develop their professional identities (Li, Grimshaw, Nielsen, Judd, Coyte, and Graham, 2009). Lave and Wenger found that within CoPs, learning occurs through participating in 'routine' but authentic activities within the work environment and through which knowledge is applied. Knowledge acquired through such experiences can then be transferred to other similar situations. Fundamental to

this learning process is learning through working alongside others, negotiating actions and sharing problem-solving (Buysse, Sparkman and Wesley, 2003).

Lave and Wenger (1991) presented learning within CoPs as a social process. Wenger (1998, Pg.73) articulated these social processes as,

'Mutual engagement, joint enterprise and a shared repertoire.'

Li *et al.,* (2009) conducted a research synthesis drawing on 13 empirical health studies and 18 empirical business studies to critique the evolution of the concept of CoPs as based on the works of Lave and Wenger (1991), Wenger (1998) and Wenger and Synder (2003). This synthesis found that CoPs could be informal or formal, interprofessional or uniprofessional, concrete or dynamic. Li *et al.,* (2009) concluded that CoPs were gaining popularity within healthcare as an '*emerging learning theory'* (Pg.7) but also noted a developing tension in the application of CoPs as a management tool to drive effectiveness.

More recently, Terry *et al.,* (2020) conducted a systematic review of research evidence to explore student nurses' and newly qualified nurses' perceptions on facilitators and barriers to learning in CoPs. Their review considered eight research studies published between 2012 and 2018, of which five were conducted in UK. Terry *et al.,* (2020) whilst acknowledging the review considered qualitative research conducted in England, Europe and Australia and therefore may not be representative, concluded that the social processes shown by Wenger have

relevance within nursing, although the study did not focus specifically on professional autonomy development. They also asserted that effective relationships between existing members of a nursing team and student nurses resulted in a sense of belonging and created opportunities for learning. These relationships were characterised by feeling comfortable to share and receive personal information, opportunities to engage in formal and informal collaborations, and feeling valued as members of the CoP (Pg.378). The studies Terry *et al.,* (2020) report on also found that interactions with other peripheral members, such as other student nurses and newly qualified nurses helped student nurses navigate the culture of the practice setting. Therefore, it is not only relationships with experienced members that result in perceptions of effective CoPs. These findings align with literature which confirms that learning in practice settings has been shown to offer student nurses opportunities to develop their sense of professional belonging (Astley-Cooper, 2012; Teskereci and Boz, 2019) in which students feel safe and secure (Dunbar and Carter, 2017). Developing a sense of belonging has been argued to be a pre-requisite for learning and development (Levett-Jones & Lathlean, 2008) and supporting student nurses to form professional identities as autonomous RNs (Arreciado Marañón and Isla Pera, 2019). Therefore, a sense of belonging and shared identity may seem to be important for establishing a CoP.

Terry ***et al's*** (2020) review suggests three barriers to learning in CoPs. First, feelings of alienation (Pg.376); when student nurses perceived they were treated as outsiders. Second, marginalisation (Pg.376); when they perceived they were

not valued as members because they had limited knowledge. Third, frustration (Pg.377); when work pressures or staff shortages result in student nurses feeling like employees rather than learners. These barriers show that it cannot be assumed that learning occurs in all CoPs.

Student nurses have been described as transient members in teams in practice settings due to the relatively brief time spent in each setting (Astley-Cooper, 2012; Morgan, 2019; Terry *et al*., 2020). In addition, as fifty percent of student nurse education takes place away from practice settings, in an academic (university) setting, student nurses will need to negotiate their learning within multiple CoPs. As such, multiple practice settings and learning in university could stand for *'tangential and overlapping communities of practice'* (Lave and Wenger,1991, Pg.98). My discussion turns to consider how learning occurs in CoPs through legitimate peripheral participation (LPP).

Learning through Legitimate Peripheral Participation

Lave and Wenger (1991, Pg.29) offered LPP as the *'central defining characteristic'* of situated learning. They present LPP as a means of understanding learning, rather than as a method of teaching. Lave and Wenger (1991) argued that LPP is the process by which newcomers achieve membership of a CoP. In this sense, peripherality is a means of gaining access to *'sources of understanding'* (Pg.37) which may occur through participation. Whilst Lave and Wenger (1991) did not

apply their theoretical concept to learning processes in nurse education, below, I discuss research studies by Thrysoe *et al*., (2010) and Molesworth (2017) that consider the application of LPP within nurse education.

Thrysoe *et al.,* (2010) conducted their study in Denmark using participant observations and semi-structured interviews. They aimed to gain insights into student nurses experiences of interacting with the multi-disciplinary team in practice settings and how LPP influenced their opportunity to learn. Data collection was through observations of ten participants for a period of four to six hours for each participant. A second research method using semi-structured interviews with nine of these participants then followed. The purpose of two data collection methods was to triangulate and offer comparison.

The researchers do not discuss what impact they may have had on the participants, or the wider practice team or on engagement between participant and team during the observations. The reporting also does not allow the reader to decide whether the narrative and the observation data provided relate to the same participant. Furthermore, whilst the reporting does differentiate data obtained through interviews and data obtained through observations, it might appear that the researchers' views about what they observed directed their reporting of participants' perceptions. This questions whether results are driven by the lived experiences of the participants, or the experiences observed and interpreted by the researchers. These are important considerations that could affect the trustworthiness of the findings. However, strengths of this study are in the detailed

reporting of comments and phrases. This allows the reader to reach their own conclusions of participants' perceptions on the degrees to which they perceived they were able to engage in LPP within the practice team and what participants perceived influenced their views.

Molesworth's (2017) study, conducted in the UK with seventeen first-year student nurses, aimed to gain insights into perceptions of students' first placement experiences and how these might contribute to attrition from nurse education. Data collection was via five individual, semi-structured interviews and two focus group interviews, each with six participants. It would have been helpful had the author indicated whether all participants had opportunity to discuss their perspectives during the focus group interviews and what affect the interplay of multiple participants had on the data generated. However, participants were able to self-select their method of participation which may have enabled those unwilling to take part in an individual interview to contribute. Reporting of results allows differentiation of data obtained from individual interviews from that obtained via focus groups. The trustworthiness of this study was evidenced through detailed reporting of the processes used in data analysis, including the preparation, organisation, and reporting of the findings (Elo *et al.*, 2014). Furthermore, the detailed reporting of data using exact quotes, allows the reader to make interpretations and confirm the conclusions made, thus strengthening credibility of findings.

These studies have relevance as Thrysoe *et al*., (2010) and Molesworth (2017) found that student nurses' perceptions on the degree to which they were able to engage in LPP depended on who they were working alongside and the context in which they were practicing. Both studies reported that student nurses perceived their mentor as a 'gatekeeper' who had authority over their opportunities to participate in LPP. Molesworth *et al.,* (2017) articulated this as the '*power differential'* (Pg.35) within practice teams.

These studies also recognised that for LPP to enable learning, a degree of non-participation was necessary in easing access to the CoP. Here, both studies concluded that students were less participative as they begin to access the CoP. Whilst these studies do not consider how perceptions on professional autonomy may be influenced by participation or non-participation within the CoP, they do provide participants' perceptions showing how feelings of prolonged non-participation can lead to a sense of being marginalised by the practice team with adverse consequences for participants' learning. Whilst both studies were small scale and did not look to generalise their findings beyond their immediate context, they add to understanding as they situate LPP in CoPs within the context of nursing and offer insights into how student nurses perceive their learning in practice settings.

In summary, the studies evidence that LPP in CoPs has been established as a social process of learning that has application to nurse education. Whilst LPP can be seen as enabling learning (Lave and Wenger, 1991), if students are kept from

participating or are unable to perceive a sense of belonging, their learning may be marginalised with students unable to make the transition from the periphery to the core of the CoP (Molesworth, 2017; Thrysoe *et al.*, 2010; Wenger-Trayner *et al*., 2015). The findings also suggests that the notion of transition as an aspect of learning through LPP may be a consideration in understanding how students see themselves as making the transitions from student nurses to autonomous RNs.

How student nurses may transition to Registered Nurses

Within literature on CoPs it is often assumed that learners straightforwardly transition from peripheral to full membership (Lave and Wenger, 1991; Molesworth, 2017). To address the aim of this study to develop an understanding of how student nurses conceive on their developing professional autonomy, I explore literature that may offer a means of understanding how transitions occur (Turner, 1969; van Gennep *et al.*, 2019).

In *The Rites of Passage,* anthropologist van Gennep recognised that different societies engaged in different social transitions (van Gennep *et al.,* 2019). He claimed that all social transitions have a common three-part structure - a separation or pre-liminal phase in which individuals or groups are removed from their previous state of being; a liminal phase, –a state of being in which individuals move from one status to another, and a post-liminal phase; referred to as an incorporation (Barton, 2007) or assimilation period (Evans and Kevern, 2015). van Gennep implied that transition through liminality is a transformational process and

that the three phases of liminality do not always proceed uniformly or in a linear fashion and can merge, oscillating between phases (Meyer and Land, 2005; Barton, 2007; van Gennep *et al.*, 2019). This is important because it suggests that transition through the liminal phases is not incremental, but progress can start, stop, and restart.

Drawing on van Gennep's work, Victor Turner's (1969) ethnographic study of rituals conducted by communities in sub-Saharan Africa analysed rites of passage from 'boyhood to manhood'. Whilst the settings and societies in van Gennep's (van Gennep *et al.*, (2019) and Turner's (1969) work were vastly different, both sought to observe the respective societies from a cultural view. Turner (1969) similarly observed the three liminal phases as individuals or groups moved from one social status to another. Turner (1969, Pg.81) placed greater prominence on the liminal phase, noting this as being *'betwixt and between,'* social statuses which was *'troublesome'* because of the sense of ambiguity experienced. However, this ambiguity supplied the '*space*' in which the individual could prepare for their new status (Evans and Kevern, 2015, Pg.2). Turner (1969) showed that during the liminal phase in which individuals were at a threshold at which their experiences and knowledge merge and reform, resulted in new knowledge, insights, and learning. According to van Gennep, once through the phases of liminality, new learning is unlikely to be forgotten (van Gennep *et al.,* 2019). Therefore, this sense of ambiguity, which may be troublesome or confusing, is regarded as a necessary aspect of transition and of learning.

Holland (1999) suggested that student nurses undergo a transition during their nurse education. With some similarities with the work of van Gennep (van Gennep *et al*., 2019) and Turner (1969), Holland's (1999) study was also ethnographic. Holland's (1999) study is useful to my study because it showed the applicability of the work of (van Gennep *et al*., 2019) and Turner (1969), in nursing. Holland (1999) studied a cultural aspect of nursing, specifically, how students are socialised into nursing. Holland's (1999) study aimed to explore the experiences of student nurses in England as they made the transition to RN status. She claimed this transition necessitated learning cultural expectations. Data were collected from observations and open-ended interviews with four groups of nursing students. Whilst in the reporting of the study Holland (1999) provided little data related to her observations, the data obtained through interviews supplied a rich description of participants' perceptions which does enable the reader to confirm the conclusions reached. Holland found three states of transition which she referred to as *'in limbo states'* (1999, Pg.229); *'becoming a student nurse, being a student nurse and becoming a qualified nurse'* (Pg.231). She showed that these states are not clearly defined, in that there was a degree of overlap because some participants were employed in *'role duality'* - other roles during their studentship and therefore had differing experiences as students and employees (Pg.233). This suggests first that transitions may not occur in a linear manner and second, that student nurses may first metaphorically separate from their status of being a student nurse, before acquiring their new identity as an RN. However, Holland's (1999) findings also give significance to the life-experiences and backgrounds that each student nurse brings with them. Therefore, liminal experiences must occur on

an individual basis. As with Turner (1969), Holland (1999) identified the importance of the liminal phase as being the threshold at which new learning occurs. Therefore, rather than seek to prevent feelings of ambiguity, student nurses should be supported to engage with this ambiguity.

Evans and Kevern (2015) conducted a meta-review of 21 peer-reviewed nursing research reports in order to evaluate the utility of the concept of liminality in a nurse education context. Evans and Kevern's (2015) review focussed on the education of mental health nurses. However, because the standards for education are the same across all fields of nursing practice (adult, children's, learning disabilities and mental health) (NMC, 2018a), their findings may be considered applicable to the education of student nurses more generally. Their review concluded that the range of contexts in which the concept of liminality has been applied, for example as a temporal construct (Holland, 1999; Barton, 2007) or as a spatial construct (Meyer and Land, 2005; Hurlock *et al.*, 2008) makes defining liminality challenging. However, none of the reports reviewed appeared to cast doubt over the usefulness and application of the concept of liminality to explain how student nurses may learn within practice settings. This suggests that the concept of liminality has become an accepted theoretical framework for exploring learning in the context of nurse education. Evans and Kevern (2015) found that the concept of liminality was applied within the nursing literature in two ways. First, to describe 'threshold concepts' - the process of learning in which students are confronted with new ideas as they grapple to understand new knowledge (Meyer and Land, 2003, 2005). Second, as a means of developing a professional identity

through assimilating the professional role of a nurse by learning the cultural expectations and social norms of being a nurse (Evans and Kevern, 2015). Such expectations and norms often form the implicit learning and tacit knowledge required of student nurses (Gourlay, 2011; Pyrko, Dörfler and Eden, 2017). However, the findings from these past studies on the applicability of the concept of liminality within nurse education suggests it will be important to keep it in mind in an analysis of how student nurses conceive on their developing sense of autonomy.

Section summary

In this section I have presented SLT (Lave and Wenger, 1991) as being potentially applicable to student nurses' learning in practice settings. I have evaluated research evidence that concludes that student nurses' perceptions on the degree to which they were able to legitimately participate within CoPs was dependent on who students were working with, the situation they were involved in and students' own levels of engagement (Thrysoe *et al.*, 2010; Molesworth, 2017). In this sense, this literature has similarities with earlier findings about relational aspects to perceptions on professional autonomy (Holland Wade, 2004; Skår, 2010; Oshodi *et al.*, 2019). The literature suggests that whilst LPP within CoPs can be seen as empowering (Lave and Wenger, 1991), if student nurses are kept from engaging in LPP, it may be a disempowering position and may become a source of marginalisation (Thrysoe *et al*., 2010; Wenger-Trayner *et al*., 2015; Melincavage, 2011; Molesworth, 2017). This is relevant for my study as it may indicate that

being marginalised is a potential barrier that may affect how student nurses conceive on their developing professional autonomy.

The notion of transition as an aspect of learning within CoPs has been shown to be an important consideration in understanding how student nurses may make transitions from student to autonomous RN. The theoretical concept of transition through liminality (van Gennep *et al.*, 2019) may provide a helpful means to consider how student nurses conceive on their developing professional autonomy as they transition through their nurse education towards becoming RNs. However, my discussion has also caused me to question how students overcome the potentially ambiguous nature of liminality to transition towards a sense of professional autonomy.

Chapter summary

This literature review has presented theoretical perspectives, concepts, and research that form the current body of knowledge in relation to professional autonomy development in nursing. I have asserted that professional autonomy is a common aspect of professionalism. However, perspectives on professional autonomy are informed by differing conceptions of professionalism. These conceptions overlap and are subject to change which complicates perceptions of professional autonomy (Noordegraaf, 2011; Evetts, 2006). Such perspectives present autonomy as means of occupational and organisational control of the work

of professionals (Wilensky, 1964; Larson, 1977; Abbott, 1988; Freidson, 2001; Noordegraaf, 2011; Evetts, 2006, 2013). However, more recent consideration of professionalism suggests that professionals develop professional autonomy through continuing professional development (Dreyfus and Dreyfus, 1980; Benner, 1982, Scanlon 2011). This suggests a transitional aspect to the development of professional autonomy.

The studies presented in section two largely sought to quantify perceptions of professional autonomy. These studies show that professional autonomy appears to be influenced by the contexts in which nurses gain experience (Baykara & Şahinoğlu, 2014; Hall, 1968; Karagözoğlu, 2009; Shohani & Zamanzadeh, 2017; Wynd, 2003). Furthermore, professional autonomy seems to be relational and influenced by the colleagues with whom nurses work (Holland Wade, 2004; Skår, 2010; Oshodi *et al.*, 2019). A nurse's sense of autonomy has been seen to be influenced by how their authority is defined and whether they perceive they have authority to make decisions and to act independently (Mrayyan, 2004, 2005; Iliopoulou and While, 2010; Labrague *et al.,* 2018; Arreciado Marañón and Isla Pera, 2019). The quantitative nature of many of these studies throws doubt on whether it is possible to quantify a phenomenon which is likely to be affected by differing individual experiences. This realisation has led me to focus my study on advancing understanding of subjective experiences and perceptions on developing professional autonomy rather than seeking to quantify and make pre-categorised generalisations. Furthermore, what these studies do not reveal is how student

nurses conceive on their developing professional autonomy and how they conceive on potential factors that influence its development.

Drawing on aspects of Lave and Wenger's (1991) SLT, specifically their writing on CoPs and LPP, considered alongside van Gennep's theory of liminality (van Gennep *et al*., 2019), supplies an approach that may enable me to discuss how the findings of my study provide insight into how students might learn to develop their sense of professional autonomy within practice settings. This review presents the background from which I can explore how student nurses conceive on their developing sense of professional autonomy and those factors that influence its development.

Chapter Four
Methodological Approach, Research Design and Research Procedures

Introduction

In this chapter I set out the philosophical and theoretical underpinnings of this study before describing my research design and procedures used for conducting this study. In section one, I give my justification for the qualitative methodological approach used. I also explain my ontological and epistemological framing for this study based on the interpretivist paradigm.

In section two, I introduce my research design. I begin with my methodological approach and justify my application of hermeneutic phenomenology, specifically aspects of the work of Heidegger (Heidegger, Stamburgh and Schmidt, 2010). Through rejection of bracketing, use of the hermeneutic circle and the application of care-structures (Heidegger *et al*., 2010) I was able to gain an in-depth understanding of the experience of developing a sense of professional autonomy from the perspectives of a small number of student nurses.

In section three, I present the research procedures used in this study. I begin by justifying why I conducted this study at my employing institution. I recognise the inherent power imbalances between myself as both researcher and manager and my participants. I explain how, as a novice researcher, I managed these imbalances. I describe how participants were recruited. I also explore how I decided the number of participants required for this study and justify my rejection

of the concept of data saturation. I then introduce my participants and finally, elucidate my management of ethical considerations in this study.

In section four, I explain my processes of data generation. Here, I justify my use of semi-structured interviews. Drawing on my reflections from conducting a pilot study, I show how the potential for bias led me to reject observations as a second method of data generation. I conclude this section by explaining my approach to transcribing the interviews and to member checking.

Section five: Data analysis provides a justification for my use of Reflective Thematic Analysis (RTA) (Braun and Clarke, 2006, 2013, 2021). I supply a detailed explanation of how I applied the six phases of RTA to my analysis of this data.

In section six, I explain how I have ensured trustworthiness in this study through the application of Lincoln and Guba's (1985) criteria.

Section one: Justifying the methodological approach

I chose a qualitative methodological approach because in seeking to explore how student nurses conceive on their developing professional autonomy, I wanted to understand their individual perspectives (Moule *et al*., 2017). A quantitative methodological approach would, perhaps, have provided a measurement of participants' perceived autonomy and enabled an analysis of specific causal

relationships between variables (Denzin and Lincoln, 2012; Parahoo, 2014). However, as discussed in the literature review, student nurses' learning in practice settings and their development of professional autonomy are both socially constructed and subjective. Therefore, a quantitative methodology that is based on the premise that the experiences through which student nurses develop professional autonomy are fixed and objective would be inappropriate to answer my research aim.

Ontological and epistemological framing for this study

My ontological assumptions are influenced by the belief that people interpret events, conditions, and their social realities individually and uniquely, so that no two people's experiences are the same. As meaning, and therefore truth, are individually constructed, each student nurse will interpret experiences and events differently and so there will be multiple perspectives on how professional autonomy is developed. My epistemological assumptions are that each student nurse will develop their knowledge of professional autonomy from their subjective experiences. My ontological and epistemological assumptions are grounded on a belief in *'the ability of the individual to construct meaning'* (Mack, 2010, Pg.7). These assumptions align in the interpretivist paradigm (Mack, 2010; Parahoo, 2014; Robson, 2011; Thomas and Hewitt, 2011). Hermeneutics is the study of meaning and interpretation (Mack, 2010) and phenomenology is the study of everyday human experiences (Gerrish & Lacey, 2015). Therefore, hermeneutic phenomenology provides an approach with which I can interpret student nurses'

experiences of their developing professional autonomy through learning in practice settings (Parahoo, 2014).

Section two: Research design

Phenomenological approaches to research seek to generate understanding by *'describing and interpreting human experience within the context of that experience',* (Moule *et al,.* 2017, Pg.201). There are many approaches to phenomenology but below I briefly introduce the approach of Edmund Husserl (1859–1938) because he is credited as the founder of modern phenomenology and its consideration of knowledge (Moran, 2000; Parahoo, 2014) and focus on Martin Heidegger's (1889–1976) interpretation of hermeneutic phenomenology as an appropriate research design for my study.

Recognising the potential of hermeneutic phenomenology for this study

Husserl's work was referred to as descriptive phenomenology (Lopez and Willis, 2004; Reiners, 2012). He looked to understand the way we '*know*' things*;* therefore, his philosophical approach was epistemological*.* He developed the concept of '*lifeworld*.' Whilst difficult to define, *'lifeworld',* also termed *'lived experiences'* (Gerrish & Lacey, 2015, Pg.212) is knowing the world as it is immediately experienced (van Manen, 2007); the everyday experiences people engage in without conscious thought. Understanding meaning requires

understanding these '*lifeworlds'*, and Husserl sought to describe the '*ordinary'* experienced by the people who experienced the event (Parahoo and Ivonne, 2014). This notion appeals to me because the development of professional autonomy is an expectation for all RNs and my study seeks to explore those everyday nursing experiences of student nurses as they work towards becoming professionally autonomous.

Heidegger's approach to phenomenology differed from that of Husserl's in fundamental ways. Rather than epistemological, Heidegger's philosophy is ontological, seeking to understand what '*things'* are, what it means, '*to be'* (Moran, 2000). Heidegger rejected the belief that we only see '*things*' as they are presented rather than seeing the real *'being'* of the '*thing*' (Moran, 2000). In *Being and Time* (Heidegger *et al.,* 2010), Heidegger recognised that '*being'* cannot be separated from the world and so he does not refer to '*consciousness*' (Moran, 2000; Heidegger *et al.,* 2010) preferring instead '*existence*' (Koch, 1995). Therefore, Heidegger presented that to understand meaning is to understand our very existence in the world or '*being-in-the world*,' (*Dasein*) (Heidegger *et al*, 2010). Heidegger argued that phenomenology requires seeing meaning through interpretation rather than description and intuition (Moran, 2000). As such, this has relevance for my study as it supplies an approach to analysing and interpreting my data, from which I hope to be able to offer conclusions as to how student nurses involved in this study perceive they are developing their professional autonomy.

Heidegger wrote that '*Being-in-the-world'* embodies what it is to be a human being; the '*specific mode of being of humans,'* and of the human beings '*being there,'* respectively (Heidegger *et al.*, 2010, Pg.238). However, Moran (2000) proposed that there is a lack of clarity about Heidegger's meaning of *being-in-the-world (Dasein*). As such, Moran offered the meaning as either the '*essence of human nature or a set of transcendental conditions which make human existence possible.'* (Pg.238). This indicates *being-in-the-world* as having three inter-related aspects, the world, the self and the relationship between the world and the self. As the world and the self cannot be separated, these are co-constituted (Greatrex-White, 2008). *Being-in-the-world* is therefore always experienced in relation to others, it embodies what it is to be human;

> *'being-with-with-others belongs to the being-of Dasein, with which it is concerned in its very being.'* (Heidegger *et al.*, 2010, Pg.120).

As the aim of my study was to understand how student nurses conceive on their developing professional autonomy, I not only wanted to describe the participants' experiences but looked to understand the meaning of these experiences through my interpretation of what they told me. This would include gaining an understanding of the inter-related contexts that influenced participants' perspectives on how they conceived their developing sense of professional autonomy. Drawing on aspects of Heideggerian hermeneutic phenomenology therefore, provided a means through which I could explore student nurses'

experiences of developing professional autonomy and how they made meaning of this.

Applying Heideggerian hermeneutic phenomenology

To address my research aims, I applied specific aspects of Heideggerian hermeneutic phenomenology which seemed to offer me relevant conceptual ideas to inform how to conduct my research. Each of these will be discussed below: First, rejection of bracketing; second, application of the hermeneutic circle and third, application of care structures.

The concept of bracketing is founded on the assumption that new knowledge may be created by separating out presuppositions (personal beliefs: Here, see chapter one) to prevent these from influencing the process of gaining an understanding of participants' experiences or the analysis of these experiences (Cooney, Dowling, Murphy, and An, 2013). In this way 'knowing' occurs by looking past preconceptions and assumptions through *'phenomenological reduction or bracketing'* (Gearing, 2004. Pg.1438). Heidegger rejected the concept of bracketing (Heidegger *et al.*, 2010) because, he argued, to achieve understanding requires recognising the context in which the phenomenon was experienced (Gearing, 2004).

This leads into the second aspect of Heideggerian hermeneutic phenomenology which influenced my approach -the concept of the '*hermeneutic circle'* (Heidegger

et al., 2010). Heidegger described this as a metaphorical, circular process that recognises that interpretation is achieved through the back-and-forth relationship between the component parts of a participant's experience and their whole experience and the component parts of all participants' experiences. Use of this circular process of analysis means that attention is given to the smallest aspects of the data in individual participant's interviews and linked to the combined data from all interviews. Cohen, Kahn and Steeves (2000, Pg.58) provide a helpful illustration of how use of the hermeneutic circle can aid analysis of experiences;

> *'…the metaphor that fits is that of a person stepping back from a painting to better view it as a whole.'*

The concept of the hermeneutic circle enabled me to 'step back' and reflect on the individual experiences offered by each participant and to understand them in the broader context of social and cultural contexts within nursing (Flood, 2010) and through my personal context of being a nurse and a nurse educator (Finlay, 2011).

