From healthcare assistant to registered nurse:
an exploration of the status of knowledge
in the experience of role transition

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Abstract

This study explores the status of knowledge during the transition experienced by healthcare assistants (HCAs) becoming registered nurses. It also seeks to highlight the tension between the representation of *'sacred'* and *'profane'* forms of knowledge in nursing higher education and in healthcare practice.

Twenty former HCAs were interviewed. Eight were nurses who had taken the Diploma of Higher Education several years earlier and twelve were students currently taking the BSc in nursing. Bernstein's knowledge code theory informed the theoretical basis of this work, which draws extensively on Maton's legitimation code theory (LCT) (Maton, 2014). The specialisation device of LCT was used to identify expressions of *epistemic knowing* and *social knowing* in participant interviews. The semantic device was used to identify expressions of *semantic density* and *semantic gravity.*

Findings show how knowledge affects the whole social, cognitive and statutory transition described here. It is a core component of the decision-making process from accessing the health care sector as HCA, to engaging in the project of becoming a nurse. Knowledge is also central to the expressions and attitudes of recognition or condescension received by HCAs in daily practice from patients, nurses and other health care professionals. It is an element of power used by nurses in particular to maintain occupational separation from HCAs.

Knowledge also formed the backdrop to various challenges encountered by former HCAs during the nursing course at university and when returning as a student to clinical placements. Findings suggest that nursing higher education frames HCA knowledge as the 'wrong kind of knowledge' and HCAs as the 'wrong kind of knower'. This imposes a form of relegation of their embodied knowledge in the process of changing role and status within the health sector.

Findings are of interest to government agencies and the higher education and healthcare sectors.

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Chapter 1   Background and context of the research

1.1   The healthcare assistant: origin, role and potential

Activity that supports nursing has always been an essential (Gillett, 2010), albeit controversial (Edwards, 1997), feature of healthcare since the inception of the National Health Service (NHS). Various titles for support workers have been in use since 1948 including, nursing auxiliary, nursing assistant, ward orderly, ward clerk, bath attendant and family aide (DHSS,1987). The Healthcare Assistant (HCA) is the contemporary manifestation of this nursing support role, comprising seventeen percent of the 1.3 million NHS workforce (Cavendish, 2013) and is currently the main provider of personal and intimate care for patients (washing, feeding, toileting etc).

The HCA role can be traced back to the shift of first level nurse education from NHS 'apprenticeship' training into higher education (HE) in 1986 (Knibbs et al, 2006). With the pre-1986 in-service apprenticeship model, nursing students were healthcare employees providing continuous bedside care under the supervision of a registered nurse. The implementation of Project 2000 (UKCC, 1986) gave nursing students supernumerary status and caused a loss of this hitherto continuous nursing student presence from the clinical practice area (Kessler et al, 2010). The healthcare assistant (HCA) role was created to replace the supernumerary students who had previously assisted nurses in providing basic care. There are several other titles also found in use; Healthcare Support Worker, Clinical Support Worker, Nursing Assistant and Nursing Auxiliary. Healthcare Assistant is the main title used for the role in both the private and public sector, and is the title used throughout this thesis.

However, despite this broad and generally accepted role, the precise function of HCAs in individual healthcare settings is somewhat ambiguous. As registered nurses have become increasingly remote from the patient's bedside, performing a more advanced and strategic role in healthcare delivery (Kessler et al, 2010) and management (RCN, 2005), there have been inevitable consequences for skill-mix in care settings (Sutton et al, 2004). Many HCAs have taken on greater clinical responsibility and now perform clinical patient assessments such as blood pressure monitoring and therapeutic interventions such as ear syringing, injections and wound

dressings. Consequently, HCAs have been variously portrayed as both the liberator and the usurper of nursing (Traynor et al, 2015) as they assume the role of provider of intimate patient care and various clinical assessments, both previously the exclusive domain of registered nurses**.** (Wanless, 2002; James et al, 2010).

Some investigators have attempted to define the exact role of HCAs (Brant and Leydon, 2009; Workman, 1996) but have had limited success in identifying discrete areas of clinical practice where HCAs can be described as having a clearly defined role. However, a more substantive survey of 750 HCAs across 4 geographically distinct NHS Trusts (Kessler et al, 2010) found that HCAs could be categorised into one of five types depending on the nature and scope of their work. The typology rested upon the proportion of personal and intimate care such as feeding, washing, toileting; routine clinical tasks such as blood pressure, pulse and blood glucose monitoring; bedmaking and ward stock control; and more advanced tasks such as electrocardiogram (ECG) monitoring.

The combination of skill-mix review, blurred occupational boundaries between nurses and support workers, and the rise of new managerialism (Costea et al, 2008) during the 1980s and 1990s, has led to an arena that is highly contested and politicised (Bach et al, 2005). While NHS Trusts have sought to deploy HCAs to activities left vacant as nurses pursue a broader and more advanced professional role, most research on the impact of the HCA role has focussed on skill-mix (e.g. Daykin and Clarke, 2000), the quality of patient care (e.g. Kessler et al, 2010) and safety issues (e.g. UNISON, 2016b). It has also identified the politically sensitive nature of the HCA role. For example, the increased use of HCAs in the clinical setting has been referred to by Daykin and Clarke (2000) as a 'Fordist' strategy by managers attempting to reconcile the competing pressures of increased demand and patient throughput with reduced budgets and loss of nurses from the bedside. Their study revealed nurses' objections and ambivalence towards a plan to increase use of HCAs to address the economy of scale deemed necessary by NHS management, despite the benefit to nurses in terms of advancing the scope of their clinical practice and management role.

Adding to this complex landscape, NHS Workforce Development Confederations, a strategic management alliance of NHS and non-NHS employers created in 2001 to devolve more power to individual NHS Trusts (Department of Health, 2002a), introduced another layer of support worker in the form of the Assistant Practitioner (AP). Although APs only make up a small fraction (1%) of the total support worker population, their creation in 2006 represented an example of a relatively new form of managerialism, where local and national 'leadership' by managers was encouraged (O'Reilly and Reed, 2010).

Requiring the direct supervision of a state registered practitioner, the AP role was created ostensibly to assist the highly pressurised practitioner across a number of the allied healthcare professions in addition to nursing e.g. dietetics, speech therapy, podiatry, radiography etc. The aim was to bridge the gap between the relatively routine tasks of the traditional HCA and the more demanding activities of the state registered practitioner. However, in their study of the AP role, Traynor et al (2015) noted that this NHS management goal was only achieved by manipulation of the workforce and role migration to cheaper workers.

Furthermore, Wakefield et al (2009), in their examination of nursing AP job descriptions, found wide variation and disparity in the role and responsibilities of the advertised posts across six clinical specialties within a single NHS Trust, reflecting the subtle use of management power to achieve their aim of maximum 'flexibility' in the workforce. This phenomenon was replicated on the national NHS jobs website. Wakefield et al (2009) commented that the intermediate AP role had allowed employers to exploit the unstable boundaries between support workers and professional staff, as managers could now shift 'high dimensionality' tasks from state registered practitioners to support workers who occupy a 'lower dimensionality' social space.

There are also gender and social class issues in operation here. Although women make up 78% of the NHS workforce, and 90% of HCAs are women (Kessler et al, 2012), 64% of management executives are men (Smith, 2014). This large and persisting gender gap in the NHS is due to a privileging of the stereotypical masculine traits of competitiveness and performativity over the nurturant, supportive and empathic traits typical of

the mainly female workforce (Miller, 2009). The emotional labour of caring, crucial to successful patient outcomes, is largely invisible or actively ignored and does not feature in the metrics-driven quality measurement culture of new-managerialism in the NHS. Furthermore, the unequal division of labour in healthcare settings where HCAs do the 'dirty jobs' is a force contributing to the structure of the social field (Sayer, 2011). Representing a major structural cause of social class inequality, women in low status jobs are restricted from achieving their full potential because their work is seen as relatively meaningless (Sayer, 2009). However, despite the repetitive and burdensome nature of their work, many HCAs report they feel valued by patients, families and colleagues (UNISON, 2016a). This phenomenon creates a sense of 'belonging' to a group with a 'homogeneous habitus' and this may also contribute to the structure of the healthcare field (McNay, 1999).

Critical management theorists have long viewed the workplace as a location for power struggles between competing groups (McKenna, 2004). Thus, my study has the potential to further explore organisational power dynamics and opportunities for management to achieve their strategic aims in healthcare settings. My study also has the potential to explore gender and social class issues associated with the HCA role. Indeed, Huppatz (2006) drawing on Skeggs (1997) and Lovell (2000) makes a convincing case for more research on the interaction between gender, social class and the embodied practice of caring work.

However, a further outcome of research on the impact of the HCA role has been an intensification of the much longer-term debate on the knowledge and skills required for registered nursing practice (Pfeil, 2003; Allen, 2009) and attempts to define the occupational boundary between HCAs and nurses (Nancarro and Borthwick, 2005; Daykin and Clarke, 2000; Dahle, 2003). What do nurses need to know for 'professional' practice and how is this differentiated from the HCA role? Hidden, and as yet unexplored, in data presented in studies on NHS management strategy, such as Daykin and Clarke (2000), Wakefield et al (2009) and Traynor et al (2015), is the implicit and yet fundamental role of the status of knowledge in the relationship between actors in the healthcare field.

In their introduction to the journal Critical Discourse Studies, Fairclough et al (2004) summarise how use of language and how people act and organise may become recognisable as a particular discourse in the manifestation of power. Thus, one of the aims of my study is to explore how language is used in the context of knowledge in the healthcare field as positions are contested between HCAs and nurses. Specifically, my study contributes to and extends research on the organisational analysis of power by exploring the status of knowledge during role transition of HCA to state registered nurse.

1.2   Policy drivers for HCA progression to registered nurse

New Labour policy in the 1990s attempted to address a national shortage of qualified and registered staff in key public sector roles such as healthcare, teaching and policing (Taylor, 2005). Their decision to create new categories of 'assistant' for professional groups was a low-cost policy with immediate effect. HCAs were to assist registered nurses, teaching assistants (TAs) were to assist qualified teachers and community support officers were to assist police officers. These assistant groups, particularly HCAs and TAs then became the focus of New Labour education policy drivers for 'upskilling' the workforce to fill specific gaps created by shortages of registered staff and limitations on public spending (Field, 2000).

However, an additional problem emerged in the early 2000s when the UK experienced a demographic dip of young people (ONS, 2010) and a sudden decline in potential candidates for nurse education. Combined with a global shortage of overseas nurses available to join the UK workforce via immigration (International Council of Nurses, 2004), this led to a significant nursing recruitment problem for the NHS. HCAs were thus identified as an immediate and partial solution to the problem of under-recruitment to vacancies in registered nursing. The Department of Health (DH) was aware that many HCAs had aspirations to become registered nurses, having variously portrayed the HCA as a 'substitute for qualified nurse' and as an 'apprentice nurse' (Department of Health, 2002b). These role descriptors were reflected by HCAs themselves in a study by the National Institute for Health Research (2010). Kessler et al (2010) found that between 43% and 59% of HCAs had taken employment in this caring role as a general proxy

for nursing. Many had career aspirations to registered nursing status, 26% within 3 single National Health Service (NHS) Trusts in the South, Midlands and the North and a 40% aspiration rate in a London NHS Trust.

The healthcare trade union Unison also identified the phenomenon of HCA aspiration to nursing in each of four reports on HCAs in the health sector over twenty years (Thornley,1998; Unison, 2008, 2010, 2016a). A strategy emerged of NHS Trusts and HEIs 'growing their own' nurses from this local source (McKenna et al, 2007) and, with over 400,000 HCAs providing healthcare across the UK, the national pool of potential nurses is substantial.

The UK government subsequently made policy statements for HCA progression to registered nurse training via Department of Health (DH) circulars 1998/044 and 1998/182 (DH, 2006; DH, 2010). The DH recommended that NHS Trusts facilitate HCA secondment to enter HE for registered nurse (RN) education and clinical training. Thus, since 1998 former HCAs have been making the transition to RN status with government approval and support. Apart from the benefit of this alternative source of potential nurses, the basic premise of the strategy implicit, but not directly stated, within DH statements appears to be that the previous healthcare experience of the HCA will smooth their transition to registered nurse status, with benefits for the student and patients alike. More specifically, HCAs have personal insight and understanding of healthcare, they bring relevant knowledge and skills to nurse education and training, and socialisation into nursing is assisted by previous HCA experience.

The Francis report (Francis, 2013) published in the wake of the public enquiry into the significant failings of Staffordshire NHS Trust, recommended that all intending applicants for nursing HE and training should spend 12 months working as an HCA. Again, no explicit rationale was given for this recommendation. However, the public perception had been growing for some time, fuelled by the portrayal of modern nursing in the national press (Gillett, 2012), that the current obsession with an academic and 'less caring' nursing education was somehow to blame for the failings at Staffordshire NHS Trust. The assumption of the Francis report seemed to be that a period of employment as an HCA would provide the intending applicant for nursing education and training with opportunities

for the development of relevant skills, knowledge and a caring attitude (The Guardian, 2013). No evidence for this assumption was provided in the report.

1.3   The recent history of nursing education

The apprenticeship route to registration as a nurse, involving competency-based training and practical assessment, disappeared in 1986 as part of the 'professionalising' strategy of UK nursing. The United Kingdom Central Council for Nursing and Midwifery (UKCC,1986) recommended that first level nursing education change from an exclusively in-service apprenticeship model into a combined higher education and apprenticeship model.

This wholesale shift from an exclusively vocational and apprenticeship preparation to one rooted in academia was known as Project 2000 (UKCC, 1986). The aim was to achieve UK-wide registered nurse (RN) preparation via HE by the year 2000. Consequently, education for first level nurse registration shifted from NHS Trusts and into HE. To achieve first level nurse registration and a licence to practice from the UKCC, students would complete a combined university programme and a National Health Service (NHS) nursing competency assessment scheme. This was effectively two courses in parallel; the HE Diploma at a university (50%) and the clinical apprenticeship training in designated healthcare practice placements (50%), where nursing students were supernumerary to the workforce under the aegis of the university. The overall aim was to produce nurses who would be 'knowledgeable doers' rather than handmaidens to medicine (Brenchley and Robinson, 2001).

In the early 2000s, following almost two decades of the HE diploma route to nurse registration, there was a further significant development in nursing education, a proposed evolution of nursing into an all-graduate profession. The Nursing and Midwifery Council (NMC) first made various policy recommendations during the early 2000s and then formally ratified a university degree as the registration qualification for nursing (Nursing and Midwifery Council, 2010). The pre-registration nursing curriculum would be centred on a distinct body of evidence-based nursing knowledge produced in large part by a growing community of nurse researchers.

The dynamic that emerged between higher education and the nursing profession meant that first level nurse preparation effectively joined the system of mass HE in the UK. The steady stream of postgraduate nurses joining the workforce coupled with the continuous presence of undergraduate student nurses on wards and clinics for practice placement learning was a constant reminder to all healthcare staff and particularly HCAs, who may have wished to nurse, that the route to NMC registration required academic prowess as well as practical experience. Unison (2010) believes that this perception may have been responsible for the decline in HCA aspiration to nursing, from 50% in 1998 (Fowler 2003) to 41% (Unison, 2008) and then to a low point of 33% (Unison, 2010). However, this gradual decline in HCA aspiration to nursing that mirrored the 'academicisation' of nursing during the 1990s and 2000s seems to have reversed recently with 65% of HCAs surveyed stating that they would like the opportunity to progress to registered nurse (Unison, 2016a) despite the academic route to be negotiated.

1.4   Issues for HCAs: socialisation into HE

Notwithstanding the recovery of HCA interest in progression to nursing and despite the academic path to be followed, the requirement for a university degree as the minimum tariff for entry to the NMC nursing register may create difficulties for HCAs who have aspirations to be registered nurses and whose exclusively vocational preparation has provided some clinical experience but perhaps not the academic preparation required for success on a degree course. Like many undergraduates (Crozier and Reay, 2011), seconded HCAs may lack the appropriate social and cultural capital to succeed in the HE environment (Schuller and Field, 1998), leading to poor academic progress, possible failure and loss of experienced staff from the nursing workforce.

Furthermore, some students in HE have a relatively weak and vulnerable learner identity due to a poor quality secondary education coupled with a relative lack of formal preparation for university life (O'Donnell and Tobbell, 2007). A general feeling of a lack of entitlement and differences in socioeconomic background to other students may even lead to feelings of being an 'impostor' (Reay, 2002). For former HCAs, the process of transition to and through university may involve considerable challenges.

While there is no published data on numbers of former HCAs being recruited by HEIs, there is also no published data on the attrition of former HCAs from HE nursing programmes. Local anecdotal data (KB, King's College London) suggests that HCAs seconded to degree programmes represent less than 2% of a typical cohort and may face particular problems relating to their minority status and potential lack of preparedness for the rigours of HE. Heyward et al (2008) found that, compared to undergraduate students with only academic qualifications on entry, those with only vocational qualifications were twice as likely to leave HE in the first year. In Bourdieu's terms (1989), the field of higher education is likely to pose a relatively alien landscape and the undergraduate HCA may struggle to create a learner identity commensurate with the expectations of the university (Lave and Wenger, 1991).

In as much as they are being inducted and socialised into HE practices with the final goal of full participation in the academic community, O' Donnell and Tobbell (2007) have described all undergraduates as legitimate peripheral participants in communities of practice (Lave and Wenger, 1991). This model positions students as relative 'outsiders' in a community of practice (Wenger, 1998), their legitimation status and identity being negotiated as they engage, more or less successfully, with the new and challenging learning and assessment culture of HE as the community of practice. Bruner (1990) has described negotiation of identity as peoples' need to make sense of what they are doing and what is happening to them and Wenger (1998) provides a compelling argument for the role of identity in students' trajectory of learning.

Thus, HCAs who embark on a degree course have the significant task of dealing and coping with change. HCAs are effectively moving from one community of practice or field (Bourdieu, 1989) (the clinical environment) to another (the HE environment). They are required to adapt, to become socialised into the role of undergraduate student in the unfamiliar field of HE and negotiate an acceptable identity as an undergraduate student (Merriam et al, 2003). However, individuals are not passive recipients of change but are active agents in the transition and socialisation process (Giddens and Sutton, 2014 pp132-4). Theories of socialisation reflect the tensions between the environment and the individual (Willis, 1977; Bourdieu, 1989; Giddens, 1984) and can be conceptualised in terms of

structure and agency. Issues of social structure and of social agency are operating for HCAs while they work in the clinical practice setting and when they move into the HE setting as a student nurse.

1.5   Issues for HCAs: socialisation into nursing

Socialisation in nursing has been a consistent area of interest to nursing scholars (Rejon and Watts, 2014), and more so since the move of first level nurse preparation from the apprenticeship model into HE (Melia, 1984). Authors acknowledge that socialisation occurs in both practice and education (Elkan and Robinson, 1993) and requires the acquisition of value, knowledge and skills through individual experience involving change in identity, role and relationships (Mackintosh, 2006). Socialisation appears to be the 'mantra' that nursing academics espouse as the key for the social reproduction of nurses in their own image and, despite varying interpretations, socialisation in the education and practice setting is seen as a relatively consistent and homogeneous process for all students (Brennan and McSherry, 2007). In short, the nursing literature strongly suggests that the sole aim of nursing higher education and the associated clinical training is to uniformly socialise the student into their future role as RN from a naïve starting position i.e. no previous healthcare experience (Fitzpatrick et al, 1996; Dinmohammadi et al, 2013). The nature of nursing research in this area seems to reflect the overwhelming desire of nurse academics that the new generation of nurses be produced in a way that meets an almost mystical criterion of professional quality known only to them. This is despite the fact that, even though the UK Royal College of Nursing (2014) and the International Council of Nurses (2017) have published definitions, nurses cannot seem to agree on a declaration of what nursing is and what it is not (Merriefield, 2017).

However, former HCAs embarking on nursing education are not starting from a naïve position. In the healthcare setting, HCAs will have been socialised into their HCA-specific role and there will inevitably be acquisition of cognitive and embodied knowledge (Merleau-Ponty, 1962), arising from their close-proximity care work with patients. Informal learning in the workplace is a well-known phenomenon (Eraut, 2004) and contributes to both the efficiency and effectiveness of healthcare. With learning comes knowledge and HCAs may achieve a unique and tacit

understanding (Herbig et al, 2001) of a patient's situation due to the personal and often intimate nature of their work. The notion of tacit knowledge was originally conceived by Polanyi (1967) to explain the 'hunches' that arise in situations where personal judgment is required. In this regard, Kontos (2006) has made a convincing argument for the role of the embodied human self, or the habitus of an individual interacting with the perception of a situation in a field, in this case, healthcare.

O'Connor (2007) has suggested that the transfer of most close-proximity care work to HCAs is a threat to the professional habitus of nurses and nursing students. While Larson and Jackson (2008) have established that some newly-registered nurses persist in acting as 'advanced beginners', many HCAs provide intuitive patient care arising from experientially learned perception and embodied knowledge of the person and situation (James et al, 2010). Furthermore, Benner (2000) makes a compelling case for the embodiment of skilful nursing drawing on Bourdieu's habitus and Merleau-Ponty's (1962) phronesis as rationale for HCAs gaining the perceptive skills and bodily hexis required for this regular intimate care.

However, during their nursing HE and training, former HCAs move from healthcare (a familiar environment) to HE (an unfamiliar environment), and then back to healthcare as a nursing student (a familiar environment but with a different role and purpose). Thus, HCA transition to RN involves change to occupational identity and status as former HCAs move across boundaries between these fields. How former HCAs describe and explain the elements of this transition process in terms of knowledge is the aim of this study.

1.6   Research aims

This study represents a logical extension to my previous widening participation role at King's College London. I was actively involved in short courses designed to assist students in their development of academic skills. However, these courses were premised on a 'deficit model' of preparation for HE i.e. the assumption was that students may lack academic skills essential for success and this gap may be remedied by a single exposure to typical academic practices.

This study aims to go beyond this simplistic model by exploring the wider perceptions and experiences of HCAs as they make the transition from HCA through HE to registered nurse.

Specific research questions are:

> How do former HCAs articulate their knowledge acquired as an HCA?

> What is the role and status of knowledge as former HCAs describe their transition to RN?

> How is knowledge involved in the relationship between HCAs and nurses during transition?

The next chapter examines the extent to which this phenomenon has been investigated to date.

Chapter 2　　　Literature

2.1　Preamble

The motivation for this research project came from my education work with HCAs as director of Uni4U, a widening participation to HE and social inclusion project in the Faculty of Nursing and Midwifery at King's College London. I regularly attended the annual HCA conference run by the Royal College of Nursing. I was impressed by the extent and depth of HCA knowledge, both practical and theoretical. For example, during a workshop on clinical skills, HCAs were able to discriminate between different types of pressure sore from colour photographs, identify the likely cause and indicate the most appropriate intervention. The content and depth of the material covered in the workshop was typical of the level in a university class for second year undergraduate nursing students.

However, other than a general desire to investigate how this knowledge had been acquired, what perception HCAs had of this knowledge and how it may have influenced the experiences of former HCAs (who had made the transition to registered nurse), I had no particular research questions in mind when I conceived the research proposal for this study. My general aim was to explore the self-reported experiences of former HCAs as they made the transition from employment as an HCA, through a university diploma or degree course and to registration as a nurse. I wanted to investigate the phenomena de novo, as far as possible without influence from previous work in this area.

2.2　A dilemma on literature and methodology

There is an inherent tension in the decision of whether, or to what extent, the 'relevant' literature needs to be identified and reviewed before research takes place. Differing approaches to literature reflect differences in the methodological approach to data analysis. Some authors recommend delay in engaging with the literature until directions begin to emerge from the data (Glaser, 2004; Punch, 2005; Silverman, 2010). This approach is favoured by advocates of grounded theory (Charmaz, 2003) who emphasise the (inductive) emergence of theory from the raw data through analysis 'uncontaminated' by existing theory or literature.

In contrast, Burton and Steane (2004) propose that the literature, in terms of a critical review of theory, practice and previous investigations, is required to build a foundation for research questions. They argue that the role of literature is to support a position that runs through all elements of the thesis (proposition, justification, evidence, findings) and necessitates investigation from the outset to inform development of meaningful research questions. This approach is recommended by those who believe that the researcher cannot remain distant from preconceived ideas and influences found in literature. In this situation, data analysis is concept-driven (deductive). An important decision for the novice researcher to make, therefore, is to what extent the literature should be investigated at the commencement of a study.

Although this study did not adopt a purely inductive approach utilising grounded theory as the methodological framework and thus requiring complete separation from the literature (Strauss and Corbin, 1998; Charmaz, 2003), it equally did not take a deductive approach (Ritchie and Lewis, 2003) where theory and literature are necessarily pre-existent. The study is, therefore, located towards the inductive 'end' of the inductive-deductive research continuum. This requires the researcher not to be overly influenced by concepts from the literature so as not to preclude or obscure insights derived from the data (Silverman, 2010).

Furthermore, various authors advocate caution in the use of literature before the commencement of any study, irrespective of the research design. For example, Glaser (2004) advises against an in-depth review and recommends taking a broader view of the issues relevant to a study. Punch (2005) also points to the importance of deliberate delay in addressing the literature, while Silverman (2010) extends this by emphasising that the relevant literature cannot be accessed until direction(s) begin to emerge from the data analysis. It is difficult, if not impossible, to anticipate research findings that may emerge.

Fortunately, it is possible to strike a balance at these relatively polar positions (Holloway and Wheeler, 2010). Although it was essential to view the research as a unique investigation of participants' experience and to be open to the likelihood of completely fresh and novel insights, it is also difficult for any researcher not to be at least minimally influenced by their

early reading of the literature arising from their personal motivation to embark on the research in the first place. Social phenomena worthy of investigation do not arise magically from the 'ether', but are necessarily imbued with the personal interests and philosophical standpoint of the researcher. Thus, Holloway and Wheeler (2010) advocate flexibility in the use of literature in the early stages of research, while trying to retain a sense of distance to avoid being unduly influenced by this. They identify the importance of at least making links with historical and current lines of enquiry in the area of interest.

As I wanted to remain completely open to what my research participants were saying without undue influence from the literature, I decided to employ this 'hybrid' approach of Holloway and Wheeler (2010), thus striking a balance between the relatively polar positions outlined above. This approach meant that I could make links with historical and current lines of enquiry in the transition of HCAs to and through HE to nursing registration. In this way, I would retain a sense of distance and avoid undue influence from literature not necessarily directly connected with the study at this early stage. Therefore, a sense of pragmatism requires that researchers investigate the literature to discover if any similar work has previously been done and to consider how the proposed study might further knowledge in the field.

2.3   Search strategy

The initial search strategy was essentially a scoping exercise to establish the extent of the literature on health care support workers in general and healthcare assistants (HCAs) in particular.

The aim of the literature search was twofold:

- to identify the widest range of literature relating to HCAs

- to identify any previous empirical work that may have examined the experiences of former HCAs during their transition to and through higher education to achieve nurse registration

The objective was to 'cast the net wide' and capture all articles that featured HCAs. Two major health and social science databases were employed for the search process. The International Bibliography for Social

Sciences (IBSS) accesses 19 databases including the British Nursing Index and Sociological Abstracts (see http://search.proquest.com/ibss/advanced for the full database list). The Cumulative Index for Nursing and Allied Health Literature (CINAHL) accesses nursing and allied health literature for 2800 journals (see http://www.ebscohost.com/ for full details). The main advantage of using these databases is that they cover a very wide area of health, nursing and social science literature. The rationale for search terms follows.

The title healthcare assistant and support worker are ubiquitous terms throughout the United Kingdom with support worker being used interchangeably alongside HCA. Thus 'healthcare assistant', the 'HCA' acronym and 'support worker' are obvious candidates as search terms. However, the search required some variation with the search terms for healthcare assistant because some authors separate the words 'health' and 'care', while the plural form 'assistants' also seems to be used. Thus, additional search terms were; health AND care AND assistant; healthcare AND assistant(s). Given the stated aim of the study, I also searched for 'university', 'higher education', 'transition' and 'nurs*'. Use of the asterisk instructs the search engine to collect papers with the words 'nurse', 'nurses' and 'nursing'.

2.4   Summary of search results

The earliest appearance of the terms healthcare assistant (HCA) and health care support worker (HCA) in the literature was 1990. This is perhaps unsurprising as it corresponds to the time when HCAs filled the 'care-vacuum' left by the migration of student nurses into HE for their healthcare education (UKCC, 1986). These student nurses had previously provided basic bedside care as part of their NHS apprenticeship nurse training.

The vast majority of papers retrieved (n=358) were descriptive commentaries rather than research reports. All search results were systematically examined online for discreet topic areas and collated accordingly. Three broad topic areas could be immediately identified from within the search results and the papers were placed into one of these categories.

- the occupational role of HCAs
- the controversy around state registration and regulation of HCAs
- education and training issues

The decision to organise the search results into these categories was based on the individual titles of the articles. Each article was also scrutinised to confirm that the content matched the title. These categories represent the major areas of discussion, debate and controversy surrounding HCAs

The literature arising from these searches was mainly descriptive and showed the wide variation in, and controversial nature of, the occupational role of HCAs. The literature abounds with differing views on the role of the HCA amid calls for a national registration scheme driven by the increased clinical responsibility of the HCA role and concerns over public safety and professional accountability. The controversy appears to mainly arise from contested occupational boundaries associated with certain clinical activities. Many HCAs are performing clinical functions that were until recently the domain of qualified nurses (Butler-Williams et al, 2010). One NHS Trust has reported that HCAs are being trained for invasive techniques such as peripheral cannulation and monitoring of physiological recordings such as electrocardiogram (Leigh, 2003) to assist junior doctors with heavy caseloads.

The literature on regulation and registration of HCAs is derived from concerns that shifting occupational boundaries have implications for patient safety and protection. The potential for erosion of professional status of nurses also appears to be a major concern and features widely. There is similar concern about the preparedness of HCAs for their wider clinical role. This issue of HCA education and training for their new responsibilities was similarly reflected in the literature.

2.5   Five previous studies on HCA transition

From the wide search described above, five papers were located which reported on investigations of the experiences of HCAs during their transition from support worker to registered nurse. These five studies (Gould et al, 2004, 2006; Wood, 2006; Mayne, 2007; Brennan and McSherry, 2007) represent a brief flurry of research activity during the mid-

2000s on the experiences of former HCAs during their transition to becoming registered nurses. These studies are listed below.

The titles are:

1. Seconding healthcare assistants to a pre-registration nursing course: evaluation of a novel scheme (Gould et al, 2004)
2. Seconding healthcare assistants to a pre-registration nursing course: role transition to qualified practitioner (Gould et al, 2006)
3. Socialisation of seconded healthcare assistants (Wood, 2006)
4. Transition from clinical support worker to nurse (Mayne, 2007)
5. Exploring the transition and professional socialisation from healthcare assistant to student nurse (Brennan and McSherry, 2007)

Superficially, these studies would appear to have investigated the phenomena of interest. Three of the five studies (Gould et al, 2004, 2006; Mayne, 2007) located their rationale within the circumstances and discourse operating at the time, the problem of a contracting supply of nurses and the latent source of nursing students from within an existing substantial HCA workforce as a potential solution to this problem. Two of the five studies (Wood, 2006; Brennan and McSherry, 2007) extended this rationale by framing their research within the literature on professional socialisation in nursing.

However, the studies were not framed within the wider literature on transition to and through HE and there was no engagement with the literature on the sociology of education, knowledge or learning. Furthermore, despite shedding some light on socialisation of HCAs to the role of RN, there were methodological and theoretical limitations in each of these studies. The five studies are examined in the critical summary below.

2.6   Critical summary of the five studies

Gould et al (2004) explored the general clinical and academic experiences of HCAs as they progressed through a nursing diploma course. The study design was longitudinal with interviews conducted at 3 months, 12 months and at the conclusion of the 36 month course. Two consecutive intakes were recruited to the study and the demographic characteristics were typical of HCAs nationally (Kessler et al, 2010). However, despite these

methodological strengths, the study was more of an evaluation of their particular university secondment scheme. The primary motivation was the contribution of the HCA secondment programme to the government policy of encouraging widening participation to nursing (NHS, 1998) rather than a focussed investigation into student transition experiences rooted in social theory. As much of the paper was devoted to stakeholder perceptions of the course as was given to the student experience. Furthermore, there was limited exploration of HCA knowledge and experience derived from previous healthcare employment, minimal exploration of the HE experience and little exploration of HCAs' perceptions of their role and the nursing role. These former HCAs reported stress with academic level (particularly biology), the volume of reading and the theory component of the HE course. Participants also expressed anxiety about study skills and stated that their NVQ level 3 was not helpful for nurse education.

This 2004 study was followed up by Gould et al (2006) to explore the reflections of the same former HCAs once they had completed the HE diploma, registered and taken their first nursing job. Although the findings were interesting in terms of participants' self-assessment of their clinical skills and confidence in dealing with complex situations and managing junior staff, there was minimal exploration of personal change or development arising from the HE experience. There was only passing reference to the academic demands of the HE programme and participant perceptions of lack of preparation in terms of study skills. Participants reported the 'reality shock' (Maben and Macleod-Clark, 1998) of nursing and fear of failure despite previous HCA experience. They also reported stress in returning to their previous ward where they were known as a former HCA. The interview questions were task-based, focusing on clinical skills and general employment performance such as team working and workload management. Furthermore, the study could only recruit four participants and comments by stakeholders, such as NHS managers, were inconsistent with the findings. These are major weaknesses and have been separately criticised by Culley (2006).

In a similar study, Wood (2006) examined the clinical practice experiences of former HCAs in their transition to mental health nursing, using four concepts drawn from the nursing literature that were conceptualised and presented as 'socialisation theories' but do not feature in the wider

socialisation literature. Although this study demonstrated certain methodological strengths in terms of being a longitudinal study and the range of participants' social and clinical backgrounds, the sample size was relatively small (n=8) and their HE experiences were not explored. Participants described slipping back into the HCA role and experienced some dissonance as a consequence. Although there was an assumption by the authors that HCAs had transferrable knowledge and skills, this was not explored.

Mayne (2007) investigated the experiences of clinical support workers (CSWs), the Scottish equivalent of HCAs, on a university nursing course using questionnaires and a single focus group discussion involving just seven students. Referring to the participants as 'non-traditional' students, the author explored their experiences during the first year of training, following a one-year preparatory course (Higher National Certificate in Healthcare). Although the reported findings related to some aspects of student transition and adult learning, the discussion and conclusion focussed on the students' clinical practice experiences and socialisation into nursing rather than the HE experience or academic life. The main finding was that the CSWs encountered some role ambiguity during their socialisation into the role of professional nurse due to their previous experience as bedside healthcare workers. Issues relating to CSW self-perceptions of their knowledge and skills, and the higher education transition process and learning were only minimally explored.

In their study, Brennan and McSherry (2007) drew exclusively upon the nursing literature for a three-part model of HCA transition to student nurse; role confusion, exposure and reality shock. Small focus groups of former HCAs met at the commencement of each academic year and at the conclusion of the course. Again, socialisation within the healthcare setting was the main focus. As in the studies above, the authors only drew upon a narrow interpretation of socialisation from within the nursing literature. The study did not examine the transition or socialisation through HE. There was very little exploration of the HE experience in this study and the authors did not examine HCAs' self-perceptions of their knowledge and skills. As with Wood (2006) and Mayne (2007), participants in this study reported being used as an HCA by the clinical placement and slipping back into the HCA role when it suited the participant themselves. Brennan and McSherry

identified issues of role identity and reality shock, both well documented in the nursing literature since the inception of university-based nurse education in 1986 (Gerrish, 2000; Maben and Macleod-Clark, 1998). The authors concluded that student 'withdrawal' into the HCA role at times of stress and vulnerability in the healthcare setting requires greater exploration. Their final questions were, 'What issues are at play and what drives students to retreat?' This study has addressed this phenomenon.

In addition to the five studies discussed above that explored former HCA transition to RN, one additional paper (Dearnley, 2006) examined the transition experiences of state enrolled nurses to registered nurses. SENs are second level nurses who have completed a basic training in nursing. Although the participants in the study were not HCAs, an element of Dearnley's rationale for the study was a recognition that increasing numbers of HCAs will be entering HE for the first time and that changes in understanding, knowledge and clinical practice may be observed in this latter relatively new undergraduate group. With five semi-structured interviews over two years, Dearnley mapped her findings onto a theoretical model 'Women's Ways of Knowing' (Belenky et al, 1986) as a lens through which to view the participants' experiences. However, although the study explored how the transition experience impacted on participants' perceptions of different 'ways of knowing nursing' the exact nature and meaning of this knowledge was not explored. The nature and significance of nursing knowledge was assumed.

These five studies (Gould et al, 2004, 2006; Wood, 2006; Mayne, 2007; Brennan and McSherry, 2007) represent a brief period of research activity during the mid-2000s to investigate the experiences of former HCAs during their transition to qualified nurse. The authors' motives appear to be genuinely directed towards exposure and illumination of the transition processes involved. However, despite these declared intentions, none of the studies have attempted to investigate HCA perceptions of knowledge acquisition while employed as a support worker, of transfer to the nursing student role and subsequently to the nursing role once qualified.

These studies have tended to focus exclusively on the socialisation of HCAs and other support workers into the professional discourse of nursing rather than the university experience *per se* and the effects of higher

education. With one exception, all five transition studies from my search described their main conclusions in terms of what the authors call 'professional socialisation'. There was very limited investigation of academic transition and the overriding preoccupation of these studies reflected the need to investigate the processes surrounding integration of the former HCAs into the nursing culture. Furthermore, given that transition of HCA to RN, framed in terms of socialisation, is deemed significant in the five studies, none explored the HCA relationship with registered nurses in practice. Most of the literature referred to above and categorised into the three main areas identified above, was exclusively nurses' and managers' perceptions of HCAs. There was minimal coverage of HCA perceptions of their role and their relationship with registered nurses. The basic premise of the five studies described is that nursing students' future practice is shaped by nurses and clinical areas. However, none of these studies investigated the relationship between HCAs and nurses. This study has addressed this phenomenon.

There seems to be little interest in what former HCAs have learned from the role, how they construct their knowledge within the context of their work, how this knowledge is valued by others in practice settings, first as an HCA and then as a student nurse in practice and in HE. None of the studies acknowledge or explore HCAs' self-perception of their role in healthcare, the knowledge acquired as a support worker or the previous education of the former HCAs. As there is a lack of a definition of an agreed role for HCAs and HCA levels of responsibility vary widely across the healthcare sector, the HCA self-perception of the knowledge arising from their role and its contribution to their transition through HE and clinical practice 'apprenticeship' is worthy of investigation. These five studies on HCA transition through HE to registered nurse did not address any of these concepts, issues or areas of concern.

There also appear to be no studies that have investigated these phenomena with former HCAs who have been qualified and working as nurses for a period of some years. As my research explores what former HCAs say about their role as HCA and how they describe the knowledge and skills they gained from this experience, my study will involve both current students and former HCAs who have worked as nurses for several years. The former participant group will provide data on the student

experience of the degree course while the latter group will give the perspective 'from a distance'.

All five studies took place when the minimum academic tariff for nurse registration was the Diploma of Higher Education (Level 5) i.e. before the threshold level for nursing registration with the UKCC became a degree (Level 6). My study included current students who were taking the degree course to nursing registration. This provided an additional dimension to my study in that these participants were talking about their experiences in the early stages of the contemporary degree course whereas the majority of the participants who were current nurses at the time of the interview took the diploma route to nursing registration during the era of Project 2000.

2.7   Issues arising from the five studies

During my reading and analysis of the five studies on HCA transition to RN, I was struck by their complete lack of coverage and indicative reference to the wider literature on transition to and through HE. The only mention of academic issues facing students were; stress with study skills, volume of reading, the complexity of biosciences as a curriculum subject (Gould et al, 2004) and generalised 'fear' of transition (Mayne, 2007). While role confusion of HCAs during clinical practice placements is reported in several of the studies, the authors do not draw upon any other literature on occupational socialisation nor do the studies adequately theorise this phenomenon. HCA transition has been theorised only within a narrow range of discrete nursing literature. My study explores how former HCAs describe their learning and knowledge, and the value attributed to this knowledge by different agents in the field.

The authors of these five studies do not, in my view, engage with any of the relevant and substantive issues relating to student transition. Given my background and involvement in widening participation to HE, I had a naïve expectation that these issues would at least have been mentioned. Although much of the transition literature tends to focus on identifying risk factors and barriers to success for young undergraduates, typically A level students with subsequent interventions to smooth their passage, I expected to see at least some mention of the broad issues facing all potential students as they approach life at university. For example, Hussey and Smith (2010) identify 4 major challenges for any student in their transition to

HE: knowledge, understanding and skills; autonomy; approaches to learning; social and cultural integration and the student's self-concept. Given the declaration in each of the five studies examining HCA transition to RN, that HCAs represent a potential source of graduate nurses, their general lack of typical academic credentials (A levels) expected by HE, their maturity on entry and their minority status in a cohort of students, are major omissions.

There was also a lack of acknowledgement that former HCAs belong to the wider category of vocational education and training (VET) students attempting to make their way through HE to a professional future. Controversy persists on what distinguishes social care from 'professional' nursing in terms of the knowledge base for practice (Merriefield, 2017). While the wider literature acknowledges the diversity, life experience, socio-economic status, backgrounds and vocational knowledge and skills the VET students bring to university courses (Colley et al, 2003) there was no acknowledgement of this in the five HCA to RN transition studies.

Furthermore, the lack of reference to the general discourse of social inclusion and policy initiatives to widen HE participation for under-represented groups in the UK is lamentable in the five studies. There are distinct lines of research and substantial literature on transition to HE, examining the transition experiences of increasing numbers of 'non-traditional' and mature applicants to HE arising from several decades of policy initiatives in the UK. Ecclestone (2009) has categorised these into three investigative domains: studies that examine people's sense of self (identity); their capacity for autonomous, empowered action (agency); and, the effects of structural factors (class, gender, race and economic and material conditions).

Some of the issues that I had expected to see at least identified in the five HCA transition studies (appraised above) or in the wider HCA literature, are listed below:

- alienation and engagement (Mann, 2007)
- learner identity (Briggs et al, 2012)
- experience in the first year of university (Low and Cook, 2003)
- feelings of being an 'impostor' in the university (Reay, 2002).

- students' engagement with their subject (Anderson and Hounsell, 2007; Meyer and Land, 2003)
- beliefs and attitudes towards knowledge and learning (Rodriguez and Cano, 2007)
- deep and surface learning (Marton and Saljo, 1976)
- weak and vulnerable learner identity; lack of formal preparation for university life (O'Donnell and Tobbell, 2007)
- knowledge, understanding and skills; sense of autonomy; approaches to learning; cultural integration and self-concept (Hussey and Smith, 2010),
- what is learned at university: the SOMUL project (Brennan et al, 2010)
- threshold concepts and troublesome knowledge: the ETL project (Meyer and Land, 2003)
- impact of HE on students and society (Pascarella and Terenzini, 2005)

These topics and authors have influenced my practice as an educator in both further and higher education. The next section outlines the personal origins of this research project and some specific influences on the direction of my work.

2.8 Influences on me as a practitioner and researcher: Reay, Crozier and Bourdieu

At this point in the thesis I will declare my interest in Bourdieu's Theory of Practice (Grenfell and James, 1998) to the aims of my study. There is an irony in this self-declaration as Bourdieu is emphatic that researchers have a responsibility to their readers to be reflexive in the research process (Deer, 2012). This means acknowledging my position in the academic field, declaring what is at stake for me in undertaking this research and being aware that I may project my own vision of the world onto the social practices which I am investigating.

Widening participation and social inclusion have been a continuous thread in my working life in both Further Education (FE) and Higher Education. My interest in social and cultural capital was first stimulated while developing Access courses to Higher Education during the 1980s. This initial interest

accelerated once I entered HE as a lecturer in biosciences for nursing education and, once in the university, I had direct exposure to some of the problems, risk factors and barriers to success faced by new undergraduates during their transition through HE. Maintaining my contacts with the FE and adult education sector led to my conception and implementation of Uni4U, a social inclusion and widening participation project operating across South East London (Bryant, 2002, 2004). Funded by the European Social Fund and the Learning and Skills Council, the aims of Uni4U were to *'improve the study and employment skills of adults in areas of relatively high social and economic disadvantage, and to support mature students in nursing, midwifery, health and clinical sciences'* (Bryant, 2010).

My reading extended to papers from the literature on transition and widening participation, including some that had used Bourdieu's theory of practice as their conceptual framework. For example, the work of professors Diane Reay and Gill Crozier was influential in my original conception and subsequent development of the Uni4U programme. Diane Reay extensively examined the HE experiences of mature and non-traditional students in terms of social class, gender and race (Reay, 1998, 2000; Reay et al, 2002). Her work illustrates the utility of habitus, field and cultural capital to investigate the relationship between structural factors and personal agency in students' experience of HE. Gill Crozier has also published widely on widening participation and social inclusion. For example, Crozier et al (2008) examined the experiences of middle class and working class students across four different types of HE institution. Students' personal habitus was found to mediate both the choice of university and the students' perception of the quality of the learning experience once there. This latter phenomenon was explored by Reay et al (2010) who found that profound adjustments were required by students whose personal habitus did not align comfortably with the institutional habitus of the university. Bamber and Tett (2000) subsequently argued for universities to recognise that the interactions between personal and institutional habitus may impact negatively on students' sense of learner identity.

Crozier and Reay (2011) have also studied how working class students respond to the academic demands of HE. Using Bernstein's (1996) concept

of invisible pedagogies and the abilities that students bring to unfamiliar learning situations to elucidate what is going on and how to respond, they found significant differences between an elite pre-1992 and an egalitarian post-1992 university in terms of pro-active and structured learning support and students' sense of belonging to and success within the academic community. The unifying analytical tool of these studies is Bourdieu's theory of practice, specifically habitus (Maton, 2012) and its interaction with cultural capital (Schuller and Field, 1998).

Personal habitus refers to the relatively durable qualities and enduring dispositions that emerge from an individual's social and familial life history. This form of habitus represents the internalised structure of lived experience from infancy, through childhood and into adulthood (Nash,1999) and thus gives rise to and explains peoples' dispositions to think, act and respond both to their current environment and to changing circumstances. Personal habitus is malleable and has the potential to be changed by experience (Bourdieu and Wacquant, 1992). In contrast, however, institutional habitus, described by Thomas (2002) as the power of certain classes and groups within organisations to control individual behaviour, tends to be more stable and is less likely to change over time due to a combination of institutional inertia and the self-interest that often characterises large organisations. The cultural capital of the dominant group in the university is reflected in the institutional habitus of curriculum, level of academic support and working relationship between staff and student.

Although Bourdieu's concept of habitus has been employed in hundreds of education studies, in contrast, Bourdieu has only relatively recently begun to appear in the health care literature. For example, the potential for Bourdieu's theory of practice for nursing research was flagged in the mid-2000s by Rhynas (2005) and again by Lopes et al (2013). Specific studies that have employed Bourdieu's thinking tools in nursing and midwifery research are; habitus as a tool to investigate communication between nurses (Sieger et al, 2011); capital, habitus and field to explore school nurses' perceptions of their professional role (Morberg et al, 2012); the influence of cultural interactions and education on the emerging midwifery habitus (Hobbs, 2011). In the medical literature, an early paper by Kirschner and Lachicotte (2001) employed habitus to explore doctors'

attitudes to good mental health care and more recently the potential role of Bourdieu's theory of practice was offered as a means to explain the socialisation of medical students into the profession (Emmerich, 2014).

Bourdieu's theory of practice is one of two theoretical frameworks that underpin this study. The other is Bernstein's code theory of knowledge. The next section introduces the debate on the role of knowledge in the status and legitimation of nursing practice and nursing education. A rationale then follows for the potential value of the respective theories of Bourdieu and Bernstein to this study.

2.9   Knowledge for nursing: sacred or profane?

In their transition to registered nurse via HE, HCAs are moving from the bedside of a hospital ward to the classroom desk of a university, that is to say, from the world of intimate bodily care involving feeding, drinking, washing and wiping, to the world of the university involving lectures, seminars and tutorials. On leaving the HCA subfield, HCAs are on a learning trajectory through HE that has the ultimate destination of RN. Their transition involves moving from the 'profane' world of personal care involving everyday knowledge into the academy where 'sacred' disciplinary knowledge holds sway (McNamara, 2008). During their journey through the HE degree programme, former HCAs will also return to healthcare on several occasions as a university nursing student on clinical practice placement. As well as a store of knowledge arising from previous healthcare experience, the former HCA will additionally have exposure to 'sacred' knowledge arising from their time as a student in the HE field. The former HCA, now in the role of university nursing student, will be viewed by other actors in the HC field as a representative of the HE world. These are massively contrasting worlds and represent a significant challenge for HCAs. The HC field for the HCA is the profane world of close-body care while the university is an esoteric and sacred world.

The binary conception of knowledge, characterised in this case by the difference between the activities involved in personal care of patients and the academic activities of HE, has a long history. The difference between everyday experience and intellectual knowledge, was originally distinguished in the nineteenth century by Durkheim as the difference between the *sacred* and the *profane* (Young and Muller, 2014) and by

Vygotsky as the difference between *theoretical concepts* and *everyday concepts* (Young, 2003). Gibbons et al (1994) later reconceptualised this to *mode 1 knowledge* as discipline-based and *mode 2 knowledge* as problem-focussed. Young (2008a) took this concept of binary divide further in describing *context dependent* knowledge (non-curriculum knowledge) versus *context independent* knowledge (curriculum knowledge).