Heidegger (2010) identified the starting point of the hermeneutic circle as the researcher making their pre-suppositions explicit through reflexivity. Reflexivity is the process through which I was able to develop self-awareness (Clancy, 2013) and to evaluate the influencers that have informed my decisions (Davis, 2020), such as my age, gender, affiliations and personal and professional experiences (See chapter one) (Bradbury-Jones and Bradbury-Jones, 2007; Berger, 2015). In applying the hermeneutic circle and with my rejection of bracketing, by thinking critically about how I have been able to use my prior knowledge of professional

autonomy in nursing, with the understanding I have gained from engaging with relevant literature and existing research, these have informed my interpretation of the participants' experiences to achieve new understanding. The interplay of these presuppositions which for me are my '*familiarity of everyday interaction'* (Horrigan-Kelly, Millar and Dowling, 2016, Pg.3) mean that fundamentally these presuppositions are an essential aspect of how I interpreted the participants' experiences (Dreyfus, 1991, 2004; Horrigan-Kelly, Millar and Dowling, 2016). By overtly recognising my presuppositions, as I conducted analysis and interpretation of participants' experiences, I engaged reflexively (Gearing, 2004) to ensure I did not inadvertently focus on existing theories within nursing that held relevance. I ensured I repeatedly questioned my developing understandings so that, in adherence with interpretive phenomenology, my analysis was data-led. Furthermore, applying reflexive processes (Heidegger *et al.,* 2010), enabled me to examine the nature of my involvement at all stages of this study, to consider the boundaries of my own knowledge and to qualify my influence on data generation and analysis to prevent my existing understandings overwriting emerging realities (Gearing, 2004) so that, *'priority should be given to the new object rather than to one's preconceptions'* (Heidegger *et al.,* 2010. Pg.95). In so doing, reflexivity also enabled me to recognise how my presuppositions and experiences might have influenced any methodological bias, which can enhance trustworthiness in my study (Lincoln and Guba, 1985).

The third aspect of Heideggerian hermeneutic phenomenology which I applied to my study is Heidegger's articulation of care structures (Heidegger *et al.,* 2010).

Heidegger presented care structures as concern for, or connectedness to, another person's *'lifeworld'* (Miles *et al.,* 2013). As such, care requires being involved with others and therefore it is relational. My interpretation of Heidegger's concept of care structures is that they represent a means of making sense of 'things' (Horrigan-Kelly *et al.*, 2016), which requires a respectful concern for others and for their experiences.

Heidegger argued that to appreciate care, one must recognise temporality as '*one of the fundamental structures of human existence,'* (Mackey, 2005, Pg.183). *Being-in-the-world* is recognised in its temporal situatedness, this is its *'connectedness'* to its past, present, and future. Heidegger did not perceive temporality as linear (Annells, 1996) or chronological (Horrigan-Kelly, Millar and Dowling, 2016). Heidegger interpreted care structure as having three temporal dimensions as future, to past, to present (Dreyfus, 1991; Heidegger *et al.*, 2010; Horrigan-Kelly *et al*., 2016).

Heidegger presented future '*possibilities'* as being defined by past experiences. Rather than being presented as linear time, Heidegger (2010) recognised future as *'being-ahead-of-itself'* (Dreyfus, 1991, Pg.240) and therefore being concerned with possibilities or potentialities that may present themselves (Wilson, 2014; Horrigan-Kelly *et al.,* 2016). Furthermore, Heidegger situated *being-in-the-world* as being experienced and interpreted from its pre-existing world, its past (Heidegger *et al*., 2010; Smith *et al.,* 2009). Based on this philosophical positioning, I have interpreted this to mean that mine and the participants' experiences of, for

example, professional autonomy, nurse education and research are influenced in that they are already informed by our past knowledge and experiences. Therefore, participants' histories, their previous experiences, will contribute to and inform their present state of *'being,'* their understanding of autonomy and of being autonomous.

Heidegger presented past experiences through the concept of *'thrownness'* (Heidegger *et al.*, 2010; Horrigan-Kelly *et al*., 2016; Moran & Mooney, 2002). *'Thrownness'* recognised that *being-in-the-world*'s being finds itself '*already-being-in-the-world'* (Heidegger *et al.*, 2010, Pg.134). Withy (2014, Pg.72) exemplified *'thrownness'* in that,

> '*We do not choose the time, place or culture into which we are born, but must start from this in everything we do.'*

Heidegger (2010) stated,

> *'The expression, thrownness is meant to suggest the facticity of its being delivered over'* (Pg.131).

Therefore, to be *'thrown'* is to be situated within a particular context, a certain state of mind. Heidegger also indicated that *'thrownness'* reveals itself in '*moods,'* (Heidegger *et al.*, 2010, Moran 2000, Pg.13). For me, these moods can be '*moods*

of everydayness (anxiety, boredom, anonymity)' or '*emotional commitments*, *cares, and worries*,' (Pg. 223). Fundamentally,

> *'Mood makes manifest 'how one is coming along.' In this 'how one is' being in mood brings being to its 'there,' (Heidegger et al., 2010, Pg.131).*

To understanding the participants' experiences of developing their sense of professional autonomy, I need to recognise their past experiences, their understanding of the challenges they felt they had faced in their practice learning and the opportunities they had experienced towards becoming professionally autonomous. However, I was equally aware that my past experiences as RN and educator would affect my interpretations of these experiences.

Heidegger indicated that *'Being-in-the-world's* present is represented by *'fallenness'* (Dreyfus, 1991, Pg.240) or *'absorption'* (Wilson, 2014. Pg.2911) in which '*being-in-the-world'* is caught up and immersed in the here and now. Participants' experiences of their developing sense of professional autonomy were articulated as they experienced them at the time of their interview, informed by their previous experiences and their expectations for their future professional autonomy. Therefore, in recognising care structure and its temporality, *being-in-the-world* is simultaneously *'already in, already ahead and amidst'* (Dreyfus, 1991. Pg.244). In applying Heideggerian care structure, I seek understanding of participants' concern and what is of importance to them regarding their sense of

professional autonomy, whilst recognising and making explicit that which is of concern and importance for me (Horrigan-Kelly *et al.,* 2016).

Heidegger's (2010) philosophical presentation of care-structure was important to me as it is this *'concernful'* involvement that caused me to question my personal beliefs about how I viewed my world (see chapter one). It helped me to advance my thinking in relation to the potential for research to take account of people's competing social realities and their *'concernful'* involvement, their *being-in-the-world,* and their *being-with-others*. This was what altered my thinking to questioning 'how' in relation to the professional autonomy development of these participants rather than merely 'how much' of professional autonomy and therefore enabled me to focus on what I perceived was important to me.

Heidegger (2010, Pg.43) discussed three modes of *being*- authentic, inauthentic and the undifferentiated mode. Heidegger recognised the uniqueness of each individual (Heidegger *et al., 2010*) and it is this uniqueness that gives rise to the potential and possibilities that each person has (Hornsby, 1991). My interpretation of authentic mode-of-being is achieved through the realisation of, and ability to enact those values and beliefs which are important to me. For example, in acknowledging how my pre-suppositions impact on this study in chapter one. Furthermore, for me, authenticity within this study will be achieved by recognising the importance of each participant's experiences. Understanding will therefore be generated from my interpretation of the lived experiences that participants choose to share with me.

Heidegger (2010, Pg.123) referred to the mode of *being* of inauthenticity as the *'they',* the term used by Heidegger to describe how 'falling in with the crowd', accepting the views of others can stop a person from being their authentic self. Therefore, in applying this care structure, I am mindful that to be my authentic self, I must be reflexive and self-aware.

Justification for hermeneutic phenomenology to other qualitative approaches

I recognise that other qualitative approaches could have been used, for example ethnography or grounded theory. Ethnography would have required me to observe or interact in a practice setting (Denzin and Lincoln, 2012) which I determined inappropriate during my pilot study. I perceived that my interactions through direct observations of participants in their practice settings would influence my perceptions as a researcher and therefore affect what I was looking to understand. I also felt that my existing knowledge of nurse education meant I could not take a grounded theory approach (Corbin and Strauss, 2015). Furthermore, I wanted to understand the experiences of the participants, their perspectives on developing professional autonomy rather than generating a theoretical model of professional autonomy development (Creswell, Hanson, Clark Plano and Morales, 2007). As discussed above, hermeneutic phenomenology has enabled me to use my existing knowledge drawn from having worked as a nurse in roles that included student

nurse, staff nurse and ward sister, and of having worked in nurse education as senior lecturer and more recently, senior manager.

Section three: Research procedures

I first explain why I chose to locate this study at my employing institution. I then discuss the inherent power imbalance between me, as researcher, RN, manager, and the participants, and the steps taken to mitigate the effects of this imbalance. I explain my initial plan to recruit eight to ten second and third year student nurses and how through purposive sampling, eleven participants were recruited. I also justify my rejection of the concept of data saturation and why through completing eleven interviews I perceived I had generated sufficient, in-depth data to address my research aims. I then introduce my participants. Finally, I explain my processes for managing the ethical considerations within this study using the framework provided by Beauchamp and Childress (2013).

Locating this study

I perceived there were benefits and challenges to conducting this study at my employing institution. Benefits included that I had access to the student population. By gaining an understanding of practices at my own institution, I could then consider if enhancements could be made to students' experiences. I felt I would be less able to do this if the study were conducted at a different university. However, I was also

aware of the power and privilege my position conferred and therefore, was mindful of managing this challenge as I reached out to recruit students.

Managing power imbalance as a novice researcher

Fundamentally, a power imbalance between researcher and participants exists in research (Råheim *et al.*, 2016). It is therefore important to recognise and mitigate this (Karnieli-Miller, Strier and Pessach, 2009). All participants were student nurses studying at the university at which I was employed at the time of data generation. This may have resulted in vulnerability for participants if they felt obliged or coerced to participate (Moule, *et al*., 2017). Also, my position as a senior manager was a position of power and influence (Allen, 2004; Phillips, Kristiansen, Vehvilainen, and Gunnarsson, 2013). Participants may have been aware of my role within the university at the point at which they chose to take part in the study. However, I had not taught, been involved in any disciplinary processes or assessed any participants' academic work. Until engagement with this study, I had not met any of the participants. I tried to mitigate the effect of my seniority by providing participants with information about the study in advance of the interview, giving them time to consider whether participating was the correct decision for them. I also ensured that participants were told in written and verbal formats that their participation in the study was entirely voluntary and whether they chose to take part or later decided to withdraw, this would not affect their nurse education. I ensured my approach to the recruitment of participants was not coercive by sending the study information by email to participants and by 'dropping

in' to the end of lectures on just one occasion for each student cohort. Similarly, for this reason I did not follow up students who initially came forward but then did not respond to my request to confirm arrangements for their interviews. Throughout recruitment and interviews, I was mindful of adopting a dress code that was not identified as formal, power-dressing, but equally one that was not overly casual and showed the respect in which I held the participants. During the interviews, I also shared a little of myself and my experiences of having been a student nurse to acknowledge a similarity of experiences. I ensured that all participants understood my role within the university. Whilst I acknowledge the potential for a power imbalance, I was not aware that this potential affected either communication between participants and myself or the quality of their data.

Deciding the number of participants

I considered the number of participants I needed at my planning phase. In order to manage the large amount of data generated in phenomenological research (Braun and Clarke, 2019; Finlay, 2014; Guest, Bunce, and Johnson, 2006; Malterud, Siersma, and Guassora, 2016), based on reading other studies that used hermeneutic phenomenology (Baird, 2007; Skår, 2010; Wilson, 2014; Ho, Chiang and Leung, 2017; Morrell-Scott, 2019) I set out to recruit between eight and ten participants.

My aim was to seek the cooperation of participants who could respond to the interview questions and so had some experiences in relation to developing

professional autonomy. I recruited participants using purposive sampling which required deliberate judgements to select participants based on the premise that those selected can provide the data required (Sgorbini, O'Brien and Jackson, 2009; Robson, 2011; Parahoo, 2014). Patton (2002) identified that purposive sampling was likely to recruit the most interested students who were willing to share their experiences. Whilst this has the potential to introduce bias, Patton (2002) also encouraged that this approach will yield the richest data. As a nurse educator, I knew that second- and third-year student nurses would have experience of learning in both theory (in university) and practice settings. They would have had opportunity to apply theory to practice, to reflect on their first-year experiences, to provide nursing care alongside RNs and to begin thinking about developing their professional autonomy. I excluded first-year student nurses as they may not have had experienced practice settings and, even if they had, that experience would potentially be restricted to a few weeks and a limited range of practice settings.

After explaining the study to the course leader for pre-registration nursing and evidencing confirmation that ethical approval was granted, I obtained permission to email a request for participants (see Appendix Two) to the university email addresses of all second-and third-year nursing students. I also spoke to groups of students after lecture time (once for each cohort) to request participation, address any queries, requesting interested participants to contact me via email or telephone. Before informing groups about this study, those who did not have an interest were able to leave the lecture room and so not engage further. I wanted to

ensure I did not interrupt lecture time and wanted to be clear with students that this study was not related to their progress or a requirement of their course.

Initially fifteen students contacted me. Of these, five students spoke to me at the end of their lecture, the other ten students responded directly to my email. Thus, by using both email and end of lecture 'drop in,' I was able to reach more participants than using email or drop ins alone. However, as two students did not respond to my follow-up emails, I felt that they had decided not to pursue further involvement. One student withdrew from the course, and one was diagnosed with a long-term illness, I felt it inappropriate to continue whilst they needed sickness leave. Therefore, eleven participants were recruited.

Rejecting the concept of data saturation

Whilst I had planned to recruit 8-10 participants, as a novice researcher I wanted to be able to justify this decision. My starting premise was to evaluate my position about data saturation. As I started this study, I understood data saturation to be achieved when no new information, codes or themes can be discerned in the data (Lincoln and Guba,1985). However, this definition felt at odds with the concept that individuals interpret experiences and events differently, giving rise to multiple perspectives. As such, this made me question whether it can be possible to reach a position of having no new information. I considered Hennink *et al's*., (2016) application of meaning and code saturation. Hennink *et al* asserted that to achieve meaning saturation requires a greater amount of data than to achieve code

saturation. Using the interview data from my pilot study, I identified the codes that I considered central to the research question. However, I suspected that when I coded data from multiple interviews, in addition to finding similarities, I would find new codes within each interview. I became less confident that this process would provide me with any sense of completeness.

I then explored Malterud *et al's,.* (2016, Pg.1753) use of '*information power'. They* say that a research design with greater *'information power':* having a concise aim, specific participant characteristics, highly developed theoretical background and rich data, requires a lower number of participants. However, this method seemed restrictive because it suggested that analysis would give precedence to the frequency with which concepts were discussed rather than on the meaning of concepts expressed by participants (Sim *et al.*, 2018, Pg.627). I was also concerned that, in trying to interpret patterns of meaning across my data from all interviews to show common, or at least predominant themes, I might lose sight of codes that appeared less frequently. These codes perhaps appeared in a single participant's interview and may therefore be missed but were important to address the aims of this study (Buetow, 2010). Using the hermeneutic circle, I reflected on my ontological positioning; the individuality of experience and the reality of multiple truths, and I accepted that within phenomenological research there *'is no saturation point with respect to phenomenological meaning',* rather, a topic can always be researched and explored further (van Manen, Higgins and van der Riet, 2016, Pg.5). Therefore, my focus was to ensure I balanced my requirement to collect rich, detailed data that would enable me to address my research aims with

respecting participants' time and effort needed to attend and conduct interviews. I felt I had achieved this after completing my eleventh interview.

Introducing my participants

An overview of participants is provided in figure 1 below. Whilst participant group sizes in qualitative research are not set with the intention of being representative of a wider population (Moule *et al.,* 2017), I hoped that the findings of this study would be useful to add to academic understanding of how student nurses conceive on their developing professional autonomy. Therefore, I was pleased that participants were from adult, children's and mental health fields of nursing practice. During the interview, I asked participants to describe their demographic characteristics and ethnic backgrounds (see Appendix Four). Participants representation was in line with the wider pre-registration nursing population at the institution at which the study was conducted. However, these considerations were not determining criteria for participation as I was unaware of them prior to meeting the participants at their interview. Additionally, during the interviews, I learnt that the participants had collectively experienced placements in six different NHS trusts and a number of private, voluntary organisations. This range of practice experiences in which participants may have had opportunities to develop their professional autonomy may also enhance the quality of data generated.

Participant details	Nurse education
Kerry • Female • White British • English as her first language • Age range 18- 22 years • Interview duration 51.24 minutes • Interview date: 03/05/2018	• BSc (Hons) Adult Nursing • Second year, semester 2 • Three adult nursing placements - Endoscopy, Medical ward, and General Practice.
Briony • White British • English as her first language • Age range 23-26 years • Interview duration 51.16 minutes • Interview date: 10/05/2018	• BSc (Hons) Mental Health Nursing • Second year, semester 2 • Three adult nursing placements - older adult ward, Community mental health nursing team and Health visitor.
Esme • Female • White British • English as her first language • Age range 23-26 years • Interview duration 64.41 minutes • Interview date: 30/05/2018	• BSc (Hons) Adult Nursing • Second year, semester 2 • Three adult nursing placements - Operating theatres, Community hospital and Rehabilitation unit.
Clare • Female • White British • English as her first language • Age range 26-40 years • Interview duration 75.27 minutes • Interview date: 30/05/2018	• BSc (Hons) Children's Nursing • Second year, semester 2 • Three children's nursing placements – Two different children's wards and Health visitor.
Louise • Female • White British • English as her first language • Age range 26-40 years • Interview duration 75.11 minutes • Interview date: 01/06/2018	• BSc (Hons) Adult Nursing • Second year, semester 2 • Three adult nursing placements - medical ward, day surgery unit and Ophthalmology.
Abby • Female • White British • English as her first language • Age range 23-26 years • Interview duration 53.35 minutes • Interview date: 04/06/2018	• BSc (Hons) Mental Health Nursing • Third year, semester 2 • Six mental health nursing placements including: community mental health nursing, inpatient mental health, mental health recovery, community mental health nursing, older adult mental health, and health visitor.
Andy • Male	• BSc (Hons) Adult Nursing • Second year, semester 2

• Filipino • English as his second language • Age range 26-40 years • Interview duration 45.12 minutes • Interview date: 11/06/2018	• Three adult nursing placements, medical ward, community nursing and rehabilitation unit.
Sue • Female • White British • English as her first language • Age range 26-40 years • Interview duration 87.01 minutes • Interview date: 08/08/2018	• BSc (Hons) Adult Nursing • Third year, semester 1 • Three adult nursing placements - surgical unit, district nursing and medical ward.
Lara • Female • White British • English as her first language • Age range 26-40 years • Interview duration 75.52 minutes • Interview date: 16/08/2018	• BSc (Hons) Adult Nursing • Second year, semester 1 • Three adult placement- surgical ward, health visitor placement and outpatient department.
Ann • Female • British Asian • English as her first language • Age range 26-40 years • Interview duration 71.37 minutes • Interview date: 03/09/2018	• BSc (Hons) Adult Nursing • Third year, semester 1 • Previous qualification in nursing • Three adult nursing placements, surgical unit, medical unit, and elective experience.
Ruth • Female • White British • English as her first language • Age range 26-40 years • Interview duration 75.39 minutes • Interview date: 10/09/2018	• BSc (Hons) Adult Nursing • Third year, semester 1 • Five adult nursing placements- day surgery, specialist nurses, medical ward, surgical ward, and general practice.

Figure 1: Summary overview of participants

Managing ethical considerations

Ethical approval was granted by the University of Birmingham's Ethical Review Committee in July 2017. My employing university, where data were generated, confirmed that no further ethical approval was needed. For me, the salient ethical

considerations were to ensure participant consent, confidentiality, and non-maleficence (Beauchamp and Childress, 2013).

In advance of, and at the start of their interview, participants received a copy of the consent form and were offered opportunities to ask questions. Providing participants with information about the study in advance gave them time to consider the purpose of the study and whether participating was the correct decision for them (Hardicre, 2014). Each participant then confirmed their agreement to participate and signed their consent form (Hardicre, 2014). Participants had the right to decide to take part and the right to withdraw from the study at any time. They were told that their data would not be included in the report of the study should they withdraw (Beauchamp and Childress, 2013).

As I conducted face-to-face interviews with the participants, they could not be anonymous to me. However, maintaining confidentiality extends beyond the participant to their data and ensuring confidentiality when the study is reported (Robson and McCartan, 2016; Ingram, 2019). I was also mindful that due to the in-depth data being generated about each participant's experiences there was a risk of breaching confidentiality (Morse, 2015). Therefore, identifiable information such as previous employment details, exact age, and the names of placements, organisations and other people were removed from the participants' transcripts. Participants were also assigned pseudonyms.

I considered whether participants would disclose unsafe nursing practice, for example, a breach of the professional code or actions that affected patient safety. This was potentially problematic because as a RN, I am bound by the NMC Code (NMC, 2018d) and would be required to report if poor practice or patient safety concerns were disclosed. Given the aim of the research I felt that this was unlikely. However, reflecting after my pilot interview, I realised this was a naïve assumption as with such in-depth interviews the potential for disclosure is always present. I ensured participants were aware, through the written information provided and verbally at the start of the interview, that should unsafe practice be disclosed which could have put patients, staff, or other students at risk, I would need to discuss this specifically with the participant.

I similarly acknowledged that there was a risk that participants could experience emotional harm if discussions related to their personal experiences (Beauchamp and Childress, 2013; Moule *et al.*, 2017). One participant did discuss the death of a patient for which she said she had felt unprepared. I listened to her relate her experience, how she had dealt with it and the action she said she took to enable her to cope with this event. After the interview had finished, I signposted the support available should she want to access this.

Section Four: The process of data generation

In this section I begin by explaining how participants were involved in selecting where their interview took place. I also explain and justify my use of semi-

structured interviews based on Thomas' (2013) framework as my method of data generation. I explain my initial plan to use observations as a second method of data generation and how I rejected this following a pilot study due to my concerns over bias. I then explain my approach to transcription and the use of member checking.

Locating the interviews

When participants contacted me to express their interest in taking part, I emailed each participant a copy of the information sheet about the study and a consent form (see Appendix Three). I also supplied hard copies of this information before the interview began. I offered participants the choice of where to meet for interviews: my office, which provided a quiet, private space, or a more neutral place, for example, a private room within the student services department or in the university library or in the education centre at a local NHS Trust. All participants chose to conduct their interviews in my office, which on reflection, I suspected was due to convenience in relation to the location of scheduled teaching. However, this was also in keeping with the practice of how tutorials were arranged between academic staff and students. Although, at the time of the study, I was not a tutor to any nursing students and so did not know the participants prior to meeting them for interview.

Participants were interviewed as they returned to university from their placements in practice settings between 3rd May 2018 and 10th September 2018. The duration

of the eleven interviews ranged between 45 minutes and 87 minutes. Once participants' consent was given, all participants agreed to the use of a digital voice recorder. This ensured verbatim accounts were captured (Moule *et al.,* 2017). Data were saved to a laptop as an audio file immediately following the interview. The original audio file was then deleted from the recording device (Thomas, 2013).

Methods of data generation

One-to-one, semi-structured, in-person interviews are a widely established means of generating rich data through which experiences can be explored (Patton, 2002; Ritchie and Lewis, 2003; Moule *et al.,* 2017). The semi-structured approach also afforded me the opportunity to explore points raised by participants and delve more deeply into responses that addressed my research questions (DeJonckheere and Vaughn, 2019). Similarly, semi-structured interviews provided the opportunity for me to seek clarification of meaning, enhancing trustworthiness by ensuring clarity of dialogue and developing shared understanding (Parahoo, 2014; Moule *et al*., 2017). After careful consideration through reflecting on the outcomes of a pilot study (see below), I opted for single interviews with each participant at one point in time. My rationale was based on the premise that my study's focus was to explore participants' experiences of a single phenomenon; their conceptions on their professional autonomy development, rather than a broader spectrum of how learning occurs in practice settings. I also had confidence that each participant would have relevant experience and as they had given participation voluntarily, they were willing to share these experiences with me. In planning my semi-

structured topics, I had ensured opportunities for participants to reflect on previous experiences. Therefore, I considered this would capture experiences and conceptions on developing professional autonomy over time. However, I wanted to keep the time commitment of the participants to a minimum. I was also aware that across multiple interviews participants may contradict themselves which can cause inconsistencies in data (Read, 2018). I had considered using focus groups. Whilst I acknowledge the benefits these can have, particularly for obtaining multiple perspectives on the same topic, I knew I wanted to explore individual's experiences. I was concerned that data from focus group interviews may have resulted in shared understandings if group members were influenced by other group members (Gibbs, 1997).

I adapted the interview schedule framework based on the outline developed by Thomas (2013, Pg.198) (see Appendix One). This reduced potential for inconsistent questioning as all participants would be asked similarly focused questions (Gerrish and Lacey, 2015). I identified a series of key topics which included participants' feelings on their nurse education and their perspectives on opportunities for decision-making. These topics would enable participants to draw examples from their experiences of learning in practice settings, and the opportunities and barriers to working autonomously, while under supervision, when providing patient care. One topic was related to participants' experiences of working with others within the practice setting because the literature review had suggested a relational aspect to the development of professional autonomy (Holland Wade, 2004; Skår, 2010; Oshodi *et al.*, 2019). I also included questions

specifically about professional autonomy which I addressed towards the end of the interview. Whilst I was aware that participants would know that professional autonomy was the focus of my study, I wanted to build up a picture as to how they perceived they may have been developing this before discussing it explicitly with them (Baird, 2007). So doing, may have influenced their responses (Parahoo, 2014).

Thomas' (2013) framework encourages the identification of a series of *'prompts',* which are possible follow-on questions, and a series of *'probes,'* designed to seek out examples or to push for further detail. Preparing these in advance gave me confidence to manage the direction of the interviews whilst giving participants opportunity to provide full and detailed accounts (Gerrish and Lacey, 2015). On reflection, this planning enabled participants to give more detailed and in-depth responses. Disadvantages of semi-structured interviews include that they can be time consuming and labour intensive compared to quantitative methods, such as questionnaires (Moule *et al.*, 2017).