Following the binary approach, most research in education has been premised on the view that knowledge is either objective and decontextualized or it is socially constructed and reflects power relations in society. This led to views of knowledge that were polarised between essentialism and relativism, the latter holding sway for much of the second half of the twentieth century. Curriculum, or intellectual, knowledge of the powerful, was viewed as a social construct reflecting unequal power relations in society, due to social class, ethnicity and gender, and was being imposed on the education system in the UK (Young 2008b).

However, the notion of knowledge having its own internal structure, taking different forms and being amenable to analysis has emerged gradually from the original work of Bernstein (1971), a lone voice for the role of knowledge during this period. Bernstein emphasises the role of boundaries between domains of knowledge, suggesting that only successful negotiation of these boundaries provides opportunity for acquisition of knowledge and expression of associated power. Unlike his contemporaries of the latter half of the 20th century, who viewed knowledge purely as a reflection of power relations between educational settings and wider society i.e. relations to knowledge, Bernstein took the view that there were relations within knowledge and these relations could be analysed. A key element in Bernstein's thesis is that education is not simply and exclusively a process. Although the process is important, learning must involve knowledge.

Young (2008b), while not completely abandoning the relativist position of the late twentieth century which emphasises the role of power and subjectivity in the study of knowledge, has acknowledged that there is a problem with knowledge as an exclusively social construction because, if the premise is that culture determines knowledge, then knowledge becomes arbitrary. Latterly, the work of Young and Muller (2007, 2010), Moore (2013) and Maton (2014) has attempted to move the study of

knowledge away from an exclusively relativist position. If knowledge has a central role in education and learning as a distinct field of study, then Maton and Moore (2010) suggest that contemporary accounts of education and learning are afflicted by 'knowledge blindness'.

In foregrounding the role of socialisation in preparing students for practice, as we have seen in the five studies that examined the transition of HCA to RN, nursing academics have similarly marginalised or ignored the role of knowledge in nursing education. As an example of this phenomenon, there is no evidence in the five studies described above whether previous experience as an HCA, and the knowledge and skills acquired does or does not benefit HCA progression through nursing HE and training to RN. There appears to be an assumption that nursing and its underpinning knowledge is a 'given' and all that is needed is socialisation into the mysteries of nursing.

Furthermore, there exists a significant controversy and long-standing debate on what nursing is and what it is not. Is it a science or an art? Does it require theoretical knowledge or everyday knowledge? Can anyone 'nurse' because caring only requires the knowledge of everyday experience or does a nurse require specialist theoretical knowledge. Is it a profane or sacred activity? This was most recently highlighted (2 April 2017) in The Supreme Court (2017) where the difference between nursing care and social care was the issue at stake. These operational boundaries in society are reflected in the symbolic boundaries found in healthcare practice and in the academy (Atkinson, 1997). Although the origin of the case was financial (social care is less costly), the implication of agents external to nursing making a legal definition of nursing practice was sufficient for an emeritus professor and former Royal College of Nursing (RCN) President Dame June Clark to demand that the RCN and nurses urgently come to a collective definition of nursing (Merrifield, 2017). This contemporary debate surrounding an accurate articulation of what nursing is and is not, resonates with the history of other disciplines currently well established in HE.

Like medicine, engineering and architecture, all disciplines that enjoy high status in the academy, nursing is a 'region' (Bernstein, 1971) i.e. it draws upon a range of other disciplines which share a common feature of

approximation to the Bernstein definition of a singular. Regions are *'knowledge structures in which several singulars are brought together within an integrating framework'* (Young, 2008b). The significant feature of regions, and that which distinguishes them from singulars, is their outward facing nature i.e. the particular nature of regions is their relationship with an activity in and for wider society.

For both medicine and nursing, some of these singular subjects are (alphabetically) anatomy, biochemistry, economics, microbiology, pharmacology, physiology, politics, psychology and sociology. These sacred domains of knowledge are selected and singled out for special treatment both in society and the academy, where identity must be kept apart from potential 'contamination' from everyday knowledge. Medicine in England experienced a similar problem in the eighteenth and nineteenth centuries, as universities resisted the unsavoury activities of barber surgeons in the 'hallowed halls' of academe. Blood and sawdust was not welcome in an environment where the classics were revered as the only disciplines worthy of a university education (Muller and Young, 2013). However, medicine did achieve acceptance in the academy, first through the development of 'scientific medicine' in the nineteenth and twentieth centuries, second through the exploitation of the epistemic power of new contributing singulars, such as physiology, and finally through successful promotion of diagnostic and curative services to society. However, although medicine and nursing receive their legitimacy from a public service ethic, nursing as an emergent academic discipline suffers poor academic legitimacy due to the general perception that it lacks a 'canon' of sacred mysteries (McNamara, 2009). Furthermore, nursing deals much more closely with intimate and taboo body functions, a problem for the developing status of nursing in the academy.

For the former HCA, now a nursing student preparing for registration, the transition between healthcare and higher education and back again as a student, requires negotiation of these two social fields, each with their own conception of relevant and valued forms of knowledge.

How do former HCAs negotiate the transition between these fields where different forms of knowledge have different value and perform different

roles? How do former HCAs articulate the role of knowledge during their transition? These questions are explored in this study.

The next two sections outline the potential of Bourdieu's field theory and Bernstein's code theory offer in providing contrasting ways of thinking about the role of knowledge to my research.

2.10   The potential of Bourdieu's theory of practice for my research

Bourdieu's theory of practice has been increasingly used in qualitative research, both as a theoretical approach and a practical tool, since Bourdieu's seminal work *Distinction* was first published (Bourdieu, 1984). The concepts of field, capital (social, cultural, economic) and habitus are the major thinking tools of Bourdieu's theory of practice and enable the relational aspects of power i.e strategies, status hierarchies and field, to be identified and described. Other thinking tools arising from the interaction between the major concepts, developed later by Bourdieu, are hysteresis and doxa.

Individual habitus is operationalised through the various forms of capital (social, cultural, economic) that people bring as social actors to the environments and domains (fields) where they live and work. Social fields, such as healthcare and higher education, have boundaries produced by the limits of dominant social structures and accepted cultural practices. Habitus represents an individual's schemes of perception, thought and action, derived from a lifetime accumulation of social, cultural and economic capital, that are brought by the individual to operate within the social structures, fields and groups where the person lives and works.

Thus, habitus can be viewed as an explanation of how people behave or operate within a particular social field, where certain attributes of human behaviour are recognised as legitimate and where people develop a 'feel for the game' being played. Furthermore, people have the potential to be 'winners' or 'losers' in playing the game (of social practices within the field). Being recognised as a competent or good player is therefore a social good with intrinsic value as part of an all-pervading economy of cultural goods within the field (Bordieu,1989).

Similarly, healthcare is a highly-structured field where status is overtly related to credentials of title, colour of uniform, qualifications and the subsequent working relationship to patients and clients. However, beneath the relatively public manifestation of title, uniform and qualification lies knowledge as a form of 'occupational' capital arising from informal learning in the field. Knowledge and the status associated with it is a form of capital in healthcare. According to Bourdieu, status and resources which are present within a field, operate and are exchanged in contribution to the structure of that field. Furthermore, fields are knowledge-knower structures where legitimate knowledge is defined and restricted to those who have privileged understanding by virtue of their attributes and position in the field. Actors' positions in the field are determined by their capital in the form(s) recognised as such by other actors and, as in all fields, healthcare is a field where actors struggle for status and resources using social, cultural and symbolic capital. The role of knowledge practices within the field of healthcare and tacit knowledge as a form of capital for HCAs are explored in this study.

2.11 The potential of Bernstein's theory of knowledge for my research

Whereas Bourdieu describes fields as structures within which actors struggle over status and resources, and in the context of the healthcare field this includes knowledge, in contrast Bernstein (1977) describes how knowledge structures and informs the practices within the field. Bernstein's theory gives credence to the notion that knowledge is not a benign set of facts (Castells, 2000) or simply information that has been organised, communicated and 'traded' as part of the status negotiations within a field, but has emergent properties and powers of its own.

Bernstein developed the idea of boundaries of knowledge from Durkheim, emphasising the structural differentiation between fields, between theoretical and practical knowledge and between curriculum and everyday knowledge. He coined the terms 'classification' and 'framing' to describe the ways in which knowledge in general and educational knowledge in particular could be represented within fields of practice (Bernstein, 1971). Classification represents the strength of boundaries between knowledge domains i.e. the degree to which a subject is separate from other subjects.

Classification of knowledge is said to be strong between knowledge domains where the boundaries are wide and clear e.g. between physical sciences and the humanities. The concept of classification enables boundaries between forms of knowledge in the world to be identified and the relative distance and strength between domains to be assessed.

Framing is the second concept in Bernstein's model and enables the form or nature of control on the knowledge within its social or epistemic context to be identified and its relative strength to be assessed. Framing represents the way in which a subject is controlled by teachers or other authorities in the field including, in this case, nursing academics in the university and registered nurses working alongside HCAs in practice. Framing is said to be strong where the boundary between specialist or curriculum knowledge and personal experience is wide.

The history of university expansion in the UK, shows that the journey of any region discipline (with singular composites) into the academy is fraught with difficulty and involves 'culture, custom, pressure groups and a good deal of political horse-trading' (McNamara and Fealy, 2014). One of the problems for nursing is that it cannot decide which of the many potential singulars will become the mainstay of its claim to legitimacy in the university. Advocates of a '*scientific nursing*' approach cite the strength of classification and framing within the singular disciplines (biosciences, psychology, social science) that converge to form the region of nursing (McNamara, 2009). In contrast (and slightly confusingly given the juxtaposition of the same words), proponents of the *'nursing science'* approach advocate a focus on the person, in terms of aesthetics, personal knowing and ethics. Caring is central to nursing science and involves the lived experience of health, illness and healthcare (a 'knower' perspective), all highly subjective and in Bernstein's terms, relatively weakly framed.

These controversies form the backdrop of life as a nurse, both in clinical practice and in the university, and represent the hidden features of contemporary nursing. All nursing students have to find their way to registration in this confusing milieu, but former HCAs have a unique standpoint on this in that they have acquired knowledge from their close-proximity work with patients. This may be weakly framed knowledge but it is knowledge nevertheless. Their dilemma is how to make sense of it as

nursing students when studying in the academic environment and when practicing in the healthcare environment. In a sense, former HCAs entering nurse higher education represent the embodiment of the issues running through the debate on the knowledge foundations of nursing.

2.12   Legitimation Code Theory (LCT) as an empirical tool for my research

While Bourdieu's theory of practice provides a useful theoretical background for thinking about the nature of a particular field, the role of resources within a field (capital) and the behaviour (habitus) of actors in the field, the concepts of field, capital and habitus are essentially thinking tools. Similarly, Bernstein's code theory of knowledge provides a useful way to think about the nature of knowledge, its origins, structure and how it is propagated through practice in education settings. However, neither Bernstein's theory of knowledge nor Bourdieu's theory of practice offer an empirical tool kit for research on how knowledge contributes to the structure of a field nor how people use knowledge in their everyday language to negotiate their position in a social field.

Furthermore, there is an apparent dichotomy between Bernstein's and Bourdieu's view of the role of knowledge within fields. Bourdieu's theory of practice is premised on the notion that fields structure knowledge through interaction between actors' habitus, capital and the field. In contrast, Bernstein's code theory is premised on the notion that knowledge structures the field through the interaction between the boundaries of 'sacred' knowledge with strong classification (the academic disciplines) and 'profane' knowledge with weak classification (knowledge of experience). Several authors have pointed to this opposition between Bernstein and Bourdieu and have attempted to pit the theory of one against the other. For example, Harker and May (1993) compared the philosophical and sociological antecedents of Bernstein's code theory and Bourdieu's habitus in an attempt to show that they were different in their original conception and subsequent use.

However, if fields are semantic structures where people use knowledge to justify their status in the field, Maton (2000) believes that the ostensible contradiction between Bourdieu and Bernstein is artificial and can be overcome by synthesising their different approaches into a new conceptual

framework, social realism. Thus, knowledge is both social (Bourdieu) and real (Bernstein). Knowledge has both social and epistemological power i.e. knowledge is both a reflection of power relations in fields and claims to truth in fields.

Maton (2014) has proposed that the language actors use in referring to knowledge (languages of legitimation) are manifestations of practices within a particular social field such as healthcare. *What* can be known and by *who*? If the question is 'how is knowledge legitimated?', the answer is 'by the language used by its proponents'. Languages of legitimation represent strategic stances within the field and are symptomatic of the struggle for status and resources in the field.

Thus, Legitimation Code Theory (LCT) (Maton, 2014) is drawn from a synthesis of Bourdieu's theory of practice involving struggles over status and resources within fields and Bernstein's code theory which conceptualises how knowledge is structured within fields. Maton proposes modes of legitimation for different forms of knowledge. A 'knowledge mode' is employed where the knowledge relationship is towards an object of study in the world i.e. where there are 'epistemic' relations to knowledge. A 'knower' mode is employed where the knowledge relationship is due to a subject making a claim to knowledge arising from their position in the field i.e. where there are 'social' relations to knowledge. Thus, LCT is an attempt to move beyond Bourdieu's thinking tools of habitus, capital and field, and Bernstein's theory of knowledge using classification and framing of knowledge. LCT is a focus for the organising principles of languages of legitimation and legitimation devices are a way for researchers to operationalise the languages of legitimation (Maton (2014).

2.13 Summary

This chapter has provided a rationale for the study, framed in terms of implications arising from a critique of five previous studies, the role of sacred and profane knowledge in nursing and contrasting, yet complementary, theories of knowledge within fields. The next chapter describes the methodological approach to data collection and a theoretical rationale for the research interview.

Chapter 3   Methodology

3.1   Introduction

This chapter offers a rationale for the methodological approach to data collection and is divided into three sections. Following a short section on initial methodological considerations, the section on methodological approach to the study draws from an overview of social science research strategies. A theoretical and epistemological rationale for the study is then provided with summary critique. The chapter concludes with a rationale for the research interview based on the hermeneutic approach. Of particular relevance, is the presentation of research participants as social actors operating within the two fields of interest to this study; healthcare and higher education.

3.2   Initial methodological considerations

In the sense that the overall purpose of research is to investigate problems, not necessarily to solve them, but to shed light on social issues (McKenzie et al, 1997) then selecting the appropriate methodology is of central importance. Indeed, since the term 'social science' was first coined by Durkheim and Weber in the 19th century, researchers in the social sciences have developed a wide range of strategies to investigate social phenomena (Guba and Lincoln, 1994) and the 'menu' is constantly growing (Silverman, 2010). However, despite a broad and constantly evolving landscape in the social sciences, basic research terminology remains essentially unchanged. Crotty (2003) offers this summary explanation of research terms:

- method can be equated to techniques and procedures;

- methodology to strategy and process;

- theoretical perspective to philosophical stance;

- epistemology to the theory of knowledge embedded in the theoretical perspective.

Others have offered various typologies to assist researchers in their quest to unravel the large number of methodologies that are available. Lather (1991), for example, offers a discrete categorisation to inform the process

of selecting an appropriate methodology and to locate it within a particular theoretical perspective. Research endeavours may aim to predict (positivist), understand (interpretivist), emancipate (critical analyst) or deconstruct (post-modernist). As I wish to gain access to and understand the lived experience of former HCAs within the respective fields of HE and healthcare, of these four theoretical perspectives, interpretivism would appear to be appropriate for this study.

Issues of interest to the study's aim and purpose emerged from the self-reported experiences of former HCAs who were either currently engaged in full time HE and nurse training, leading to registration with the United Kingdom Central Council (UKCC), or were working as qualified nurses having previously completed a university course with consequent UKCC registration. The former group will have had current HE experiences to draw upon while the latter group were reflecting upon experiences of HE at a 'distance' i.e. with the passage of some years.

3.3   Methodological approach to the study

It should be apparent that the methodological foundation of this study does not reside within positivism. Predictions are not being made. Hypotheses are not being stated and data collection does not require a quantitative method. Positivism assumes that there is a fixed and pre-determined social reality that might avail itself to objectivist enquiry. This study is not seeking to discover unambiguous truth(s) that may be replicated. The lived experience of HCAs working in healthcare and studying in higher education are social phenomena. The phenomena of interest do not have any meaning before or independently of any consciousness of them. The meaning arises from the interaction between the subject (former HCA) and the objects experienced (healthcare and HE).

Ultimately, the most appropriate methodology for a study depends on the nature of the social world that the individual researcher subscribes to and the means by which it is possible to come to know that social world. As I wish to identify, describe and understand the experiences and perceptions of HCAs during their transition through HE to registered nurse, it is anticipated that meaning will emerge from conversations with former HCAs. Each HCA participant involved in this study will bring their version of social reality in healthcare and HE to an interview conversation and it is the task

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of the researcher to record, analyse and interpret the phenomena that are relevant to the declared aims of the research. Thus, the methodological approach advocated for this study is phenomenological located within an interpretivist theoretical framework (Lather, 1991; Crotty, 2003, p5). The potential sources of data will be former HCAs, with individual semi-structured interviews as the data collection method of choice.

3.4   Theoretical and epistemological rationale for the study: a summary critique

That this study is not located within an objectivist epistemology has already been established. However, an important issue for the study and the methodological rationale which supports it, is whether the epistemological basis lies within subjectivism or social constructionism. This dilemma is not simply a philosophical issue and therefore in some way remote from the practicalities of the research project. There are important implications that go right to the heart of the methodological rationale for the proposed study. The philosophical dilemma arises directly from phenomenology as the methodological approach and interpretivism as the theoretical basis for this approach. Phenomenology has undergone a gradual transformation since its inception in the early part of the twentieth century, from the researcher making personal and direct use of the phenomenological approach (the European model) to a more indirect or vicarious phenomenological approach (the American model).

The representation or perception of objects in the human consciousness is the founding principle of phenomenology. It is the direct and unconditional presentation of phenomena to experiencing subjects that is the defining characteristic of the European phenomenological approach to social research. Other characteristics include the concept of intentionality and the relationship between the experiencing subject and the object of experience. Terms that may be substituted for intentionality are 'relatedness' and 'referentiality' (Crotty, 2003). Intentionality, object and subject are inextricably bound up with each other in phenomenology and thus reach back to constructionism for their collective epistemological origin. In constructionist epistemology, intentionality is the key concept that links the experiencing subject and the object experienced.

Experiencing subjects, in this case former HCAs, are not described by constructionism as having a particular 'intention' toward the object of their experience. This is to misunderstand and misrepresent the meaning of intentionality. The term intentionality has its origins in mediaeval Scholastic philosophy and was expropriated by Brentano (1973) as a means to capture the relationship between subject and object in the development of phenomenology in the early twentieth century. The meaning of intentionality in this context is about humans 'reaching out' and engaging with the objects of their experience. This distinction may seem to be a minor semantic issue but the apparent subtle difference in meaning here has profound consequences for epistemology. Intentionality is the process of human subjects directing their conscious effort towards the object that is being experienced. Thus, intentionality as it was used in the early development of phenomenology by Husserl (1931), means that there cannot be an object without a perceiving subject. In other words, objects do not exist in a (human) meaningful sense without a human subject to experience that object and give it meaning.

This relationship does not mean that the subject imposes a meaning on the object while ignoring the potential meaning offered by the object. If this were the case, then the meaning would be subjective and the epistemology would be subjectivism since the object would play no part in the meaning given to it by the subject. In contrast, the constructionist epistemology embraces the dynamic between object and subject. Former HCAs (subjects) as individual social actors have social experience in healthcare and higher education (objects) to which they have ascribed meaning as a consequence of their intentionality, directedness, relatedness or 'reaching out' to the objects of their experience to create a unique and constructed meaning.

However, strictly speaking, the uniqueness of each subject (HCA) – object (healthcare or HE) phenomenon relationship should be referred to as construct**ivist** since the event or experience and the person are single entities conjoined by the intentionality of the process. Thus, constructiv**ism** is the meaning-making that is produced by the **individual** subject in relation to both material and social objects in the world. In constructivism, the construction of meaning is made by the individual. However, individual subjects rarely come to material and social objects *de novo*. Humans exist

in a world of pre-determined meaning arising from the culture that they are living in and the meaning that they convey of their experiences will be informed by this social construction.

Furthermore, when the same HCAs come to share these experiences in the research interview, they will almost certainly add another layer of social construction drawn from their own sub-culture or wider social and learning influences. The theoretical problem here is that the original purpose of phenomenology was to provide a means for experiencing subjects as researchers themselves to identify and eliminate (bracket out) culturally determined meanings for phenomena.

The original conception of phenomenology was for the experiencing subject to identify the objects of experience and give them direct and personal meaning (Husserl,1931). Thus, phenomenology requires the researcher to separately identify, examine and eliminate what is taken for granted (or socially constructed). The researcher as experiencing subject her/himself has to attempt to eliminate the prevailing influence of contemporary social culture. This process, known as 'bracketing', is a key principle of phenomenology in that the currently accepted understandings of the phenomena are placed to one side as a culturally mediated representation. Consequently, phenomenology was originally conceived as a critical endeavour because it required the researcher to identify and ignore the accepted and dominant social construction of the phenomenon and 'go back to the things themselves' (Husserl, 1970).

This is one of several arguments put forward by Crotty (2003) in his critique of phenomenological research that relies on the subject providing an account of their experience(s). Crotty is deeply critical of the departure of much phenomenological research from its origin in this 'pure' European phenomenology. Husserl's phenomenology was intended to be an approach to research, a 'weapon' even, to separate socially accepted, culturally mediated and conventional meanings for phenomena from their essential meaning. However, in much contemporary phenomenological research, the researcher is not experiencing the phenomena for her/himself in this study and therefore cannot possibly bracket out the socially constructed meaning of the phenomena as they were directly experienced by the participants.

The contemporary phenomenological approach to social research that permits the lived experience of the subject, including their own interpretation of the experience, to emerge has its own philosophical origins in American phenomenology. A full explication of this debate is beyond the scope of this thesis. However, Caelli (2000) provides a summary analysis of the theoretical and practical arguments involved, leading to a convincing synthesis and rationale for this phenomenological approach, where subjects share their experiences and perceptions with the researcher who then has vicarious experience of the phenomena being reported by the research participants.

At this point it could be argued that it is the role of the researcher to identify and tease apart the meanings that are either uniquely constructivist in origin from those that are social constructionist in origin. This research project could therefore, quite justifiably, be described as a phenomenological investigation of the interview process with former HCAs as they reflect and report on their experiences within healthcare and HE. In simple terms, the actual experience of the HCA subjects is beyond my reach as researcher. Rather, the research endeavour focuses on what the participants talk about and how they talk about it.

3.5 The hermeneutic approach: an outline rationale for the research interview.

While phenomenology has its origins in the philosophy of Edmond Husserl it was his student, Martin Heidegger who developed this phenomenological philosophy into a model with potential for social enquiry. Heidegger's development of phenomenology was grounded in the appearance of the world to experiencing subjects i.e. a person in the context of the activities of living and the associated relationships. While Husserl's well-known term 'back to the things themselves' captured the sense of protest towards the rise of positivism in the early twentieth century, Heidegger's notion of humans being born into a world of pre-existing objects and other people, emerged as a phenomenology of people living in the world with pre-existing language and culture. Heidegger coined the term 'Dasein' (being there) to reflect this reality of people living in a certain context, having relationships with things and other people and employing language and culture to operate in this, their world (Polt, 1999). Thus, Heidegger's development of

phenomenology from Husserl's essentially philosophical thesis prepared the way for an interpretive and hermeneutic approach to people's lived experience. Heidegger's emphasis of the 'relational' nature of humans being in the world, that people are social actors with a worldly existence, gives particular meaning to the inter-subjective dimension of phenomenology and the role of language and meaning-making. By emphasising the role of language, meaning and therefore, interpretation, Heidegger's phenomenology established a clear link with hermeneutics as the theory and practice of interpretation.

Thus, the phenomenology of Heidegger was subsequently the basis of a radical re-working of hermeneutic interpretation that gave first place to dialogue in its situated role as a practical human activity. For interpretivists, such as Heidegger, language is not just the instrument *by* which we engage with the world, it is *the* medium for engagement with the world. Ever since the 'linguistic turn' in philosophy and social science (Bergman, 1992), it is language and the way we speak in describing the world that, in turn, becomes human reality.

Hans Georg Gadamer and Jurgen Habermas wrote extensively about dialogue within the broader development of hermeneutics that occurred in the 20th century (Ormiston and Schrift, 1990). Although the practice of hermeneutics had been used for several hundred years as a guide to investigate the meaning of the bible and other sacred texts, from this original purpose came a later role for interpretation of human spoken dialogue. Like all interpretivists, Gadamer and Habermas believed that knowledge is an aspect of the process arising out of interaction between people and is not something 'out there' waiting to be discovered. In their hands, the 20th century saw an almost reconceptualisation of the hermeneutic approach. Although he was in a minority of philosophers who believed that the interview was a significant category of philosophical output, Gadamer gave a central theoretical role to the concept of dialogue between individuals. He insisted that the individual interview represents a means to understand how members of society are trying to make sense of their world through the process of conversation (Dostal, 2002).

However, although Gadamer and Habermas shared an approach to human understanding through conversation and dialogue, they differed in certain

crucial ways, notably in relation to power dynamics between individuals and within society. Habermas (1970) took hermeneutics further than Gadamer by introducing an element of critical analysis. Habermas gave a critical slant to hermeneutic interpretation by identifying power 'gradients' that exist between individuals and groups in society. He proposed that critical hermeneutics can provide depth and potential emancipation from social forces that can determine human experience.

Thus, there is scope for a more critical approach in this study given the nature of the phenomena being investigated and the hermeneutic perspective offered by Habermas. It may be possible to gain some insight into the occupational and subsequent power dynamics that operate in healthcare between HCAs and nurses. All participants in this study, irrespective of the date of their HE experience and professional transition, will have worked alongside registered nurses and a range of other healthcare professionals. These reported experiences may reveal tensions arising from the respective occupational discourses of nursing and healthcare support work. The experiences may also have been salient for the HCA in terms of their meaning as potential influencing factors to embark on registered nurse education as career progression.

Summary

The process of providing a methodological rationale is essential for researchers in that it helps to sharpen up the arguments to support their stated position. While this chapter has provided a theoretical and epistemological rationale for the methodological approach to the study, the process has shown that epistemological foundations are controversial and open to substantial critique. However, this is also true of competing claims of alternative methodological approaches and, in the sense that researchers have to 'pin their colours to the mast', I believe that the methodological, theoretical and epistemological issues discussed in this chapter provide sufficient grounds to move forward to the next stage of the research. The nature and process of data collection and analysis is presented and discussed in the next chapter.

Chapter 4   Method

4.1   Introduction

This chapter covers the practical issues relating to data collection. The recruitment method for research participants with inclusion and exclusion criteria, ethical issues relevant to the interview process and concerns about validity, reliability and rigour are all included. A rationale for the semi structured interview as investigative tool of choice to access the life-world of participants is also provided.

Treatment of the data comes next. Some theoretical issues relevant to data analysis are covered before details of the coding process are explained. The chapter also provides a rationale for further abstraction of the data using LCT. The Specialisation Device and the Semantic Device are used to identify languages of legitimation within participant extracts.

A tabulated guide to the organisation of the ensuing five data chapters is presented in the final section. Coding categories within the structure of each chapter are included in the table.

4.2   Approaches to data collection: manufactured and found

There are significant controversies relating to data collection that cannot be overlooked in presenting this methodological rationale. Publications by Fairclough (2001) on language and power, and Silverman (2007) on naturalistic and manufactured data, illustrate the debate relating to tensions in the type of data (found or manufactured) and the method of analysis (interpretive or critical). Each of these factors significantly influences the methodological approach to this study. The debate around found-versus-manufactured data and interpretive-versus-critical have considerable treatment in the literature and it would not be possible in this short section to do full justice to the arguments put forward by their various proponents. However, I aim to identify the key concepts within the following brief discussion.

Silverman (2007) has drawn a distinction between 'manufactured' data and 'found' data. He bases this distinction on the premise that by assembling a specific sample of people to answer pre-determined questions (p39), researchers are inevitably manufacturing their data. Silverman draws a

parallel here between qualitative and quantitative research by pointing out that when respondents become more aware of the research issue under investigation, they will alter their responses accordingly. This approach is typical of quantitative research and the determined qualitative researcher needs to be aware of this.

In making these assertions, Silverman draws heavily on the work of Sacks (1992) who is very critical of research methods that aim to tap into individuals' memories or experiences through any type of interview or storytelling. The underlying assumption in all interview methods is that the researcher is somehow tapping into the 'deep interior' of the interviewee. However, past experience and events are as much determined by present experience and culturally accepted norms, as they are by the ability of the research participants to access their personal truth. Thus, a major problem of interview data whether individual or group in origin, is that individual experience is constructed and not recalled (Crowe, 1998). The researcher will only have access to data that is, at best, a partial or fuzzy representation of participants' actions, beliefs and motivations.

Gergen (1991) has captured this notion neatly in suggesting that people do not necessarily or uniquely convert their thoughts to speech. The current form of language within which people live and work provides a resource or a framework for individuals to describe and explain themselves as social beings. In other words, the interview utterances of the participants may simply be a reflection of the accepted discourse that they are currently exposed to (the sea of language that they are 'swimming' in) i.e. a social construction, rather than their true perceptions and beliefs relating to the experiences being reported. This view is in direct contrast to the assumption of many qualitative researchers who believe that individuals are intentional agents who can access and accurately report their experiences for transcription and analysis. It is a constant problem and difficult to resolve.

However, if we accept that reality never speaks for itself and that the purpose of any research methodology must be to uncover, illuminate and analyse the data as far as that is possible, it is essential to trust that research participants have a genuine desire to provide accurate descriptions of their experiences. Thus, despite the intrinsic and well-known

problems associated with the potential manufacture of data, the source of data were former HCAs recounting their lived experience of healthcare and HE in a semi-structured interview with the researcher.

4.3   Recruitment of research participants

The primary data sources for this study were former HCAs who were either registered nurses working in NHS Trusts or undergraduate students working towards a degree in nursing and professional registration with the UKCC. Thus, at the time of the research, the participants who were currently working as nurses in the National Health Service would have had their experience of nursing education in HE several years ago. In contrast, at the time of the research, the participants studying for the BSc in nursing at London higher education institutions would be concurrently experiencing HE nursing education.

This creates an interesting dynamic within the study and introduces a perspective that may be significant during data analysis. Although both 'groups' of participants share the feature having previously worked as HCAs, their respective experiences of HE will be different. Nurses who have been registered for some years would have experienced the Diploma of Higher Education, developed and implemented during Project 2000 (UKCC, 1986) when nursing education made a 'wholesale' transition into higher education. Students on the BSc pre-registration nursing course were contemporaneously experiencing life as an undergraduate.

A purposive sampling strategy (Ritchie and Lewis, 2003, p78-80) was employed as the potential participants of interest were either nurses employed in London NHS Trusts or were students in one of several London universities.

The participant inclusion criteria were:

- former HCAs who had completed a university nursing course (degree or diploma) in the UK and were registered nurses

- former HCAs who were currently studying on a UK undergraduate nursing course

Nurse participants

Nurses (formerly HCAs) from several major NHS Trusts within central and SE London were invited to participate in the research. Directors of Education and managers of relevant training departments in these NHS Trusts were first contacted by email to establish their potential level of interest and anticipated collaboration in the recruitment of research participants. Three NHS Trusts responded positively to this initial request for participation in principal; one mental health Trust and two acute hospital Trusts. The relevant senior managers at these Trusts were subsequently sent a copy of the research proposal, a copy of the ethical approval document from UEA and a copy of the participant recruitment email and flyer. Once the Trust representatives were satisfied that the study had met their criteria for approval, an invitation to participate was sent via an email circular (appendix 1) to all nurses in participating NHS Trusts. A similar invitation to participate was also posted on the staff intranet web portal (appendix 2).

Student participants

A similar process was employed in the recruitment of potential participants from former HCAs who were studying at universities within Greater London. Initial contact with heads of schools of nursing and midwifery at four universities was made by email to establish their potential level of interest and anticipated collaboration in the research. All four university heads of school responded with an expression of interest requesting further details of the research. A copy of the research proposal, a copy of the ethical approval document from UEA and a copy of the participant recruitment email and flyer were sent for scrutiny. Once negotiations were complete and all questions had been answered, the heads of school delegated responsibility to the relevant programme and course leaders for circulation of the recruitment flyer (appendix 3) and email (appendix 4) to the undergraduate student nurse population of the relevant university. Included in this invitation was a summary of the research aim and the research process, including details of ethical approval, confidentiality and permission to withdraw from the study at any time without adverse consequences.

Once potential participants had responded to the flyer or recruitment email with an indication of interest to participate, an individual email was sent to

the individual potential participant providing further details of the study. All potential participants (nurses working in NHS Trusts and undergraduate nursing students) received a participant information sheet (Appendix 5). This described the study in plain language and informed the participants of their rights and responsibilities should they decide to take part. Participants were informed of their right to withdraw at any time without the need to give a reason. Their involvement to that point would not be shared with anyone and their contribution to the study would be deleted.

Participants were informed of their responsibilities in the study, including respect for confidentiality and anonymity of all participants. Participants were required to sign a consent form (Appendix 6) that obliged them to abide by the conditions of participation in the study. Participants received a copy of the consent form.

Response rate

A total of forty-three responses to either the email invitation or the flyer were received. However, twenty-three of these responses did not reach the interview stage. Most of these potential participants lost interest after they received the participant information sheet and the ethical approval document. There was no reply to any further emails from me.

4.4   Ethical issues

Central to ethical considerations in any study involving human participants is the prevention of harm and risk of harm to all those who participate and have a stake or an interest in the research. This includes institutions as well as people. Punch (2006) summarises a range of ethical issues that are relevant to qualitative research studies.

Honesty and trust are imperative in any research endeavour involving human participants, primarily for the protection of participants but also to ensure that the collection of high quality data is maximised. Therefore, it was essential that participants understood as far as possible what the purpose of the research was and what their involvement would be. Fully informed consent is crucial in this respect and nurse participants were given written reassurance that they would be able to withdraw from the study at any stage without detriment to their role at work or relationship with their employer. Undergraduate students were given similar reassurance

that their course of study or their relationship with education staff at the university would not be affected. Participants also received written reassurance that their participation, role (and potential withdrawal) would be completely confidential (Appendix 5). Only the primary researcher (KB) would know that they had participated (or withdrawn). Undergraduate student participants were given particular assurance that anything they said would not be attributed to them as students of a particular university to avoid compromising their relationships with academic staff.

All participants were given written assurance that anything they said would be anonymised, remain confidential and secure at all stages of the study and would be destroyed on completion. Participants were informed that the data collection instruments (tape recorder and notebooks) would be kept in a locked cabinet as would the data transcripts during and after the transcription and analysis process. Respect for information gleaned during the interview discussion itself is an important ethical consideration. It is essential that participants recognise their own responsibility for confidentiality of data. To this end, participants were required to sign a research consent form stipulating this requirement.

It was also important that participants understood how and where the data would be presented when the study was complete, that the data would feature in a final thesis document freely available to staff and students at the University of East Anglia and that the data may also appear in a published journal article and thus would have global availability. It was not possible for participants to receive a summary of the findings following data transcription and analysis due to the passage of time since the interview. Ethical approval for the study was obtained from the UEA Ethics Committee (appendix 7)

4.5 Validity, reliability and rigour

Although the features of validity, reliability and rigour in qualitative research can be thought of as falling under the general heading of 'quality' and are also an integral part of positivistic research (Smith et al, 2009), it is important that qualitative researchers do not employ a 'checklist' approach to quality issues (Barbour, 2008) nor defer to quality criteria employed by quantitative researchers. Despite the plethora of quality measures available, Yardley (2000) offers a user-friendly model that requires research

to have four over-arching characteristics. These are sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. Sensitivity to context includes features such as handling the close engagement with participants by being open about the nature of the interview process, trying to put the participant at ease and addressing ethical issues. Commitment and rigour relate to the extent to which the participants and the data are given the attention expected in an ethically sound high quality study. There is a personal dimension to this in the sense that there is an expectation that the research will pay close attention to the utterances of the participant and their apparent level of comfort (or discomfort) during the interview.

The degree of rigour in the study relates to the nature and selection process of the participants, that they are appropriate to the aim of the research coupled with the quality of the interview itself and the subsequent analysis. An expectation of high quality research is that the participant sample is sufficiently homogeneous and that the data analysis goes beyond a superficial description to include interpretation of meaning with sufficient representative examples of participants' utterances to illustrate the analytic proposition being made. Transparency and coherence relate to the declared purpose of the study and the clarity of the underlying rationale. Coherence relates to the degree of synergy between the theoretical perspective and how the study was carried out. Finally, impact and importance reflect the degree to which the study would be of relevance to the healthcare and HE communities. I believe this thesis has articulated, demonstrated and satisfied all these criteria.

4.6   Role of researcher and potential power dynamics

I was acutely aware that my professional and personal characteristics could make the research process involved in individual interviews highly problematic. The inherent process and potential power dynamic of the individual interview can greatly affect the outcome. Denzin and Lincoln (2011) argue for the creation of an equal relationship between interviewer and respondent through transparency and self-disclosure by the researcher. Thus, an attempt at self-disclosure was made during the initial stage of the interview. I stated my position as a nurse teacher in the Florence Nightingale School of Nursing and Midwifery at King's College

London. I also declared my novice status as a researcher and apologised in advance for any stumbling over questions, hesitancy, repetition and silences for thinking.

My position as a male, middle class university lecturer in a school of nursing within an elitist university inevitably creates a hierarchical relationship with the participants who will immediately be placed in an ethically dubious subordinate position (Kvale, 2006). It is known that breadth and depth of data from participants may be reduced by the unequal power-dynamic of the interview with moral and ethical problems arising from this (Fontana and Frey, 1994).

Furthermore, Kvale and Brinkman (2009), identify several features of the individual interview that illustrate the unequal power relationship operating. The participant comes to the interview anticipating their role as respondent. There is an expectation that the researcher will pose the questions from a prepared script and, despite assurances of a two-way conversation, the researcher will inevitably lead on process and direction. The participants know that the conversation has a definite purpose and this may result in a desire to 'please' the researcher with the 'right answer'. Certainly, more than one participant expressed concern about *whether 'that's what I wanted'*. Several participants made self-deprecating remarks at the conclusion of the interview such as, *'they didn't think that they had said much that would be any use'.*

This desire to please the researcher is evidence of the unequal power relationship intrinsic to the interview. These remarks of the research participants give an indication of the power gradient operating between interviewer and interviewee. Also, in trying to create a sense of collaboration in the research endeavour, the interviewer may wittingly or unwittingly manipulate the interview by creating a brief friendship with the participant. Kvale (2006) goes as far to say that the term 'interview dialogue' is a misnomer, because there is no true mutual interest in having a conversation. The interview takes place for the sole purpose of providing the researcher with data and the interviewee knows this.

4.7   Data collection: the interview process

Individual interviews were held at a time and venue convenient to the participants. I travelled to the participants' place of work or study where a

suitable room was booked for the purpose. The interview was semi-structured in the sense that the questions posed drew upon five broad topic areas and were followed with supplementary questions drawing upon perspectives raised by the participant. The questions followed a prepared schedule, the aim being to encourage in-depth accounts from the participants with opportunities for them to decide which issues were particularly relevant and what they wanted to emphasise. To this end, the questions were open-ended with the relatively neutral or least threatening questions first followed by more demanding and probing questions.

The interview is essentially a two-way encounter (Rapley, 2001) where participant and researcher are engaged in a purposeful conversation. The privileged access that the researcher has to the participants' lived experience through the individual interview represents an excellent opportunity to gain the richest data from a completely personal perspective. Furthermore, the extent to which the data emerging from the individual interview is an in-depth account depends largely on the skill of the researcher during the interview process.

At the start of the interview, participants were reminded that the interview would be recorded, that the recorded data would be confidential, would be anonymised and would be kept securely in a locked cabinet. The interview schedule was flexible in the sense that a participant's response may have covered more than one topic on the schedule or may have randomly and unexpectedly addressed issues elsewhere on the schedule. It was essential for the researcher not to be distracted by this and to keep the interview flowing by maintaining a sense of conversation with the participant. So, although my conversation topics were prepared in advance of the interview schedule, it was important that the spoken questions sounded spontaneous and original as they would in a typical conversation.

It was equally important to first establish the relevance of the issues under consideration to the participant before embarking on the interview schedule. Thus, an additional explanation of the purpose of the research at the outset of the interview was given to help focus the mind of the participant. This explanation emphasised that there were no 'right' or 'wrong' answers to the interview questions and that it was fine for participants to recount any stories or accounts that they wished. Some

participants were talking from a position of having made the transition from HCA to nursing in HE relatively recently (within the last 2 years). Others were recounting their reasons, motivations and experiences from a considerable distance in time, having qualified, registered and practiced as nurses for several years. Figure 1 illustrates the viewpoint of participants looking back across the stages of their career and their learning trajectory since first becoming an HCA.

Twenty former HCAs were interviewed using a semi-structured interview guide (appendix 8). Eight participants were current nurses having previously taken the three-year diploma of higher education in nursing (table 1). Seven of these participants had been nurses for several years having taken the diploma course several years earlier. These participants were thus looking back to the era of nursing HE when it was a new phenomenon both in the university and in healthcare practice. Each of these seven participants had achieved a significant level of responsibility in their respective clinical field of practice. One of the current nurses had completed the postgraduate diploma course one year earlier, so she was able to reflect on recent life as an HCA.

Twelve participants were current students interviewed at their university (table 2). Ten of these current students were in the first year of the three-year BSc nursing degree while two were taking the two-year postgraduate diploma in nursing having previously taken a UK university degree and therefore had previous experience of HE. All twelve had come direct from HCA work so their experience reflects contemporary healthcare.

My confidence grew with each successive interview. I could establish what was important to individual participants within the context of my broad research aims and use this to inform the further development of the semi-structured interview guide. Social science research is, of necessity, an iterative process and early interviews provided an essential 'platform' from which to progress. Each interview fed into the subsequent development of the research as additional relevant issues emerged both during the interview process itself and during repeated play-back of the recordings. Data from all interviews was transcribed and included in the study.

Figure 1   **Research participants looking back on their career and learning trajectory**

Registered nurse looking back

Registered nurse
looking back

Lay person	Healthcare assistant	Student nurse in higher education and clinical practice placement	Registered nurse

Learning trajectory

Student nurse looking back

Student nurse looking back

Lay person	Healthcare assistant	Student nurse in higher education and clinical practice placement	Registered nurse

Learning trajectory
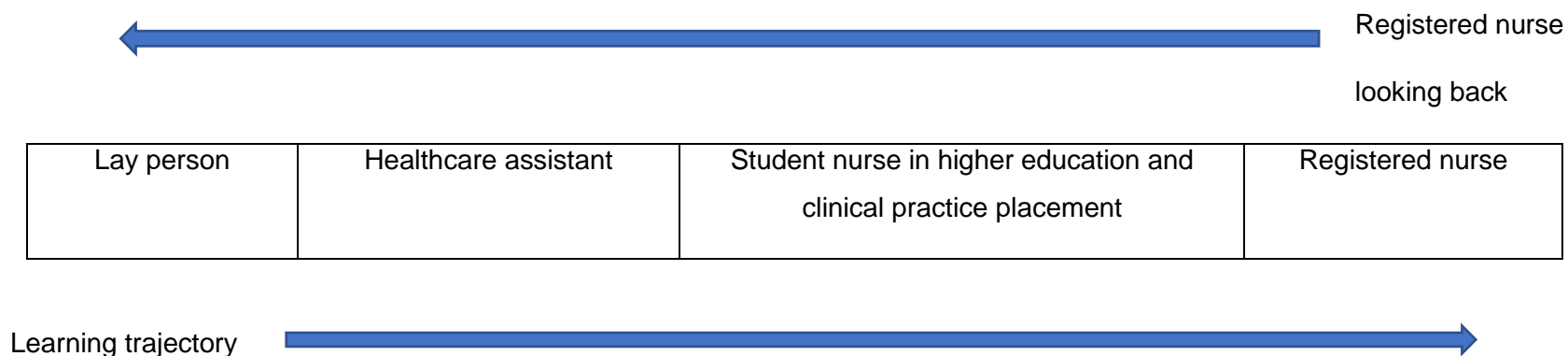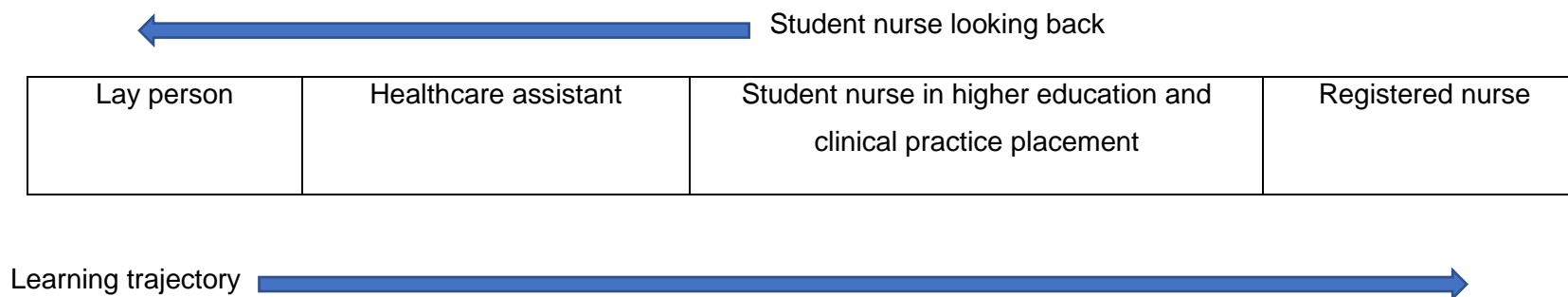
Table 1   Participants who were nurses at the time of the interview

Eight participants were current nurses. Seven had previously taken the three-year diploma of higher education in nursing and had been nurses for several years. These participants were thus looking back to the era of nursing HE when it was a relatively new phenomenon, both in the university and in healthcare practice. Each of these seven participants had achieved a significant level of responsibility in their respective clinical field. One of the current nurses had completed the postgraduate diploma course one year earlier, so she was able to reflect on recent life as an HCA.

Name	Time as HCA	Previous qualification	Qualification at registration	Current Position	Previous nursing position(s)	Time as nurse	Later qualifications
Adam	12 years (forensic mental healthcare)	None	Diploma of Higher Education in Nursing	Lead tutor (Promoting Safe and Therapeutic Services. NHS Trust Education and Training department)	Forensic mental health nurse	5 years	None
Anne	1 year (elderly mental healthcare)	GCSEs	Diploma of Higher Education in Nursing	Improvement facilitator (NHS productive wards innovation)	Team leader forensic rehabilitation	16 years	BSc Nursing
Bertie	10 years (forensic mental health intensive care)	None	Diploma of Higher Education in Nursing	Tutor (Promoting Safe and Therapeutic Services. NHS Trust Education and Training department)	Forensic mental health nurse	4 years	None
Brenda	6 years (substance misuse)	GCSEs	Diploma of Higher Education in Nursing	Senior substance misuse nurse	None	4 years	BSc Nursing

Table 1 (continued)

Christine	2 years (adult nursing)	BTEC (National Diploma)	Diploma of Higher Education in Nursing	Respiratory nurse specialist	Lead oxygen nurse	10 years	BSc Nursing.
Deborah	14 months	BSc (Hons) Biology	Post Graduate Diploma of Higher Education in Nursing (BSc biology)	Cardiac care nurse	None	7 weeks	None
Elizabeth	5 years (community residential mental health unit)	BA (Hons) English Literature	Postgraduate Diploma of Higher Education in Nursing	Community psychiatric nurse	Psychiatric Intensive Care nurse	10 years	None
Steve	10 years (adult care and intensive care)	None	Diploma of Higher Education in Nursing	Deputy ward manager (Cardiothoracic nursing)	High Dependency Unit	11 years	BSc nursing

Table 2   Participants who were students at the time of the interview

Twelve participants were current students interviewed at their university. Three of these current students were in the first year of the three-year BSc nursing degree while seven ere in the second year of the BSc. Two were in the second year of the two-year postgraduate diploma in nursing having previously taken a UK university degree and therefore had previous experience of HE. All twelve had come direct to nursing higher education from HCA work so their reported experience reflects contemporary healthcare.