As the quality of data generation is dependent on the interviewer's skill (Denzin and Lincoln, 2012), I undertook training to refresh my interviewing techniques. This included how to establish a rapport through non-verbal communication, for example, open body language, gestures and intonation and use of active listening skills; maintaining eye contact and managing silent pauses (DeJonckheere and Vaughn, 2019).

I considered whether a second method of data generation would give greater strength to my study as it would enable triangulation of data (Moule *et al.*, 2017). I was also mindful of Paley's paper which suggested that the inclusion of observations as a method of data generation would further focus my findings on the unique experiences of each participant (Bonner and Tolhurst, 2002; Caldwell, 2005; Paley, 2014). I initially proposed semi-structured observations as a second method of data generation. Unstructured observations align with the principles of interpretivism (Thomas, 2013). Observations were to be of participants undertaking simulated practice learning; conducting patient assessment scenarios (using simulator manikins) in the skills centres at the university. The observation was to be *'overt: non-participation: natural'* (Lincoln and Guba, 1985): Overt, because participants would know they were being observed and would give consent for the observation to take place; non-participation because I, as researcher, would not undertake the activity with participants; and natural because the activity would take place within participants' normal learning environment.

Learning from the pilot study

Conducting a pilot study was a requirement of the taught part of my doctoral studies. With ethical approval granted, I conducted an observation and interview with a second-year adult nursing student, Jenny (a pseudonym). The purpose of the pilot was to evaluate the methods of data generation to ensure I could generate data that addressed my research question (Gerrish & Lacey, 2015).

My reflections following the pilot study led me to conclude that in the interview Jenny and I did not discuss the experiences I had observed during Jenny's learning through simulation. Jenny offered many experiences from her nursing practice, of making decisions, working with other nurses and interdisciplinary teams and of her nurse education. These detailed accounts provided by Jenny of her lived experiences of being a student nurse and of learning in practice settings offered a fuller understanding of her perceptions on her sense of developing professional autonomy than those limited experiences of what I saw over a brief time. I also recognised that during the observation, I had made conclusions that I felt could cause bias in my approach during the interview. I concluded that for me as researcher, and to achieve the aims of this study, observation was an inappropriate method of data generation (See appendix five for further reflections on using observations as a method of data generation).

My reflections on my semi structured interview were that I realised I did not need to rely 'word-for-word' on the 'prompts' and 'probes' (Thomas, 2013). My participant's experience was unique and therefore the pre-determined 'prompts' and 'probes' just did not fit into the dialogue. However, whilst I did not rely on these, having the interview sheet at my side felt reassuring. On listening to the recording of the pilot interview, whilst I knew I had generated a lot of relevant data, I began to understand the importance of language and terminology. I realised that due to my familiarity with nursing expressions and jargon, I had taken for granted the meaning of some words and phrases that could be open to different

interpretations. I learnt I needed to question the meaning of such phrases and ask for examples so that I could be sure my understanding of meaning was as intended.

I was aware that I and my participants shared a sense of belonging to the nursing community. Also, as nursing is a female dominated profession, I shared characteristics, such as gender with most of my participants. Therefore, because of this shared belonging I held insider status (Findlow, 2012; Berger, 2015) Hayfield and Huxley (2015) caution that respective roles of insider and researcher can cause a blurring. However, they also suggest advantages to holding both roles such as being able to generate meaningful research questions. Other reported advantages include the ability to quickly build a rapport with participants (Findlow, 2012) and enabling authentic interpretation during data analysis, leading to richer findings (Fleming, 2018).

I had opportunity to present the pilot study at a research conference in 2017 (Rouse, 2017). My presentation enabled me to assess my research method, study design and analysis with an audience of my peers. I felt my presentation was positively received which gave me confidence with my research design and I felt enabled to progress with my study.

Transcription of data and member checking

I transcribed each interview within one week. I contemplated the benefits and drawbacks to inviting participants to review their transcripts, referred to as '*member checking*' (Creswell, 2009; Robson and McCartan, 2016; Moule *et al.,* 2017). Participants' perceptions were central to this study, and therefore I felt member checking would enable me to seek reassurance of the accuracy of my transcription (Creswell, 2009). However, I was also mindful that from a methodological standpoint, experiences are subject to re-interpretation through reflection (Gerrish and Lacey, 2015). I sent participants an electronic copy of their transcript. All participants acknowledged receipt of this with two requesting minor changes. One was to correct a misunderstanding in how I had heard the name of a medication and the second, was to request a change to how I had heard the specialism of a practice setting. One participant was keen to remain in touch with the study and requested a copy of my early thematic analysis of her data.

In presenting the transcribed data, I made some editorial decisions to enhance the clarity of the data extracts. For example, I removed hesitations, pauses and fillers such as *'um,' 'like'* and *'you know'.* Repeated use of the latter seemed to cause frustration for some participants when they read their transcripts.

Section Five: Data analysis

In this section I justify my use of Reflexive Thematic Analysis (RTA) (Braun and Clarke, 2006, 2021) as a framework for data analysis. I also explain why other frameworks and tools; codebook thematic analysis and interpretative phenomenological analysis (IPA) were considered inappropriate for this study. I

discuss in detail how I applied Braun and Clarke's (2006; 2019; 2021) six phases of RTA to my data and show how these phases relate to my application of the hermeneutic circle (Heidegger *et al.,* 2010).

Justifying the framework for data analysis

I wanted a framework for data analysis that would complement my adoption of the concept of the hermeneutic circle (Heidegger *et al.,* 2010). RTA enabled me to analyse data to identify themes; patterns of similarities and differences in participants' perspectives (Braun and Clarke, 2006). These authors have indicated that RTA can be employed in a variety of qualitative study designs, including hermeneutic phenomenology. In this respect RTA was a suitable framework for two reasons. First, RTA enabled me to give attention to the smallest parts of the data as well as to the participant group to facilitate in-depth analysis and generation of rich data to contextualise experiences (Braun and Clarke, 2006). Second, RTA recognises intersubjectivities of my experiences as a RN and nurse educator as a resource (Braun and Clarke, 2006). My analysis came from identifying patterns within the data and their broader meanings (Patton, 1990) and interpretation drawing on my experiences, understanding and knowledge (Braun & Clarke, 2020). Unlike with codebook thematic analysis, I did not predetermine themes and look for codes within the data that aligned to these themes (Braun and Clarke, 2020). Instead, coding and the resulting themes involved repeatedly reading the data, reflecting on my understanding, questioning alternative understandings, re-reading, and re-reflecting (Braun and Clarke, 2006).

I did consider the analytical framework offered through using interpretative phenomenological analysis (IPA) (Smith *et al.,* 2009). However, whilst IPA was developed based on psychological theory and therefore had similarities to RTA, IPA had been criticised as it could limit connectivity between experiences and socio-cultural factors (Braun and Clarke, 2006). Perhaps naively, I also perceived IPA to be very formulaic. I felt its structured application could overshadow the experiences of the participants.

I was aware that my inexperience in RTA could limit the quality of my analysis and interpretation (Braun and Clarke, 2019). To address this, my analysis of the pilot interview was independently repeated by a colleague who had recently completed a doctoral study using RTA. She then provided an opportunity for me to reflect with her through each stage of RTA, explaining my approach, decision-making, and my interpretations of the findings. Completing this process provided me reassurance that I had not selected data because they were of interest to me rather than being those understandings that I had created through my reflexive interpretation (Braun and Clarke, 2019).

Method of data analysis

Below I discuss how I applied Braun and Clarke's (2006; 2019; 2021) six phases of RTA to my data and show how these phases relate to my application of the hermeneutic circle.

Phase 1: Familiarising self with the data

I transcribed each interview verbatim, listened and re-listened to recordings and read and re-read the transcripts. Journal entries (see examples below) were made immediately after each interview of my thoughts on the interview, including participants' use of tone, humour and expressions of emotion.

Journal extract:

I perceived an openness, a warmth, in Sue. Her compassion was obvious, as was her connectedness to her patients. Sue seemed quietly confident and proud to become a nurse. I could have talked with Sue for hours. I felt a real connection.

Figure 2: Journal extract showing researcher's personal views following interview with Sue

Journal extract:

Andy and I laughed a lot! He used humour when he discussed his perceived lack of skill or competence. He also used humour as a mask when he was not happy or impressed by practice he had witnessed.
I had to work hard in this interview. On reflection, there were cultural differences, or perhaps these were gender differences or both? Andy was the only male participant. I felt that I had to clarify more to ensure I understood Andy correctly. Did this detract from the interview data?

Figure 3: Journal extract showing researcher's personal views following interview with Andy

In this phase, using reflexivity of the hermeneutic circle (Heidegger *et al.*, 2010), I started to develop my first descriptions of the data. I felt I had familiarised myself with the data sufficiently when I could recall the broad content of each interview; the salient facts and narratives and could create a mental image for myself of each participant, drawing on their own words (Braun and Clarke, 2021). Reflecting on

what made a fact interesting led me to recognise that I was beginning to analyse the data and to understand its meaning. Revisiting my journal entries at each phase of analysis enabled me to question how my suppositions influenced my interpretations.

Phase 2: Generating initial codes

I recognised a code as a *'data extract, or chunk of data,'* (Braun and Clarke, 2006, Pg.79) that represented a single idea or a particular meaning. Each code was identified with a unique alpha-numerical ordering that started with the participant's pseudonym followed by a number to represent the extract in the data. Rather than coding by line, I coded by sentence or groups of sentences to ensure that context was kept (Braun & Clarke, 2021; Bryman, 2016). Each different code label had a different meaning (Braun & Clarke, 2021) which meant that some extracts of data had multiple code labels. For example:

Code label	Data extract
Making decisions	*Professional autonomy is just having the authority to make decisions and also being in a position to be able to actually implement those decisions* (ANN4.3).
Exerting authority	

Figure 4: Exemplar of data extract coded to different code labels

To address my problem of having data extracts coded to multiple labels, I recycled my analysis by repeatedly questioning myself about why I identified a particular data extract with a particular code label, and I questioned how my subjectivities (including those recorded in my journal) led me to interpreting meaning and

whether an alternative meaning could be applied. I found I had to review and reconsider the meaning of earlier codes; code labels had to be re-defined, re-named and even removed (Braun and Clarke, 2019).

This was the beginning of my data management and enabled me to focus on the data, to find and retrieve data extracts quickly (Braun and Clarke, 2006). I wanted to include all the participants' data, so I conducted *'complete coding,'* as opposed to *'selective coding'* (Braun and Clarke, 2013, Pg.65). This meant that all data were coded, and none omitted, to enable in-depth analysis. This removed the potential for bias created by selecting data on the basis that it was interesting or matched my own perceptions (Morse, 2015). This stage of my analysis was both semantic and latent. Semantic coding was descriptive in that I captured overtly expressed meaning, (Braun and Clarke, 2021, Pg.57) using words expressed by the participants to generate code labels. However, I acknowledge that I could not separate myself as researcher from my perspectives and suppositions as a nurse and as an educator and from the theoretical concepts I had engaged with in the development of this thesis. This meant that some code labels stemmed from the inference I placed on the participants' words (Braun and Clarke, 2020). As such, these latent codes (Braun and Clarke, 2021) represented my interpretation.

Code label	**Data extract**
Semantic coding: Hierarchy	*It's the hierarchy in the NHS, I went up the chain of command because I couldn't get hold of the junior so I next went to the registrar* (LARA9.7)
Latent coding: Confidence development	*It's that fine balance, so it's not really the environment or the people making me feel enabled to do something, it's having that underpinning understanding, knowledge and having seen it done* (CLARE11.7)

Figure 5: Exemplar of data extracts coded to semantic and latent code label

I initially used Microsoft Excel® to record codes but quickly found I had merely generated an extensive list. I then used Nvivo® software and as a means of storing, recalling, and manipulating data: moving codes and refining code labels (Parahoo, 2014; Ritchie and Lewis, 2003; Robson and McCartan, 2016; Silverman, 2013; Thomas, 2013). I also found that using this software to create thematic maps and concept diagrams helped me to visualise relationships, including similarities and differences, within the data.

Before moving on, using the hermeneutic circle, I metaphorically stepped back from my codes to consider whether my code labels captured the diversity of the participants' experiences and of the meaning I had drawn from these (Braun and Clarke, 2021).

Phase 3: Generating themes

A theme illustrates a pattern in the data that captures a cluster of codes sharing a core concept and has relevance to address my research aims (Braun and Clarke, 2021). I began by identifying themes in each participant's data before looking across all participants' data. I wanted to represent each participant's data in a way that enabled me to gain an insight into their experiences. I used the words participants themselves used as theme labels so as not to intrude my suppositions - see an example below of my analysis of Esme's interview. In doing this, I felt I would be able to follow the individual accounts of what each participant told me as trustworthy representations into the final themes of this study.

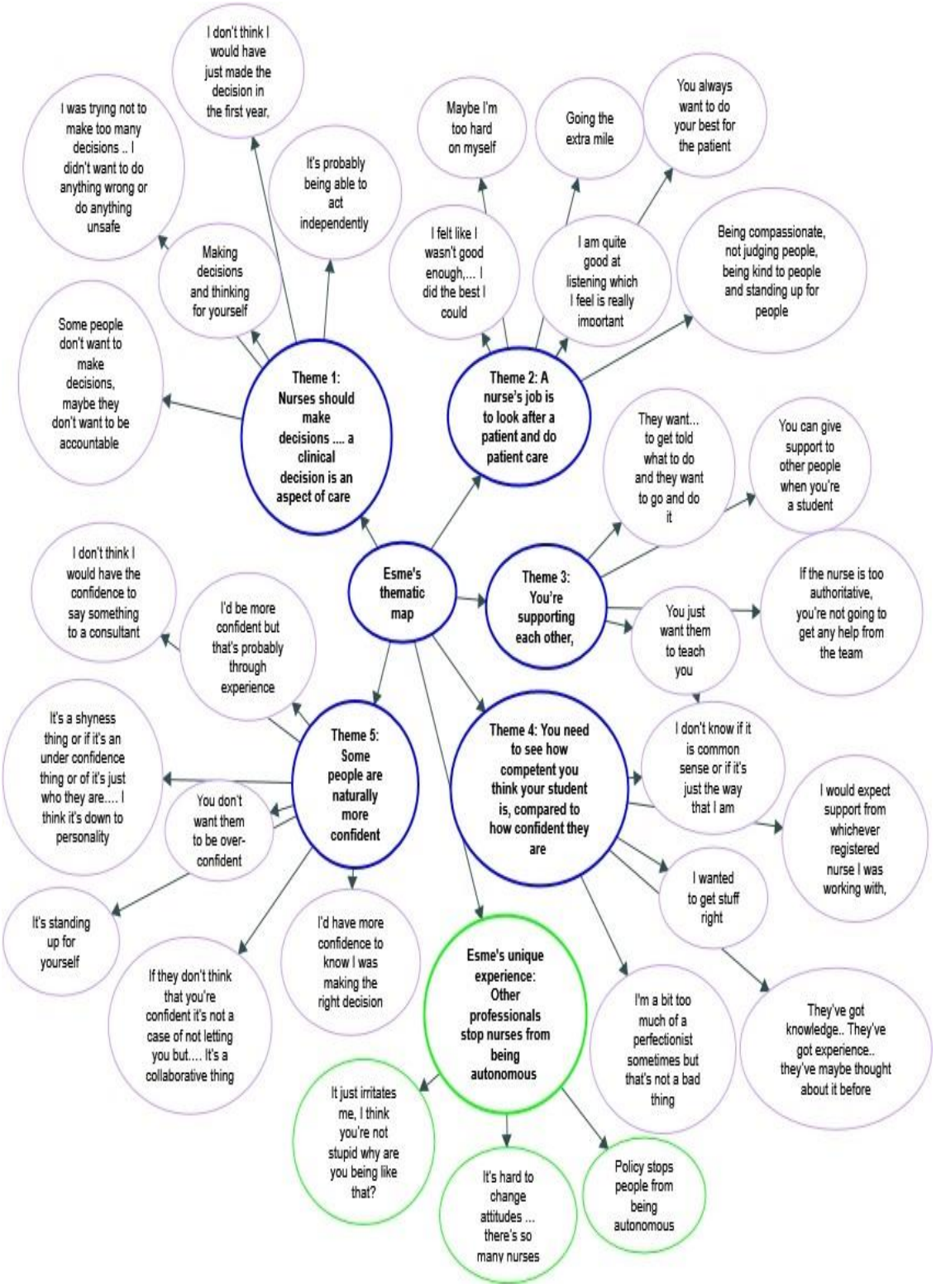

Figure 6: Example of single participants (Esme's) thematic map

(Blue indicates commonality in themes identified across participants' experiences. Green indicates themes that were unique to the participant. Directional arrows show coding within the theme).

After generating thematic maps for each participant, I began to find similarities and divergence between participants' perceptions. In this phase, I started to visualise how the individual codes from participants' interviews, related to the participant group as a whole and how the codes related to my developing themes or as named by Braun and Clarke *'candidate themes'* (2021, Pg.157). (See figure 7 below).

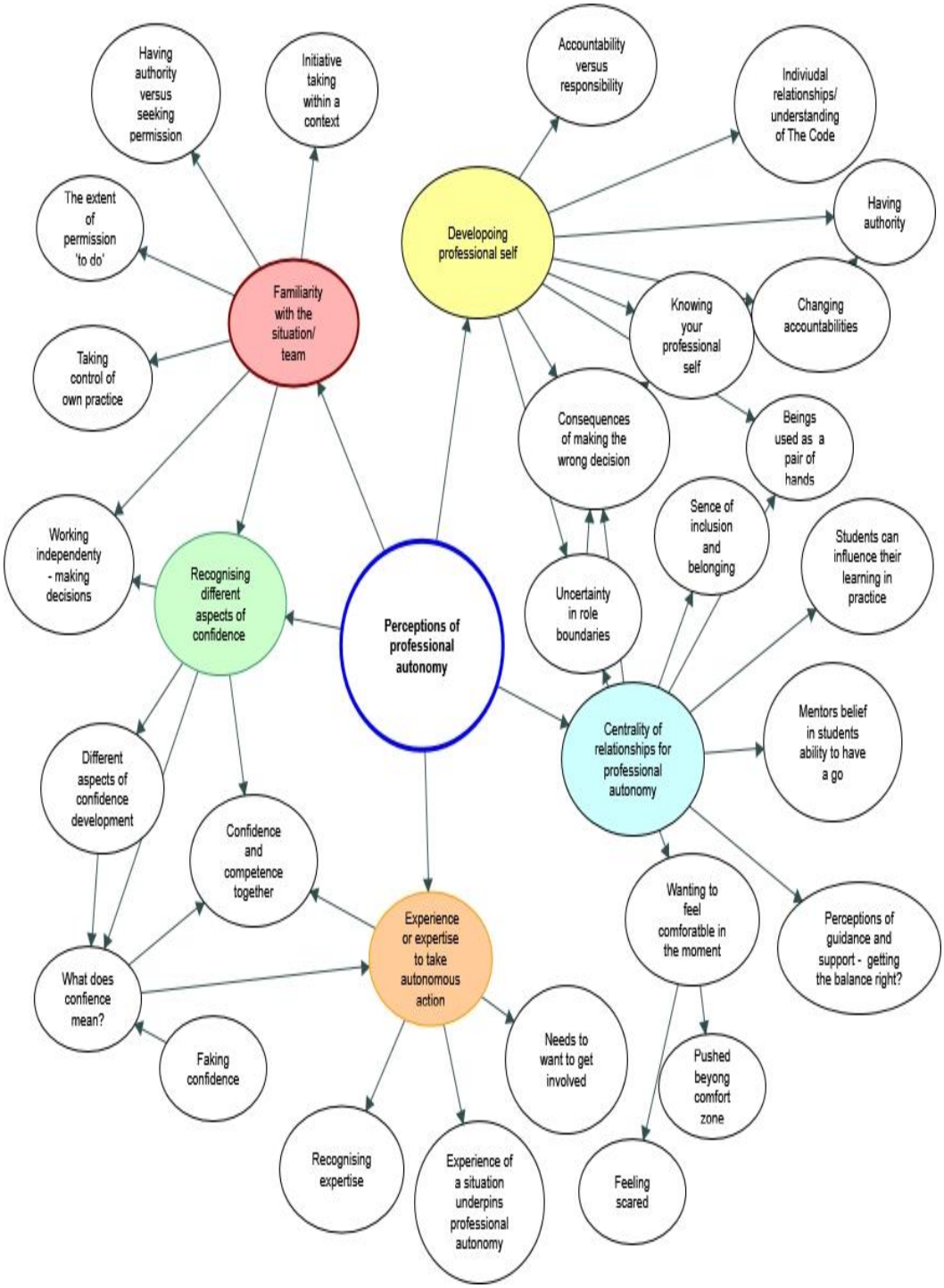

Figure 7: Candidate thematic map (drawn from all participants' data)

(Different coloured circles represent different Candidate themes. Directional arrows represent coding drawn from across all participants' data.)

Phase 4: Developing and reviewing themes

I revisited the candidate themes to confirm I had clustered the codes from different participants under each theme correctly. I also confirmed I had represented differences and similarities in participants' perceptions (Braun and Clarke, 2021). I re-engaged with the hermeneutic circle (Heidegger *et al.*, 2010), by revisiting the thematic maps I had generated from each participant's data. From these I was able to check that original interpretation still seemed right. I then refined my candidate themes by finding the boundaries to each theme with what should be included and what could be omitted, based on my interpretation of what was relevant to addressing my research aim.

I ensured each theme had a *'central organising concept'* (COC). The COC united my analytic and interpretive observations to show meaning (Braun and Clarke, 2021, Pg.145). Identifying COCs helped me to focus on my research aims and represented the emerging narrative with which I wanted to present each theme. Eventually, I was able to develop a thematic map showing the candidate themes centred around a COC. (See figure 8 below).

I also wrote up draft versions of my analysis and discussed these with my supervisor which provided opportunity for me to justify my decision-making. I was confident that through this rigorous and systematic engagement with the data my understanding of its meanings were strengthened.

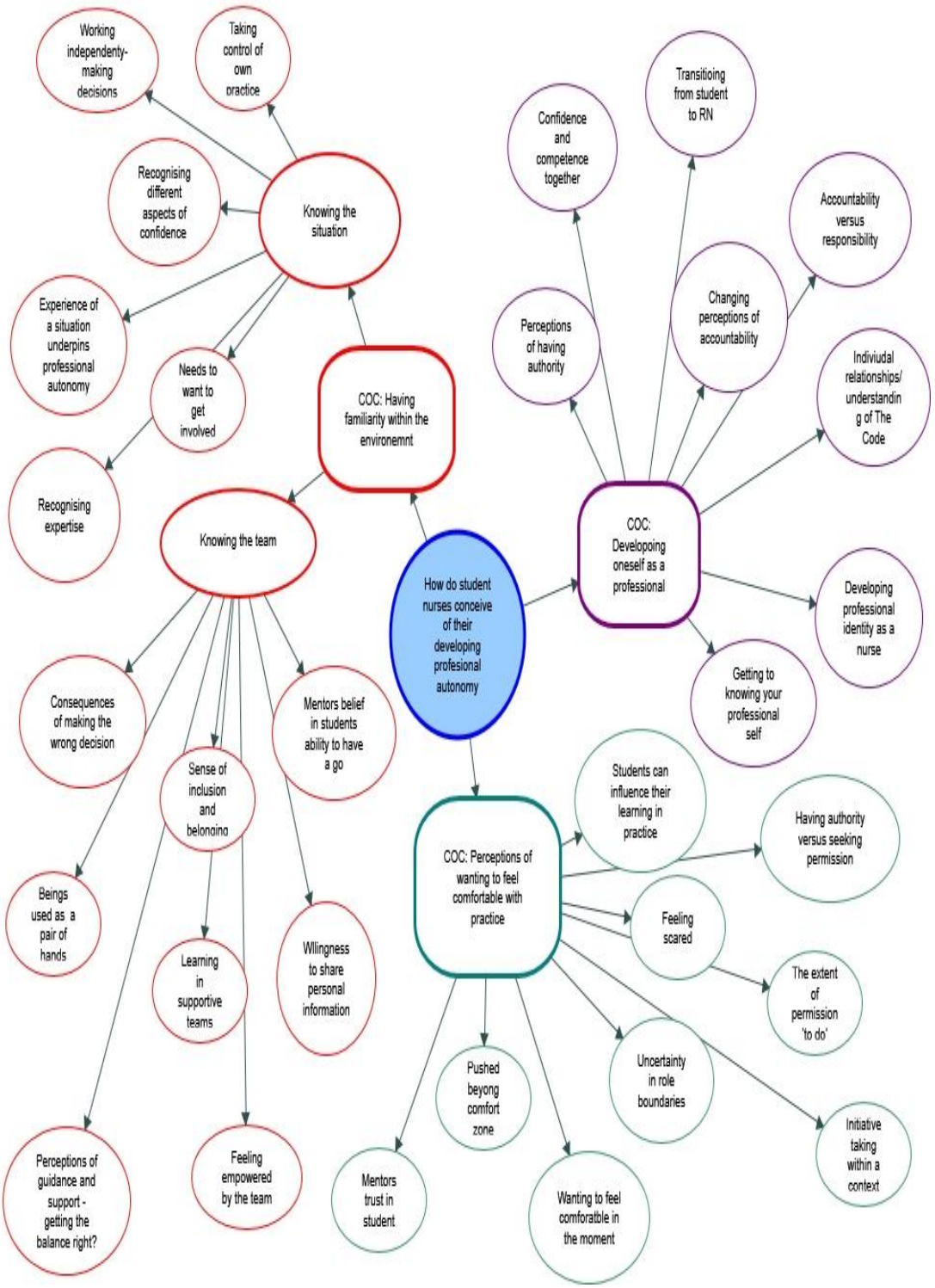

Figure 8: Thematic map of themes, showing central organising concept (COC)

(Different coloured outlines represent different COCs. Directional arrows point to candidate themes within the COC.)