Name	Previous qualification	Previous HCA position	Time as an HCA	Current course
Frances	BA Drama	Social therapy support worker in Dangerous and Severe Personality Disorder unit	2 years	Postgraduate Diploma in Mental Health Nursing (second year)
Gillian	BA Theatre Studies	HCA in psychiatric intensive care	14months	Postgraduate Diploma in Mental Health Nursing (second year)
Hannah	A levels	HCA in elderly residential care	6 months	BSc Children's Nursing (first year)
Iris	BTEC Health and Social Care	HCA in elderly residential care	3 years	BSc Adult Nursing (first year)
Jenny	NVQ III Health and Social Care Access to Higher Education BA Librarianship (Nigeria)	HCA in elderly residential care and adult care in NHS Trust	5 years	BSc Adult Nursing (second year)
Karen	NVQ III Health and Social Care	HCA in community care	18 months	BSc Adult Nursing (second year)
Lynn	Irish Leaving Certificate	HCA in community care and accident and emergency unit	13 years	BSc Adult Nursing (second year)

Table 2 (continued)

Maggie	Access to Higher Education	HCA pregnancy termination clinic	3 years	BSc Learning Disability Nursing (second year)
Nancy	MA Drama	HCA dementia care	3 years	BSc Mental Health Nursing (second year)
Olive	NVQ IV Policing Open University Level 1 Molecules, medicines and drugs	Health centre receptionist and HCA in	3 years	BSc Adult Nursing (second year)
Pauline	Foundation Degree in Sports Therapy	HCA Learning disability and adult nursing	13 years	Diploma of Higher Education in Adult Nursing (second year)
Ruth	Access to Higher Education	HCA Elderly residential care	3 years	BSc Adult Nursing (first year)

4.8   Organisation of the data: transcription

Recordings from interviews were transcribed into text format using Microsoft Word (2010). Text lines were numbered and double line spaced to assist the analytic process. Pseudonyms for research participants were used in the documents to protect their anonymity. The raw data was fully and faithfully transcribed as I wished to capture the delicate nuances of speech in the interviews; all the pauses, abbreviations, verbal tics and repetitions. Accurate transcription is essential as a great deal of meaning can be gained from careful attention to the way in which participants express themselves. This was facilitated by the use of voice recognition software (trained to the researcher's voice) and the technique of 'parroting' where the utterances of the research participant were spoken into the voice recognition software by the researcher as the digital recording was played back through headphones. A transcription convention was used to indicate and reflect the authenticity of the participants' speech (pauses etc). Twelve digital recordings were transcribed by the researcher (KB) while eight were transcribed by a professional audio typist.

4.9   Approach to data analysis

Views on data analysis in the research community appear to be formed into two major groups or 'camps' which differ according to the emphasis given to a) organising, sorting and describing large amounts of data or b) to interpreting and explaining the potential meaning of the data.

This is not to say that the 'sorter-organisers' and the 'interpreters-explainers' do not recognise the significance and value of each other's perspectives and motivations. No amount of organising and describing will shed any light on what is going on in the data (behind the scenes). Similarly, interpretation, explanation and theorising cannot proceed without some form of, at least, initial sorting and organising of data. Thus, most researchers, whatever the nature of their study employ a hybrid approach to analysis, commencing with organising the data and progressing to interpretation. This is the approach adopted in this study.

Coding is one of several terms that are used to label the process of identifying passages of text that are similar in some way and thus can be connected to each other by use of a label or code. The language of coding is variable and other terms may be used to describe this process of sorting

the data. Indexing (Ritchie and Lewis, 2003) and categorising (Dey, 1993) are two examples. However, these synonyms for the broad concept of coding belie the range and complexity in the field. Saldana (2013) describes and explains the application of twenty-five separate coding methods for initial analysis with six further coding strategies to extend the analysis and create overarching themes. The range and choice of methods is a bewildering challenge to the novice researcher.

4.10   Deductive or inductive analysis?

Furthermore, in terms of identifying themes, codes or categories within the raw data, the literature is divided between data-driven and concept-driven processes. Data–driven analysis is favoured by the advocates of a grounded approach (Charmaz, 2003; Strauss and Corbin, 1998) who emphasise the (inductive) emergence of theory from the raw data through analysis 'uncontaminated' by existing theory, whereas concept-driven analysis is recommended by those who believe that the researcher who can completely distance him/herself from preconceived ideas or influences from the literature probably does not exist. Authors who advocate this latter (deductive) approach (Ritchie and Lewis, 2003) suggest the use of 'thematic ideas' organised into an analytical framework.

Each of these approaches, data-driven and concept-driven, in their 'pure' state, probably represent the idealised form of inductive and deductive analysis respectively. Data-driven analysis is appropriate if the research is generating theory from 'scratch' and concept-driven is appropriate where theory is pre-existent. However, it is unrealistic to expect researchers to be able to adopt either one of these extreme positions. For the purpose of this study, a hybrid approach was adopted because an important feature of data analysis is to be motivated by both data-driven and concept-driven approaches (Gibbs, 2007). On the one hand, it is important to treat the data as a unique representation of participants' experience of HE and healthcare and to be open to the likelihood of completely fresh and novel insights. However, it is also important to make links within the data to existing theories and current lines of enquiry.

Crucially in this regard, despite the convention in most qualitative research that themes emerge following the coding process, Saldana (2013) indicates that initial identification of themes in the data is employed as a coding

method for many qualitative studies including, and especially, phenomenological research. This is the essence of the framework method for data analysis (Smith and Firth, 2011; Gale et al, 2013) where themes may be either drawn from the existing literature or the research questions and interview topic guide (deductively) or may emerge iteratively from the data during the analysis process (inductively).

4.11   Organisation of the data: coding

The initial sorting process was carried out using NVivo qualitative data analysis software (QSR NVivo, 2012). This enabled the raw data to be organised into large chunks of text that reflected the six major topics of conversation during the interviews. These conversation topic categories involved participants'

- route into healthcare

- experience of being an HCA

- life at university

- relationship with nurses

- experience of clinical placements

- role as a nurse (if the participant was a registered nurse at the time of the interview)

These six categories were derived from a combination of reference to the interview topic guide and thorough reading and re-reading of each transcript to ensure that this initial organisation of the date was true to the categories. Once this initial organisation was complete, each of the six categories were scrutinised for potential themes. This was achieved using the first-person then third-person approach advocated by Watts (2014). This combined approach of first-person ('what-how') coding followed by third-person (research aims) coding is an effective way of creating a 'blank slate' or replacing the 'bracketing' of the European phenomenological research model.

The process first involves scrutiny of the raw data (within the six major categories) in terms of **what** the participants are talking about and then **how** they are talking about it. The 'what?' questions represent the

descriptive element of the coding process while the 'how?' coding question represents the construction (understanding) that the participants are placing on the discrete subject of conversation. The first-person coding process becomes the first act of interpretation in the sense that a construction of meaning has been ascribed by the participants to what they are talking about. Watts emphasises that, although the researcher has an 'agenda' in terms of the research aims, the priority in coding is the view of the participant.

Two examples follow in the table below.

What was the participant talking about?	How was the participant talking about it?
Students who were not former HCAs	They were frightened by clinical placements
Prior experience as an HCA	It shaped me as a nurse

Although the NVivo computer software had potential for this purpose, I found the computer-assisted process troublesome due to a combination of sensory overload with the complex screen features of NVivo and frustration with trying to view large amounts of text through a narrow computer screen. I eventually abandoned this coding method in favour of coloured pencils on paper print-outs of data. This was a much more effective and productive method for identification of repeating responses and emerging issues. I could spread several pages of text on a large table for the purpose, move quickly between pages and scribble analytic memos directly onto the transcript and into a logbook. Clusters of colour-coded extracts began to emerge from the six major categories.

A rationale for the benefits of this colour coding process comes from a consideration of neurobiology. The human brain processes written text in a small part of the left hemisphere (Broca's area) whereas shape, form and colour are processed in the entire right hemisphere. Spoken language and written text is largely shifted to the right hemisphere for processing. Furthermore, the right hemisphere is known to have greater problem-solving capabilities than the left. The combined use of colour and NVivo to assist coding was a much more creative process than the use of NVivo

alone and resulted in thirty 'minor' categories of topics (phenomena) that participants talked about. The results from this coding process is available in appendix 9.

These first-person extracts, now organised into thirty discrete categories were scrutinised again, but this time from my perspective as the researcher. This process was informed by the aims of the research and the research questions. Passages of text where participants were doing their own interpretive or explanatory work were identified and highlighted for interpretation. Extracts were selected where they appeared to support, qualify, question or contradict some aspect of relevant literature (Watts, 2014). Of particular interest were extracts where participants raised issues related to knowledge, learning, status, authority and power.

However, there are further considerations. As well as adopting a combined phenomenological – interpretivist approach, data analysis may also take the form conversational, discourse, biographical or narrative. The data collected for this study was analysed in these ways also, because

- there was a conversation between researcher and participant

- the discourse of what it means to be an HCA or nurse in contemporary healthcare was likely to arise in the data

- the specific phenomena of interest were anticipated to arise in the data

- there was biographical and narrative data present.

All these elements appeared in the data analysis as participants talked about their life as a student, HCA or nurse.

Each chapter in the thesis examines participant extracts during their trajectory from lay person to HE nursing student and registered nurse. Participants are moving across boundaries between fields of practice and operating within these fields. Data presented in the thesis will be examined for evidence of knowledge practices within the fields of HE and healthcare. Following coding of the data using Watts (2014) first person 'what? (descriptive) - how? (interpretive)' approach, the third person interpretation of the data employed a combination of three conceptual models, Bourdieu's

Theory of Practice, Bernstein's Code Theory and Maton's Legitimation Code Theory. A summary rationale follows.

4.12   Further abstraction of the data using Legitimation Code Theory

Bourdieu's thinking tools of his field theory (capital, habitus, hysteresis and doxa) and Bernstein's code theory (classification and framing) was applied across the data. The concepts of field, capital and habitus are major thinking tools in Bourdieu's theory of practice and enable the relational aspects of power, i.e strategies, status hierarchies and field, to be described. Bernstein developed the idea of boundaries of knowledge, emphasising the structural differentiation between fields, between theoretical and practical knowledge and between curriculum and everyday knowledge. He coined the terms 'classification' and 'framing' to describe the way in which knowledge in general and educational knowledge in particular could be represented within fields of practice (Bernstein, 1971). Bourdieu's field theory is premised on the notion that fields structure knowledge through interaction between actors' habitus, capital and the field. In contrast, Bernstein's code theory is premised on the notion that knowledge structures the field through the interaction between the boundaries of 'sacred' knowledge with strong classification (the academic disciplines) and 'profane' knowledge with weak classification (knowledge of experience). Whereas Bourdieu describes fields as structures where actors struggle over status and resources, including knowledge, Bernstein (1977) describes how knowledge may be structured to inform the field (see Chapter Two).

Neither Bourdieu's social (field) theory of knowledge nor Bernstein's realist (code) theory of knowledge offer an empirical tool kit for research on knowledge practices in healthcare. Maton (2014), however, has proposed synthesising their different approaches into a new conceptual framework (social realism) where the language actors use in referring to knowledge (their languages of legitimation) are manifestations of practices within a particular social field such as healthcare and higher education. Languages of legitimation represent strategic stances within the field and are symptomatic of the struggle for status and resources in the field. Legitimation code theory (LCT) is a focus for the organising principles of

languages of legitimation and legitimation devices are a way for researchers to operationalise the languages of legitimation (Maton (2014). Two legitimation devices will be used for further abstraction of the data interpretation: the Specialisation Device and the Semantic Device.

The Specialisation Device

Epistemic relations and social relations to knowledge are the component codes of the legitimation device in LCT known as the specialisation device. Epistemic relations (ER) to knowledge focus on the relations between practices and their object or focus i.e. *what* can be legitimately described as knowledge. An example of this is the clinical assessment of blood pressure, body temperature, breathing rate, blood glucose and ECG, with their focus on physiological parameters. The knowledge underpinning this form of bio-nursing draws upon the disciplines within the biosciences and thus, would also exhibit relatively strong classification and framing.

In contrast, social relations (SR) to knowledge focus on the relations between practices and their subject i.e. *who* can claim to be a legitimate knower. An example of this is the basic or personal and intimate care of patients involving the provision of assistance with toileting, washing, feeding and drinking. This form of nursing draws upon knowledge derived from close proximity with patients and thus exhibits relatively weak classification and framing in epistemic relations but strong classification and framing in social relations. The main elements of Maton's social relations to knowledge are where the actor exhibits one or more of a natural, cultivated or social disposition to knowledge. Most HCA care work would fulfil the criteria of stronger social relations to knowledge because their relationship to knowledge as defined by the role and with close proximity to patients is socially based and cultivated. Thus, HCA work would be expected to exhibit relatively strong classification and framing in social relations to knowledge.

A 'knowledge mode' is employed where the knowledge relationship is towards an object of study in the world i.e. where there are 'epistemic' relations (ER) to knowledge. A 'knower' mode is employed where the knowledge relationship is due to a subject making a claim to knowledge arising from their position in the field i.e. where there are 'social' relations (SR) to knowledge.

The field of (higher) education and the field of clinical practice have different languages of legitimation. How the specialisation codes ER and SR are applied as legitimation codes is dependent on the context. Specialisation codes ER and SR may be combined in the combination of stronger and/or weaker to indicate an *elite code* where there is stronger ER (possession of specialist knowledge) plus disposition as an actor (social or cultivated knowledge) or a *knower code* where there is weaker ER (no specialist knowledge) plus disposition as an actor (social or cultivated knowledge).

The Semantic Device

Maton's (2014) LCT has an additional set of codes that are useful in the depiction of knowledge practices in this study. Known as semantic density and semantic gravity, these legitimation codes indicate the degree of <u>condensation</u> of meaning and the degree of <u>contextual </u>meaning respectively. Together they are known as the semantic device. Thus, the physiological parameters referred to above have higher semantic density (and weaker semantic gravity) because the meaning of the clinical assessment is condensed to symbolic form e.g. mm Hg for blood pressure. In contrast, the personal and intimate care of patients has higher semantic gravity (and weaker semantic density) because the meaning is highly dependent on the context of patient circumstances.

4.13   Summary and organisation of the data chapters in the thesis

This is the point in the thesis where the focus of attention in the first four chapters (explanation of purpose, conceptual background, theoretical rationale and practical implementation of the research) shifts to the findings arising from the data analysis. The five chapters which follow are therefore devoted to the analysis and interpretation of data. Each of the ensuing chapters (Five to Nine) presents and discusses the major category of conversation and the coded themes within each category (table 3).

For final presentation in the thesis, extracts were selected where they made a high-quality illustration of the phenomenon of interest. Given the large volume of data, the relatively high number of minor categories arising from the coding process and the need to present extracts that cogently illustrated the findings, several sub-categories were merged with existing

major categories. Appendix 9 shows that the exception to this merger process was the separation of the sub-category 'Route into care work' from its original place as a single sub-category within the major category of HCA experience. This sub-category became the focus of an independent chapter as the participants were talking about the transition process from lay-person to healthcare support worker i.e. they were crossing a boundary and becoming a social agent in the healthcare field.

Table 3   Guide to the ensuing data analysis chapters, showing the coded themes within each chapter.

Chapter 5 Route into healthcare: becoming an HCA	
Caring narrative	
Aspirational narrative	
Motivation to learn and develop	
Need for a job	
Chapter 6 Learning from the role and recognition of knowledge	
Learning from the role	Recognition of knowledge by
• Some do	• HCAs
• Some don't	• Patients
	• Nurses and other staff
	• The 'system'
Chapter 7 Motivation to become a nurse	
Influence of nursing role model	
Frustration with the limited role of the HCA	
Senior staff identify potential attributes in the HCA	
Knowledge seeking	
Chapter 8 Becoming and being a student nurse	
Approaching university	The higher education experience
• Anticipation	• Challenges
• Perception	• Responses
• Preparation	• Outcomes
Chapter 9 From classroom to clinical practice: the HCA 'within'	
Confidence in practice	
The dilemma of disclosure	
Learning in practice	

Chapter 5   Route into healthcare: becoming an HCA

5.1   Introduction

The purpose of this chapter is to present and interpret selected interview extracts that illustrate how the research participants described and explained their route into healthcare. The aim is to identify how participants reflect on the factors and circumstances that led the participants to take up the role of HCA. Participant extracts are used to illustrate themes emerging from this part of the data and the chapter is presented in sections relating to the themes arising from the coding process. Initial comparisons are made with the narrative themes used in the only other previous study that has investigated the declared motivations of people to become an HCA (Kessler et al, 2012). The narrative labels of *caring* and *aspiration* used in this chapter were originally suggested by Kessler et al (2012), from their UK-wide study involving 746 HCAs, to capture the life-narrative associated with the motivation of people to become employed as an HCA. Kessler et al (2012) described a *caring* narrative, where the HCA had a personal experience of caring for someone close to them and an *aspirational* narrative where the HCA was specifically aiming for registered nurse status. These *caring* and *aspiration* narratives can be identified in my data and are illustrated by the extracts in the first two sections of the chapter.

However, a separate *reconnecting* narrative, also inferred by Kessler et al (2012) from their data, where the HCA is returning from a previous nursing career, appears to be absent in my data. Furthermore, two participant narratives present in my study, a *desire to learn and develop*, and the *basic reality of unemployment* as a prime motivator are absent, or at least not recognised as such, in the Kessler et al (2012) study. Extracts to illustrate these participant narratives are presented in the third and fourth sections of the chapter respectively.

Whichever narrative category they are in, participants are crossing the boundary into the healthcare field. This chapter explores both the motivating narrative of participants and the experiences of participants as they find themselves in a field suffused with symbolic capital. Issues related to knowledge, status, habitus and field emerge as participants approach and enter the field.

Interpretations of extracts are discussed at the end of each section in the context of some relevant literature.

Interpretation of extracts and discussion of issues arising are thus presented within four sections as follows:

- an expressed desire to help others and previous exposure to caring work (a caring narrative)
- a stepping-stone to a healthcare profession (an aspirational narrative)
- motivation to learn and develop
- a basic need for a job due to unemployment

5.2   A desire to help others and previous exposure to caring work

Six participants identified a desire to help others or had some previous exposure to caring work as their motivation to work in healthcare. Therefore, a *caring* narrative is used in this context to represent these participants. Participant extracts to illustrate this caring narrative are presented and interpreted below. Several features attributable to caring may be identified in the extracts that follow. For Nancy and Jenny, the declared motivation to become an HCA is a general desire to help others.

> '*I saw lots of children, how their health condition is desperate without help*' (*Nancy*)

> '*I wanted something that would impact on somebody … that would have a touch of feeling into somebody's life*'   (*Jenny*)

For Bertie, meeting people with learning disabilities in an institutional setting with his father had an influence on him.

> "*My dad was an HCA (in a learning disability hospital) and it always interested me. That's what I wanted to do. I remember meeting my dad's patients when I was younger*".

For Elizabeth, it was involvement in community work that provided the personal insight and self-awareness to her aptitude and motivation for care work;

'*I did a bit of sessional youth work and found that I had an ability to connect with people and to motivate them which I hadn't realised was a strength*

Other participants expressed their motivation for care work as a result of exposure to patient care involving serious illness of a close family member. We see below how Karen and Olive come into close contact with nurses during palliative care of their mother (Karen) and father (Olive).

Karen shares her life circumstances that led to a change of occupation from the finance sector to healthcare. Karen starts with what appears to be almost a 'confession', that life up to this point spent as a mortgage advisor has been uncomfortable because giving mortgage advice apparently involves withholding or limiting the truth. If giving mortgage advice involves 'living a lie' then, for Karen, becoming a nurse represents the complete opposite, the embodiment of truth.

"*I spent all my life lying in a way… being a mortgage advisor… you never seem to tell the truth fully, whereas these* (nurses) *were being so honest when my mum passed over.*"

Karen is clearly disillusioned with her previous occupation and expresses a desire for nursing almost as compensation or atonement for past misdemeanours as a mortgage advisor. She describes the openness of the nurses during the palliative care of her mother, a time when great sensitivity would be required. The passage has a sense of transformation in that there seems to be an alternative way for Karen to live, to be a different person.

In the following extract, we see that Olive is also drawn into a caring role as a result of illness of a close family member. However, for Olive there is an element of 'priming' in that she was previously exposed to some challenging situations at the interface between policing and healthcare.

"*I got a glimmer when I worked in the police… dealing with dead bodies … most officers don't really like it… I just kind of felt comfortable…* [but] *I had to resign to look after my father who had cancer… I ended up working in the village GP surgery and I got to know a lot of the medications…. I'd be watching what the nurses were doing…*"

In this extract, Olive explains how she felt drawn to healthcare while she was working as a police officer. Despite the distressing nature of some aspects of the work such as attending scenes of sudden death, unlike most of her colleagues Olive was not challenged in this environment and describes it as stimulating interest in healthcare. Olive does not express dissatisfaction with policing as a field but she does not find what others would find stressful in the healthcare field. Caring for her father during his cancer illness, having left the police force as a consequence, contributed to her transition to a support worker role in the local GP surgery. This is where Olive identifies examples of her learning while observing the nurses and gathering information on patient medication.

Discussion

The extracts presented and interpreted in this section illustrate some drivers and influences for participants in their decision to move into healthcare as an HCA. The social construction of caring and role-modelling of significant others play a significant role.

There is a widely-held view that healthcare staff are expected to be caring people (Lewis, 2003) and that participants talking in this way may simply reflect the prevailing caring discourse in society and the social construction of nursing. More specifically, that caring represents an altruistic desire to help others a sense of shared humanity (Sanford, 2000) and is an expression of an authentic relationship between self and other (Hogan et al, 2013). For example, in the first two extracts, Nancy and Jenny articulate moral action, passion and making a difference (Price et al, 2013), all known antecedents of nursing (Watson, 1990).

While these features emerge from the interpretation of participant extracts, there is also a common feature of social knowing arising from exposure to the field. Several participants describe how the potential for work in the healthcare field emerged along with the first hint of a social knowing perspective. We hear how participants' earliest experiences of the field and the attributes of nurses were part of a narrative where participants felt 'drawn' by the field

Bertie visited the field with his father and there appears to be a combination of role-modelling and early social knowing, acquired from exposure to the field operating here. Perceptions of healthcare and the people who work in

caring occupations are often formed in childhood due to constant exposure to constructed images of the various roles. For example, in their discourse analysis of children's literature, Carroll and Rosa (2016) found that nurses were represented as caring and subordinate to doctors. Consequently, although men increasingly take on care roles (Russell, 2001), caring is still almost exclusively conceptualised as women's work (Calasanti and King, 2007) and widely viewed as an inherent trait (Hogan et al, 2013) rather than a learned skill. However, the experience of primary socialisation for Bertie suggests the development of cultural capital and a social knowing perspective arising from shared family values and early exposure to the field. Similarly, for Elizabeth, along with the caring attributes of affect and behaviour (Brilowski and Wendler, 2005), there is also a sense of social knowing in her developing relationship with young people during early experiences of the field.

Participants may be drawn to the healthcare field but they may also leave a position in a current field. Karen and Olive describe the circumstances of their transition from their previous fields, finance and policing respectively. When Karen compares life as a mortgage advisor to a potential life as a nurse, there are issues of authenticity and veracity at stake. Karen's situation illustrates all three features of the authenticity construct that are central to person-centred theory (Rogers, 2003). These features are *self-alienation*, where there is a tension between feelings about life as it is lived at the moment and a person's' thinking about themselves; *authentic living* which is the match between what people do and how they think about themselves; and *accepting external influence* which is the extent to which people permit other's values and beliefs to influence their actions and decisions. Boyraz et al (2014) have shown that when people experience these phenomena, distress and lack of fulfilment follow. We may think of Karen's experience in terms of her realisation that the field of finance is alien to her true self. She compares the finance field and the healthcare field in terms of truth and authenticity. There is a sense of 'push' away from the finance field as well as 'pull' from the healthcare field.

That she is being drawn to the field is also a significant feature of Olive's explanation of her transition to healthcare. Her recollection of learning about medication and observing nurses at work illustrates exposure to a combination of epistemic knowledge with pharmaceutics and role modelling

of powerful agents in the field. Even when exposed to stressful situations in policing, that are typical of the healthcare field, her habitus is in tune with the field.

While participants in this section explained their circumstances and motivations to enter the healthcare field as HCAs, the next section examines selected extracts to illustrate how participants talked about using the HCA role as a 'stepping stone' to nursing or an alternative heath profession.

5.3   A stepping-stone to a healthcare profession

Six participants (Ruth, Pauline, Lynn, Iris, Gillian, Deborah) took a support worker role as a prelude to embarking on a course for a healthcare profession (nursing, medicine or allied health profession). Ruth, Pauline, Lynn and Iris specifically cite an aspiration to nursing.

> *'I did want to go into nursing….so I started off as a healthcare assistant in an elderly home...' (Ruth)*

> *'I worked full time in a nursing home… cos I was interested in nursing…' (Pauline)*

> *'I thought I wanted to become a nurse …. I started doing healthcare work in a local hospital'* (Lynn),

> *'I needed hospital experience to make sure that it was definitely the right thing for me' (Iris)*

While Ruth and Pauline are unambiguous about their aim to be a nurse, there is an element of uncertainty in the extracts of Lynn and Iris. For Lynn the uncertainty is implicit, she *thinks* she wants to become a nurse, whereas Iris explicitly states her need to know that it was right for her.

For Gillian and Deborah, the motivation to work as an HCA is clearly part of a longer-term plan. Their decision to take up a support worker role is connected to a long-term aim of becoming a drama therapist and a doctor respectively. At this stage, neither see themselves becoming a nurse.

> *'My initial plan was to eventually become a drama therapist… so I found an art therapy support worker job…. and I ended up being a nursing assistant…'   (Gillian)*

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> *'I did a biology degree and I thought that I wanted to study medicine afterwards so I got a job as an HCA to build up a bit of experience in the clinical setting…'. (Deborah)*

Both Gillian and Deborah are already graduates in other disciplines and the link between their respective degrees and career aspirations can be seen. Gillian's BA Theatre Studies and Deborah's BSc in Biology would provide the necessary academic credentials to satisfy the admission tutors for art therapy and medicine respectively. However, both participants wish to gain first-hand experience of healthcare and Deborah is explicit on this aspect.

Discussion

Interpretation of extracts in this section illustrates how participants are both testing the field (*will my habitus be comfortable in the field?*) and using the field to gain experience (capital) before embarking on an HE course for nursing, medicine and art therapy. This is similar to the Kessler et al (2012) narrative category of '*aspiration'.*

The phenomenon of testing the water of healthcare before embarking on the full nursing course is widely reported in the grey literature but has not been investigated and documented in the research literature. Similarly, the number of potential nursing students who work as HCAs before nurse training is not recorded. However, searches of letters pages in journals such as Nursing Times and Nursing Standard reveals many student contributors who were overwhelmingly in favour of working as an HCA before entering nursing.

Gillian and Deborah acknowledge that they are aiming to enter a new field of practice, art therapy and medicine. There is an unstated recognition that their first degrees would provide the relevant foundation knowledge appropriate for the new field. Gillian and Deborah have cultural capital from the epistemic knowledge of their degree subjects and familiarity with the doxa of the eventual HE field for art therapy and medicine. The knowledge base of theatre studies and biology particularly are conceptualised by Bernstein (1990) as 'singulars' as they need to be translated or applied in a particular context of field, in this case drama therapy and medicine. There is a sense here that Gillian and Deborah know that they each hold a store of codified knowledge or capital that will assist their passage into their respective fields of practice. Their intention is to enter the field of practice

and hence experience from a position of relative safety as a support worker how their store of codified knowledge might be useful in the practical context. They want to test the field and gain cultural capital from the field i.e. a social knowing perspective.

There is only anecdotal evidence that many people with long term career intentions for one of the graduate health professions take up a support worker role *before* their course. However, a search of the healthcare literature revealed two published accounts of undergraduate students taking a support worker role *during* their course. Both authors identify a financial motive for working as part-time healthcare assistants during their medical degree. They go on to describe their HCA experiences as a revelation on the nature of intimate patient care, the role of HCAs and nurses and the routine function of hospital wards. Ahmed (2009) outlines several scenarios to illustrate the differences in proximity to the patient of nursing auxiliaries (HCAs), registered nurses and doctors. According to Ahmed, in each scenario involving dehydration, pain and hypoxia, it is the HCA who identifies the deteriorating patient and the need to act to avoid potentially serious consequences. In a longer and similar paper Fearnley (2014) describes in some detail the benefits of working as an HCA throughout his time in medical school. Fearnley cites his enhanced communication skills with patients, improved understanding of the multi-disciplinary team and his respect for the HCA role in direct patient care, assessment and therapy.

Although Ahmed (2009 and Fearnley (2014) worked as HCAs during their undergraduate training and have reported the benefits, this perception of HCA work is not entirely shared by other undergraduate healthcare students. For example, in their survey of medical students across the UK, the British Medical Association (BMA, 2014) found that 37% were either against or undecided about the plan by Leicester University to require first year students to work a half-day per week as an HCA. However, Gillian and Deborah had the foresight that working as an HCA before embarking on their training would be an opportunity to gain clinical experience and to gain a sense of their personal suitability or 'fit' to this working environment. Like the medical students (Ahmed and Fearnley), Gillian and Deborah recognise the benefit of entering the field as an HCA to gain experience of close proximity patient care i.e. a social knowing perspective.

A narrative of learning and development is continued in the next section where selected extracts illustrate participants' desire to learn more about healthcare through the HCA role.

5.4   A learning and development narrative

The motivation in the previous section for becoming an HCA was instrumental to a long-term aspiration. The 'destination' for participants was to become a graduate nurse, medic and drama therapist. In this section, the extracts illustrate how participants made a gradual shift towards becoming an HCA as a result of learning in employment with a caring component. These participants did not declare a specific aim or aspiration to become an HCA i.e. there was no 'destination' as such. It was the exposure to caring work and the learning derived from it that stimulated their move towards becoming an HCA.

Selected extracts illustrate how participants talked about the influence of learning at work on becoming an HCA. Brenda and Maggie make specific reference to learning in the context of their employment, as a driver to become an HCA. Brenda identifies a lack of confidence in talking with people about sensitive issues as the stimulus for taking a counselling course.

> *"… I had my own practice as an aroma therapist … lots of people quite often would want to talk about emotional stuff which I didn't really feel qualified to be discussing…. So I did a counselling course. I think I've got this life-long learning kind of thing…. I get bored if I don't do anything"*

A short while later in the interview we hear that this new learning in counselling has provided Brenda with the motivation and confidence to apply for a position as an HCA in mental health care:

> *'… I thought I need to be in a situation where I can actually practice some of these skills… I was out of work as well so I went along to a job fair at our local hospital and I ended up signing as a bank healthcare assistant… although that wasn't my intention at the time… I had no concept was letting myself in for ..* [Laughter]*… Absolutely no idea! I just ended up walking into the psychiatric wards!'*

It appears that her informal learning has partly driven Brenda's decision to work in the care sector. While it is the case that the need for a job is high on her agenda because she is unemployed, it is significant that she is motivated by the exposure to formal learning and a desire to apply her new skills in a suitable setting.

Maggie exploits a learning opportunity at work to enhance her knowledge:

> "'I was quite keen to develop in terms of patient contact, and my skills. There was quite a lot of just following instructions, but I quite enjoyed it because I was able to follow the patients through…when they come out of the anaesthetic. You're doing their observations and then you're accompanying them up into the extended recovery area. I became more confident in that environment."

The opportunity to experience close patient care and the associated learning is appealing to Maggie. Although the role was limited in scope, Maggie identifies clinical assessments as part of the caring role and the potential for learning

Discussion

Maggie and Brenda declare that learning from experience at work is part of their rationale to move into the healthcare field and become an HCA. Although learning at work may be described as haphazard, idiosyncratic and driven by serendipity (Marsick and Volpe, 1999) it is also widely acknowledged that this kind of informal learning is initiated by the learner and is motivated by intent to develop (Billet, 2010). For Brenda, the decision to start a counselling course arises from an informal learning experience. Here we see how a routine situation in Brenda's working life as an assistant in a health food shop was a stimulus to learn more about counselling. Her decision to embark on formal learning is a response to the sensitivity of these situations and a desire to enhance her communication skills. She wants to know more so she can help her clients. That mental health is her choice of care work is also significant given that this area of care work is not necessarily the first choice for many people, due to the prevailing public image of mental illness (Schomerus et al, 2012). Furthermore, a counselling qualification would also bring a certain legitimacy and greater credibility to the role.

For Maggie, the decision to exploit a learning opportunity was taken in response to a request for her to transfer from her role as an advisor in a pregnancy termination clinic to be an 'HCA-for-a-day' in the post-anaesthetic recovery ward. For both Maggie and Brenda, the desire to learn is bound up with acquisition of the necessary capital to feel comfortable in the field of healthcare. They become HCAs after making the decision to learn more. There is a social knower perspective to both these situations. Whatever the care setting, it is the close proximity to patients and the development of social knowing that leads to employment as an HCA. There is also the possibility of exposure to epistemic knowledge in both situations. The meaning of blood pressure and pulse rate are examples for Maggie and medication used in mental health settings is an example for Brenda.

In the next section, the necessity of employment is the main driver for entering the healthcare field. Issues of knowledge and learning emerge after participants move into the healthcare field.

5.5   A basic need for a job

The need for employment was a common economic driver for three participants (Adam, Francis and Steve) and, although their early experiences of care work were different, discomfort, anxiety and self-doubt arise in all their accounts. For Adam and Steve this is experienced during the early stages of becoming an HCA. For Frances, it is experienced during the anticipation of the healthcare field.

Needing employment on arrival in the UK, Adam was steered by his uncle, a psychiatric nurse, towards an HCA post.

> *'I was a bit fed up in Ireland… and he got me a job as a healthcare assistant in care of the elderly, so it wasn't a vocational calling for me….*

However, he left this elderly care HCA post almost immediately,

> *'I just wasn't ready for it at that age* [19]*, I'd walked straight off a building site into this very different environment'*

One year later, while he worked as a barman in the hospital Trust social club, he was encouraged by a unit manager to return to the ward environment as an HCA in a mental health care setting.

> *'…. he felt that I had all the attributes to be a healthcare assistant working in the forensic service'*

This was immediately confirmed to Adam as he had a very different experience in mental health care compared to care of the elderly.

> *'I fell in love with the job…. I loved the patient interaction… the social interaction…I got a greater understanding of the job'*

While Francis was unemployed following graduation in drama, a friend steered her towards a job in mental healthcare. Her anxiety was raised during the interview when reference was made to the client group

> *'I was scared because of my own preconceived ideas about mental health'*

However, Frances was immediately enthralled by the work,

> *'I've loved it every single day … no one was hostile or aggressive and violent… they were all just really happy… it was great fun.'*

For Steve, the main concern is having a job compounded by a deeper concern of whether he is capable of working in a hospital because, apparently, only '*clever'* people do this. Steve's perception seems to be that there is a minimum level of intellectual ability required to be employed in healthcare. His self-doubt is clearly evident in that he thought it would never happen.

> *"I didn't have a job at the time! There was an HCA job going and I thought 'I want to get that job but I'm not clever enough to go and work in hospitals … I didn't think I would ever do it"*

Later in the interview we hear how Steve's concern about not being clever enough to work in a hospital is brought into sharp focus early in his experience of the field. Steve's struggle with feelings of inadequacy and self-doubt were greatly amplified by the ward manager's decision to put him in a white coat on his first day because there were no nurse tunics

available. The extracts below capture Steve's anxiety and lack of confidence.

> "Well, I was scared stiff… I had never done anything like that before and I didn't have a uniform so they gave me a doctor's white coat… So, that made me even feel even more like that I stuck out because some people came up to me and said 'doctor?'…"

In this passage, Steve expresses the fear that he was anticipating before starting the job. The first day of work on a ward must have been difficult enough without the added burden of a white coat to draw attention and amplify his sense of vulnerability. Although the white coat has gradually disappeared from hospital wards over the last 10 years due to concerns about cross infection, it still carries enormous meaning and power in healthcare settings (Palacios-González and Lawrence, 2015). The hospital white coat is instantly recognised by the public as a powerful symbol of the field.

The contrast between his position at the time (first day as a support worker) and the outward status conferred by the white coat could not be greater. So, for Steve to wear this potent symbol of authority and power, he had effectively realised the fears he expressed while considering whether to even apply for the HCA post. Although Steve laughed at the conclusion of his story, this was for him clearly an uncomfortable first experience of work in healthcare.

Discussion

Adam entered the field of healthcare with no previous experience, i.e. without any relevant cultural capital to draw upon. In making the transfer from the construction industry to elderly healthcare, the sense of discord (hysteresis) between his habitus and the field was profound. However, while still on the periphery of the field, working in the hospital social club, Adam is observed and informally assessed by a healthcare manager who detects cultural capital that might be appropriate to forensic mental healthcare. That Adam reports a completely different and positive experience in this subfield, indicates that his habitus and associated social and cultural capital were in tune or synergistic to this different sub-field of healthcare.

The reputation of the field was an issue for Frances and Steve. Just the thought of a mental healthcare setting for Frances was enough to elicit a sense of fear, whereas Steve's anxiety was due to a sense of inadequacy. Frances' concerns evaporated when she was actually in the field and there is synergy between habitus and field. Unfortunately for Steve, his concerns about the field are realised when his outward appearance bestows upon him the symbolism of expert knowledge and the embodiment of biomedicine. Tension between field conditions and self-appraisal of his capital resources lead to hysteresis.

5.6   Summary

Although there is considerable research on the outcomes of people's plans in life and how they accomplish their plans once they have decided (Sheldon, 2014), there is little published work on how people come to know in the first place what they want to do. This chapter has presented data that sheds some light on the original motivations of participants to become HCAs. Within the range of reasons articulated by participants, interactions between field, habitus and capital appear from the interpretation of the extracts. The role of knowledge also emerges as some participants wish to use the HCA role to gain experience and insight into healthcare. A desire to learn also feature in the rationale for some participants.

Exposure to and early learning from the healthcare field begins the process of social knowing while some participants use language from the wider social discourse on caring to justify and enhance their reasons for becoming an HCA. Some are seeking a change of life-direction in becoming an HCA. With this comes a change of identity but at least it is possible. Open contemporary societies (Giddens, 1991) mean that people are not necessarily stuck in a role, with an identity that brings distress and unhappiness.

Participants' awareness that knowledge derived from direct patient care may be an asset plays an important part of the rationale for those participants who wish to 'test' the healthcare field, for personal suitability and potential progression to higher status roles. Close-proximity care work as an HCA develops occupational capital and contributes to a social knowing perspective for the aspirational participant.

For others, becoming an HCA is almost secondary to the desire for learning and development. The job is an opportunity to operationalise previous learning with the bonus of learning more. Participant learning and the desire for learning precedes the motivation to become an HCA. Development of social knowing is almost guaranteed with the further opportunity for development of epistemic knowing if field conditions are appropriate.

Discord, and the potential for discord, between field and habitus is a feature of some participant experiences. It appears that becoming an HCA, with employment as the priority, may bring tension during anticipation of the healthcare field and once in the field and hysteresis for some participants between habitus and field.

The next chapter examines participant perceptions of their learning in the HCA role and recognition of HCA knowledge by others in the HC field. How do participants talk about their learning and what do others say about HCA knowledge?

Chapter 6 Learning from the role and recognition of knowledge.

6.1 Introduction

People learn continuously throughout life (Foley, 2001) and learning in the workplace through interactions with others is a long-standing and important feature of the informal learning literature (Coffield, 1999). However, research on the specific antecedents to informal learning that operate at the individual level is minimal and has mainly focussed on theory development. For example, constructs of personality such as conscientiousness (Bakker et al, 2012) and self-efficacy (Bandura, 1986) have been used to investigate the role of human agency in motivation for learning. While both these constructs have some explanatory value where learners are already in a *formal* learning situation (Major et al, 2006; Colquitt et al, 2000), the role for these constructs as an antecedent to *informal* learning is minimal (Noe et al, 2013). However, a link between informal learning and a sense of agency in the workplace has previously been suggested by Eraut (2004) and, in their study, Noe et al (2013) found that individual energy and enthusiasm were related to differences in motivation for informal learning.

Differences in motivation to learn is the premise of the first section of the chapter. Five participants describe how they did or did not learn from the HCA role. The second section draws on extracts from eight participants to illustrate how HCA knowledge is constructed and valued by various agents in healthcare settings; HCAs themselves, patients, nurses and other staff, and the 'system' (NHS Trusts and HE).

6.2 Learning from the role

In the first part of this section *(Some do and some don't)* a distinction made by a nurse participant (Deborah) between two 'types' of HCA based on what she sees as motivation to learn seems to confirm this 'common-sense' variation in motivation to learn.

The second part *(Some do)* draws on two extracts from nurse participants (Steve and Christine) who appear to add credence to Deborah's observation by offering some insights into the motivation of HCAs to learn from the role.

The third part *(Some don't)* draws upon extracts in which a nurse (Anne) and a student (Pauline) describe situations where their learning was limited.

6.3   Some do and some don't

In this first part of the section, Deborah differentiates between HCAs based on motivation to learn. She makes a distinction between HCAs who seem to proactively decide to learn from their experience and those HCAs who apparently do not wish to do this. Some HCAs, irrespective of previous educational attainment, are more motivated to investigate and learn.

> *"some just complete the task and don't even begin to look into what that means and analyse what they've just done… and then you get others who have… not necessarily a more educated background… they are more intrigued and they choose to learn more and understand it"*

Some HCAs, according to Deborah, perform their care tasks without considering the implications of their actions. For these HCAs there is a lack of awareness, or a lack of interest (or both) in the significance and consequences for the patient. However, from this extract it is not clear whether the HCAs concerned are naïve (they don't know what they don't know) or whether they are fully aware and are perhaps reluctant to act on their knowledge. This reluctance may stem from HCA self-appraisal of their status with the field. Learning is inevitable in any human activity and so knowledge will have been acquired during work activities. However, the HCA may choose not to express this knowledge or enquire further for fear of generating more work and a wider and perhaps unwelcome scope of responsibility.

Extracts are presented in the following two parts of this section that superficially at least seem to support the notion that some HCAs are more motivated to learn (Some do) while others apparently lack motivation (Some don't).

Superficial examination of these illustrative participant extracts appears to support the 'common-sense' notion that HCAs vary in their motivation to learn. However, further analysis reveals that knowledge practices are employed by nurses for boundary management and influence the nature, scope and impact of learning by HCAs.

Finally, despite lamenting the general perception in the healthcare sector that HCAs are limited in what they know, and valuing the learning opportunities that the HCA role provides for HCAs who aspire to nursing, Deborah herself uses the distinction between epistemic and social (sacred and profane) knowledge to place a limit on the nature and value of what HCAs can learn and know.

Some do

Steve and Christine (both nurses) illustrate how HCAs can start the process of moving from a social knower position to an epistemic knowledge position using patient information available to them.

An example of this is in the first extract where Steve's experiences in high dependency cardiac care illustrates the process of informal, self-directed learning during his time as an HCA. In this case Steve observes patient assessment data on an electrocardiogram (ECG) monitor and makes the link to a potential negative outcome for the patient. For Steve, this represents a move away from the HCA world of profane knowledge arising from close-body personal care and towards the world of the sacred where meaning comes from knowledge with stronger epistemic relations and with high semantic density.

> *"it was a steep learning curve… interest was gained by doing things and then I wanted to do more things… and then I sort of learned just by seeing…the ECG monitors, I learned basically what the rhythms were, I had no idea why they were a certain way… I learned how to recognise an emergency rhythm and I was like first on the scene and that was scary … trying to jump on someone's chest!"*

Although there is an admission of ignorance of what the ECG means (as a reflection of underlying heart activity), there is demonstrable enthusiasm for learning arising from doing the job. It would seem that without recourse to any other source of information or training, Steve has learned how to discern an emergency ECG rhythm from a non-emergency rhythm. This is an impressive achievement. The ECG trace is a complex dynamic recording of the electrical events of the cardiac cycle in real time. Although the biological principles connecting the ECG trace to the cardiac cycle of the heart are an apparent mystery to Steve, this does not deter him from learning as much as he can and taking appropriate action when the need

arises. Although he describes the difficulty associated with learning-by-doing as a *'steep learning curve'*, Steve also acknowledges his motivation to **do** more and curiosity to **learn** more, ultimately leading to situations where, despite the fear, he feels compelled to act on this knowledge and commence emergency resuscitation.

The ECG recording has considerable semantic density due to the highly condensed symbolic nature of the information contained within the trace depicted on the ECG monitor. The shape of the trace as it moves across the screen is laden with meaning. The amplitude of the peaks and the troughs and the distance between them are just 2 set of variables amongst many which could indicate the nature and extent of cardiac pathology. Despite the complexity of the trace, Steve has assimilated sufficient meaning to recognise the imminent implications of what he calls an 'emergency rhythm' for the patient concerned and to take action. Wittingly or unwittingly, Steve has incorporated some aspects of both the symbolic meaning of the trace (semantic density) and the meaning for the patient (semantic gravity) into his practice as an HCA.

Learning of this nature is not necessarily expected of HCAs by nurses and doctors, agents with more capital and status in the field, but despite this, the knowledge acquired by Steve has a strong epistemic basis and high semantic density. The knowledge imbued within the ECG also represents symbolic capital of significant value. The ECG trace is widely depicted in public and many people would recognise the image as a symbol of contemporary healthcare. That Steve has acquired this 'insider' knowledge over time represents a change in his occupational competence and greater sense of agency and confidence in unpredictable circumstances. Rather than immediately report the emergency rhythm, his sense of personal agency is activated to initiate emergency resuscitation.

However, opportunities for acquisition of powerful epistemic knowledge by HCAs through informal learning in practice can be lost. In the next extract, Christine first shares her recollection of her own learning as an HCA and then discusses how the HCA role has been affected by the implementation of a generic clinical assessment tool which may lead to reduced learning for HCAs.

"I learned it all on the job…. (I) would have to realise when somebody was hypertensive, or their blood sugar is 9 …. Whatever it was we would have to recognise… but now it's just sort of there for you… you just add up the scores and alert the nurse…I don't know if that takes away from you (the HCA) *recognising why they* (the patient) *are there… little things can influence the results… I wonder if we are just taking so much away* (from the HCAs) *…"*

We can see in this extract that not only is Christine (the HCA) measuring and recording clinical observations, she is taking responsibility for knowing the threshold for hypertension and raised blood glucose (hyperglycaemia). Furthermore, this appears to be a collective responsibility (*'we would have to recognise')* and a sense of active engagement and learning on the part of HCAs in the process of measuring and monitoring clinical parameters.

There is high semantic density in these clinical assessments. The meaning of blood pressure is reduced to a symbol. It is condensed in the values of systolic and diastolic pressure expressed as mm Hg. These units of systolic and diastolic blood pressure (mm Hg) only have meaning to those agents with specialist knowledge. Furthermore, knowing when the patient is hypertensive would require comparing the values of the patient's systolic and diastolic blood pressure as it is measured with the threshold value for hypertension.

Similarly, a blood sugar (glucose) test result of 9 has high semantic density due to its condensation in the value expressed as mmol/L. The meaning is apparent only to those who share the specialist knowledge that the unit symbol (mmol/L) represents the concentration of glucose in blood. The semantic density of this knowledge is extended by the individual knowing that there is a range of values corresponding to health and that values outside this range represent a problem for the patient. Christine cites a blood sugar of 9 (mmol/L) knowing that the value is outside the healthy range. That this represents a problem for the patient is also an indication of the semantic gravity of the blood sugar value in the context of the prevailing circumstances of the patient.

However, according to Christine, the contemporary HCA it seems, is no longer required to think about the significance of the individual measurements *('… but now it's just sort of there for you…')*. The cumulative

score of several measurements, without the HCA needing to think about individual assessment data, now provides the mechanism for alerting the nurse. This part of the extract identifies the loss of semantic significance for the HCA. The implementation of a scoring system as the basis for identifying a patient problem means that the significance of the individual clinical assessments no longer has to be considered by the HCA. The potential semantic density of a particular health assessment e.g. blood pressure, becomes lost to the HCA as it is fed into a generic scoring system. Specific knowledge of the units of assessment and the significance of individual values compared to a normative range is no longer required of HCAs.

There is also a consequence for semantic gravity. Given that HCAs work in such close proximity to patients, the immediate context-dependent meaning of individual clinical assessments may also be lost or, at least, significantly reduced. The phrase *'little things can influence the results'* is relevant here. Christine expresses a lost learning opportunity for the HCA and potentially a lost opportunity for a clinical intervention for the patient. HCAs are in close proximity to patients, providing personal and often intimate care. Therefore, the '*little things'* that would be apparent to the HCA in the context of a particular patient could be linked to an unusual result. Christine links the '*little things'* known to the HCA and to the learning opportunities offered by relating these to the individual clinical assessments. There is a sense of regret that this has removed HCA knowledge and experience from the assessment process.

Some don't

Involving personal care and routine clinical observations typical of the HCA role, the extracts from Anne and Pauline below illustrate the social, natural and cultivated (social relations) origin of the knowledge arising from this work. While both participants describe limitations to their learning, analysis of the extracts indicates that knowledge practices in the care setting create barriers to their understanding of the significance of their work.

In the following extract, Anne describes how the hands-on and intimate care tasks, typical of a support worker role, were delegated without explanation. Although Anne does not explicitly state that she wants to know more, there is a sense of frustration conveyed in this passage.

> *"…we helped them with their personal hygiene, feeding and participated in groups … I didn't really understand what was going on. I was just asked to do things and there was no clear understanding of why"*

The practical and rudimentary job of assisting clients with basic daily living activities is not enough for Anne. Here is an enquiring mind expressing alienation arising from a combination of the directed, task-oriented work and lack of rationale offered by the nursing staff. Even Anne's mention of group activity, which would involve social interaction beyond that associated with washing and meal times, is included as a routine delegated task. We have the sense from Anne that there must be more to this if only it were explained by nurses to the support staff who provide the personal care.

From an LCT perspective, Anne's situation is one of 'social knower' i.e. social relations are relatively strong and epistemic relations are relatively weak. Her disposition is exclusively social as the knowledge required for her care work derives exclusively from the natural, cultivated and social attributes of the HCA. Anne identifies the activities of daily living that she assisted clients with but the principles of specialist and epistemic knowledge underpinning the care are not made explicit by the registered nurses i.e. there is weak framing of epistemic relations to knowledge.

In the next extract, we see again how HCAs may be excluded from the underpinning epistemic knowledge necessary for the relevance of their care to become apparent. Also, the role of knowledge practices in the creation and maintenance of occupational boundaries between nurses and HCAs are raised.