Phase 5: Interpreting the data and defining the themes

After identifying COCs, I had generated a large number of candidate themes, some of which were overly broad and complex, in that they covered too many unrelated concepts. I knew that I needed to further develop my analysis and interpretation. However, at this point, the effects of the Covid-19 pandemic were beginning to be felt within the United Kingdom and my priorities turned to my family and my work in the education of healthcare professionals. This meant that I took a temporary break from further data analysis, using the time available to focus on other aspects of my study. By the time I returned to focusing on analysis, Braun and Clarke had published their book; *Thematic Analysis: A Practice Guide* (2021). This book offered extensive guidance on approaching and deepening data analysis. Using this guidance, together with re-engaging with the idea of the hermeneutic circle (Heidegger *et al.,* 2010), I returned to the work of analysing and interpreting the data. I revisited the coding and thematic maps of individual participant's experiences. I affixed to my study wall each participant's thematic map and my own maps showing what I had identified as central organising concepts. This visual representation was invaluable. I was able to look across the data, to both see the whole and its parts together (Heidegger *et al.*, 2010).Through this ongoing process of analysis and interpretation, which at times involved taking a break and 'stepping back' and through following the detailed guidance provide by Braun and Clarke (2021), I was able to review the COCs and candidate themes to define those that addressed my research aims. I wanted themes that were sufficiently broad to enable the various facets to be explored; those similarities and divergences that mark the complexity of experiences (Braun and Clarke, 2021, Pg,

91). I ensured a richness to the data by using participants' data extracts. This resulted in refining my analysis to four themes.

Theme one: Familiarity as a precursor to developing confidence,
Theme two: The student-mentor relationship,
Theme three: Establishing a sense of belonging as a member of the team,
Theme four: Transitions towards professional autonomy.

Phase 6: Producing a report to form a picture of the whole

This final phase was consideration of what should go into the report as well as what could be omitted (Braun and Clarke 2006). This proved challenging because I had so many data, I felt relevant to the aims of my study, and I wanted to present everything! Using the hermeneutic circle reflexivity, I revisited my analysis, specifically the COCs, the similarities and divergences in data and my research aims to clarify what I wanted to present to my reader.

Section Six: Establishing trustworthiness

Evidencing trustworthiness was my means of assuring quality in this study. Here, I sought to establish a foundation of robustness and credibility so that my findings can contribute meaningfully to what is known about how student nurses conceive on their developing professional autonomy. To achieve this, I identified Guba and Lincoln's (1985) four criteria for ensuring trustworthiness to enable me to produce

research that was trustworthy in all stages of its design, analysis, the reporting of my findings and in the conclusion and claims I have asserted (Morse, 2015).

Lincoln and Guba's (1989) criteria have been identified as a *'pragmatic choice'* because of their applicability and acceptability (Nowell *et al,* 2017, Pg. 4) by those who have *'differences in ontology and epistemology'* (Green, 2000, Pg. 982). Thus, Lincoln and Guba's criteria for trustworthiness are often applied in the context of interpretive research methodologies (Elo *et al.,* 2014). This, therefore, aligned with my ontological positioning of this study. Judgements regarding the trustworthiness of this study were based on four criteria: credibility, dependability, confirmability and transferability (Lincoln and Guba, 1985). Below I explain how these criteria are evidenced in this study.

In this study credibility is shown through articulating methodological integrity and congruence between its philosophical positioning, design, and methods. Here, my research design was consistent with the methodological approach that I stated at the outset of the chapter (Lincoln and Guba, 1985; Levitt *et al.*, 2017). My use of a journal enabled me to record my feelings and identify my pre-suppositions so that I would recognise potential bias if it occurred. This was an important aspect of my reflexivity, rather than a means of data generation. In turn, I was able to synthesise my experiential knowledge and understanding which enabled me to see where my suppositions influenced my analysis and, if necessary, to step back and re-think. Furthermore, reflexivity, through the processes of the hermeneutic circle

(Heidegger *et al.*, 2010), enabled me to examine my involvement in all stages of this study, for example, my decision not to continue with data generation through observations, to consider the boundaries of my own knowledge and to qualify my influence on data generation and analysis to prevent my existing understandings overwriting emerging realities (Gearing, 2004).

To establish dependability, I provided detailed information of the study design and methods used for RTA (Braun and Clarke, 2006) to verify that its findings are consistent with the interview data generated (Lincoln and Guba, 1985; Morse, 2015). Together, my explanation of how each stage of RTA was conducted supply an audit trail that explains and justifies my decision-making. Similarly, to demonstrate confirmability (Moule *et al.*, 2017), I have explained my analysis and interpretation to show how I arrived at the final themes (Armour *et al.,* 2009). I have also addressed potential concerns about my insider status as a RN, an educator, senior manager, and researcher which informed my pre-suppositions and through which I bring a unique worldview to this study.

Transferability is the potential to *'transfer my findings to another context,'* (Morse, 2015, Pg.1213). I have acknowledged that this study is based on my analysis and interpretation of a group of student nurses' experiences at one institution. I have exercised extreme caution against extrapolating generalisable conclusions that do not reflect my participants' experiences or the context of nurse education in which this study was set (Braun & Clarke, 2021). However, in describing the participants, the context and circumstances of this study in detail, including my analysis and

interpretation, I have provided a rich, contextualised understanding of these participants' experiences of developing their professional autonomy. Through this, the reader is able to evaluate the potential to apply my interpretation to other contexts and settings (Braun & Clarke, 2021; Noble & Smith, 2015).

Chapter summary

I presented my methodological approach to give justification for the ontological and epistemological framing of this study within the interpretivist paradigm. In alignment with this framing, hermeneutic phenomenology was appropriate because I looked to interpret individuals' lived experiences of their developing sense of professional autonomy. I discussed my rejection of descriptive phenomenology as I perceived the concept of bracketing was both unrealistic and had the potential to limit this study by preventing my own experiences and suppositions from informing my analysis. I have explained my approach to the reflexivity enabled through my application of the hermeneutic circle (Heidegger *et al*., 2010) and the Heideggerian concept of care as a means for me to explore the experiences of others.

I have presented my research procedures that enabled me to address my research aims. I also explained my use of semi-structured interviews and rejection of observations as a second method of data collection. I introduced the eleven student nurses who were recruited to take part in this study and my position on the concept of data saturation. I also identified how I managed ethical considerations

related to gaining permission to conduct this study and protection of the participants through consent, confidentiality, anonymity, and non-maleficence (Beauchamp and Childress, 2013). I justified my framework for data analysis using RTA and have presented a detailed explanation of how I conducted data analysis through each stage of RTA (Braun and Clarke, 2006, 2019, 2021). Finally, I have outlined my approach to establishing trustworthiness throughout this study. In the following chapter, I present my findings.

Chapter Five
Participants' perceptions on their developing professional autonomy

Introduction

Four overarching themes resulted from my analysis and interpretation of participants' experiences. These themes communicate my understanding of how these student nurses saw their development of professional autonomy. Theme one is entitled: *Familiarity as a precursor to developing confidence*. Here, I explore variations in participants' perspectives on what was meant by familiarity and show that becoming familiar with a practice situation appeared to facilitate the development of confidence. This, in turn was seen as enabling professional autonomy development. From this, I conclude the importance of supporting student nurses to develop their familiarity within their practice setting.

In theme two, I explore differing and similar perspectives amongst participants related to *the student-mentor relationship*. For some participants, a sense of professional autonomy arose from active engagement in nursing tasks with mentors, where mentors were perceived as taking an interest in the student nurse's learning. Some participants also referred to factors that appeared to hinder their development as autonomous practitioners: lack of support for learning and being prevented from active participation in nursing activities were commonly expressed views. A sense of having too much responsibility or being marginalised (Lave and Wenger, 1991) by the mentor with whom they were working were less

frequent but still important perspectives in understanding development of professional autonomy.

Theme three: *Establishing a sense of belonging as a member of the team* reveals why a sense of being a part of the team was viewed as important for professional autonomy development. Broadly, developing a sense of belonging in the team within the practice setting enabled opportunities for shared decision-making by talking through rationales or seeking clarification in respect of specific decisions. I then discuss how participants characterised a sense of belonging. Here, participants offered several differing characteristics including having their contributions valued, feeling respected as individuals, and knowing the strengths and weaknesses of the team. Finally, I discuss the ways in which participants said they tried to find their place within the team which included asking for help, and permission-seeking.

Theme four: *Transitions towards professional autonomy,* evidence that the development of professional autonomy was perceived as a process of transition. While ideas about the nature of the trajectory towards professional autonomy differed between participants, all expressed the view that as they transitioned towards professional autonomy, they became more accountable. Finally, I explain how, as participants progressed towards becoming RNs, their feelings of confidence to be professionally autonomous on graduation might temporarily wane. My analysis offers an insight into the ways in which this decline in confidence may be managed. Here, personal and professional reflection was

identified as a means of building confidence through experience. Drawing on others for support and advice was also commonly expressed.

Theme one: Familiarity as a precursor to developing confidence

Participants expressed a common idea: that familiarity (having a thorough knowledge or having mastered a nursing skill or procedure) with a particular practice situation enabled the development of a sense of confidence. This, in turn, seemed to facilitate a sense of being able to practice with greater autonomy. First, I show that perspectives on 'familiarity' ranged from familiarity with procedures and types of patients to familiarity with nursing practice more generally. Broadly speaking, a sense of familiarity seemed to depend on the extent of participants' experience in a particular practice situation. Second, a sense of confidence and perceptions of professional autonomy were linked; unfamiliar situations seemed to negatively impact upon participants' perceptions on their confidence. Third, some participants suggested that 'confidence' was something that a person could pretend to have; to give the appearance of confidence in the hope of being seen as confident. In this way, how participants thought that they were viewed by others might be seen to impact on how they perceived their own confidence, and this influenced their sense of professional autonomy.

Recognising the familiar: 'If I've seen the same patient a number of times...'

I begin by drawing on data from Clare, Esme, and Andy's interviews, illustrative of a commonly expressed view that familiarity with a situation fostered the

development of confidence and enabled participants to make decisions and act on them. Conversely, in unfamiliar situations, participants regarded their ability to make decisions as being inhibited. Differing perspectives were offered about what it meant to have a sense of familiarity within a given situation or practice but commonly, a sense of familiarity was dependent on the extent of nursing experience brought to a situation by an individual. By understanding how students recognise familiar aspects of nursing practice, this may offer insights into how to facilitate their professional autonomy development as they move to new practice settings.

Extracts from Clare, Esme and Andy's interviews demonstrate their desire to become familiar with their practice situation. For them, a sense of familiarity with their patient or with the immediate nursing situation enabled them to feel that they knew what action they could take autonomously. Esme and Andy were studying adult nursing, whilst Clare was studying children's nursing. All three were in their second year of nurse education. Clare was about to start her placement in a neonatal unit and explained her lack of familiarity with this specialism:

> *When I was caring for an older child…, it was, there's two of us, one of us is going to turn the oxygen up and get the oxygen bag and I'm going to be getting the tracy [tracheostomy] box and cutting the tape to take the blocked tracy out after suctioning. Very extreme, but it should demonstrate that I had competence and confidence around tracys and just decided and acted in a significantly life-threatening situation. …Whereas [if] I haven't worked with neonates, I…. wouldn't be confident. Would I use a facemask, or would I just waft the oxygen? I haven't seen it; I can't be confident.*

Clare's lack of familiarity with caring for neonates appeared to affect her confidence to conduct a procedure with which she had previous experience and had felt confident to conduct when caring for an older child. Clare's lack of familiarity appeared to generate a sense of uncertainty and of feeling unprepared to manage this procedure. This may be indicative of Clare having a liminal experience.

Esme suggested that confidence came from having previously nursed a particular patient or performed a specific procedure:

> *If I've seen either the same patient a number of times or the same wound a number of times or the same symptoms. …I think I'd have more confidence to know I was making the right decision, so I would be able to have had the confidence to say this is what we're doing.*

Esme and Clare drew confidence from their familiarity with specific patient conditions or nursing procedures. Their perspectives show that a sense of familiarity might enable them to feel confident to act autonomously.

Esme and Andy showed how lack of familiarity with a particular specialism might be a barrier to a sense of autonomy:

> *….Say you are a band five and you'd worked for 10 years on a vascular ward and then you go and work in ITU [intensive care unit], you wouldn't be autonomous. You couldn't be because you wouldn't know what to do in ITU necessarily. (*Esme*).*

> *New nurses have never been in the situation, so they don't know what to do. If you had many years of experience, then you would just do it. I haven't been to Accident and Emergency; I don't know what to do. I would look a bit incompetent; experience is a barrier to being autonomous.* (Andy).

They both talked of how familiarity, gained through experience, enabled them to feel that they could practice autonomously. This shows that these students may need to be supported to transfer their knowledge and the confidence gained from familiar experiences to those they are unfamiliar with.

Students with more extensive previous nursing experience seemed better equipped to deal with unfamiliarity. Ann, Sue, Ruth, and Abby were in their final year of nurse education. They offered differing perspectives, drawing on their experiences as student nurses. Whilst Ann and Sue were able to apply earlier learning to new situations, Ruth discussed how starting in unfamiliar settings disrupted her confidence. Abby talked of a progressive process of learning that enhanced her confidence in unfamiliar situations.

In contrast to these three pre-qualifying students, Ann, who was already a RN but was completing a second registration, offered a conceptualisation of familiarity that seemed to refer to her practice environment more generally:

> *[As a Registered Nurse] I feel very autonomous in charge of my unit. I made sure everything was… as smooth as possible; my patients are safe; my staff are safe. I knew the environment and the patients, it was nice, I felt*

> *like I was in charge.* ...[As a student], *there have been situations where I've just done it. …If someone looks unwell, I would automatically do physical observations without someone telling me to do that because I know to do that.*

Ann, with more nursing experience, felt able to transfer her knowledge of nursing care to a new situation. Whilst a sense of familiarity was important to all these students, each student's experience was unique, implying that individual conceptions of familiarity may themselves be dependent on the particularities of the context. These differences in conceptions of familiarity offer potential challenges to those supervising and assessing students' learning because they show the individual nature to familiarity.

Sue had worked as a healthcare assistant for several years before starting nurse education. Like Ann, Sue seemed to recognise that earlier experience might enable her confidence to build more quickly in new situations. However, Sue talked about the amount of time that might be needed to develop familiarity within a new placement:

> *You become autonomous more quickly if you've had the experience and you're more confident, so after a month of working in ITU, a nurse that's been trained for 20 years is confident and might be yeah, I'm fine now, I know what I'm doing. Whereas if you are newly qualified and you been working for six months you might think that I need more than a month.*

Sue said she had experienced placements of typically eight weeks duration. Her assertion that a newly qualified nurse with six months experience may need more

than a month to develop a sense of autonomy in unfamiliar situations raises a question as to how much time student nurses need in order to become familiar with protocols, patient conditions, and staff in a new setting, as a means to developing their sense of confidence, and hence their professional autonomy. This suggest that induction procedures that encourage reflection on past practice and recognition of what is familiar and unfamiliar in new situations may be important. Ruth offered her experiences of starting new placements. She referred to this as: *'…Starting a new job all the time.'* She went on:

> *...You have to go in and introduce yourself and be the person you hope you'll be at the end, from the first day. Be approachable, be enthusiastic and be all those things that you want a great employee to be from day one, even if you're not feeling confident and brilliant about it. It's that coming out and then going back in and coming out and going back in. You want everybody to have a really wide-ranging experience but …it's really hard. …To be confident is to feel like you've got the knowledge to be able to make decisions. …You need to be able to practice to be able to develop confidence and to develop autonomy.*

Ruth, like Sue, was in her final year of nurse education. She seemed to recognise that starting a new placement might affect her confidence. Whilst this may be indicative of liminal experiences, Ruth acknowledged the requirement for students to gain broad practice experiences across a range of nursing settings. However, the need to become familiar with each new practice setting may impair the effectiveness of multiple, short placements in facilitating the development of professional autonomy, if students have insufficient time in those placements to develop their familiarity.

Abby had successfully completed all her practice placements and was in her final weeks of nurse education. She suggested a means through which she was able to become familiar and to feel confident in performing specific skills:

> *I wouldn't feel safe as a practitioner if I didn't feel confident. To be self-confident you need to have knowledge about a skill, learnt a skill, practised a skill, and then demonstrated you are able to fulfil that skill.*

Abby articulated a progressive process of learning through which she appeared to draw together knowledge, experience, and a sense of familiarity to enable her to perform a skill independently. This suggests a possible process through which students may be supported to develop skills in familiar situations and then transfer these skills to unfamiliar situations to foster confidence to develop professional autonomy.

In summary, the main differences between participants' accounts were whether familiarity was acquired by repeated exposure to the same type of patient or procedure, or to previous experience in nursing more generally. Since each students' experiences are unique, so will be their conceptions of familiarity. Overall, however, a sense of familiarity appeared to be important in enabling participants to feel confident to act autonomously. Therefore, assessing students by meeting with them and gaining an understanding of which aspects of nursing practice they are familiar with in advance of a new practice placement, may assist them to transfer their experience and confidence to unfamiliar situations.

Fluctuations in confidence: 'Like a wave':

The second aspect of familiarity as a condition for developing professional autonomy was related to gaining, sustaining, and losing confidence. Sue and Ruth were in their final year studying adult nursing, whilst Briony was in her second year of mental health nursing. All suggested that even in situations that seemed familiar, their sense of confidence fluctuated. Sue stated:

> '*autonomy - it's like a wave because you can have things that happen in your career that are going to knock your confidence, that can bring you down,'*

suggesting when her confidence waned, her ability to act autonomously ebbed. She went on to say:

> *…so then you have to build yourself back up. If you really know what you are doing, you're confident, you're on the ball, everything is going well, you feel you can make those decisions. …It's about empowering people, praising them when they've done well and explaining when they haven't done so well, but in a nice way. It's not about criticising people and bringing them down. It's about building people up.*

Sue emphasised the relationship between her confidence and her ability to make decisions autonomously. She also indicated that encouragement or criticism from others could cause her confidence to fluctuate. Ruth suggested another factor that

seemed to make her confidence fluctuate was the negative outcome of an action or decision:

> *I suppose if you've done something and if it's been a successful outcome, or you feel that you've made the right decision, then you are more likely to do it again. But, if you've maybe done it and it wasn't the outcome you wanted, you might take a little bit longer before you feel confident that you can do it again.*

Briony also recognised that her confidence fluctuated, and highlighted that her confidence might fluctuate more often during every day:

> *You're not going to feel confident at acting independently and making decisions twenty-four hours of every day. I would like to think I'll be in a place where I feel this is the job for me! When you're studying this degree, you have so many days when you think, I don't know if I can do this? Have I got thick enough skin for it? I'd like to think I'd have the confidence to know that I chose this job for a reason, I'm secure in it, I feel happy in it and I'm good at it.*

In contrast to Sue, who offered a view that her confidence might dip at points throughout her career, Ruth and Briony indicated that their confidence fluctuated considerably. In Briony's case it even made her question whether she could complete her nursing degree.

The ebbs and flows in confidence described by Sue, Ruth and Briony suggest that confidence and professional autonomy do not develop in a linear way but ebb and

flow over time. This raises the question of how student nurses can be prepared and supported when and if they experience fluctuations in confidence.

A façade of confidence: 'Fake it until you make it'

Giving the appearance of being confident, in the hope of being considered as such, was a strategy adopted by a number of participants to manage unfamiliar situations. Ruth and Ann drew parallels between what others thought of them as nurses, and how this might influence their confidence and ability to act autonomously. Ruth's reference to pretence seemed to suggest she had developed a way to give the appearance of confidence:

> *It's double edged; if you can appear confident and if people think you are confident, you then start to become more confident. If you can put that front on at the beginning, that's definitely what I do. I pretend I'm confident; I'll smile and talk to everybody and not be in my shell. It's those first impressions. …It's putting that front on.*

When Ann talked of her previous experience of making the transition from student nurse to RN, she acknowledged that she did not feel confident immediately on becoming a RN. She used pretence to give the impression of confidence:

> *You don't suddenly become qualified and think, Oh my God, I'm confident. Initially it was: fake it until you make it. I have to have this image where I've got it all under control, inside I'm panicking. …You just need this façade initially and then you will grow into it.*

Ruth and Ann's references to forms of pretence showed that the way they presented themselves to others did not match how they were feeling. Ruth's and Ann's concern to give the appearance of confidence was important to them; when they could not do this it had potential to cause anxiety. For these participants, presenting a façade of confidence, enabled them to adapt to new or unfamiliar situations. This raises a question as to how students can be supported to consider how their confidence is affected when changing practice setting and what strategies could support their transition – other than 'faking it', which could pose risks to patient and staff safety.

Theme summary: Growing familiarity and confidence to develop professional autonomy

To conclude, while the previous literature indicates a link between confidence and autonomy (Oshodi *et al.,* 2019: Holland Wade, 2004), my study adds to what is known by asserting that familiarity, as a precursor to developing confidence, is a salient factor in the development of professional autonomy. These findings therefore offer a fresh insight into the relationship between familiarity and developing confidence. They also suggest how familiarity develops. For some participants, familiarity came from having already experienced similar situations. For others, from repeated experiences of nursing the same patient or medical condition. These findings are similar to those of Baykara & Şahinoğlu (2014), Shohani & Zamanzadeh (2017) and Wynd (2003) who recognised that perceptions of qualified nurses' abilities to be professionally autonomous may be influenced by

the length of their experience in a particular environment. However, my study highlights that the process of becoming familiar with practice contexts, for example, the ways in which the team works, the nursing skills and procedures conducted, the type of patient conditions, are what enables confidence towards the development of professional autonomy. Therefore, these findings raise questions about whether student nurses are given sufficient time, an indeed what might be ‘sufficient time’ for individual students, in a practice setting to enable a sense of familiarity to practice autonomously.

The notion of learning through practicing is discussed in the works of Lave and Wenger (1991) and appears relevant here. However, during their nurse education, student nurses make frequent transitions to unfamiliar situations, including new placement settings, new practice teams. They must also develop competence in nursing patients with conditions they were previously inexperienced in managing. The processes involved in entering a new practice setting in which student nurses question their confidence and ability to act autonomously as they learn new ways of working, develop new nursing skills and knowledge are suggestive of having liminal experiences (Turner, 1969; Holland, 1999; Evans and Kevern, 2015; van Gennep *et al.*, 2019). This study suggests that confidence and professional autonomy do not develop in a straightforward linear way but fluctuate over time. Student nurses’ learning might therefore be helped through individualised induction programmes and by individualised learning plans to recognise the importance of confidence and how it develops with increased familiarity with a practice setting. This may enable student nurses to identify what skills and

knowledge they are familiar with and bring with them to their new practice settings to enable them to make safe and effective transitions to new and unfamiliar practice situations.

Theme two: The student-mentor relationship

All the participants in this study discussed the importance of their relationships with mentors, and identified some of the factors in that relationship that either facilitated or hindered the development of professional autonomy. Broadly speaking, the support received from mentors was the most frequently cited factor that appeared to enable participants to develop towards professional autonomy. Whilst support was commonly perceived as active participation in the role expected of a RN, some participants offered their perspective that support was being encouraged to make decisions which enabled them to feel their contributions were valued by their mentors. In turn, having a sense of being valued for the contributions they made to patient care and to the nursing team as a whole appeared to instil confidence in these students to develop towards professional autonomy. Two specific factors were cited as hindering the development of professional autonomy. First, a sense of being undervalued when participants' views on patient care needs were not considered. The second factor was organisational. Here, heavy workload of mentors and poor staffing levels were perceived to limit opportunities to engage with nursing tasks and the expectations of the RN. I illustrate this by drawing on data from interviews with Louise, Lara,

Briony, Ruth, and Clare, all of whom detailed some of the factors that facilitated or hindered their professional autonomy development.

Facilitating factors: 'I felt like my mentor believed in me'

There was some commonality of views about the factors that seemed to positively influence the development of participants' professional autonomy. The first was being supported by their mentor to take part in tasks that were perceived as authentic to the role of a RN. The second was establishing collaborative partnerships with mentors that appeared to focus on meeting participants' individual learning needs. The third was feeling valued by their mentor for their contributions to patient care. A less commonly expressed facilitating factor related to being challenged to take on new skills and responsibilities safely.

Louise and Lara were second-year adult nursing students, Briony was a second-year mental health nursing student and Clare was a second-year children's nursing student. Each had completed three placements, whilst Ruth, a third-year adult nursing student, had completed five placements. Each participant had a mentor in each of their placements, although Louise and Lara said they had more than one mentor in some placements.

I begin by exploring a commonly mentioned perspective that being engaged in authentic nursing tasks, described as tasks which participants equated with the role of the RN, contributed to a sense of developing professional autonomy.

Louise and Lara talked about factors which they found enhanced their confidence to develop their nursing practice:

> *My mentor was really good, and she gave me lots of confidence. She asked me to do things like admit a patient. She would stand aside and let me do it, but then she would sweep in afterwards just to make sure I had done it okay. She was quite confidence building as well, nurturing. …Actually, just wanting you to succeed and being interested in what you're learning about, wanting to teach you. …If you meet a good mentor, it's worth its weight in gold, and it really helps to say I want to be like that person, (Louise).*

> *It's just being given the opportunities and having the right supportive mentors who are always happy to show me, teach me things. It's them having that time to teach you and show you what needs to be done and then also having the confidence in your abilities to let you go. Like, I'll show you and then you go off and do it, and it's giving them the confidence to feel I can do that. …I've had quite supportive mentors so far; I haven't had any bad experiences yet. …They have your back. They stood up for me and kind of backed me up (Lara).*

There were differences between participants in respect of the factors that they saw as supporting their engagement in authentic nursing tasks: for Louise, support came from knowing that her mentor would confirm if she had performed a task correctly. For Lara, it was having a task or skill demonstrated to her before she practiced it herself.