> *"We do the housekeeping side of things, the bed making and assisting with personal care and hygiene and then doing the basic clinical observations. Although now they (university tutors) say they're essential! I didn't realise at the time how important they were. You would just do them and you didn't really think very much".*
>
> *(Pauline)*

Pauline similarly identifies the core and routine care tasks of an HCA. However, she also describes a new-found awareness of the significance of

clinical observations. Having previously (as an HCA) included cardiovascular, respiratory and temperature observations in the same category as housekeeping, bed-making, personal care and hygiene, she has subsequently discovered (now as a nursing student) the significance of clinical observations. These assessments of biological function were performed alongside and previously undifferentiated from housekeeping, bed-making, personal care and hygiene. The routine nature of the clinical observations did not apparently require much thought when she was an HCA. However, these basic activities have now been reclassified by Pauline to 'essential'. No explicit rationale is offered for the upgrade in their status so we have no evidence for Pauline having fully internalised the purpose of clinical observations.

The distinction between Maton's (2014) social relations and epistemic relations to knowledge is demonstrated again here. As an HCA, Pauline's experience shows how all these care activities were indistinguishable from each other i.e. they were weakly framed. However, the clinical observations of blood pressure, breathing and body temperature as assessments of biological function have stronger epistemic relations. Their meaning is also condensed to a symbol, mm Hg, breaths per minute, ºC respectively, and so they also have high semantic density. However, Pauline has conflated these aspects of bio-nursing with social care. While it is true that these clinical observations are routine in healthcare settings, accurate assessments require both sensitive motor skills and some insight of the healthy range of these parameters i.e. what is a 'normal' value for pulse or blood pressure. The significance of this information, its epistemic value, only becomes clear for Pauline once it has been framed as such by the university. This knowledge has now been strongly framed for Pauline through exposure to HE. The knowledge code practices of HE have enabled Pauline, the student nurse, to determine the difference between the clinical observations as 'legitimate object' (blood pressure) and other possible objects (bed making).

There is a detectable element of tacit regret from Pauline in this passage that she did not previously recognise the implications of clinical observations to patient welfare. The question arises as to whether the NHS Trust in general or the nurses in particular could have done more to engage Pauline in the significance of clinical observations i.e. to provide the framing

required for Pauline to recognise the semantic differences between bed-making and clinical observations.

It is conceivable that Pauline was inhibited from finding out more about the meaning and significance of pulse, blood pressure, breathing, temperature assessment due to the occupational boundaries that prevail widely in healthcare settings (Nancarrow and Borthwick, 2005) and particularly between HCAs and nurses (Bach et al, 2012). Nurses may allow HCAs to perform clinical observations alongside their role of basic care due to pressure of patient workload. Indeed, nurses frequently require and even encourage support staff to carry out routine clinical observations.

However, Spilsbury and Meyer (2004), in their study of HCA routine work, found that although HCAs were measuring and recording clinical observations, they were doing so without any instruction or guidance from nurses. Furthermore, the nurses in this study said that they assumed that HCAs knew what they were doing and why. However, this may not have been the case. An alternative consideration is that nurses may decide to not share with the HCA the specialist knowledge needed to provide insight into both the semantic density of the knowledge associated with the assessment and the semantic gravity of the knowledge to the particular situation i.e. the meaning of the assessment in the context of individual patients. Nurses may do this in order to maintain their position in the field. Thus, withholding from HCAs both the semantic density and the semantic gravity of this knowledge effectively maintains jurisdiction over nurses' distinctive contribution to patient care. There is a tension between the need to get the work done and the occupational boundary work necessary to maintain nurses' specialist knowledge and thus their status.

The value of learning from the HCA role is further illustrated by Deborah in the next and final extract of this section. However, while she gives credit for the knowledge accrued by HCAs and expresses its personal value for her during the period before she entered post-graduate nurse education, Deborah's analytical comments provide insight into how nurses use specialist knowledge to create boundaries and maintain their status position in the field.

Furthermore, despite Deborah's declaration in the first extract of this section that HCAs vary in their disposition and motivation for learning,

implying that HCAs are themselves responsible for whether they learn or not, analysis of this final extract shows that Deborah herself employs knowledge practices to place a limit on what HCAs might come to know.

> *"I think quite a few people make the assumption that they (HCAs) don't know much at all which isn't always correct, they just see the person in the grey uniform…"*

> *"they* (HCAs) *would know that the saturation was wrong… that it's bad to have low levels of oxygen in the blood… they would know that it's not good if it goes below 90%.... but the difference is that I* (as a biology graduate) *would be able to understand what is happening inside the body"*

> *"I learned so much as an HCA… I learned more in my first year as a healthcare assistant than I did in my first year of my postgraduate nursing programme…"*

In this extract, Deborah starts by indicating the perception that many people have of HCAs, that they are an invisible and naïve group of healthcare workers. Despite the distance in the passage between the two phrases *'make the assumption'* and '*the person in the grey uniform',* the idea conveyed seems to be one of relative invisibility of the HCA indicated by *'just see'.* What then follows is an example of an important clinical parameter, oxygen saturation, which Deborah uses to illustrate HCA learning and potential contribution to patient welfare. It seems HCAs know that 90% (oxygen saturation) is the threshold value as a cause for concern.

However, she then compares this experiential learning of HCAs with the depth of her biological knowledge. Being a biology graduate apparently provides insight into physiological events beyond the numerical value of oxygen saturation. Its qualitative (and almost superficial) significance described by HCAs as *'bad… not good',* is eclipsed by her superior knowledge. Deborah declares for herself a *'depth of knowledge and understanding'* that other HCAs would not have. She justifies the strong epistemic nature of her knowledge both in terms of the semantic density located within *'oxygen saturation'* and its semantic gravity i.e. in the context of that particular patient. According to Deborah, the HCA can only go as far as understanding that the threshold for *'not good'* is 90% oxygen saturation. Although the meaning within the context for the patients gives high

semantic gravity, the symbolic meaning of the 90% oxygen saturation is only truly available to those with access to the necessary epistemic (sacred) biological knowledge. Deborah asserts that she has been able to draw upon and apply her specialist knowledge (semantic density) as a biology graduate to the particular circumstances (semantic gravity) of individual patients. Again, occupational boundary work is implicit in all this. Deborah acknowledges that HCAs have learned and are aware of the threshold value for problematic oxygen saturation but, at the same time, she stakes an elite code claim to the meaning and relevance of this to what is hidden inside the patient's body. Thus, Deborah positions herself in the field using the elite legitimation code, as one who possesses both specialist knowledge as a biology graduate and the necessary disposition as social actor derived from her previous HCA role in providing direct care and her current position as registered nurse.

Later in the extract, Deborah acknowledges that the extent of her own learning was due to her early experiences as an HCA. Deborah identifies long-serving HCAs as care workers who do, in fact, know a great deal. A sense of gratitude is conveyed when Deborah compares the value of her learning as an HCA to her time as a postgraduate nursing student. Despite her graduate biological knowledge, in stating that she learned more in her first year as an HCA than in the first postgraduate diploma year, Deborah deals a blow to the widely-held notion that '*HCAs don't know much'.* They clearly do know a great deal if a biology graduate who has worked as an HCA makes this comparison and places HCA knowledge above the first year of a postgraduate diploma.

However, despite Deborah's acknowledgement that she learned a great deal as an HCA, this is framed exclusively in terms of social relations to (profane) knowledge. The personal learning in her first year as an HCA is the dispositional (knower code) knowledge that Deborah accrued as a consequence of the cultivated and social acquisition that goes with the role of HCA.

Furthermore, analysis of this extract has shown that Deborah uses the legitimation device of specialisation and strong epistemic relations to knowledge to justify her position as an elite knower. This contrasts with

HCAs who, although they acquire knowledge, according to Deborah cannot see inside the human body with an 'epistemic lens' as she can.

Discussion

The premise of this section has been that the nature and extent of HCA learning depends on the individual characteristics of the HCA. However, while the extracts presented and discussed in this section illustrate the extent of informal learning that is possible by HCAs during their work, scrutiny of these extracts using LCT has shown that knowledge practices influence power relations between nurses and HCAs. These knowledge practices contribute to boundary management between nurses and HCAs and may inhibit learning by HCAs.

Due to their proximity to patients, HCAs occupy a position in the field of healthcare where they have stronger social relations to knowledge and, despite the routine and relatively profane nature of HCA work, there is potential for exposure to knowledge with stronger epistemic relations. However, we have seen (Pauline) that knowledge with stronger epistemic relations may be withheld. Nurses may supress the epistemic and semantic significance of knowledge underlying a particular clinical activity in order to maintain their position in the field. Knowledge as capital is used by nurses in occupational boundary work to maintain their superior status in the field. Although HCAs may be exposed to knowledge with stronger epistemic relations, this may be undifferentiated for the HCA from care activities with stronger social relations to knowledge. We have also seen that, although framing of strong ER knowledge is not provided by nurses in the clinical area, it is subsequently provided through HE once the HCA becomes an undergraduate nursing student.

Extracts presented and analysed in this section, to illustrate how former HCAs talk about their learning, show that HCAs are performing clinical observations and assessments beyond their traditional role of intimate and personal care. Nurses have wider scope of practice and greater responsibility as NHS Trusts respond to increased demand for healthcare and advances in technology. This has created a working environment where HCAs have filled the gap by taking up activities that were previously the exclusive domain of registered nurses. Observation of skin integrity, blood pressure, pulse and respiration rate, haemoglobin-oxygen saturation,

blood glucose and ECG represent potential learning situations with stronger epistemic relations to knowledge. Indeed, that HCAs recognise, understand and act upon clinical information with stronger epistemic relations to knowledge may be critical for patients. This was illustrated by Steve and Christine who acquired knowledge with stronger epistemic relations and semantic density as a result of their exposure to and involvement with clinical assessment activities. There was the potential for cardiac arrest in Steve's scenario and diabetic keto-acidosis in Christine's scenario. Although the ECG trace for Steve and the blood glucose figure for Christine are both objective measures of changing physical and chemical parameters, their significance and interpretation requires the typical personal involvement of the HCA at the point of contact with the patient i.e. knowledge with stronger social relations. Thus, the combination of clinical data with stronger epistemic relations to knowledge and the close proximity knowledge with stronger social relations, was critical for the patients concerned and became part of the occupational repertoire for these particular HCAs. In LCT terms this moves the HCA towards the status of elite code knower (possession of specialist knowledge plus social and cultivated disposition as actor in the field).

Although these participants are reporting their experiences across a wide range of healthcare settings, knowledge practices in the field of health care create limitations on what HCAs know and influence how they talk about what they know. There are clearly issues of status and power emerging which relate to knowledge practices in the field and the relationship between nurses and HCAs. Furthermore, through the analysis, interpretation and discussion of these extracts we see how legitimation practices imbue capital in the field. Maton's (2014) LCT model has proved useful in illuminating the differences between the forms of knowledge as capital that are in play within healthcare settings and differentially identified by participants as forms of capital. More specifically, the legitimation devices of specialisation codes (epistemic relations and social relations to knowledge) and semantic codes (semantic density and semantic gravity of knowledge) have operational utility in the analysis of how participants talk about what they do and what they know about what they do. Languages of legitimation are operating in healthcare setting and represent strategic

stances in the field to stake claims to knowledge as capital i.e. what can be known by who, what is legitimate knowledge and who decides.

These issues of recognition and value of HCA knowledge are explored further in the second section of this chapter.

6.4   Recognition of HCA knowledge

In this section, participants describe how their knowledge and experience was differently recognised, constructed and valued in healthcare. The extracts have been selected from the coding categories relating to how participants described their role as an HCA and their working relationships with nurses. There are four subsections to illustrate the recognition of HCA knowledge by the following agents;

- HCAs
- patients
- nurses and other health professionals (HPs)
- the 'system' (healthcare and HE).

The section starts with an extract from a single participant (Hannah) that illustrates how HCAs describe knowledge acquired from close personal care. How this intimate care is valued by patients is illustrated in the extract that follows (Deborah). Next, drawing upon extracts from five participants, (Adam, Frances, Lynn, Hannah, Olive) the main body of this section examines how these former HCAs describe the attitude and responses to expression of HCA knowledge by nurses and other health staff. Two contrasting perspectives emerge from these extracts. HCA knowledge and experience appears to be either **ignored** or **valued** in care settings.

However, analysis of these extracts shows that these contrasting perspectives share a common feature. Knowledge practices operate in both situations (even when HCA knowledge is valued) to maintain occupational boundaries between the profane world of HCAs and the sacred world of nurses and other healthcare staff.

The final two extracts (Karen and Gillian) conclude the section by illustrating that the 'system' (healthcare and HE) does not sufficiently recognise the knowledge acquired by HCAs during their time in care work.

Recognition by HCAs

In the extract below, Hannah describes how knowledge is derived from HCA routine close-body care.

> *"They* (HCAs) *do the stuff that no one else will do…although they are not registered they still know a fair bit… they know when a pressure sore is coming up and they know exactly what to put on it"*

The first point to be drawn from this extract is that, while Hannah as a first year (first term) undergraduate pre-registration nursing student, may not be the best judge of the appropriateness of the HCA intervention for a looming pressure sore in this situation, the point of interest here is that she observed that the HCAs identified the early signs of a pressure sore and then go on to make an intervention. As a former HCA, Hannah recognises and values the knowledge of her former colleagues but, in referring to the stuff that no one else will do, Hannah is making direct reference to the routine and profane nature of HCA work, the close-body work of feeding, toileting and personal hygiene. These are set apart from care activities requiring more esoteric and specialised knowledge characteristic of the domain of registered nursing. However, Hannah gives these HCAs credit for being able to identify the early signs of a pressure sore and make a therapeutic decision. These HCAs are using the knowledge acquired over time from their close-proximity profane work. The HCAs concerned have probably not come to the care setting with specialist knowledge of pressure point inflammation. The knowledge required, slight reddening of the skin on the bony prominences of the body, is highly dependent on the patient context for its meaning and will have been acquired through gradual cultivation in the care setting.

Recognition by patients

The value of HCA close-body care to patients is similarly illustrated in the next extract as Deborah tells us that patients' comments focus on the sensory qualities of their care experiences i.e. in terms of how they feel. This is unsurprising as personal and intimate care is the mainstay of HCA work activities and it demonstrates the contribution that HCAs make to the patient experience. However, if knowledge practices are a means for actors to legitimate their position in the field, we see how Deborah uses epistemic knowledge to perform occupational boundary work during the interview.

Deborah's explicit use here of a legitimation device during the interview, in the context of her reflecting on the contribution of HCAs to patient care, provides a useful insight into the attitude and contribution of knowledge practices by nurses towards the knowledge and experience of HCAs. Deborah lets us know that she has specialist (sacred) knowledge that sets her apart from the profane world of the HCA.

> *"it's the basic nursing care that is often what makes the biggest amount of difference to the patient… I often overhear them saying 'my HCA gave me the best shower, I feel much better'… they won't say 'my beta-blocker dose has been raised'… which arguably that's the reason that they're in there* (hospital)*…'*

Deborah follows her praise for HCAs by comparing the patient's vocalised positive experience of a shower, assisted by an HCA, with a change in medication. There is a suggestion that the patient's subjective feelings of improvement could be attributed to the increased dose of a beta-blocker with a consequent reduction in anxiety. This is a known effect of beta blocker medication.

Although the essential message in this extract is that many patients attribute their sense of wellbeing while in hospital to the basic care provided by HCAs, Deborah also displays her epistemic knowledge in the passage. This is interesting and significant for the following reasons. Although she gives credit to the HCA for improving the patient experience, Deborah demonstrates in the interview situation that she has specialised knowledge. She draws attention to the social relation dimension of healthcare, acknowledging that this is what gives support workers recognition from patients, while also performing boundary work by using epistemic knowledge that indicates her professional identity and status.

However, by making reference to beta blocker medication, Deborah uses a knowledge code legitimation device of strong epistemic classification and high semantic density where meaning is condensed to a symbol, in this case the term 'beta blocker'. Deborah is indicating that she has epistemic knowledge <u>and</u> is the right kind of knower by virtue of her position as a nurse i.e. she has the status of elite knower (Maton, 2014). This combination of legitimate knowledge and legitimate disposition as a carer thus provides occupational separation and a definitive boundary with HCAs

who would only have legitimate disposition as a carer in terms of social relations to knowledge.

Recognition by nurses and other HPs

In the extracts which follow, participants describe the responses of staff to the contribution of HCA knowledge in care settings. In the first extract, Adam describes how his contribution as an HCA to group discussion was ignored, while a similar contribution following his registration as a nurse was valued. In contrast, later extracts (Frances and Lynn) illustrate how HCA knowledge is valued by a psychologist and a nurse. However, this may be interpreted as exploitation of HCA knowledge where it suits the needs of the care setting. In the final extracts of this section (Hannah and Olive), participants describe how they felt appreciated when nursing staff assisted with their learning in practice.

The first extract from Adam is an example of how former HCAs express the lack of value attributed to their knowledge and experience in care settings. Adam provides a perspective on his HCA experience from several years distant as a nurse. Adam refers to situations where he had the potential to make a contribution during key times in the workplace when staff were gathered and patient issues were being discussed.

> *"Whether it was a staff meeting, handover or ward-round, I would generally say the same things that I used to say* [as an HCA]. *But instead of being irritating and dismissed, as soon as I qualified it became very valuable".*

However, despite similar knowledge being offered by Adam, both as an HCA and as a registered nurse, his point is clear. HCA knowledge has low value due to the lower occupational status of HCAs. Adam's contribution to the ward staff meeting placed him up against the occupational boundary between HCA and nurse, and would have been viewed as an attempt to cross it.

In contrast to this example of HCA knowledge and experience being directly ignored, we now hear a different perspective from four participants who describe how their knowledge was valued by nurses and other healthcare staff. The first extract from Frances working as an HCA in a mental

healthcare setting, illustrates that HCAs have knowledge that registered health professionals are interested in.

> *"… while you are sitting out with the patients, you are finding* [things] *out. It's the HCAs they* [psychologists] *come to when they are writing their reports… 'How has* [patient name] *been? I know you've got a relationship with him' ".*

Frances starts by describing the learning and insights into the potentially useful patient information she is exposed to during her routine care work. She then cites the clinical psychologist who wants access to the knowledge that she has of a particular patient. This indicates that professional staff on the ward know that HCAs have intimate knowledge of patients. Although this knowledge has a knower-code derivation with stronger social relations to knowledge, it is exactly this feature of the HCA knowledge that makes it particularly valuable in a mental health clinical setting.

Although Frances and Adam both worked as HCAs in mental healthcare, their recollection of the value of their knowledge is different. Adam was ignored while Frances was sought out and proactively heard. This may be due, in part, to a difference in ward culture or a change in attitude to HCAs in the years separating their HCA experience. However, this is more likely due to the difference in the settings. If Adam's contribution had been acknowledged in the public setting of a ward meeting, this would have 'broken' the implicit boundary that nurses use knowledge practices to maintain. Ignoring Adam's contribution maintains power relations and occupational boundaries for nurses. In contrast, Frances was approached by a single psychologist and their meeting was private.

In the next extract, Lynn also cites the value of her HCA knowledge to the care setting. However, in this case, an element of exploitation emerges as the nurse involved knew that Lynn was a former HCA with commensurate skills and knowledge.

> *She* [nurse] *was getting me to teach post-grad students … to do practical skills and I thought you're just taking the piss! I'm a first-year student nurse, I shouldn't be teaching them".*

Lynn could have been flattered by this acknowledgement of the value of her HCA knowledge to the life of the ward. Instead, the sense of injustice

expressed by Lynn is clear. Lynn has crossed the boundary from HCA to student nurse. She is in the same position as the post-graduate students she has been asked to teach i.e. a university student preparing for nurse registration. The post-graduate HEI course takes 2 years before registration, whereas the BSc course is 3 years. Although there is no indication from the extract about the exact nature of the practical skills that Lynn was asked to demonstrate to the PG students, it is highly likely that these would have involved close-body care or clinical observations, typical of the HCA role. There is an element of occupational boundary work implicit in this situation. While it is true that the staffing level on the ward at the time may been insufficient for the nurse to demonstrate these skills herself, the delegating nurse considered these activities to be within the remit of a former HCA. The activities did not reach the threshold level of epistemic or 'sacred' knowledge which only a nurse could do.

The next two extracts (Hannah and Olive) show that some nurses do take the time and trouble to assist HCAs with their learning and appear to value HCA knowledge in the process. Although Hannah and Olive express gratitude for the attention from nurses, analysis of the extracts shows that knowledge practices operate for occupational boundary maintenance even when nurses and HCA cooperate for learning.

An individual nurse is cited by Hannah as assisting HCAs with their learning.

> *"… if you had a question and you wanted to learn, she* [nurse] *wouldn't make you feel small. She would make you feel like you did know what you were talking about… talking to the healthcare assistants as if they did know something".*

The immediate implication of this extract is that Hannah has previously been diminished following attempts to ask questions and learn from other nurses. Her knowledge and experienced has been devalued by the attitude of other nurses. However, in contrast to the prevailing attitude towards HCAs in this care setting, the approach and demeanour of this nurse was different. This nurse used language that conveyed a sense of regard and value for HCAs. She is 'reaching across' the boundary between nurses and HCAs created by the use of knowledge practices. Repetition by Hannah of the message conveyed by this nurse that HCAs have knowledge of value gives additional strength to the point that she is making here.

A sense of gratitude by HCAs for nurses being interested in their learning continues in the next extract where Olive describes how nurses would 'reward' HCAs with help in NVQ course work.

> *"The nurses seemed to acknowledge that they* [HCAs] *did a lot of the hard work while they* [nurses] *were having to do the drug rounds or the paperwork. They* [nurses] *also helped them* [HCAs] *if they were doing their NVQs. They'd always set time aside to help them with that every shift. They were very good that way".*

Superficially, this extract seems to illustrate that nurses value the learning and development of HCAs, and Olive appreciates the time and effort of the nurses involved. However, implicit in the extract is a local 'deal' between HCAs committed to close-body patient care and nurses too busy with medication and patient records to be involved in direct patient care. The boundary between the profane work of the HCA and the sacred work of the nurse emerges in this extract. Furthermore, the NVQ is a competency-based qualification involving assessment of skills derived from HCAs' position as social knower and minimal exposure to knowledge with stronger epistemic relations characteristic of the nursing role. So, the nurses involved in HCA learning and assessment through the medium of the NVQ can maintain occupational separation. Their status, derived from knowledge with stronger epistemic relations, is safe and the NVQ is a formal process of maintaining that safety. Further evidence for this role separation, involving knowledge practices and boundary work, is located in Olive's final phrase. There is a feeling here that Olive 'knows her place' in the hierarchy, almost that the nurses acted from a sense of occupational 'largesse'.

Recognition by the 'system'

The final two extracts illustrate a significant issue for HCAs in general and particularly those who aspire to nurse education. Where does their knowledge fit in a system that seems to valorise epistemic relations to knowledge over social relations to knowledge?

The first extract (Karen) illustrates, that while HCAs complete the routine care work, there is limited engagement with them by the healthcare system. For Gillian, in the second extract, the extent of knowledge held by long-serving HCAs warrants a different and dedicated route to nurse registration.

> *"HCAs just got on with their job. There is no out-of-the-box* [thinking].
> *They* [HCAs] *say … 'No one is including me so why should I bother?'"*

Karen indicates that this antagonistic reaction from HCAs is borne out of resentment, due to lack of acknowledgement by nurses that HCAs may have something more to bring to patient care. Although Karen describes this phenomenon in a detached way, giving the impression of talking about her HCA colleagues, this may also be a reflection on her own attitude to care work as an HCA. Whether it is Karen or her colleagues, this extract conveys a sense of the HCA not being valued for anything other than routine care work.

Karen is effectively saying that if her knowledge acquired as an HCA were valued, then she could offer more. Karen's use of the 'box' metaphor illustrates the limitations placed on HCA knowledge by nurses and the occupational boundary work operating in this situation. HCAs are 'minions' and not encouraged to come out of the box. The system does not seem to want to lift the lid of the box to see what it might contain.

This section closes using an extract from a student (Gillian) which conveys a similar message to the opening extract of this section (Hannah) i.e. that HCAs acquire significant knowledge from their work. However, Gillian goes further by stating that the extent of HCA knowledge requires an alternative route to nurse registration or at least some form of credit by HE during their nurse education and training

> *"… there should be a separate course for support workers who*
> *want to go into nursing… because some* [who] *have been support*
> *workers for 10 or 15 years… and... will have a massive body of*
> *knowledge in their particular field"*

Gillian's statement reflects the value that she places on the learning associated with and attributable to the support worker role. However, Gillian does not elaborate on the nature of this *'massive body of knowledge'* i.e. the extent to which it is derived from epistemic relations (specialist knowledge acquired through exposure to situations where meaning is condensed into symbols with high semantic density) or through social relations (knowledge acquired exclusively through the close proximity of HCAs to patients and clients where meaning is highly dependent on the context). Whichever it is, Gillian is saying that the current system does not

work for HCAs because the knowledge acquired by support workers does not 'fit'.