Ruth and Briony similarly talked of feeling supported by their mentors. Ruth reflected on a positive experience as a first-year student when she felt that her

mentor had valued her contribution by listening to her views about patients. Briony also felt that her mentor had sufficient confidence in her abilities to include her in discussions about patients' care needs. However, Briony also drew confidence from being a member of a wider multidisciplinary team:

> *The first placement …my mentor was brilliant. …If you feel like you're supported and you can share decision-making about patients, you're more likely to feel that you can be autonomous. …I felt valued when she was talking to me because she would listen to me… She would talk to everybody in the same way, not talking down to people who you think, their job isn't as important as mine, (Ruth).*

> *I felt like my mentor believed in me. She knew what she was doing, she gave me confidence. I got more of an opportunity to arrange multi-disciplinary team meetings, I was in on every patient being discussed with all the different disciplines and knew where we're going to go from here, who do we need to get involved, are they on the right path, what do we need to do, (Briony).*

Whilst support to complete authentic tasks seemed a consistent factor for these four participants in developing towards professional autonomy, their perspectives about the nature of that support differed. For Louise and Lara, it was having support to develop proficiency in specific skills and nursing tasks, whilst for Briony and Ruth it appeared to be having a voice in shared decision-making about patient care. These differences suggest professional autonomy development may be facilitated differently for individual students and that it would be unwise to assume that a single approach would be right for all students.

Collaborative relationships in which mentors and students appeared to work together to meet the individual learning needs of participants seemed to be another key factor in supporting participants towards autonomous practice. A third factor that facilitated development towards autonomous practice was feeling that, as students, these participants' contributions to patient care were considered meaningful, in that they had a voice in decision-making.

I draw on experiences discussed by Briony and Clare to present a fourth factor, although expressed less commonly. This was recognising those nursing practices that participants were confident with, which enabled them to push safely beyond their comfort zones, and those nursing practices which they did not feel confident to perform safely. Briony described being provided with an opportunity to develop professional autonomy with which she was comfortable. She gave an example in which she had referred a patient to a specialist mental health service, under supervision. In this situation, Briony seemed to be afforded an opportunity, free from criticism, to develop towards autonomous practice. This, in turn, appeared to enable her to take on greater responsibility relevant to the role of the RN:

> *Being a student, if I made any mistakes, she would have recognised that. If I needed some support or help, I could have gone to her, and she would have known what to do. So, I felt comfortable in doing it. She gave me feedback in a way that I didn't feel stupid, so I was confident enough to do it myself. I thought the situation was being handled completely even though there was only me that was specifically doing it. …That was good experience for making decisions. It's about being able to recognise what your comfort zone is but also being able to push yourself out of that comfort*

zone if you need to. I felt comfortable doing that at the time but not everybody would. ...I think knowing yourself is very important.

For Briony, there seemed to be two factors that contributed to her sense of comfort; First, she had confidence that her mentor would be available and provide feedback, in a non-judgemental manner. This allowed Briony to access expertise and support from her mentor when she felt she needed it. The second factor appeared to be her ability to reach a comfortable understanding with her mentor about what she had the confidence and competence to do on her own, working within her *'comfort zone.'* From this position, she seemed able to push herself to engage in new learning, knowing her mentor was available should she need support.

Clare discussed a situation on a children's ward in which a parent appeared to fall asleep whilst holding his baby and she felt she should have intervened. This situation seemed to cause her discomfort and a sense of personal concern:

Maybe I was trying to be autonomous by saying I'm making this decision, but I made the wrong decision. …Remembering that experience haunted me. For me working autonomously puts a picture in my mind of me going off and doing what I want to do, making decisions independently. …It's about me doing what feels comfortable to me in that moment. …It's about reserving my confidence. Unless I feel competent in something I'm not going to rush ahead and do it, it's that fine balance. But then confidence can sometimes be dangerous. …There are people who make autonomous decisions although they may not make safe decisions. There is a difference between safe autonomy and dangerous autonomy. I would prefer to be safe

> *by knowing the boundaries. … I had a fantastic mentor which helps. …It's allowing us to make decisions and not punishing us for making mistakes because inevitably when everyone has permission to make decisions for themselves, mistakes will be made. I need to feel supported by the nurses supporting my decision.*

Like Briony, support from Clare's perspective, was finding a balance between her mentor letting her practise autonomously when she felt confident and supporting her by stepping in before she made a wrong decision. When this balance was not reached and an incorrect decision was made, the consequences *'haunted'* Clare. This is concerning because fundamentally it could be unsafe for patients, the student and staff. However, such feelings could cause stress and a reduction in confidence. Clare seemed to suggest that too much confidence, working outside limitations, could lead to *'dangerous autonomy,'* represented by unsafe decision-making and working outside of boundaries. For Clare, a further factor that supported her towards autonomous practice was feeling she had support to make independent decisions. Support, in this sense, seemed to mean having confidence that her mentor accepted that as a learner, Clare would not always make the correct decision.

In summary, the most commonly cited facilitator of the development of professional autonomy seemed to be the relationship participants formed with their mentors. My analysis found specific aspects of this relationship which were deemed helpful. First, individual support to encourage active participation in authentic nursing activities and decision-making about patient care. Second, the seeking and valuing of their views. Third, mentors taking an interest in participants'

learning and providing constructive feedback on performance, which signalled a collaborative approach to meeting individual learning needs and providing appropriate support. Less commonly cited, but still noteworthy factors, included students trusting that mentors would identify or correct mistakes, seeing mentors as a means of support should mistakes occur and supporting students to safely push past their *'comfort zones'.* All this suggests that it is important for mentors to consider how they can support student nurses to recognise areas of their practice that they are comfortable with, in order then to identify further areas for development towards professional autonomy.

Factors hindering the development of professional autonomy: 'They are just so busy'

Participants also discussed experiences with their mentors that they regarded as impacting negatively on their developing professional autonomy. Broadly, a lack of support was a commonly raised factor but there were differences in participants' views of the nature of support. Some participants found interpersonal difficulties as problematic for receiving support, whilst some saw organisational factors as a hindrance. Briony and Ruth perceived that their individual contributions to patient care were not valued. Ruth, Lara, and Louise discussed how organisational factors, such as inadequate staffing seemed to result in a lack of support for their learning.

Briony said, *… I know how it feels to be a stranger on the ward…'* She continued:

> *Students don't feel valued because they feel that although they spend the most time with the patients and although they know them the most, what they recommend isn't always followed through, but you never know why or even that anyone thought about it.*

For Briony, two factors seemed to contribute to her sense of isolation. First, that her views about patient care were not valued, so she felt that she was not listened to. Second, not being given feedback about why her views of patient care were not implemented. Ruth also talked about factors that contributed to a sense of a lack of support for her learning:

> *If you've got a poor mentor who won't let you do anything …or you're observing her the whole time, or even just lets you get on with things on your own when you need her support, you don't really get the chance to develop that professional autonomy. …It was, 'You've come to work here, well off you go, get on with it'. If you feel you're very much on your own and it's all on you, then that makes it difficult to be autonomous because you feel that you haven't got that support there. … It was really busy, they didn't have enough staff, so it was really challenging, and it really undermined my confidence as well as my learning, it wasn't brilliant.*

Ruth discussed two specific factors; first, feeling unsupported either through being prevented from participating in nursing activities or through being given too much responsibility for her stage of nurse education. Second, organisational factors, such as how busy staff were, or inadequate staffing seemed to limit her opportunities for developing professional autonomy. The outcome appeared to be disempowering for her. Louise, similarly, discussed how adverse organisational factors could have a negative impact on her relationship with her mentor. She was

explicit that because of high workloads, some students had to perform in the role of paid staff, rather than having the status of learners. Louise said: '*I think some students, they just feel like they're treated like HCAs (Health Care Assistants).*' She continued:

> *…In ITU [intensive care unit] my mentor made me do all the washes and all the obs [observations]. …I think if you submit to that role then perhaps that's how …you might be treated. …There are so many ill patients and too much work to do. That's where you've got to use your own self-confidence and put yourself out there and say, once I've finished that work, could you show me such and such. That's where you've got to create your own opportunities. I think that is purely down to the demand on the nurses not being able to take the time to actually teach us. They are just so busy.*

Student nurses have supernumerary status within practice settings (NMC, 2018). This means that while they are part of the nursing team for the purpose of gaining clinical experience through exposure to the role of the RN, they are not regarded as part of the paid workforce or included in the staffing numbers required to deliver safe nursing care (RCN, 2019). This raises a question as to how consistently supernumerary status is implemented for all students as a way of enabling access to learning and as a means of supporting professional autonomy development. Louise seemed to negotiate her learning opportunities by agreeing to first complete what she perceived as paid work tasks, in order then to be afforded new learning opportunities.

Lara also talked about the weight of expectations placed on students by their mentors. However, whilst Ruth and Louise talked of being asked to undertake tasks that they considered may not have progressed their learning, Lara indicated her belief that the role of a mentor was to facilitate her learning, but responsibility for her learning rested with her. Lara also said she was asked to do tasks that she felt were beyond those she should perform as a student:

> *You're given a mentor; however, they are there just to facilitate your own learning. You've still got to find those opportunities yourself. I think that is purely down to the demand on the nurses not being able to take the time to actually make decisions. I think they are just so busy; they have to just take what somebody else has said, because they've got too many patients to look after. My mentor asked me to do several things, different things, and she said, 'I wouldn't ask if I didn't feel you could do it.' I will be asked to do things I'm sure I'm not allowed to do so I have to say, 'I'm not allowed to do that and can I just double check actually.'*

These participants' descriptions of their experiences suggest that in situations of high patient need and staff shortages, there could be a sense that they had to prioritise meeting organisational needs over their learning. Therefore, these participants' perceptions suggest learning the role of the RN was given a lower priority than meeting work needs. This shows that there may be, in some instances, a lack of clarity about the supernumerary status of the student nurse and some tension between being part of the workforce and negotiating opportunities for learning. This tension has the potential to hinder professional autonomy development.

Clare offered another perspective on the factors which she felt negatively affected her ability to seek support. Whilst this was not a widely expressed view, it is noteworthy because it relates to the process through which student nurses' competence is assessed. Clare talked about the influence she perceived her mentor could exercise over the outcome of her assessment:

> *If I've got a query, so if I raise this with my mentor and it's about something that she's doing, do I…then impact on our relationship because she's my mentor and … if I question what's she's doing, it feels that if you're questioning something that's happening in front of you, it's going to be a negative thing. ……your mentor's got to do your assessment on you so you can't afford to make mistakes.*

Clare was concerned that she could not ask questions of her mentor because of her mentor's influence over the outcome of her studentship. This suggests a possible tension between the mentor's roles as supervisor and that of assessor. Whilst this might affect the outcome for Clare in achieving her qualification, Clare's perception suggests a reluctance to ask questions and so might adversely affect learning and development of professional autonomy.

The above analysis suggests some of the factors that were perceived to hinder the development of professional autonomy. First, a perceived lack of support for learning was articulated by participants as feeling that their contributions to patient care were disregarded or limited by their mentors. Second, organisational factors, such as high staff workloads and inadequate staffing levels or a blurring of roles of students as learners and as paid workers were potentially detrimental to learning

and development. Furthermore, a tension between the mentor's roles of supervisor and assessor, could prevent students from asking questions were a less common, but nevertheless noteworthy, factor that could hinder development towards professional autonomy.

Theme summary: Factors that facilitate and hinder autonomous practice

In conclusion, I found commonly cited factors related to the student-mentor relationship that were seen to facilitate development of professional autonomy in my study. These findings confirm studies by *Oshodi et al.,* (2019), Skår, (2010), Holland Wade (2004) which demonstrated a connection between a RN's professional autonomy and relationships formed with others. However, this study offers additional insights into the factors in the student-mentor relationship that enable professional autonomy development. First, was the availability of support to engage in authentic nursing activities. The second factor was students' perceptions that their mentor had an interest in their learning and in supporting their progress towards autonomous practice. A third factor was that students' individual learning needs and prior nursing experiences were seen as being recognised by their mentors.

This study also threw light on participants' feelings on aspects of the student-mentor relationships that hindered development of professional autonomy. Notable were participants' perceptions that their contributions were not valued when their views were not sought or were disregarded. Second, and tentatively, the influence

that mentors held over students' progression to qualified status could be experienced as a hindrance. Whilst Oshodi *et al's.,* (2019) study discussed the importance of such relationships for autonomous practice in RNs, my study further suggests that, for some student nurses, being challenged to push beyond their comfort zones whilst being supported to avoid undue risk may enable movement towards safe autonomous practice. In common with Karagözoğlu (2009) findings of, my study also identified organisational factors, such as high staff workloads and inadequate staffing levels, as potentially leading to inadequate support or a blurring of the student's role as learner with that of paid worker.

Theme three: Establishing a sense of belonging as a member of the team

Below, I present data which suggest that opportunities to develop professional autonomy may be fostered by a sense of being valued as a trusted member of the team. A commonly stated view was that trust arose through developing a sense of belonging to, and receiving support from, the nursing team. Participants also expressed a desire to draw on their team's experience to share the processes of decision-making. In turn, this, was seen as enhancing their confidence in their own decision-making and facilitating their development of professional autonomy. Second, I show that a sense of belonging in a team was characterised by feeling that participants' contributions were respected. However, there were differences between participants in terms of how a sense of respect was experienced. First, being asked to participate in decision-making about patient care. Second, developing trusting relationships with team members. I also show how a sense of

exclusion or indifference to students' individual circumstances was experienced as marginalisation. When a sense of belonging was absent, this appeared to negatively impact on confidence which, in turn, inhibited professional autonomy development. Finally, I consider how participants tried to integrate within teams by understanding their student role and its boundaries. The data illustrate the ways in which participants achieved this. For some participants, developing their confidence, or knowing the limitations to their competence, seemed important; for others, permission-seeking seemed to be a means by which they could establish a sense of control over their own practice.

Shared decision-making to develop professional autonomy: 'It's not necessarily independently as in, it's just you'

I begin by showing that professional autonomy development occurred in the context of shared decision-making within the team which supplied opportunities for gaining support and advice, and for learning. I draw on data from Sue, Ruth, and Clare. These participants all expressed the view that professional autonomy meant making independent decisions, but they also recognised that it was supported by shared decision-making with the team. As third-year students, Sue and Ruth were coming to the end of their nurse education and were starting to apply for posts as staff nurses. Sue began: '*We need autonomy to be able to be working independently, making decisions'.* She went on:

> *It means being able to work, not on my own, because I would still always see myself working within a team, but being a decision-maker of my own, other people listening to what I have got to say and making decisions and*

having that knowledge and …feeling I can really make a difference to those patients. We need to be able to be working independently making decisions. It's definitely important to be autonomous but it's definitely important to work well within that team as well. …Working as part of a team, talking about why we do things that way or how we made that decision.

Similarly, Ruth indicated that professional autonomy meant making independent decisions drawing on knowledge and experience:

Working autonomously is having those problem-solving skills, so having information and being able to think, what's going to happen if I do this? So not always having to follow instructions. It's being able to decide for yourself and using all the knowledge that you have got and the experience. It's not necessarily independently as in, it's just you. But maybe there's a team of you, so you can say to somebody, what do you think of this? Or, I was going to do this, what do you think? I think it doesn't necessarily have to mean completely on your own, but it's getting information from lots of different places and then being able to say, ok so this is what we are going to do.

Sue and Ruth appeared to draw comfort from being able to access the expertise of team members to share in decision-making. In this sense, their professional autonomy appeared to be developed within the context of teamwork. Clare's perspective suggests that although she understood that professional autonomy meant making independent decisions, she was less clear about how she could be professionally autonomous:

It's about me saying, me doing what feels comfortable to me in that moment. To be autonomous is to be making those decisions. I don't think I

> *make personal decisions when I've got my uniform on as such because I'm then bound by the code so I don't see that I can be truly autonomous as a nurse. Maybe, it's more I can function as a leader in my own work, I can lead my own caseload, or I can …direct the care plan for the patient I'm looking after. But that's still structured by the input of other people and talking with the team. I don't know what the opposite to autonomous is but if I didn't feel part of the team, I would be absolutely making delayed decisions and very, very nervous decisions!*

Like Sue and Ruth, Clare saw that her ability to develop autonomous practice was supported by collaboration with the team and through shared decision-making. As a second-year student, Clare seemed to be developing her understanding of what it meant to be professionally autonomous. She indicated that not feeling that she belonged in the team would have a detrimental impact on her confidence, her ability to make prompt decisions and be autonomous. These participants, as student nurses were not autonomous practitioners and therefore sharing decision-making within their team was right for safe practice. My analysis suggests the importance of enabling student nurses to develop a sense of belonging in their teams. This, in turn, enabled the development towards autonomous practice because participants were able to 'sound out' others' views or seek other team members' expertise as they were rehearsing their skills in decision-making and developing independence in their decision-making. As such, this collaboration shows the social processes within CoPs that are based on '*mutual engagement, joint enterprise and a shared repertoire'* (Wenger, 1998. Pg.73).

A sense of belonging: 'It's about valuing and respecting all the nurses that are working within that team'

Below, I first draw on data from Clare, Briony and Sue's interviews which offer insights into how participants' sense of belonging was experienced. Belonging was described by participants as a sense of being respected within the team. For Clare and Briony, respect was characterised as the ability to take part in shared decision-making. For Sue, a sense of belonging was reached through establishing relationships of trust with team members.

I then discuss data from Ruth, Lara, and Louise's interviews that reveal contrasting descriptions of a sense of exclusion from the team in which they were placed. This sense of exclusion seemed to have a detrimental impact on participants' confidence. However, there were differences between participants in terms of how exclusion was characterised. For some, it entailed a sense of being kept on the periphery of the team; for others it was not having earlier experiences valued. Understanding how student nurses might be supported to feel included within a team may offer insights into how to facilitate a sense of belonging, and in turn, develop professional autonomy. Alternatively, these insights might help student nurses to recognise when a sense of belonging is absent and to seek help.

Clare said that feeling included by the team was characterised by '*encouragement and communication*'. She went on:

> *They valued my thoughts. …There was a deterioration of a child and the nurses said to me. What do you think? …You can mull things over together. … it didn't matter that I'm not the qualified nurse. It's nice to be involved in that sort of decision-making. They valued my thoughts on the appearance of the child, which was not good! It's about valuing and respecting all the nurses that are working within that team and allowing them to make decisions. …It's having a good relationship within the team.*

It appeared that being asked her views and perceiving that these were valued in this situation gave Clare a sense of belonging. However, this needed more than just encouragement or communication; Clare wanted to feel that contributions she made to the shared decision-making of the team were valued, while recognising a difference in status between herself and the RNs in the team.

Briony also suggested that she needed to feel valued as a professional as well as for the contributions she could make to the team:

> *It's not feeling that if you left tomorrow, that you'd be immediately replaced. Students come and then they go! I think you need to feel like you have value within the workplace and that you're not just part of the bigger team but also professional on your own. …If you've got a team that are inspired and engaged to work with you, you can achieve anything you want to achieve.*

Clare and Briony's sense of belonging seemed to be characterised by feeling they could contribute to the work of the team. Moreover, that the team appreciated

these contributions. This appreciation was shown through a process of sharing ideas with team members to reach agreement.

Similarly, for Sue it was not just being within the team that enabled her to feel autonomous; receiving constructive feedback characterised her inclusion and enhanced her confidence which empowered her to be autonomous. This seemed to create a sense of belonging:

> *It's about working within a team that empowers you to be autonomous. …Praising them when they've done well and explaining when they haven't done so well …it's about building people up and that's great. It's having good relationships. Having people around you that are encouraging, supportive, and recognising you as an individual. If you've got a happy team, cohesive team, we all know each other, we all know how we work, we all know our strengths and weaknesses, that's going to result in better patient care. I need them to have trust in me and for me to trust them! …In fact, I wouldn't work somewhere where I didn't think that happened because I would really struggle.*

Sue also stressed the importance of team members valuing each other's strengths and weaknesses and being aware of each other's abilities and limitations. This signalled a satisfactory level of trust amongst those members of that team. Therefore, being able to establish trust within her team characterised Sue's sense of belonging.

In marked contrast, Ruth, Lara, and Louise discussed placements in which they perceived that they had not been made to feel part of the team. Ruth discussed an experience in which she '*felt almost invisible'.* She continued:

> *It was very, very difficult to become part of the team. I don't think some staff even knew my name, except being called 'the student'. You feel it's them and us. I was definitely on the outside. I think it's that some places just don't like having students. …It really undermined my confidence, and I don't think I really learnt anything new in eight weeks.*

Ruth's notion of *'them and us'* and of being *'on the outside'* seemed to imply that she was inhibited from learning from the experiences of existing team members and that her contributions were not valued. This sense of being on the periphery of the team seemed to adversely affect her confidence.

Lara talked about a similar experience of being an outsider. In her earlier role as HCA she had removed intravenous cannulas. She spoke of her experience in one placement: *'After six weeks, …It felt like they didn't even want to know my name.'* She continued:

> *It wasn't until my last week, …that they let me remove a cannula and they were really surprised I could do it and I was like, I've been telling you I can do it because …it was like normal day-to-day work for me! ...It was so frustrating; I'm going to be expected to be a nurse in charge of patients and making decisions. They didn't know what I could do. They made me feel a bit nervous, they didn't want me there.*

Being called ‘the student’ rather than by their own names emphasised Ruth’s and Lara’s sense of exclusion from the team. Additionally, it seemed that a lack of recognition of Lara’s earlier experiences deepened her sense of exclusion.

Louise also talked of an experience when she felt she had been excluded:

> *Towards the end of the placement, I had worked out that nobody in the department had ever asked me to work with them, I had to ask them. When I picked up the courage to say something they were like, ‘we didn’t even realise that we hadn’t done that.’ Hopefully by me saying that, for the next student they will ask! I had to be quite creative to seek out learning opportunities. …It’s nice to feel part of the team but the team can really knock someone’s confidence and make you doubt yourself. …It’s quite easy to recognise when a team doesn’t work together.*

Louise’s contribution suggests that, in some circumstances, a team’s ways of working may have a detrimental impact on a student’s sense of belonging. These participants’ views show that not every team supports students to develop their professional autonomy. Again, these negative views seem to underline the importance of developing a sense of belonging in the placement team. It also suggests that there may be times when students may need to seek help from senior staff or the wider university team to assist their integration into a placement team or educate the team to competently support students.

These finding show why a sense of belonging is important to developing professional autonomy. Feeling valued and respected as individuals appeared to be key aspects of participants’ perceptions of belonging. However, the absence of

a sense of belonging was detrimental to confidence and hindered opportunities to develop professional autonomy. For nurse educators, consideration should be given as to how students can be supported to quickly become part of the team to develop their sense of belonging. It also points to the need for teams to understand the role and place of students.

Establishing boundaries in the team: 'I know a bit more about what is expected of me now'

The third aspect in this theme relates to understanding the ways in which participants tried to become trusted team members. Sue, Lara, Ann, and Clare, for example, demonstrated keenness to clarify the boundaries of their roles as student nurses with other team members. However, participants achieved this in diverse ways. Both Sue and Lara, tried to make themselves part of the team. For Sue, becoming a trusted team member entailed developing a clear understanding of the expectations of her role, whilst Lara tried to create a sense of trust. Ann and Clare both discussed using permission-seeking; however, there were differences in how they applied this to their practice.

As a third-year student, Sue talked about how her understanding of being a student nurse had developed. While Lara, in her second year, talked about knowing her limits:

> *I know a bit more about what is expected of me now. I understand what the role is. I was probably different when I first started as a student nurse really.*

> *When I first started …I thought that maybe I was bottom of the pecking order! It's finding your feet and feeling confident… It's definitely important to ask for help, don't just think, 'I know what to do,' and do it wrong. …I'm very open, I'm very chatty, I'll do anything, I just want to learn. I will always help in the work that they've got to do, but it's not about learning, it's about making them see me as one of the team. If they say to me 'I'm just on the phone so, can you get this gentleman off the bedpan' then of course I would, I wouldn't think twice.* (Sue)

> *It's hugely important to know your limits. But it's also taking the initiative, that's what I've always done in all my placements is use my own initiative and demonstrate to my team that I am a competent student nurse to be able to be involved in those decisions. The way that you engage with your patient and your colleagues, reflects on what they will give you to do, sort of duty-wise. …So that's nice to be told, 'I trust you to do this'.* (Lara)

As a means of getting the team to treat her as a team member, Sue helped with the 'work' of the team. Sue seemed to separate being seen as a member of the team from her learning. Sue also appeared to have concluded that asking for help was beneficial to her understanding of the boundaries of her role and helped her establish her place in the team. Developing a sense of belonging seemed to require active engagement by Sue as well as action from the team. For Lara, becoming a trusted team member seemed to entail knowing the boundaries of her competence and pro-actively working within these. These views suggest these participants were seeking opportunities to participate peripherally in legitimate nursing tasks. Gaining the trust of their teams seemed to enable Sue and Lara to make the transition from newcomer to member of the team in a fuller sense,

trusted to complete nursing tasks. These processes of gaining trust shows how these participants were able to transition towards becoming members of the community of practice (CoP) (Lave and Wenger, 1991). Sue's perspective offers further discernment into transitions within nursing education. She supplies insight into how student nurses may perceive themselves as starting at the bottom of a hierarchy, becoming socialised into nursing and progressing from a position of perceived powerlessness to developing the level of professional autonomy expected of an RN.

Ann and Clare discussed seeking permission as a means of supplying clarity about boundaries. However, the ways in which they used permission-seeking differed. Ann, with her existing RN status, used permission-seeking as a means of developing confidence about what decisions she had authority to make independently. Clare referred to giving herself permission to decide what activities she would undertake:

> *I'm not completely able to see what I can and can't do, but it just feels very much hierarchical with regards to making decisions. As students, we don't know what we can do. So, I always get permission. …It's all about the team, I need them to have trust in me. Then it's just being able to think and feel you can make those decisions and to make a difference. …I think a lot of students are afraid to do so because they feel like they need a lot more go-ahead from senior staff to be able to make those big decisions. …I don't think it's apparent as a student that you are able to make autonomous decisions. I think it feels like you're boxed in a little bit with regards to what you can and what you can't do, but it's ok if you ask your mentor and get permission.* (Ann)

> *At the moment it's safe stuff that I give myself permission to do without having the support of my mentor or the ward team. It's having to build up the knowledge of that environment over a number of weeks, having the confidence to say, well I know what the nurse would do if she was here, so I'm going to do it. …From what I understand of the word autonomous, it has to be an agreed boundary to making those decisions and I don't know where you learn that. (Clare)*

For Ann, asking for permission appeared to clarify the boundaries within which she had the authority to safely make some decisions autonomously and gain the trust of the team. For Clare, learning about her practice environment and how nurses worked within it seemed to help her understand her boundaries and what she could do or give herself permission to do, when working without direct supervision from her mentor. However, despite having completed half of her nurse education, Clare still seemed unclear on how to establish boundaries, whilst acknowledging that boundaries needed to be agreed. Clare considered how other nurses would act in a particular situation to give herself the confidence to replicate their actions safely and independently.

The data show that these participants clarified boundaries in different ways. However, they commonly expressed the view that boundaries enabled them to develop trust within the team, to understand what tasks and what decisions they could make independently, or in Ann's case, to know where her authority to act autonomously rested. Therefore, understanding boundaries enabled inculcation in the team and a sense of belonging. Through this participants seemed able to

make decisions or to complete nursing tasks and so work towards professional autonomy, under supervision.

Summary: Developing professional autonomy within the context of the team

The development of professional autonomy appeared to be enabled by students engaging with the team in shared decision-making and working within established boundaries. This study confirms the findings of Oshodi *et al.,* (2019) that RNs related their autonomy in decision-making in the context of the team. However, the findings of this study further our understanding by pointing to the importance of student nurses, as temporary team members, feeling that they have become trusted members of the team. In turn, this may enable them to develop their professional autonomy. The analysis also corroborates the findings of Molesworth (2017) and Thrysoe *et al*., (2010) in that a key identified characteristic of a developing sense of belonging was feeling respected as an individual. My study has given insight into the differences in meaning 'being respected' had for these participants. For some participants having a voice in shared decision-making about patient care was a salient perspective, whilst for other participants establishing a sense of trust with team members was the prominent perspective. Therefore, this points to the importance of valuing each student nurse and in recognising that a variety of approaches may be required to support student nurses to establish a sense of belonging within the teams in which they are placed.

Lave and Wenger (1991) identified the importance of establishing CoPs by creating a sense of belonging within a work team. My analysis has shown that a sense of belonging enabled some participants to work towards the development of their autonomous practice through decision-making. Also of note, the lack of a sense of belonging was seen as adversely impacting on participants' confidence. Furthermore, perceptions on being excluded were characterised by participants in a number of ways which included; feeling that they were on the outside of the team and that their earlier experiences were not valued. This emphasises the sometimes taken for granted authority team members may have over these participants' learning opportunities and access to the CoP (Thrysoe *et al.*, 2010; Melincavage, 2011; Molesworth, 2017). Recognising how students might be included within the placement team and how they should be made to feel that they are, supplies opportunity to support students' sense of belonging, or to seek help should it be absent.

My findings show that understanding the boundaries of their roles as student nurses- the extent to which they could make decisions about patient care or work independently, was an important aspect of participants feeling they belonged as trusted members to the team. However, different perspectives were expressed about how such boundaries were established which points to valuing the individuality of each student. This finding concurs with earlier findings of Iliopoulou & While (2010) with regard to RNs, and those of Arreciado Marañón & Isla Pera (2019) with regard to student nurses. It reinforces the need for role clarity as a precursor to autonomous practice. However, as the experiences of some

participants illustrate, not every team is regarded as supporting student nurses in developing professional autonomy. The possibility that a team may not be able to integrate a new member and support students' learning was not particularly acknowledged in Lave and Wenger's (1991) work. Student nurses and those responsible for their learning need to recognise the importance of developing a sense of belonging in the team because, as shown here, learning to develop professional autonomy is not achieved through just supervision and assessment. Here, the student-mentor relationship in which a sense of trust is reciprocated that facilitates learning is central to its development.

Theme four: Transitions towards professional autonomy

All participants reported they knew they would be autonomous as RNs, yet they also reported they had not been taught about professional autonomy. In this section, I first illustrate a commonly held perspective that professional autonomy develops through making increasingly complex decisions during the transition through nurse education. There was also a commonly articulated view that the process of becoming autonomous entailed increasing accountability. I then explore participants' perceptions that their ability to perform autonomously might weaken temporarily once they had achieved RN status.

The process of becoming autonomous - 'You're expected to become more autonomous; you're expected to be more accountable'

I first draw on data from Ruth, Lara, and Esme's interviews to illustrate their similar perspectives that professional autonomy develops progressively through the course of nurse education. In this sense, these participants talked as if they would inevitably reach a state of being able to practice autonomously. There was also commonality in view that professional autonomy developed through the process of iteration and through practicing increasingly complex decision-making. However, there were differences in views as to whether this process developed incrementally through each year of nurse education or whether it was fostered through learning from making complex, impromptu decisions in practice settings. Whilst there seemed agreement that the trajectory towards developing professional autonomy could be different for each individual, there was some commonality that the process of developing professional autonomy meant becoming accountable for nursing practice and for decision-making. Here, differences were in whether accountability was perceived as being *'scary'* or whether being able to account for decision-making offered a means of justifying the extent of one's autonomy.

Ruth seemed to regard the development of professional autonomy as predictable and as an expectation as she progressed through her nurse education:

> *As you progress through your training, you're expected to be more autonomous, you're expected to be able to make decisions and even if you're checking with somebody, you're expected to become more autonomous; you're expected to be more accountable. It's about developing through your education and becoming more autonomous as you go through* it.

Similarly, Lara showed that developing professional autonomy was something which happened as she transitioned through her education:

> *It will be even more developed as I go through, so something that you can build on. …I guess everyone has the potential, so if you start both at the same time, they have the same potential to end up with the same autonomy, but it depends on how you get there. On the wards you just have to develop it through baptism by fire. …makes you think on your toes, I think it speeds up your decision-making. …How you can act quicker.*

Unlike Ruth, who saw a linear relationship between professional autonomy development and time, for Lara, this process occurred through making difficult or challenging decisions in response to particular situations. Lara recognised that development of professional autonomy might vary between individuals, but suggested that, ultimately, the same end point of professional autonomy was reached.

Esme, like Ruth, suggested a direct relationship between the development of professional autonomy and time. Here, decision-making increased in complexity and independence as Esme transitioned through her nurse education:

> *The second year is just more challenging than first year. But it needs to be, otherwise you're never going to be prepared to actually qualify. …I don't think I would have just made a decision independently in the first year, but now I'd be more confident. It really depends on the student. I think definitely once you're into your third year, probably even in the second year, you*

> *should be making decisions. You need to build up those thought processes and build up that decision-making yourself. Because otherwise, you're just going to qualify and then you're going to have to do it on your own and you won't know what you're doing. …Some people don't want to make decisions, maybe they don't want to be accountable for stuff, but then they're probably in the wrong job.*

For Esme, the process of developing professional autonomy seemed to be dependent on the growing confidence of the individual with their decision-making. This suggests that it necessitates confidence with decision-making and that it occurs on an individual basis. Esme also indicated that there seemed to be a relationship between decision-making and accountability. In this respect, a further commonly articulated view was that the process of becoming autonomous was coterminous with becoming accountable. Louise offered, *'When we qualify there is more accountability'.* She continued:

> *I just think you've got to be more responsible, which means you've got to be able to know why you are doing something, you've got to know the evidence for the decisions you make... Thinking of being qualified makes you feel a bit nervous, but you're not going to be alone, so I don't know why I'm going to feel nervous. …It's because you are going to be essentially the one who's name is going to be making that decision. You need to have the support of people around you, and you can ask for advice from other people.*

Louise defined accountability as knowing the evidence on which she based her decision-making. However, she seemed to draw strength from the idea that she would have support from her team as a new RN. The sense of nervousness

Louise's perceptions, as a second year student, as she considered her transition to RN status, indicated she may be occupying a liminal space. Ruth, similarly, defined accountability as the ability to use evidence to justify her decision-making:

> *Having autonomy is also to be accountable for your practice. You have to be able to justify to yourself and to others why you are making those decisions and what evidence you have used. ...It's all on you, its accountability. …Some days it's really exciting and I'm really looking forward to it [qualifying], but then …the accountability does feel overwhelming because you do become independent. …You have to like being a nurse; it does feel that it's all encompassing, that it's every part of your life that you can't get away from it. It does feel like it crosses over the boundaries from work to personal life, and I don't know whether that should be separate or whether it's …that you are a nurse, that's who you are, rather than you're not a nurse at home.*

Ruth appeared to be trying to decide where the line between her accountability as an autonomous RN was drawn and appeared to question whether there were any such margins. Lara and Sue also related professional autonomy with accountability:

> *Having autonomy is also to be accountable for what you're doing and accountable for your practice. You have to be able to justify to yourself and to others why you are making those decisions and what evidence you have used. … If you work to the guidelines and you can prove that actually this is why I've done this. It's your rationale then that can protect you, if you justify what you have done and back it up, (Lara).*

> *I am so worried about being newly qualified. …It's just that feeling that it's suddenly all on you, and it is really, because …We are responsible for what we do out in practice, it's very difficult to explain isn't it? …Being a decision-maker of my own, having that knowledge on my own. We become accountable, (Sue).*

There was a universally held view that accountability meant first, being able to justify decisions through knowing the evidence on which a decision was based and second, that becoming professionally autonomous meant being held to account. However, there were different conceptions of accountability. For Louise, Ruth, and Sue, becoming accountable seemed to give them a sense of anxiety, whilst for Lara, being able to account for her decision-making seemed to be protective as it provided her with a means of justifying her autonomous practice.

Transitioning to autonomous Registered Nurse: 'At the very beginning, I'll be less autonomous'

In this last section, I draw on data from Lara, Sue, and Ruth's interviews because these illustrate a common view that professional autonomy may not be achieved immediately on qualification, and that a sense of professional autonomy might temporarily wane during the transition from student to RN. As Lara offered, '*It might take a while before I am happy to make those decisions!'* She continued:

> *By the time I come to the end of this thing I'm going to be expected to be a nurse in charge of a certain amount of patients and making decisions. In that sense, you do have autonomy. …When you are qualified, because*

> *even though you have the support of people around you and you can ask for advice from other people, essentially you are going to be the one that is going to make that call. …It's just that newly qualified period when you've got to step up from being a student. It's quite scary!*

Lara seemed to be predicting a transitional period between ending her nurse education and becoming a RN, which for her seemed 'scary.' This transitional period indicates being positioned at a threshold between student nurse and RN status. During these periods, liminal experiences can produce uncertainty and feelings of disorientation. Similarly, Sue suggested that, on becoming a RN, she would need time before she felt fully confident with her decision-making:

> *I've just got in my head that we'll be autonomous practitioners because we are qualified. When I'm qualified, I just need to give myself time to grow my confidence again. …So just because I will be that autonomous nurse, it doesn't mean I will feel I can make those decisions! …I think it will come from reflecting, feeling more confident, working well within the team. …I'm hoping that my last placement will really set me up. …I suppose in my head I'm going to pretend that I'm qualified and think, what would I do in this situation.*

Sue's contribution suggested a conflict or perhaps ambiguity between being regarded as autonomous by virtue of holding the title of RN while initially not feeling sufficiently confident to make autonomous decisions. However, she appeared to draw strength from thinking that her confidence would increase through reflection and by working with her team. Furthermore, in her final placement as a student, Sue talked about pretending to be qualified. This shows

her desire to practice her professional autonomy before she became an accountable RN.

Ruth said that '*At the very beginning, I'll be less autonomous.'* She went on:

> *I think I'll be quite tentative at the beginning. …It's that reflection time isn't it, thinking about how things work, just that going over things, checking yourself and checking with somebody else and that will change as you've been qualified for longer. But at the beginning, I think probably lots of people are much less autonomous than when they are in their final week of their final placement. It's just those tentative baby steps, you can make sure it's ok and then, you can start to become more autonomous again.*

Ruth predicted that her sense of autonomy would decrease for a period as she transitioned from her final placement as a student nurse to being qualified as a RN. Like Sue, Ruth appeared uncertain as to how she might feel about her professional autonomy during this period.

The findings show that the transition from student to newly qualified RN was perceived with a degree of trepidation. As Sue and Ruth were approaching the final six months of their studentships, they seemed to be predicting a transitional period which might affect their confidence (van Gennep *et al.,* 2019; Holland, 1999). They suggested they would manage the loss of confidence through internal self-reflection to think through decision-making and the external support of others. This suggests that student nurses can be prepared for this transition by understanding that as they move from student nurse to RN, their confidence and

sense of professional autonomy may alter, or they may not comfortably feel autonomous immediately on qualifying.

Summary: Transitioning towards becoming autonomous and accountable Registered Nurses

The findings of this study highlight an expectation on the part of these student nurses that professional autonomy would be achieved over time. There was a commonly held view that professional autonomy entailed independence, accompanied by complex decision-making. This suggests professional autonomy development requires students to actively engage in rehearsing complex decision-making and autonomous practice. However, there were differences between participants' views regarding whether professional autonomy development was achieved through incremental progression in decision-making across each year (or level) of nurse education or through exposure to rapid decision-making in challenging situations. This seems to contradict the findings by Karagözoğlu (2009) that perceptions on professional autonomy decrease as students transition through later years of study. However, it does show that the development of professional autonomy is not linear or predictable. This aligns with van Gennep *et al's* (2019) argument that liminal transitions do not always proceed uniformly and indeed students could move back and forwards between liminal phases (Barton, 2007; Meyers and Land, 2005). It seems important to prepare student nurses for transitions. This may be by enabling them to conceptualise how transitions may affect their sense of confidence and professional autonomy. Opportunities for

rehearsal of autonomous practice by sharing decision-making and collaborating with their team may support such transition through nurse education.

The findings also reveal that participants saw a clear link between professional autonomy and accountability. This aligns with Freidson's (1994) definition of professionalism in which he positions autonomy as accountability to the standards, values, and behaviour expected of the profession. And, with the NMC (2010, Pg.13) expectations of RN to balance autonomy with responsible and accountable practice. Commonly, participants saw accountability as the ability to justify decision-making using evidence. However, some participants perceived the prospect of becoming accountable as worrying.

Finally, the data shows that some participants were aware that their sense of professional autonomy would falter in the period immediately after qualification. Whilst some participants had developed this insight, not all participants articulated this perception, although they may have recognised this but simply not articulated it. Therefore, student nurses would benefit from knowing, perhaps more explicitly that during transitional points as they have liminal experiences, their conceptualisations of their professional autonomy might change. However, some participants were trying to think through ways in which they might draw on their own internal resources and seek external support from others to develop a fuller sense of professional autonomy, once formally qualified. This, therefore, offers an indication of how student nurses might be prepared for such transitions.

Chapter summary: Conceptions on professional autonomy development

In this chapter I have presented my thematic analysis and interpretation of data from participants' interviews. I conclude that the development of professional autonomy is viewed as an individual, liminal, transitional experience which continues throughout nurse education and on into professional practice as an RN.

The importance of developing confidence to practice autonomously has been apparent throughout. Whilst earlier research has highlighted the relationship between confidence and professional autonomy (Oshodi *et al*., 2019: Holland Wade, 2004), this study adds to what is known by showing how confidence develops through a sense of increasing familiarity. Familiarity was conceptualised in a number of ways: familiarity with the practice setting, its patients, and their medical conditions, but also with the type of nursing the team performs, and how the team is structured and operates. Familiarity seemed to facilitate the building of confidence to make decisions and appeared to be a way of developing professional autonomy. However, transitions to new and unfamiliar situations appeared to cause participants to question their confidence to make autonomous decisions which may show they were undergoing liminal experiences. Similarly, participants' feelings about how they were regarded by others appeared to have the potential to make them question their own sense of professional autonomy. Understanding how familiarity with aspects of the practice context may contribute to confidence building could enable students and mentors to recognise those practises that seem 'comfortable'.

This study has also shown when an individual's confidence fluctuates so does their sense of professional autonomy. When entering and working in a liminal space such as starting in a new placement or when contemplating graduating to become a RN, participants seem to experience and predict changes in confidence and in their ability to act autonomously. Therefore, supporting students to name those aspects of nursing practice with which they are already familiar and confident, may help them to transfer their pre-existing knowledge and understanding to less familiar situations.

The student-mentor relationship appeared to be of paramount importance to participants in this study. Some specific aspects of this relationship seemed to facilitate professional autonomy development. First, the provision of individualised support that focussed on active participation in authentic activities relevant to the role of the RN was commonly cited. This aligns with the concept of legitimate peripheral participation (Lave and Wenger, 1991) which would require the learner to be engaged in aspects of nursing care whilst working alongside a knowledgeable and experienced mentor. A second factor which was seen as helpful was the feeling that contributions to patients' care were valued by the mentor. Third, collaborations with mentors that included feedback on performance and being allowed to practice autonomously, under supervision were also valued. In turn, this facilitated a sense of being socialised into the nursing role. Finally, although less commonly expressed, was the recognition of students' position as learners in which mistakes are part of learning.

Furthermore, this study has shown some of the factors that hinder the development of professional autonomy. These included a perceived lack of support for learning, whether through feeling disregarded or marginalised by mentors, or through organisational difficulties such as staffing shortages which limited opportunities for learning. Importantly, a perceived lack of regard, on the part of the mentor, for the individual student and their learning needs was consistently viewed as detrimental to the development of professional autonomy. It appears therefore, to suggest a uniform approach to the relationship between mentor and students is not appropriate and supports an individualised student-centred approach.

A further aspect of participants' conceptions on professional autonomy related to their experiences within teams in practice settings. This study has shown that opportunities for professional autonomy development were enabled through sharing in the decision-making of the team. Opinions differed as to whether shared decision-making meant seeking confirmation of decisions or accessing expertise when needed. However, establishing a sense of belonging within the team and trust with team members was viewed as important to professional autonomy development. This points to the need to enable students to become part of the team quickly. Therefore, whilst the data commonly illuminate feeling valued and respected were important to belonging, as temporary and supernumerary members of the team developing belonging merits further consideration. This study also highlights that a feeling of being kept on the periphery of the team by

virtue of being a student, or by not being recognised for their contribution to patient care, may inculcate exclusion.

This study has shown that developing professional autonomy was consistently seen by these student nurses as entailing a process of increasing independence with increasingly complex decision-making. Whilst it seemed taken for granted that on registration with NMC, participants would become autonomous practitioners, perceptions showed autonomy developed incrementally as a natural part of the transition through nurse education through the experience of complex decision-making in acute practice situations. Becoming accountable for one's decisions was commonly viewed as part of the transition to autonomous RN status. Here, accountability meant justifying decision-making based on evidence. For some participants the idea of becoming accountable for autonomous practice caused anxiety. This points to the need to ensure student nurses are adequately prepared for their transition to autonomous RN. The study suggests that at transition points, such as starting a new placement or moving from being a student nurse to becoming a RN, one's perception of one's ability to practice autonomously may fluctuate or decline. Therefore, it should not be assumed the development of professional autonomy is linear or consistent. This has implications for nurse education more generally as it speaks to the importance of personalising supervision and support arrangements.

Chapter Six
Discussion and Conclusions

Introduction

In this chapter, I discuss how participants regarded their transition towards developing professional autonomy by focusing on three areas. First, I discuss student nurses' conceptions on their developing professional autonomy in the context of their nurse education (research aim 1). I assert that student nurses may develop professional autonomy through liminal experiences (van Gennep *et al.,* 2019). Drawing on SLT (Lave and Wenger, 1991), I consider the ways in which developing familiarity within the practice placement enabled these participants to feel that they could manage liminal experiences.

I show that the findings of this study illuminate some of the factors that influence student nurses' development of professional autonomy (research aim 2). I begin by summarising those factors which were regarded as facilitating or hindering participants' liminal transitions - time and space and supportive relationships with mentors and the practice team. Since student nurses are transitory, temporary and supernumerary members, it appears to me that they are permanently peripheral members of a CoP. Drawing on participants' descriptions of their experiences, I argue that it is engagement with the social processes that form CoPs (mutual engagement, joint enterprise and shared repertoire) (Wenger, 1998) rather than achieving full membership within the CoP that helped professional autonomy development in these student nurses.

I discuss implications of my findings for how nurse educators can further support the development of professional autonomy among student nurses (research aim 3). I suggest some practical means through which student nurses might be supported to manage their liminal experiences. I also assert the importance of student nurses' having supernumerary status as a means of facilitating support, time and space to work through liminal experiences.

In the last section, I present my conclusions to this study. I summarise what these findings add to the academic and professional bodies of knowledge in respect of professional autonomy development during nurse education. I also present my dissemination strategy. Finally, I reflect on my own transitions through liminal experiences during doctoral study.

Student nurses' conceptions on their developing professional autonomy in the context of their nurse education (Research aim 1)

The concepts of liminality (van Gennep et al., 2019) and SLT (Lave and Wenger, 1991) provide theoretical frameworks with which I discuss these student nurses' conceptions on their developing professional autonomy. The findings of this study reveal the importance, for these participants, of their becoming familiar with their practice settings, and understanding the expectations on them in these settings. Through increasing familiarity, they seemed able to develop the confidence needed for professional autonomy development. I claim that this study has found

indicators of liminal experiences within nurse education. I then show the diverse ways in which participants conceived they grew familiarity with their practice settings as a means of managing liminal experiences.

I then apply SLT as a framework to consider how professional autonomy development might occur through LPP (Lave and Wenger, 1991). I show the diversity of activities participants articulated and which I claim constitute LPP. I then assert it is engagement in LPP which may facilitate professional autonomy development.

The development of professional autonomy through liminal experiences

As discussed in chapter three, the term liminality refers to a transitional state or threshold between one stage and the next or one social status and another (van Gennep *et al.,* 2019; Turner, 1967). A person in the liminal phase, and undergoing liminality, has started the transition to, but has not fully reached, their new stage or status (van Gennep *et al.,* 2019). This is relevant to participants' perceptions on their developing professional autonomy as they transitioned from newcomer to trusted team member by being socialised into nursing. This transition was from having a lack of familiarity with the practice setting, its patients and the team's ways of working to becoming confident student nurses able to understand which nursing tasks they could complete independently and under direct supervision. Furthermore, participants in this study reported changes in their feelings on their

confidence that gave rise to uncertainty in their role. Liminal experiences have been described within existing literature as experiences of *'ambiguity'* (Turner, 1967, Pg.465); of *'troublesome knowledge'* (Meyer and Land, 2003, Pg.1); of *'disillusionment'* (Hurlock *et al.,* 2008, Pg.292)*; 'of uncertainty and confusion'* (Evans and Kevern, 2015, Pg.2). Thus, these participants' perceptions are indicative of having liminal experiences.

Participants discussed a variety of indicators of liminal experiences that were not mutually exclusive. First, in the course of undergoing a liminal experience some participants' existing understanding was called into question as they were confronted with new knowledge (Meyer and Land, 2005; Land *et al*., 2014). This was shown by the uncertainty experienced as participants encountered new information about patients and their care, nursing practices and their team's unfamiliar ways of working. The process of applying existing knowledge and understanding to an unfamiliar context may result in the formulation of new knowledge and understanding (Allan *et al.,* 2015). Therefore, the process of recontextualising newly acquired knowledge may present a challenge to a previously-held sense of professional identity exacerbating a sense of ambiguity (Gourlay, 2011; Allan *et al.,* 2015; Ibarra and Obodaru, 2016).

The second indicator of having liminal experiences was participants' perceptions on being *'betwixt and between'* (Turner, 1967) being newcomers to the practice team and being team members, trusted to make decisions and take more autonomous action, although under supervision. These findings highlight

participants' wanting to make the transition to the status of trusted team member by developing their understanding of their place within the nursing team. For participants, the boundary between newcomer and trusted team member sometimes seemed elusive with little recognition of when this status has been achieved.

A further indicator of participants' liminality was the degree of nervousness with which they predicted becoming accountable as RNs. In the liminal space between the status of student and that of RN, some participants predicted that their professional autonomy would diminish from what they had perceived it to be as third year student nurses. This appears to confirm the findings of previous research where is has been reported that newly qualified nurses felt overwhelmed by the increase in accountability which exacerbated feelings of social isolation (Smythe and Carter, 2022). This concern was raised in the report: *Reducing Pre-Registration Attrition and Improving Retention (RePair) report* (HEE, 2018). This report emphasised that perceptions of increased accountability resulted in feelings of anxiety and isolation in newly qualified nurses. This was cited as a primary cause of attrition in nursing. The findings of this study reinforce the view that further action is needed to support student nurses about to qualify and newly qualified nurses to manage liminal experiences during this transition.

This study shows that developing professional autonomy is through a process of increasing familiarity. It is therefore, an individual, transitional process, characterised by liminal experiences. In turn, the process of emerging from a

liminal phase with a better sense of understanding appeared to facilitate participants to integrate into the practice team and to develop confidence in performing to the expectations of their role within that team. Furthermore, through becoming more familiar, it appeared that participants were able to manage liminality to develop towards autonomous practice. However, the process of transition is multi-faceted, with oscillation between the phases of liminality (van Gennep *et al.,* 2019). As such, it is challenging to predict when liminal experiences start and when they end, and this has implications for how student nurses might be supported.

Increasing a sense of familiarity as a means of managing liminal experiences

Participants commonly cited events such as starting a new placement or contemplating graduating, which caused their confidence to wane. This accords with research by Skår (2010) and Oshodi *et al.,* (2019) who reported the importance of RNs having confidence to practice autonomously. This study furthers understanding of professional autonomy development in student nurses because it confirms the importance of having a sense of confidence. Moreover, that this may be helped by becoming more familiar with the work of the team in the practice setting. This study also throws lights on the processes entailed in professional autonomy development, which participants commonly experienced as nonlinear, unpredictable, and variable.

Having shown participants conceive on their professional autonomy development as necessitating familiarity, as a precursor to having confidence, I demonstrate a number of ways through which participants defined and established familiarity with the practice setting. First was the desire to understand the expectations of their role in the context of their team. This desire was previously articulated in relation to knowing the boundaries to autonomy within the student nurse's role (Labrague *et al*., 2018; Arreciado Marañón and Isla Pera, 2019). Permission-seeking prior to completing tasks provides a '*legitimate narrative'* (Ibarra and Obodaru, 2016, Pg.52). Which, for some participants gave validity to undertake nursing tasks. Through this, participants could be incorporated into the social norms by becoming familiar with the culture of nursing by helping them to become attuned to the often-unspoken ways of working of the practice team (Allan *et al.,* 2015). In this way boundaries were established to create safe environments in which to learn and work.

The second way in which participants defined and established their familiarity was becoming familiar with new patients and new types of medical conditions. Participants indicated they needed to take responsibility for personal learning about patient conditions and their nursing management in each practice setting. As such, the ability to be self-directed called for individual agency; the ability of the student to take some control of their own situation. However, participants commonly voiced this was only possible if they perceived their mentor took an interest in their learning. Here, there were differing views as to what was meant by mentors taking this interest. For example, mentors demonstrating a nursing task

before participants performed that task themselves; knowing mentors would correct mistakes before these impacted on patients; wanting mentors to push participants beyond their ‘comfort zones’ and more commonly, wanting to feel views on patient care needs were valued. Therefore, this suggests there is no single approach to how participants perceived mentors showed an interest in their learning. However, broadly, creating collaborative partnerships that support all student nurses towards professional autonomy seems important. Moreover, collaborative partnerships between mentor and student nurse appear to require establishing a balance between giving and receiving support and allowing students the freedom to take the initiative themselves.

Finally, developing familiarity was commonly perceived as enabling increasing independence in handling complex decision-making, through drawing on previous knowledge and experience. However, participants perceived themselves as becoming independent decision-makers through different means: incremental progression through gradual introduction to decision-making; or exposure to rapid, complex decision-making within the practice setting. Whilst these differing perspectives shed light on the complexity involved in understanding how student nurses conceive of their professional autonomy, it seems clear that contextual factors are relevant to the development of autonomous decision-making (Johansen and O’Brien, 2016).

van Gennep (van Gennep *et al.,* 2019) and Turner (1969) suggested that the liminal phase was finite with a fixed end point, typically characterised by

progression to a new role or social identity. However, in this study, some participants reported feeling excluded from the practice team or perceiving a lack of learning during a placement. As such, there seemed no guarantee that liminal experiences would produce certainty about expectations of the student nurse's role, assimilation into the practice team or professional autonomy development. In part, this may be because progression through nurse education entails recurrent transitions to new placements wherein student nurses often learn and work alongside a number of different health professionals. This suggests participants may not progress through liminality uniformly or in an incremental manner or, indeed, that liminal experiences result in emergence to new status of trusted team member or competent student nurse. This indicates a contradiction in which student nurses may be viewed as having frequent and/ or repeated liminal experiences which may also indeed be persistent while *'being a student nurse'* (Holland, 1999, Pg. 231).

Employing Situated Learning Theory as a framework for understanding professional autonomy development

The concept of liminality aids understanding that professional autonomy development is an individual, transitional experience through which familiarity is increased as a precursor to confidence development. However, to understand how these participants conceived on their professional autonomy development, it is necessary to give attention to the learning processes through which they may have had opportunity to increase their familiarity and confidence and from this position to develop their professional autonomy. Here, I draw on the framework of

SLT (Lave and Wenger, 1991). I link activities that participants found helped active participation and decision-making relevant to the role of RN, to my claim that understanding LPP can aid our awareness of professional autonomy development.

Professional autonomy development through Legitimate Peripheral Participation

Lave and Wenger (1991, Pg.29) defined LPP as:

> *'...a way to speak about the relations between newcomers and old-timers, and about activities, identities, artifacts and communities of knowledge and practice'.*

I show how this study sheds light on the nature of activities that may constitute LPP within nurse education. I also discuss the qualities of the student-mentor relationship that participants perceived contributed to establishing collaborative partnerships to enable LPP and through which professional autonomy may be developed.

Commonly, opportunities to engage in authentic nursing activities were seen as an important aspect of professional autonomy development. Here, authentic activities were those that were perceived to be activities and decision-making relevant to the role of the RN. However, participants perceptions differed on which types of activities contributed to their professional autonomy development. These perceptions, whilst not mutually exclusive, included; learning specific skills by

working directly alongside mentors, having a sense of being involved with mentors in the processes of decision-making about patient care, feeling their views were heard and valued by their mentors, and being provided with opportunity to safely rehearse accountability in decision-making. These findings contribute to an understanding of the nature of the activities that may constitute LPP in the context of nurse education and how LPP may support the development of professional autonomy. Engagement in LPP appeared to result in challenges to participants' existing knowledge, values and behaviour. Such challenges may themselves have generated uncertainty, and the potential for liminal experiences.

My interpretation of participants' experiences was that personalised, mentor-led support for learning enabled collaborative partnerships that promoted active engagement in LPP and in turn, professional autonomy development. This accords with earlier research which suggested that the relationship between a student nurse and their mentor is central to student nurses' learning and professional development (Saarikoski *et al.,* 2007; Bradbury-Jones *et al.,* 2010; Jack *et al.,* 2018). My findings shed light on a range of qualities which participants perceived on being important in these relationships for professional autonomy development: trust, respect, and valuing the contribution that students could make to patient care and the work of the team. This range of qualities when considered with the diversity in activities found in this study, which I have claimed constitute LPP, highlight the uniqueness of the relationship formed between mentor and student. This suggests that a single approach to this relationship would not work for all students and all mentors.

Section summary

The findings of this study illuminate some of the similarities and differences between student nurses' conceptions on their developing professional autonomy in the context of nurse education. I have claimed first that confidence development necessitates becoming increasingly familiar across a range of aspects of nursing practice. Second, I suggest that professional autonomy development was viewed as occurring as participants transitioned through experiences undergone in a liminal phase. This study, therefore, contributes to understanding by showing a variety of indicators of liminal experiences as enacted within nurse education and through which professional autonomy may be developed. In so doing, I have drawn attention to the complexity of liminality. Here, I suggest that liminal experiences can increase feelings of ambiguity in understanding participants' role as student nurses and exacerbate feelings of uncertainty about their place within the practice team. In turn, I have claimed that there is a paradox in which liminal experiences may occur often and repetitively but may also be persistent during studentship. These participants' experiences have suggested that professional autonomy may not develop in a predictable, linear or straightforward way as student nurses progress through their nurse education.

This study has also illustrated activities that may constitute LPP in the context of nurse education. Recognising these activities as LPP furthers understanding of the learning processes that can support professional autonomy development.

The findings underline the importance with which participants conceive of collaborative relationships with mentors based on trust, respect, and valuing their contribution made to patient care and the work of the practice team. Furthermore, participants' perceptions on their professional autonomy development illustrated the importance of individualised support that promotes active participation in LPP, acknowledging that there is no single, optimal approach.

Factors influencing student nurses' development of professional autonomy (Research aim 2)

I draw on literature which discusses SLT (Lave and Wenger, 1991), to highlight some of the factors that appear to influence the development of these student nurses' professional autonomy. I argue that professional autonomy development is facilitated when LPP includes episodes of participation in authentic activities relevant to the role of the RN, and non-participation in such activities. However, I show that when non-participation resulted in a disconnect from the learning context because of perceptions on mentors' high workloads and inadequate staffing levels, participants conceived their professional autonomy development was hindered.

I also consider the issues of peripherality and marginality within LPP. Peripherality relates to the position a student, as newcomer, occupies within the CoP. Lave and Wenger (1991) proposed that as learning occurs, newcomers transition from the periphery to the centre of the CoP. Marginality occurs when non-participation

becomes the prevailing form of peripherality (Lave and Wenger, 1991). Perceptions of some participants on being marginalised adversely impacted opportunities for developing professional autonomy. I also discuss supernumerary status of student nurses and claim that it can be a facilitator for LPP which can influence professional autonomy development. I then assert that unlike the apprentices in Lave and Wenger's (1991) original works, participants were permanently transient, temporary and peripheral members of the CoP. However, it was their engagement in the social processes that form CoPs that helped their professional autonomy development.

Participation and non-participation in LPP

Participants conceived that actively taking part in authentic nursing activities, which I have indicated constituted learning through LPP, seemed important for developing their professional autonomy. Wenger (1998, Pg.167) set out the *'relations of participation and non-participation'*, in which he claimed a degree of non-participation should be encouraged as an aspect of peripherality. Non-participation; the opportunity to temporarily stand back from performing nursing activities, can be an important way for student nurses to develop relationships with existing team members. Evidence of non-participation as a positive form of LPP was seen in a number of ways in this study: it provided time and space needed to enable participants to develop their familiarity with a situation, to work through liminal experiences and to develop collaborative relationships with mentors. Non-participation should therefore be seen as an unexceptional, natural aspect of

learning through LPP (Wenger, 1998). However, Lave and Wenger (1991) indicated that non-participation does not mean having a *'disconnect'* (Pg.37) from the learning context. Furthermore, non-participation does not imply *'marginality'* (Wenger, 1988, Pg.166). In this sense, depending on the form non-participation takes, it can be both a facilitator and hindrance to professional autonomy development.

Participants commonly found two specific forms of non-participation that gave rise to perceptions on a *'disconnect'*. This first form of disconnect seemed to result from participants' feelings on their mentors having high workloads. Mentors (and since the change to NMC standards, practice supervisors and assessors) were expected to supervise student nurses' learning whilst also prioritising the demands of patients' care and the clinical environment. As shown in this study, meeting these requirements can mean participants perceiving they have to negotiate with their mentor their participation in learning opportunities. This highlights the influence mentors were perceived to hold over opportunities for participation and non-participation in LPP. Lave and Wenger (1991, Pg.36) acknowledged that because CoPs are social structures there is the potential for unequal power relations and hierarchies between newcomers and old-timers. However, they do so from a perspective that LPP can be seen as empowering or disempowering. Thus, they do not give any depth of analysis to how hierarchical relationships might influence learning through LPP. Wenger later recognised this by offering, *'the theory takes learning as its foundation and its focus, not power'* (Wenger, 2010. Pg.8). Furthermore, in the examples used to illustrate their theory, Lave and

Wenger (1991) imply that CoPs are characterised by generally stable relations. However, student nurses are transient members of a CoP. Also, as seen in the perspectives of some participants, mentors (practice supervisors and assessors) have a dual role of enabling students' learning and assessing students' competence. Thus, influencing whether student nurses progress in their studies and ultimately qualify as RNs. The impact on learning of the inherent power dynamics in the hierarchy that differentiates student nurses and mentors/ practice supervisors shows a potential theoretical gap that may require further research.

Participants perceived a second form of non-participation that related to a disconnect from personalised, mentor-led support for learning because of inadequate staffing in the practice setting. This resulted in an apparent blurring of roles in which some participants perceived mentors used them to fill gaps in the workforce. As such, participants suggested they completed low-level tasks they were already competent to perform rather than being mentored through tasks they needed to become competent in. In such situations some participants did not see this as activities, authentic to the role of the RN and which contributed to their learning the role of the autonomous RN.

Recognising these two forms of disconnected non-participation furthers understanding of how non-participation may lead to student nurses feeling unsupported because of the way others supervise and support their learning. Thus, the development of professional autonomy may be hindered by

circumstances outside the participants or their mentors' control (Kupferberg, 1999 cited in Andrew *et al.,* 2008).

This study's findings suggest that it cannot be assumed that all student nurses, in all practice settings, will be able to engage in effective participation and as legitimate peripheral practitioners. My discussion has shown that LPP should be seen to include episodes of both participation and productive non-participation, influenced by extrinsic and intrinsic factors to student nurses. Here, striking a suitable balance between legitimate participation and legitimate non-participation becomes another key factor that can influence student nurses' development of professional autonomy.

Peripherality and marginality - facilitators and hindrances to professional autonomy development

Peripherality *'suggests an opening, a way of gaining access to sources for understanding through growing involvement',* (Lave and Wenger, 1991, Pg.37). Peripherality is used as a positive term as a means of situating learners within the activities defined by the community. Depending on the specific activity or situation, the peripheral status of the member may vary. For example, peripherality may occur through observation (non-participation) rather than active participation in a task or situation. As their level of competence and confidence increases, students should transition from peripheral to more central participation and with increasing

independence (Lave and Wenger, 1991). For some participants, this transition seemed to require developing trusting relationships with their mentors that included, for example, having confidence that mentors would identify and correct mistakes before any detrimental impact occurred. Once this trusting relationship was established, exposure to unfamiliar situations, under supervision, enabled participants to safely push beyond their *'comfort zones'* and thereby extend their knowledge and deepen their understanding towards autonomous decision-making. Conversely, should student nurses be prevented from such participation, peripherality then becomes disempowering and a form of marginality (Wenger, 1998, Pg.166). For participants who described feeling on the outside of their team, marginality was articulated in a number of ways: not being addressed by their names but being called *'the student'*; not having their previous experience and capabilities recognised; not feeling that an interest was taken in their learning, or not being asked by team members to collaborate on patient care or nursing tasks. Such experiences show how participants perceived they were prevented from, or could not, gain access to sources of learning. Marginality thus, hindered their developing professional autonomy.

The current model of nurse education means student nurses may spend relatively short periods of time in different nursing specialisms. They may also experience multiple placements in each year and across their education. Thus, student nurses are temporary, transient and peripheral learners within the practice team. These findings have raised questions regarding whether the supernumerary status of student nurses is consistently implemented for all students as a way of enabling

access to learning and as a means of enabling professional autonomy development. Supernumerary status means that student nurses are not part of the contracted workforce but can participate in learning opportunities alongside experienced professionals (Fuller *et al.*, 2005; NMC, 2018b). In this sense, it enables a positive form of peripherality that supplies time and space for student nurses to develop familiarity to manage liminal experiences and so enables opportunities for developing professional autonomy. However, supernumerary status has also been subject to criticism with perspectives being offered which suggest this status can prevent student nurses becoming fully competent at the point of registration with NMC (Allan, Smith and O'Driscoll, 2011), particularly with regards to developing competence in time management and delegation skills (Mansour and Mattukoyya, 2018) leading to perceptions on the transition from student nurse to RN as being *'a shock'* due to a perceived reduction in support for decision-making (Ho, Stenhouse and Snowden, 2021, Pg.2377). Therefore, depending on how consistently and effectively it is implemented, supernumerary status, as a form of peripherality can influence professional autonomy development.

Hodkinson and Hodkinson (2004, Pg.4) claimed that Lave and Wenger (1991) did not consider differences in how experienced workers, new to an established team, learnt compared to inexperienced newcomers. Whilst all student nurses attend practice settings for the purpose of learning, it would be inappropriate to consider them as a homogeneous group. Student nurses bring varying degrees of relevant experience to their studentship and indeed, all student nurses gain experience as

they progress through their nurse education. Starting a new placement may mean a student nurse is situated on the periphery as a new member to that placement team. However, as seen in this study, some participants brought with them differing degrees of relevant experience; as health care assistants who, for example, felt competent to remove intravenous cannulas, or able to replace tracheostomies in specific situations. For these participants, peripherality may not necessarily mean always being situated as an inexperienced newcomer in relation to aspects of nursing practice. This shows the importance of understanding each student nurses' learning needs relevant to their professional autonomy to influence its development.

When viewed through the lens of peripherality this study shows that access to resources such as time and space, individualised support for learning or developing trusting relationships with mentors and supervisors may supply opportunities which facilitate professional autonomy development. However, if peripherality becomes marginality, this may inhibit this process by blocking access to such resources. I have positioned student nurses as temporary, transient and always peripheral members of the practice team. Therefore, this positioning has the potential to facilitate, and to hinder, professional autonomy development and as such, has implications for nurse educators.

Belonging is important for professional autonomy development

This study has shown the importance of a sense of belonging within their practice team for participants to feel confident to make decisions, whilst under supervision, and thereby work towards professional autonomy. Establishing a sense of belonging enabled opportunities for participants to engage in nursing tasks as legitimate peripheral learners. This finding is similar to that of previous research in nursing which, whilst not specifically focussing on professional autonomy development, identified the importance of developing a sense of belonging to the team in order for learning to occur (Astley-Cooper, 2012; Dunbar & Carter, 2017; Levett-Jones *et al.,* 2009; Morgan, 2019; Terry *et al.,* 2020; Teskereci & Boz, 2019). Similarly, the desire of student nurses to feel a sense of belonging has been well documented (Melia, 1987; Levett-Jones *et al.*, 2007; Manninen *et al.*, 2013; Ford *et al.*, 2016; Jakubik *et al.*, 2016; Ashktorab *et al.*, 2017). This study has shown that feeling valued and respected as individuals appeared to be key to participants' perceptions on belonging. This, in turn, appeared to promote a sense of trust which helped opportunities for decision-making and professional autonomy development.

Developing a sense of belonging to engage in learning opportunities as part of the team aligns with the concept of learning in CoPs (Lave and Wenger, 1991). Lave and Wenger indicated that only competent members can occupy a central position within the CoP. Therefore, achieving a central position within a CoP is possibly unattainable for student nurses. I argue that it is engagement in the social processes that form CoPs, rather than achieving central membership of the CoP,

that is important for influencing student nurses' professional autonomy development.

The social process of mutual engagement (Wenger, 1998) was shown in participants' descriptions of a range of authentic learning activities that appeared to constitute LPP. Fundamental to the process of mutual engagement were the interpersonal relationships formed between participant and mentor, and participant and the wider practice team. Whilst participants' views differed about how they were made to feel valued, there were indications of mutual engagement, such as receiving constructive feedback, that enhanced confidence with nursing practice. Mutuality also requires being responsive to others (Wenger, 1998) and this was shown by participants feeling valued when their contribution to the team's shared decision-making was recognised.

The second social process of CoPs was that of joint enterprise (Wenger, 1998). Here, joint enterprise was seen as participants recognised the central purpose of the practice team was meeting patients' care needs. There was also evidence of joint enterprise in how some participants negotiated the boundaries and expectations of their role with their mentors to establish a shared understanding of how they could contribute to the team. This joint enterprise of negotiation appeared to enable participants to perceive clarity in the expectations of their role.

Finally, the third social process in CoPs was having a shared repertoire. Wenger (1998, Pg.83) said this was:

> *'Routines, words, tools, ways of doing things, stories, gestures, symbols, genres, actions or concepts that the community has produced or adopted in the course of its existence, and which have become part of its practice'.*

Commonly participants discussed their need to become familiar with nursing practices and routines. Through this familiarity participants seemed able to develop with their mentors and the wider practice team a shared repertoire of procedures, processes, and jargon. In this way, participants were inculcated into the social norms of nursing; those often unspoken rules of conduct that characterise the attitudes, beliefs and values to which the team conform and through which a sense of belonging is established (Scot Rousse, 2016).

Through this discussion, I have questioned the place of these student nurses within CoPs. The findings have shown how engagement with the social processes that form CoPs provided participants with a sense of belonging which, from their perspective, helped their developing professional autonomy. With reference to my earlier claim that these participants were transient, temporary and peripheral members of the practice team, this study has furthered understanding of how professional autonomy is developed through engagement with the social processes that operate within CoPs, rather than from the position student nurses occupy within CoPs.

Section summary

This study has highlighted some of the factors that student nurses regarded as influencing the development of professional autonomy. Striking a suitable balance between participation and non-participation is important because when non-participation becomes marginality this may hinder professional autonomy development. I have also shown the influence some participants perceived mentors held over their ability to take part in LPP. Here, I have indicated the need for further research to explore how unequal power relations between members can influence the development of professional autonomy. I have shown the influence individualised, mentor-led support has on participants' learning as when this is absent, opportunities for LPP are hindered.

I have suggested that supernumerary status can give time and space for students to engage liminally as a means of developing professional autonomy. Importantly, I have also argued that these participants, unlike the apprentices in Lave and Wenger's (1991) original text were transitory, temporary and peripheral members of CoPs. Therefore, Lave and Wenger's framework does not really hold up in this quite different type of situation. For participants, occupying a central position within CoPs was unachievable. However, engagement in the social processes that form CoPs appeared, from the point of view of these participants, to help professional autonomy development. As such, the findings of this study highlight that it is engagement with the social processes of CoPs, rather than the place occupied within CoPs, that enabled a sense of belonging and development of professional autonomy. I have suggested a second theoretical gap related to how always being

transient, temporary and peripheral newcomers, might influence learning through LPP that may call for further research.

How can nurse educators further support the development of a sense of professional autonomy among student nurses (Research aim 3)

I have argued that professional autonomy appears not to develop in a predictable, linear or straightforward way as student nurses progress through nurse education. Furthermore, I have suggested that liminal experiences may occur often, repetitively and /or persistently during each placement and throughout a nurse's education. The interaction of organisational factors related to support and supervision, and personal factors, such as perceptions on developing a sense of trust and belonging also suggest that personal autonomy development is conceived on in multiple ways.

Nurse educators, in the context of this discussion, are university-based educators who hold responsibility, in collaboration with practice learning partners, for the quality of nurse education (NMC, 2018a). Nurse educators are responsible for preparing student nurses for their practice learning, and for preparing those who support, supervise and assess student nurses' learning in practice (NMC, 2018a). The challenge for nurse educators is developing education programmes that ensure consistency of opportunity. Here, it seems important to ensure that all student nurses have opportunities to understand and manage their liminality (van Gennep *et al.,* 2019), as a means of becoming familiar with their practice setting, and in so doing, take part in learning through LPP and engage in the social

processes that constitute CoPs (Lave and Wenger, 1991). In this section I first suggest how nurse educators could further prepare student nurses prior to their practice placements to recognise and manage liminal experiences in order to progress towards professional autonomy. I then suggest that supervisor and assessor training might include, if not already, opportunities to develop an understanding of liminality (van Gennep *et al.,* 2019*)* and of SLT (Lave and Wenger, 1991). This, in turn might enable supervisors and assessors to enhance opportunities for student nurses to work safely towards autonomous practice. I go on to consider student nurses' induction into practice settings. Here, I suggest how nurse educators might structure the process of induction to enable student nurses to reflect on how they can transfer their existing knowledge and skills to new and unfamiliar placements. I highlight the need for student nurses to be encouraged to collaborate with their supervisors in shared decision-making about patient care from the very beginning of their training. I argue that individual learning plans could offer consistency of learning across multiple placement settings with different supervisors. Finally, I revisit the issue of the supernumerary status of student nurses, focussing on the role of nurse educators in making students and supervisors aware of the value of this status as a means of accessing opportunities for developing professional autonomy.

Pre-placement preparation to support professional autonomy development

Previous research studies have concluded that starting new placements can be an emotionally challenging time for student nurses (McNamara, 2015; McCloughen *et*

al., 2020). Student nurses should be prepared and equipped to meet such challenges (Lopez *et al.*, 2018). However, at present there appears to be little or no guidance on this, but it would be valuable to include such guidance in protocols for preparing students for their placement. One means of achieving this could be to teach student nurses about liminality and the impact liminal experiences may have on their sense of confidence. An understanding that liminal experiences are a normal aspect of transitions, might help student nurses to recognise them when they occur. Furthermore, equipping student nurses with the knowledge of the potential discomfort that may go with liminal experiences is likely to ensure that they are not overwhelmed or discouraged by them.

A further responsibility of nurse educators is to prepare practice supervisors/ assessors for their respective roles in supporting student nurses' learning (NMC, 2018b). Therefore, practice supervisor and assessor training could also routinely include the concept of liminality (van Gennep *et al.,* 2019) and its potential impact on student nurses' confidence.

Within nursing literature, *there is a rich heritage of research into decision-making and judgement,* (Thompson *et al.*, 2013, Pg.1720)*.* However, despite the abundance of literature on decision-making in nursing, the methods by which student nurses learn to make clinical decisions have not been considered as being dependent on their approach to learning (Joshua and Ingram, 2020). For students preparing for their placements, education around SLT and LPP (Lave and Wenger, 1991) as an approach to learning may support them to engage comfortably in

decision-making in their placement learning experience. Similarly, during the preparation of practice supervisors and assessors, nurse educators can inform them of LPP as an approach to learning. Furthermore, of how LPP might provide a means of supporting student nurses to safely make decisions about patient care from early in their nurse education and with increasing complexity as their competence and confidence develop. This, in turn, might place supervisors and assessors in a stronger position to support student nurses to utilise the learning opportunities that may go with the liminal phase.

Induction into the practice placement to support professional autonomy development

Whilst having an induction to new practice settings is an NMC requirement (NMC, 2010, 2018) often this focuses on developing familiarity with the physical environment and its policies and processes. The processes of induction to their practice settings should enable student nurses to recognise and to work through liminal experiences. From a practical perspective, it would be valuable for nurse educators to frame the process of induction to encourage student nurses to assess how their previous knowledge, skills and experiences might be applied to their new practice setting. Here, nurse educators' role would be to encourage students to engage in personal reflection to recognise what pre-existing understanding they bring with them to their new and unfamiliar environment.

For the participants involved in this study, the relationships they formed with their mentors seemed central to facilitating the type of learning opportunities that

enabled professional autonomy development. The recent policy change in nurse education has resulted in an end to the role of mentor. This has been replaced with separate roles of practice supervisors and practice assessors (NMC, 2018b) (see Chapter Two). In addition to working with practice supervisors and practice assessors directly whilst meeting patients' nursing needs, having time formally allocated at the start of placement in order to get to know their supervisor/ assessor would enable the newcomer student to integrate smoothly into the nursing team. This, in turn, may afford student nurses a sense of trust and belonging to enable them to safely push past their 'comfort zones' as they develop towards professional autonomy.

The findings of this study have also demonstrated the importance of individualised support for student nurses' learning. When this support was felt to be present the participants seemed able to engage in shared decision-making about patient care. Some of the concerns expressed by participants about the consistency of support might be mitigated by placing stronger emphasis on how the individual learning needs of each student nurse can be identified and supported. Supervisors and assessors, in partnership with student nurses, could be encouraged to create individualised learning plans at the start of a practice placement. Such plans could then be disseminated to all those responsible for supervising the student nurse's learning.

Supernumerary status: a means of enabling professional autonomy development

Supernumerary status has been described as a ‘safe space’ (Elcock, Curtis and Sharples, 2007) that enables student nurses to develop their knowledge, skills and professional behaviour (Evans, 2022). This study has revealed that the pressure of patient needs, and staffing shortages may have contributed to some participants feeling disconnected from their learning when they perceived the activities they engaged with did not contribute to their learning. The findings of this study raised questions regarding whether supernumerary status was consistently implemented for all participants as a way of enabling access to learning. It is, therefore, important for nurse educators to communicate to student nurses and supervisors the benefits of student nurses having supernumerary status in respect of this providing them with time and space to manage liminal transitions, to engage in LPP and so to develop their autonomous practice.

Summary: Liminality and Situated Learning Theory as learning approaches to support the development of professional autonomy

Nurse educators can raise awareness with student nurses, practice assessors and supervisors of the concepts of liminality (van Gennep *et al.,* 2019). Of note is supporting student nurses, assessors and supervisors to understand liminal experiences as subjective, potentially discomforting and individually felt (van Gennep *et al.,* 2019). Furthermore, recognising that liminal experiences can happen at transition points, such as starting a new practice placement, may

prepare student nurses for if, and when, they experience liminality. Equally, understanding that liminal experiences may affect perceptions on confidence may better enable supervisors and assessors to support students as they work through these experiences.

Similarly, nurse educators can prepare practice supervisors and assessors for their roles in supporting the development of professional autonomy in student nurses by helping them to develop their understanding of the concept of SLT. Specifically, understanding activities that constitute LPP and the social processes that form CoPs (Lave and Wenger, 1991) may offer an approach to learning that enables practice supervisors and assessors to guide student nurses as they develop professional autonomy.

Induction into the practice placement, if appropriately structured, supplies an opportunity for student nurses to develop familiarity and confidence which will enable them eventually to become professionally autonomous. It is the responsibility of nurse educators to structure placement inductions in a way that enables these effective relationships between student, supervisor and assessor to develop. Induction to the placement can also supply an opportunity for student nurses and supervisors/ assessors to work together to develop individualised learning plans. This might also help to mitigate any disruptions or misunderstanding arising from students having multiple supervisors. Through supporting student nurses to contribute to decision-making as appropriate for their

level of competence, this may provide them with opportunity to rehearse professional autonomy in readiness for their transition to RN.

Finally, nurse educators can communicate to practice supervisors and assessors how supernumerary status provides student nurses with time and space to manage liminal experiences and to engage in LPP.

The contributions made by this study

In this section, I first present my contribution to academic understanding. I focus on this study's findings that professional autonomy develops through an individual, transitional process which is nonlinear, unpredictable and variable. I also consider how this study has contributed to what is known about the concepts of liminality (van Gennep *et al.,* 2019). Here, at transitions, students' perceptions on their confidence and abilities to act with autonomy might wane as they experience liminality. I also present engagement in the social processes that form CoPs, as an aspect of SLT (Lave and Wenger, 1991) as an approach to learning that may support the development of professional autonomy.

I then discuss the contribution this study makes to professional understanding. I focus on the range of nursing activities that constitute LPP as surfaced through this study. I discuss the salience of the relationships formed between student nurse and practice supervisor/ assessor in providing opportunities for professional

autonomy development. I also offer potential applicability of the findings of this study to a broader health professions audience.

I then present areas for potential research related to furthering understanding about the role of LPP in nurse education. I also suggest it is timely to evaluate the roles of practice supervisor and practice assessor (NMC 2018b). I describe my dissemination strategy as work in progress. Finally, I offer my personal reflections on my doctoral studies, recognising my own liminal experiences.

Contributions of this study to academic understanding of student nurses' conceptions on their professional autonomy development

Previous studies have recognised a relationship between confidence and professional autonomy (Skår, 2010; Arreciado Marañón and Isla Pera, 2019; Oshodi *et al.*, 2019). This study adds to this understanding as the findings suggest that there is a relationship between perceptions on increasing one's familiarity with patients' conditions, nursing care needs, the expectations of team members and placement routines as a precursor to confidence development.

These findings also contribute to academic understanding as they show that for these participants, professional autonomy development is an individual, transitional process, characterised by liminal experiences. Furthermore, the process of professional autonomy development is nonlinear, unpredictable, and variable. Therefore, student nurses' perceptions on their professional autonomy

are unlikely to be stable and will be influenced by changes to, or within, the placement environment.

This study has revealed the concept of liminality (van Gennep *et al.*, 2019) is relevant to how professional autonomy develops in the context of nurse education. Liminal experiences have the potential to influence perceptions on confidence which may, in turn, impede the smooth development of a sense of professional autonomy. The provision of space and time to question their own knowledge and understanding may facilitate student nurses' professional autonomy development.

This study has shown that nurse education entails an ongoing state of transience, and peripherality. Fundamentally, within practice settings, student nurses are trainees, they are temporary, they are learners. This questions the notion of how student nurses can move from the periphery to the core of CoPs (Lave and Wenger, 1991). However, when encountering liminal experiences, which are subjective, potentially discomforting and individually felt (van Gennep *et al.,* 2019) developing a sense of belonging seemed important to these participants. An approach to learning that supports engagement with the social processes that form CoPs (mutual engagement, joint enterprise and shared repertoire) (Wenger, 1998, Pg.73) can help a sense of belonging. In turn, this enabled engagement in LPP which supported professional autonomy development. As such, the position student nurses occupy within CoPs, seems less essential for their development of professional autonomy.

Contributions of this study to professional understanding of how student nurses may develop professional autonomy

This study has contributed to professional understanding as it has revealed the diversity of perceptions on the types of nursing activities that constitute LPP in the context of nurse education. Such perceptions included direct support in skills development, perceiving views were valued by mentors and opportunities to rehearse decision-making and accountability. Broadly, however, legitimate participation in authentic nursing activities and decision-making relevant to the role of the RN were seen as an important aspect of professional autonomy development. Nurse educators work with many tacit assumptions in the course of their day-to-day practice. This study has enabled me, as a nurse educator of longstanding, to look at nurse education through the eyes of student nurses. In so doing, I have illuminated the perhaps taken-for-granted, 'everyday' assumptions about how student nurses perceive the process of professional autonomy development in the course of their education.

This study has also illuminated some of the factors that influence student nurses' sense of their developing professional autonomy. In particular, it has highlighted the importance of forming collaborative relationships with their mentors and members of the practice team. These relationships may also enable students to recognise liminal experiences and deal with the lapses in confidence which are likely to accompany the process of moving towards registered status. However, it has also revealed that when relationships between student nurse and practice

supervisor/ assessor are such that marginality is experienced, this can hamper the students' sense of professional autonomy development.

The centrality of interpersonal relationships, and particularly the previous role of mentor, and now practice supervisor, as gatekeeper to participation in LPP, and the identification of liminal experiences leads me to conclude that professional autonomy may not develop in a predictable or straightforward way. As such, I would argue that it cannot be assumed that all student nurses in all practice settings will be afforded opportunities to engage in learning activities that constitute LPP. Therefore, ensuring consistency of opportunity for all student nurses to engage in LPP is a key role of nurse educators.

This study has revealed the complexity of professional autonomy development from the perspective of student nurses. There are a number of challenges that have potential to impede opportunities for student nurses to develop their professional autonomy. First, the reported continuing shortage of RNs to supervise and assess student nurses in practice settings (Castro-Ayala *et al.*, 2022). Second, the planned further increase in the number of student nurses that are to be educated and so will require placements within practice settings (NHS England, 2023). More student nurses learning in practice settings, looking to develop a sense of belonging and vying for opportunities to engage in LPP will place increased demand on placement capacity, and on the roles of practice supervisor

and practice assessor. These challenges further underline the complexity facing student nurses as they develop their professional autonomy.

Many other health professions disciplines, such as paramedicine and physiotherapy, employ a similar model of pre-registration education whereby students develop their proficiencies and learn to develop their professional autonomy through learning in practice settings. The findings of this study may therefore be of interest to students and educators within those professions.

Areas for further research

This study has looked at student nurses' perspectives on their developing professional autonomy. It has surfaced their perceptions on potential power dynamics in the inevitable hierarchy that differentiates student nurses and mentors/ practice supervisors. Here, further consideration may be given to the influences perceptions on this power dynamic have on how student nurses engage with LPP. This has relevance for two reasons. First, all RNs, irrespective of their experience in nursing or their designation (e.g. staff nurse, matron) are expected under the Code to provide supervision (NMC, 2018d). It may, therefore, be beneficial to understand how supervisors' perceptions on their own professional autonomy influence opportunities they afford to the student nurses they supervise to develop their professional autonomy.

Second, in addition to RNs, other registered healthcare professionals can supervise student nurses' learning within practice settings, and therefore provide opportunities to engage in LPP. It is, therefore, relevant to understand how supervision provided by other healthcare professionals influences opportunities for student nurses to develop professional autonomy. As such, I have suggested the need for an evaluation of the impact the changes to how student nurses are supported, supervised and assessed in practice setting (NMC, 2018b), particularly the roles of practice supervisor and practice assessor, influence student nurses' perceptions on their professional autonomy development.

Student nurses are temporary and peripheral members of the practice team. However, rather than being 'newcomers' to nursing, some may bring valuable and relevant experience. I have thus suggested developing an appreciation of how being experienced newcomers might influence learning through LPP that may warrant further research.

Plans for dissemination

At the outset of this study, if appropriate, I wanted to use these findings to inform the delivery of nurse education at my own institution. By discussing my findings with colleagues, I have been able to influence some slight changes within the nursing curriculum. Prior to student nurses starting their first practice learning placement, they are offered teaching on liminality and the potential for having liminal experiences. This is aligned to information on sources of support and

advice should potential liminal experiences become problematic. In addition, guidance within the documentation used by students, practice assessors and supervisors during practice learning has been revisited to give greater clarity to expectations during induction processes. These expectations include directing student nurses to reflect on what aspects from their previous experiences have relevance to their new and unfamiliar placement to identify their individual learning needs.

Whilst there is an academic audience for this study, there are also educational and professional audiences. I consider it important to raise awareness of professional autonomy development by informing nurse academics, nurse educators, supervisors, assessors and student nurses of these findings. I have started to implement my dissemination strategy by presenting my early findings at the Networking & Innovation in Healthcare Education (NET) Advance HE 2021 conference (Rouse, 2021). My future plans include writing for publication in an educational nursing journal that reaches to audiences that include nurse educators, supervisors and student nurses.

Personal reflections on my doctoral studies

Below, I first reflect on my decision to write this thesis in the first person as a means of aligning my own approach with that of interpretivist enquiry. I then reflect on the applicability of this study to my own and other professional settings. I show that this study has afforded me the opportunity to influence curriculum

development not only within nurse education within my own institution but more widely in the field of healthcare education. Finally, I describe my own learning during the process of conducting this study and producing this thesis.

Deciding to write the thesis in the first-person

There were two reasons behind my decision to write this thesis in the first person. First, in adopting a first-person writing style, I aimed to make transparent my subjective engagement in the study (Mack, 2010). My decision also aligned with the hermeneutic tradition, emphasising the interconnectedness between myself and the participants in the study (Moran, 2000; Mack, 2010; Parahoo, 2014). Furthermore, I wanted my work to be accessible to a range of potential readers, including student nurses, healthcare professionals, nurse educators and other educators beyond the healthcare field.

The applicability of the study's findings to the field of professional education

First and foremost, this study contributes to academic and professional understanding of student nurses' professional autonomy development. However, it also offers insights which may be applicable to professional education in other areas of healthcare where theory and practice-based learning are combined. Indeed, this theory-practice based model is widely used in other fields, for example higher-level apprenticeships and teacher training. Below I suggest how educators in such fields might support students to recognise and manage their liminal

experiences within practice-based education. I then describe how I applied my learning from this study to the field of paramedicine.

The findings from this study suggest that those responsible for supporting students' learning in practice settings (for example, mentors, supervisors, and assessors) require an understanding of liminality as a natural aspect of the learning process which may affect students' sense of confidence. Furthermore, they need to consider how students develop their capacity for managing the potential ambiguities and uncertainties of liminal experiences.

Such an understanding may, in turn, equip educators to find ways of encouraging students to reflect on their previous experiences and on their feelings on entering a new placement setting. For example, they might encourage their students to recognise what existing knowledge and skills they bring to their new placement settings. In addition, they might encourage discussion about students' feelings on starting a new placement and how they may impact their initial sense of confidence. By adjusting curricula to include consideration of the concept of liminality and its impact on the placement experience students might also be helped to recognise when to seek appropriate support.

Within my own institution I have begun to demonstrate the applicability of my findings to other areas of training for the health professions. Following an opportunity to discuss my research with the course leader for paramedicine at my institution, I was approached to provide instruction to the paramedic teaching

team. Together, we adapted the curriculum in this area to ensure teaching on liminality (van Gennep *et al,* 2019) was included. I have also motivated the teaching team to consider social constructivist approaches to learning and teaching, in particular, to consider the theoretical underpinnings of situated learning (Lave and Wenger, 1991).

The wider relevance of the study to the field of healthcare education

As I finish writing this thesis, a new raft of policy documents related to the field of healthcare has emerged, including reports on the provision of midwifery services in the UK (Independent Maternity Review, 2022; Kirkup, 2022) and reports on the lessons from the events surrounding neonatal deaths at a hospital in Cheshire (The Lancet, 2023; Whiteing, 2023). These recent reports cite failures in professionalism and autonomous decision-making (Independent Maternity Review, 2022, Pg., 41; Kirkup, 2022, Pg. 4) with the need for improvements in leadership, governance, and whistleblowing procedures. However, reading these reports leads me to ask similar questions to those I raised at the outset of my study, about how the development of professional autonomy and professionalism among frontline health care workers is conceptualised, nurtured, and recognised. There remains, it appears, a gap in recognition of the complex processes by which autonomy is achieved, as well as a potential lack of clarity about the boundaries and limits of autonomy in this area.

In the course of working on this study, while I was able to find independent academic studies and studies commissioned by the NMC, I was unable to locate

research conducted by the NMC itself. However, I have been encouraged by the interest shown by some colleagues in the NMC in the findings of my study. Having been afforded the opportunity to discuss my study and NMC policy on professional education and training, I was subsequently invited to work with others to review selected aspects of the regulation of nurse education (NMC 2018c). In particular, I was asked to participate in a working group to review the NMC processes for monitoring universities and approved education institutions (NMC 2023). My role was to offer a registrant's perspective on the process, in order to ensure a balance between universities' autonomy in programme delivery and accountability to meeting the established standards of nurse education. This suggests that small-scale, in-depth studies, conducted by professionals, may have the potential to influence policy at a higher level.

Reflections on my personal learning

During the process of undertaking this study I experienced a sense of liminality which has, at times, caused me to doubt myself and my abilities. On reflection, two lessons have emerged for me, as a researcher, which may be of value to others. The taught part of my doctoral studies helped me to increase my knowledge and develop my confidence in conducting research. I felt sure early in the planning of this study that I wanted to apply aspects of Heideggerian hermeneutic phenomenology. However, I initially found it challenging to engage with this methodological approach. As well as immersing myself in reading about Heidegger's work, I joined a phenomenology study group and in this safe space, I

felt able to sound out my understandings. The first lesson for me, therefore, was about the value of engaging with others as an essential step in developing understanding.

Second, it is important to stress that generating in-depth data and developing critical, and interpretative analysis is an iterative, cyclical process. However, it is worth noting that while Reflexive Thematic Analysis (Braun and Clarke, 2021) offered a phased and structured approach, taking breaks away from this circular process enables one to revisit interpretations with fresh eyes, to challenge interpretations and to see the ‘bigger picture’.

Having emerged from the liminal experiences entailed in undertaking doctoral level studies. I recognise a meaningful change in my degree of self-awareness – how I view my world and my *being-in-the-world* (Heidegger *et al.,* 2010). As I started out on my doctoral studies, I naively expected to find a universal truth that captured student nurses' perceptions on their professional autonomy development. Through the support I have received and, more significantly, through learning to critically interpret the views of others, I appreciate the complexity and uniqueness of individual experiences and have come to accept that there are multiple understandings of how student nurses conceive of professional autonomy. A single, universal truth is, for me, unimaginable.

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Appendix One: Student interview activity sheet

Before the interview:

a) Give participant information sheet about the study and check that they are happy with the information they have been given.
b) Ask participant to sign and date consent form x 2. Retain one and return one to participant
c) Remind participant again that the interview will be audio-recorded, and check they agree to this.

Semi-structure interview

Issue/ Topic	Questions	Possible follow up (prompt)	Probe
About you/ preconceptions	1. Can you tell me why you wanted to become a nurse?		Can you give examples?
	2. What values or attributes do you think you have that have helped you in doing nursing?		Anything else?
	3. What did you do before your nurse education?	What were/ are you employed as?	Do you think this has contributed to your nursing? How?
Nurse education	1. During your nurse education so far, what are the most important knowledge, skills, or attributes that you have been taught?		Anything else?
	2. In what ways do you think these benefit patients or improve patient care, or do they not benefit patients?	Why?	
	3. Are there other knowledge, skills, or attributes that nurses should have that you are not being taught about?	What other knowledge, skills or attributes do you think you should be taught during your nurse education?	Why?

	4. Can you recall a situation, in either simulation or practice, in which you have had to act independently?	Any other situations?	
	5. What skills or knowledge do you think were important in this situation?	Why?	
Clinical decision making	1. Do you have any examples where you have made a clinical decision?	E.g., perhaps when you were caring for a patient?	Anything else?
	2. What skills are needed in your view for clinical decision-making?	Why?	
	3. Reflecting on your clinical practice, when you have reached a decision, what do you do with the knowledge or information you have gained?	Do you always act on the knowledge you have gained? Why?	How do you act on this knowledge? Anything else?
	4. Why is being able to make clinical decisions important to being an effective nurse?	Why does this make nursing effective?	
Support/ Relationships with others	1. When you make decisions, who do you turn to for support?	Anyone else?	
	2. What would need to happen through this support to make you feels supported?	Why?	
	3. Have you supported others in making clinical decisions and acting on these?		Would you consider these role models? Why?
	4. What skills do you think you use when you give this support?	Why?	
Multi-disciplinary working	1. Are you involved in multidisciplinary work?	What does this involve?	How does this help patients?
	2. How important is multidisciplinary working?	What is good/bad about	Anything else?

		multidisciplinary working?	
	3. How effectively do you think nurses collaborate with other professionals?	Do you have any examples?	Anything else?
	4. Do you think nurses are valued as equal members of the multidisciplinary team?	Why? What do you think patients think about the role nurses have?	What do you think nurses need to do to ensure they are valued equally?
Regulation	1. What do you think regulation contributes to nursing	e.g., NMC	
	2. What is the purpose of The Code?	Can you think of benefits and drawbacks to having this?	Why?
Expectations	1. What are your career goals for the future? In 5 years. In 10 years?		What skills/ knowledge/ attributes will you use to do this?
	2. What type of role do you think would give you the greatest sense of job satisfaction?	What do you think would affect or enhance your satisfaction?	
	1. What do you think will the role of the nurse will be like in the next 5 or 10 years?	Why?	
Autonomy	1. I am interested in understanding professional autonomy- what do you think this is?	Why?	Anything else?
	2. Reflecting on your clinical practice, do you think some nurses are more autonomous than others?	Why?	
	3. What roles to these nurses hold?	What is it about their role that you think makes them more autonomous?	Anything else?

	4. Do you think there are any barriers or opportunities for nurses having autonomy?	What about benefits for nurses if they are autonomous?	What about for nursing?
	5. Do you think you are more or less autonomous now than you were at the start of your nurse education?	Why?	
	6. Do you think you will be more or less autonomous when you become a staff nurse?	Why?	
	7. Can you give any examples in which you have been taught about autonomy in either theory or in practice?	Should autonomy be taught in theory, practice, or both?	Why?

To conclude the interview:

a) Is there anything you have not had a chance to say that you would like to add?

Thank you

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Appendix Two: Participant information

There has been little recent research into the development of professional autonomy in nursing students and specifically how student nurses perceive they develop professional autonomy.

The aims of the project are to:

- How do student nurses conceive of their developing professional autonomy in the context of their nurse education?
- What factors do student nurses perceive as influencing the development of professional autonomy?
- How can nurse educators further support the development of a sense of professional autonomy among student nurses?

The Nursing and Midwifery Council (2017, Pg.3) states "*professionalism is characterised by the autonomous evidence-based decision making of members*…." They also identify that the attributes or pre-requisites of being a leader and of promoting professionalism is autonomous practice and the ability to encourage autonomous, innovative practice. Raising the bar: Shape of caring: A review of the future education and training of registered nurses and care assistants was published in March 2015 (Willis, 2015). It follows a series of reports that seeks to address the needs for the future nursing workforce in England in order "*to continue to provide a world class health and care workforce*" (Pg.3). It builds and draws on a series of high-profile reports that resulted in unprecedented public scrutiny (Francis Report, 2013; Berwick Report, 2013; Keogh Report, 2013; Bubb Report, 2014). All these reports share common issues regarding a lack of compassion, knowledge, education, and competence, calling into question the validity of the

This research involves interviewing second- and third-year undergraduate pre-registration students studying adult, children s, and mental health nursing. Individual interviews will last for about 45-90 minutes and will be recorded and transcribed. The students and university will remain anonymous, and the geographical location will be disguised. Student information and data will be treated confidentially and anonymised in any writing about the project. A brief summary of key findings will be made available to all participants. The research will be used for a doctoral thesis as well as research reports written for academic journals and conference presentations.

Students have the right to withdraw from the study at any time up to one week after the interview has been conducted. To withdraw from this study, participants should contact Jo Rouse in person, by telephone or by email. Participation or non-participation in this research project will not affect students' learning opportunities, assessment outcomes or grades awarded.

In the event of disclosure of unsafe/ unethical practice, this will be discussed with the participant and referred to the Programme Leader.

For more information, contact Jo Rouse at: j.rouse@xxx.ac.uk . If you have questions or concerns about the study, please contact Professor Ann-Marie Bathmaker: [redacted]

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Appendix Three: Consent form

This consent form is a record of your agreement to take part in this interview for the research project: An exploration of student nurses' perspectives of professional autonomy.

Your signature on this form indicates your agreement with all the statements below.

- I agree to take part in the study. I have received information about the project and have been able to ask questions.
- I know that my participation is voluntary and that taking part or not taking part will not have any effect on my study or progression in my nursing programme.
- I know the researcher in this study is Jo Rouse, a student studying a Doctorate in Education and an academic at my university, email: [redacted] and Jo's supervisor is Professor Ann-Marie Bathmaker: [redacted]
- I agree to being interviewed for about 45-90 minutes about my understanding, experiences, and perspectives of professional autonomy, developing professional autonomy and the relevance of autonomy in nursing.
- I know that my interview will be recorded and stored securely electronically before being transcribed and that the transcription will be stored securely electronically.
- I know that I will be able to review the record of the transcript of my interview and will be able to discuss the initial analysis of my data via Skype or email. I will also be offered the opportunity of receiving, via email, a 2-page project report summarising the outcomes of the study when the study is completed.
- I agree that what I say during interview can be quoted in reports or presentations about the research project, if my name, university, and any identifying features are not included.
- I know that I have the right to withdraw from the study at any time up to one week after interview has been conducted. I know that there will be no negative consequences or penalties if I withdraw. If I withdraw, I understand that no information about me and from me will be used in the study. To withdraw from this study, I know I must contact Jo Rouse in person, by telephone or by email.
- I know that this study has ethics permission granted through the University of Birmingham and permission from the Pro-Vice Chancellor for Students at my university.
- I know that in the unlikely event of discourse of unsafe/ unethical practice, it will be discussed with me and referred to the Programme Leader.

Name_____

Signed_____

Date_____

Contact Details: (Please circle preferred method of contact)

Mobile Number: _____

Email address: _____

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Appendix Four: Demographic Questionnaire

(to be completed by researcher in discussion with participant)

Name_____

1. **What is your age?**

18-22 ☐ 23-26 ☐ 26-40 ☐

41-55 ☐ 56 or older ☐

2. **What is your gender?**

Male ☐ Female ☐ Other ☐

3. **What is your ethnic background?**

_____

_____

4. **Is English your first language?**

Yes ☐ No ☐ If No, please state first language:-

_____

5. **How would you best describe your parents' social class?** (The Office for National Statistics, Standard Occupational Classification 2010)

Social class	Comment
Higher managerial, administrative and professional occupations	
Lower managerial, administrative and professional occupations	
Intermediate occupations	
Small employers and own account workers	
Lower supervisory and technical occupations	
Semi-routine occupations	
Routine occupations	

Never worked and long-term unemployed	

6. **What was your highest level of qualification when you started nurse education?**

Highest qualification on entry to nurse education	Comment
Level 8: PhD/ Doctorate	
Level 7: Masters	
Level 6: Degree	
Level 5: Foundation Degree/ Higher National Diploma or equivalent	
Level 4: Certificate in Higher education, Higher National Certificate or equivalent	
Level 3: A level, BTec, Access to Higher Education or equivalent	
Vocational training: please specify	

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Appendix Five: Reflections on using observations as a second method of data generation

On reflection, during the observation as a non-participant, I felt detached from the experiences Jenny was having; I felt removed from the world of the phenomenon I was exploring. During the observation, I was attempting to give a measurement to quantify, to pinpoint exact skills and to qualify an experience. I was using my perceptions of what I was observing, not Jenny's perceptions, to explore how she conceived on her developing professional autonomy.

I was also aware that my own subjectivities as a RN and an educator led me to make conclusions about Jenny. For example, whilst I had not met Jenny prior to this study, during the observation I concluded Jenny was an academically able student, she was also confident and clinically competent. As we completed the semi-structured interview, I felt that my suppositions about Jenny might influence the way I posed the topics for discussion and how I engaged with her. I perceived that this would introduce a bias (Gerrish and Lacey, 2015).

Reflecting and re-engaging with the philosophical positioning of interpretative phenomenology, I concluded that to achieve the aims of this study, observation was for me, an inappropriate method of data generation. I also concluded that as Jenny and I had not particularly drawn from the observation experiences in our conversations in her interview, it was unethical to ask participants to be observed.

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