Discussion

This section has examined selected participant extracts to illustrate how former HCAs describe recognition of their knowledge by different agents in healthcare settings (HCAs themselves, patients, nurses and other healthcare staff, and the 'system'). We have seen how these agents construct HCA knowledge arising from their work in terms of social and epistemic relations to knowledge.

In contemporary healthcare, nurses have largely been replaced by HCAs in performing a greater proportion of close-proximity care work, with consequent reduced exposure of nurses to SR knowledge. Thus, nurses and support workers may develop different understandings of patients depending on the nature of the healthcare setting and their respective proximity and frequency of care for patients. Despite this, nurses recognise the value of HCAs in providing this personal care.

Although HCAs are primarily involved in personal and intimate care work with stronger social relations to knowledge, within the routine of close-body care, we have seen that there is opportunity for acquisition of more strongly classified epistemic knowledge. HCAs learn how to respond with healthcare interventions predicated on this ER knowledge and when HCAs attempt to express their knowledge in the care setting, this may be ignored or suppressed.

We have also seen how, when HCA knowledge becomes important in the care setting beyond its immediate purpose and value for patients, staff may gain access to it, either 'under the radar' by seeking out HCAs individually and privately for an update, or publicly when the knowledge is considered sufficiently protected or remote from any ER interpretation by the former HCA. Nevertheless, nurses continue to describe the HCA contribution to patient care exclusively in terms of social relations to knowledge. Separation from HCAs is achieved by nurses' reference to specialist or 'sacred' knowledge i.e. nurses use knowledge practices to maintain their status position in the field.

HCAs may be given credit for their learning arising from close-body work, to the point where nurses may assist HCAs with their NVQ training coursework. However, there are limits placed on the significance of this knowledge by nurses in terms of its epistemic content and semantic density. The legitimation devices of *specialisation* and *semantics* are used by nurses to stake claims to knowledge involving greater status and power. This feature of the relationship between nurses and HCAs, involving struggles over the relative significance of social and epistemic knowledge, appears to have become institutionalised within the practice of healthcare settings and the means by which HCA knowledge may be recognised for its contribution to HCA progression to registered nurse.

6.5   Summary

Participant extracts presented and interpreted in this chapter illustrate the role of knowledge in the negotiation of status in the healthcare field. The notion that HCAs may differ in their motivation to learn is eclipsed by the role of knowledge practices in the healthcare field by nurses and others. Close-proximity care provides abundant social knowing for HCAs while also providing opportunities for epistemic knowing. HCAs may learn a great deal from their role and take on caring activities with underlying epistemic knowledge whether or not the healthcare area provides relatively low-tech or high-tech patient care. However, knowledge legitimation practices imbue capital in the field and influence who has access to and may express this knowledge capital.

While nurses value the personal care provided to patients by HCAs, the knowledge arising from HCA work is differentially described and constructed. Some HCAs may be performing care activities with strong epistemic relations to knowledge, approaching elite knower status in some situations. However, although valuable knowledge held by HCAs by virtue of their role may be accessed by nurses and others without being publicly valued in the field, nurses may perform occupational boundary work to suppress the significance of the knowledge capital imbued in the work of HCAs.

We see in forthcoming chapters how former HCAs conceptualise their existing knowledge from learning and their response to knowledge with stronger epistemic relations. The next chapter explores issues of motivation

for and aspiration to higher education and registration as a nurse. How do participants talk about what motivated them to aim for nursing? Knowledge, knowledge practices and the status of knowledge emerge from the data.

Chapter 7   Motivation to become a nurse

7.1   Introduction

The previous chapter examined the research participants' role as an HCA, the learning associated with it and the recognition of knowledge acquired by HCAs. The purpose of the current chapter is to explore how research participants described and explained their motivation to become a nurse i.e. the move from the HCA sub-field to the nursing sub-field within the main field of healthcare. There are four sections to the chapter reflecting the themes arising from the coding process (see methodology; chapter 3);

- Influence of nursing role model
- Frustration with the limited role of HCA and desire for increased responsibility.
- Senior staff identify potential attributes in the HCA
- Knowledge seeking

Selected extracts are presented and interpreted within each section of the chapter to illustrate the relevant theme. Throughout the chapter issues emerge relating to the construction of knowledge as a form of capital and the differential status of HCAs and nurses. The themes, '*Influence of nursing role model'* and *'Frustration with the limited role of the HCA'* reflect the symbolic use of language in the field to denote knowledge as capital held by nurses and issues of status and autonomy within the field. The theme *'Senior staff identify potential attributes in the HCA'* reflects the identification, by significant agents in the field of attributes (capital) in the HCA commensurate with nursing. The theme '*Knowledge seeking'* reflects a desire by participants to extend and enhance their knowledge beyond what they see as the limitations of the HCA.

7.2   Influence of nursing role model

Although there were no questions in the semi-structured interview that explicitly asked about this potential factor, the motivating influence of nursing role models was spontaneously and specifically cited by many participants. Extracts from a single participant are presented and interpreted to illustrate this motivating factor. The three extracts capture the essence of this category and provide some useful insights into the

relationship between forms of knowledge as capital and the status of social actors in the field.

The following three extracts from a single participant (Anne) illustrate the role modelling theme.

> *"and I saw her…. she just looked so professional, she was giving out the medication, she seemed to be interacting with the patients in a very different manner to what I was used to… and I wanted to do that… I wanted to learn, she was like a role model"*

In this extract, Anne describes her observations of the working practices of a nurse during a drug round on the ward, particularly how she interacts with patients and the difference with Anne's own working experience as an HCA. There is almost a mystical quality to this experience, where Anne, while on a visit to the store room, has a vision of a graduate nurse who has the look of a '*professiona*l'. Although it is not clear what Anne means in her reference to the professional appearance of this nurse, we can infer that it has something to do with the approach and body language of this nurse with patients. There is no substantive information to go on here other than Anne's observation of the nurse's behaviour in the field and Anne's desire to emulate her way of being.

In the extract which follows, Anne elaborates on one aspect of the substance of her aspiration, referring to knowledge as part of her rationale.

> *"I used to pick up on the science of the RMNs* [Registered Mental Nurses]*, they used to get blood results back which they talked about, 'potassium'… and they used to understand what was going on and they interacted with the patients a bit differently…* [whereas] *it was more like looking after the public for me* [as an HCA]*"*

Anne is listening in to a conversation where registered mental health nurses (RMNs) are discussing the constituents of patients' blood test results in relation to a particular health issue or therapeutic intervention. The word *potassium* is cited by Anne as evidence that the nurses knew what they were talking about and could use this knowledge as a foundation for understanding the implications for this patient and their subsequent interactions with patients.

In the final extract of this section, Anne makes specific reference to the knowledge exhibited by some nurses in their work.

> *"There were some nurses who were more knowledgeable than other nurses and seemed to know what they were doing… it was the confidence that came with that and the ability to act on the knowledge and do the right thing…. it kind of drew me to that…. Yeah, that's kind of interesting!"*

The role of knowledge in enhancing confidence to act appropriately for the patient is attractive for Anne. There appears to be a gestalt moment in the final phrase where, during the interview, Anne recognises for herself the significance of this.

Discussion

The three extracts from Anne presented above, of the nurses who inspired her, are examples of the personal practice, clinical experience, knowledge and skill brought to patient interactions which Price and Walker (2007) have attributed to the craft of nursing practice. Most craft knowledge is accrued tacitly (Polanyi, 1967) because it has been acquired in specific and idiosyncratic contexts. Drawn from experience in the field and observable to others in the clinical setting, craft knowledge is described by Perry (2009) as being *'resident in the knowledge base'* of the exemplary practitioner. Although we do not know what the nurse said, how she said it or how she moved on the ward, the look and behaviour of this nurse made a significant impression on Anne. Anne observes the field manifestation of the nurse's attributes and goes on to express her aspiration to acquire the necessary capital and become a nurse with similar characteristics.

Anne refers to *'science'*, *'blood results'* and *'potassium'* almost as an embodied quality of the nurses informed by this powerful knowledge capital. The nurses' specific reference to *'potassium'* as a constituent of blood demonstrates their stronger epistemic relations to knowledge in contrast to the stronger social relations to knowledge of the HCA expressed by Anne as *'looking after the public'.* The epistemic quality of the nurses 'scientific' knowledge and its relatively high semantic density (serum potassium levels would be expressed as mmol/L) is a form of occupational capital that contributes to the nursing status in this field. Knowledge as

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occupational capital in the field is playing a role here in shaping habitus, informing actors' field position and thus their status.

In the final extract from Anne, we see how knowledge as occupational capital 'feeds' the habitus to enhance confidence in the field. Confidence itself, arising from knowledge acquisition, becomes a form of capital as it gives strength to the nursing habitus. Anne realises that confidence to act for the patient arising from epistemic knowledge was a motivating factor for her.

In this section, we have seen how the nursing habitus and knowledge capital may be observed in the healthcare field by HCAs to draw them towards nursing education. HCAs observe nurses and make inferences about their knowledge capital. Felstead and Springett (2016) found that nurses who role model 'professional' attributes have a powerful influence on others in the field and personal charisma in particular has been known as a motivating characteristic in role modelling since early work by Bucher and Stelling (1977).

The capital that informs and drives the nursing habitus comes from craft knowledge acquired in the field (Price and Walker, 2007) and from knowledge with stronger epistemic relations acquired during nursing education in HE. In role modelling of craft knowledge and epistemic knowledge, nursing habitus displays practical mastery or a 'feel for the game' in the field (Thomson, 2012) and may influence others in the field including HCAs who may wish to emulate this nursing habitus.

However, this role modelling of nursing behaviour and knowledge as nursing attributes may also contribute to the sense of frustration experienced by HCAs and contribute to their desire for increased responsibility as they compare their own significant knowledge acquired in the field and want to use this independently from nurses.

In the next section, the HCA role is referred to as both constraining and insufficient to meet individuals' needs for autonomy and authority in the field, with participants expressing the desire to move away from the HCA role.

7.3   Frustration with the limited role of the HCA

Frustrations with the limitations of the HCA role coupled with a desire for occupational independence and more responsibility were an identifiable category of motivation to become a nurse. This section starts with an extract (Adam) that reflects the general sentiments of those participants who have been registered nurses for several years and had been an HCA for several years before. In the extracts that follow (Lynn, Frances and Bertie), a desire for autonomy and status in the field also emerge as significant drivers for progression. The reasons and rationale differ but the underlying motivation for control is common. The final extract (Steve) illustrates the comparison that HCAs make between their knowledge and student nurses' knowledge when the latter are working alongside former HCAs during the clinical practice placements of the HE nursing course. Issues of valorisation of knowledge, status and power come into sharp focus.

Adam's sentiments below capture the essence of this coded category. The basic limitation of the HCA role is a primary 'push' factor for Adam to think about moving on to become a nurse. Adam had been an HCA for many years and without staff development there is no scope for progression from the boundaries of the HCA role.

> *"I'd reached a plateau… outgrown the job. I wasn't challenged any more. At HCA level you don't get the same opportunities (as nurses).*

In the following extract, Lynn's desire for the expanded role expressed by Adam is articulated in terms of authority and status.

> *"In recent years, I know I was becoming…. I wanted to do more…. to have more control… more power over how my patients' needs are met. I wanted the RN after my name. I didn't want people countersigning my actions"*

In the opening phrases, there is the sense that Lynn is expressing her own awareness of personal change and development, of starting to move towards nursing. The HCA role is both limited and limiting for Lynn. The restrictions of the HCA role need to be shed so that the nurse within can be

set free. Furthermore, Lynn is not deterred by the prospect of legal responsibility for patient care.

Similarly, for Frances, despite her relatively new experience as an HCA, having only been in the job for a few months, her motivation to become a nurse stems from a desire to have more power and autonomy for clinical decision-making. In the extract below, Frances describes a significant learning experience with a patient during her time as an HCA where a combination of personal development through learning on the job and desire for autonomy led to her decision to apply for nursing education.

> *"I was on the DSPD unit and the patient was incredibly difficult… his diagnosis was antisocial and narcissistic personality disorder with a really horrific index offence... I had to learn a completely new set of skills* (as an HCA) *to work with him and I learned so much about myself…. It was such an incredible experience but I could not have the lead … and I just thought, I want to do this but I want to have a bit more power… a bit more say, because I was not a qualified nurse…. Yeah, I wanted a bit more of a sure footing"*

In this extract, Frances describes a profound learning experience while working as an HCA on a Dangerous and Severe Personality Disorder (DSPD) unit. The challenges involved in working on such a unit are extreme and Frances indicates the specific difficulties associated with this particular patient.

Although there is no information on the training and support that may have been in place, I made the assumption that Frances would be working within a wider therapeutic team. The experience for Frances seems to have been life-changing in that it has contributed to her decision to progress to nursing education and state registration. Learning as an HCA is not limited to aspects of physical care. The knowledge arising from the challenging circumstances of this mentally ill patient has not only contributed to the development of new skills but greater self-awareness in the process. The evident desire for more influence indicates that the learning from this patient experience is not being fully operationalised while Frances remains an HCA. To gain knowledge acquired from higher education nursing would provide status and emancipation from the HCA role.

The link between the low status of the HCA position and a low-level of responsibility continues in the next extract. However, Bertie frames his desire for increased responsibility in terms of a life-course narrative. He has been an HCA for long enough.

> *"I didn't get any qualifications at school and I got to the age of about 22 and I thought… I really need to make something of myself now… I really need to push myself. No disrespect to the HCAs but I thought I don't want to be an HCA all the time… I want to better (myself), I want to be the next level up… I want to be in charge… I want to make these decisions… I want to have that responsibility"*

There is desire for progress and advancement. Motivation driven by aspiration for status, power and responsibility is clearly evident. Bertie cites three contributing factors to his decision; a perceived qualifications deficit, his age and his ambition for an enhanced identity. There is the sense that Bertie has discovered a world where he has an opportunity for personal development and greater autonomy.

However, Bertie is speaking from the standpoint of a registered nurse with several years' experience in the field. He reflects on certain key experiences and features of his life to create a narrative of personal triumph over negative prevailing circumstances. His use of galvanising language illustrates a resolve to move on from the role of HCA. Later in the interview, Bertie validates his sense of achievement by referring to denigrating personal comments made about him by school teachers earlier in his life.

> *"I remember when I was younger at school, some of the teachers saying… 'oh you'll be nothing! You'll be a nobody… I think back to then and then I look to now and I think…'there you go, I've proved everybody wrong'"*

Although Bertie previously offered his respect to the role of the HCA, the echoes of teachers' voices giving their prediction of his eventual status in life give us access to another significant aspect of his motivation. He has defied their predictions to become a registered nurse (and later a manager), both roles with significant status in the healthcare field.

In the next extract, Steve also refers to accrued knowledge from experiential learning. However, frustration emerges as he works alongside

final year undergraduate students and makes a comparison between their knowledge and his.

> *"… this is going to sound terrible but seeing the quality of some of the student nurses coming through… I thought… 'why don't you know that? You'll be qualifying soon'.. I felt like I was teaching them. I know I'm an HCA but you should still be able to teach me a few things. I began to think… 'I could do that'.. so yeah I got more vexed about it and started to think about doing my training"*

Central to this extract is the phrase *'I know I'm an HCA'.* What does Steve mean by this? Status issues are clearly operating here, status of position and status of knowledge. Steve is comparing his knowledge and expertise as an HCA with the knowledge of student nurses working on his unit (we can infer that the students are in the final year of their course because Steve refers to them as *'qualifying soon'*). So, this phrase could be interpreted as recognition and verbal acknowledgement that the HCA as support worker is at the lowest point in the healthcare infrastructure and therefore relatively unknowing. In other words, '*I know that I'm (only) an HCA'.*

It could also be interpreted as acknowledging the extent of practical knowledge that HCAs have as a consequence of many years' experience in healthcare. The next part of Steve's sentence seems to provide part of the answer. That student nurses '*should still be able to teach me a few things'* suggests the answer because the phrase is prefaced with *'but'* rather than with '*so'.* The use of *'but'* infers that Steve has an awareness of just how much he has learned as an HCA. There is also a sense of expectation that final year undergraduate nursing students would bring new knowledge to Steve's attention in the practice placement and disappointment when they do not. There is an element of shock and injustice that student nurses who are about to qualify and gain registration as a nurse do not have the knowledge of a (lowly) HCA, nor, in Steve's opinion, the knowledge required to operate as a nurse. The sense of injustice that permeates this extract is crystallised when Steve expresses his irritation at the situation and his growing motivation to embark on nursing education. What started in this short extract as an expression of embarrassment at 'whistleblowing' on an ineffective system ends with anger and a motivation to move on.

Discussion

The participant extracts presented and discussed in this section illustrate how HCAs feel that their role is limited by constraining factors operating within the field. There is a sense of momentum towards nursing education. Each participant extract reflects a different situation or set of circumstances. However, a common feature across the participant extracts is a desire for more autonomy, responsibility and power in the field. This could be said to arise from a growing disjuncture between the HCA role as it is defined by the employing organisation in each situation and the HCA habitus as it changes due to capital being accrued as field conditions change. A sense of purpose towards nursing education emerges in all the participant extracts.

Furthermore, working as an HCA may offer significant learning experiences and contribute to occupational capital. An individual's habitus is constantly changing as field conditions change i.e. there is reciprocal exchange between field and habitus. Capital, in this case occupational capital in the form of knowledge of the field, is constantly 'feeding' the habitus as HCAs live and work in their respective practice areas. Sometimes, as we have seen, HCAs actively seek out new knowledge to enhance their store of capital. This new capital then sits inside the HCA but may not be expressed due to the limitations of the HCA role within the field. The manifestation of the HCA habitus in the field may not reflect the full range of occupational capital accrued by the HCA over time.

HCAs and nurses make comparisons between actors in the field using knowledge as a measure of capital to denote status. With this process comes a sense of frustration as the role prescribed by the employer does not accommodate the changing habitus of the HCA arising from their enhanced capital. The term Bourdieu uses for the sense of discord arising from tension between the habitus and field is hysteresis (Grenfell, 2012, pp 126-131).

While Bourdieu uses the term hysteresis to explain the sense of breakdown between habitus and field experienced by people when a new set of field conditions is suddenly imposed, the concept also has value in situations where field conditions change, individuals (HCAs) may rise to that challenge, enhance their store of capital and feel the consequential effects

in their habitus. This disruption between habitus and field, experienced as hysteresis may provide opportunities for individuals to improve their field position or status. However, in the case of HCAs, this is limited to institutionally-based (field) opportunities for boundary transition from HCA to nurse mediated and effected by nursing education.

While the extracts used in this section differentially illustrate participants' frustration with the limited role of the HCA and desire for increased responsibility in terms of power, authority and status, the central concept to emerge from the interpretation of participant extracts is a growing sense of agency i.e. participants want to operate independently of the determining constraints of social structure (Calhoun, 2002). In the case of HCAs, these constraints are the limits placed on their role within the healthcare field.

However, agency is more than just the reaction against something or circumstances at a single point in time or place. There is a dynamic aspect to human agency which is not found in most theories (Emirbayer and Mische, 1998). Agency has a life course dimension with influences from the past, orientation towards the future and engagement with the present (Biesta and Tedder, 2007). We see influences from the past at work in Lynn's self-awareness of her change in perception at the prospect of becoming a nurse. Both the visibility and status of the RN credentials are an important statement of capital in the field for Lynn and in Bertie's references to unpleasant school experiences. Similarly, we see orientation to the future in Bertie's desire to 'better himself' and to Steve's thought that 'I could do that'. An example of engagement with the present occurs where Gillian acts in her current environment to enhance her knowledge capital.

Frances' store of occupational capital has increased considerably as a result of her HCA experience. However, Frances indicates that she does not have sufficient voice within the team on the DSPD unit, that the knowledge arising from her experience is inhibited and that she would need to gain state registration as a nurse to achieve greater input to the intervention strategy for patients. She has accrued powerful knowledge (occupational capital) which she is not able to express while she remains locked within the constraints of the HCA role.

In the next section, I describe how occupational attributes accrued by HCAs may be identified by managers as a 'latent-yet-emerging' nursing habitus.

7.4 Senior staff identify potential nursing attributes in the HCA

Two extracts are presented in this section to illustrate participants' spontaneous comments on being identified as having the attributes of a potential nurse. Participants spoke about being encouraged by a particular person to pursue nurse education and registration. As HCAs, they apparently demonstrated qualities and characteristics that were identified by senior staff in the practice setting as being commensurate with the role of registered nurse. While both extracts (Karen and Christine) illustrate the common feature of recognition by significant others, of attributes commensurate with nursing practice and an emerging nursing habitus, there is a separate and distinctive quality to the extract from Christine relating to anxiety about the academic demands of moving from the HCA subfield to the nursing subfield. This phenomenon is explored more fully in chapter 8, where participants describe their life at university.

For Karen, the identification of her potential to be a nurse came from a senior nurse in the field.

> *"the matron wanted me to do nurse training….. said I had the right attributes… nothing fazed me… I was confident in certain situations. You go in and find that people have obviously passed away, some of the younger HCAs took a few days to get back to normal"*

The evidence for these attributes is described by Karen as maturity and confidence when presented with seriously ill patients or a death at home. According to Karen these qualities were identified by the matron as valuable assets for nursing.

However, Christine, despite her confidence with the nature of the practical work involved in nursing and the practice development nurse (PDN) identifying her potential for nursing, was disinclined to apply for nursing education. Although the PDN expresses her incredulity, Christine explains her reluctance to apply as due to fear of the academic work that she anticipates on the route to nurse registration.

> *"the practice development nurse couldn't quite work out why I didn't want to push it any further…. I was scared… not scared of the work practically speaking but I was scared academically"*

At this time, Christine was working as an HCA and metaphorically 'looking over the fence' into nursing. The practical work involved is not a problem. She feels that her practical competence is sufficiently well developed to cope with the demands of the nursing role as she sees it. The issue for Christine is her expectation of the requirement for academic competence in nursing.

Discussion

The extracts in this section illustrate how powerful actors in the field may contribute to participants crossing the HCA-nursing boundary by spotting attributes deemed relevant to nursing. HCAs as social agents in the healthcare field demonstrate their potential for nursing through the manifestation of relevant capital accrued in the field. Although the literature is limited, what research there is does appear to support this phenomenon. Studies by Traynor et al (2015) and Waugh et al (2014) give credence to the notion that HCAs with the appropriate capital and emergent habitus are identified by powerful others in the field who can smooth the HCA passage to nursing education.

Only one study (Traynor et al, 2015) has examined potential nursing attributes in a group of healthcare support workers. Former HCAs had embarked on a 1-year university course leading to a certificate in higher education and subsequent employment as a nursing assistant practitioner. As in Waugh et al's (2014) study, most of these HCAs were handpicked by ward and clinical department managers as appropriate candidates for (advanced) assistant practitioner (AP) training.

There is no information about the meaning of 'appropriate' in the context of the Waugh et al study. However, given the routine close-proximity care provided by HCAs to patients, it can be inferred that there is something qualitatively different about HCAs who are identified as potential nurses. Interestingly, all participants in the Waugh et al study stated that they had usurped nurses as the carer closest to the patient, taking over nurses' core work. Their supervisors and managers had encouraged them to take up the AP training with many being singled out as particularly confident and ambitious. For Christine, this does not seem to be the case. While expressing confidence in the practical domain, i.e. social knowing informed by (profane) experiential knowledge, she anticipates stress in the move

from the HCA field position to the field position of nurse, as epistemic knower informed by (sacred) epistemic knowledge.

Participant extracts presented and discussed in this section have illustrated how relevant occupational capital may be imbued by HCAs working in the field and then identified by powerful agents who can influence the progression of the HCA to nursing. In the next section, participants anticipate the learning and knowledge that the HE course will bring. Some actively seek out learning opportunities in their clinical practice to enhance their store of capital in preparation for nursing higher education.

7.5   Knowledge seeking

The extracts in this section illustrate how participants talked about the prospect of learning in HE. First, Pauline and Elizabeth anticipate the knowledge acquisition and intellectual development of their forthcoming university nursing course. Then, Ruth and Gillian discuss seeking out learning opportunities in the clinical practice setting. The common feature of these extracts is a motivation to learn, a desire to increase and enhance their store of knowledge.

The first extract (Pauline) links with the sense of frustration separately identified as a motivating factor discussed earlier in this chapter. However, in contrast to Christine's sense of foreboding at the prospect of nursing higher education in the previous section, Pauline anticipates the knowledge that she will acquire on the course.

> *"I was limited within my role, so I was excited about all this new information I was going to learn"*

Similarly, Elizabeth is keen to progress and views the HE qualification as both a means to satisfy her need for knowledge and an expanded role as a nurse.

> *"I wasn't intellectually challenged in that role. I thought that getting the qualification, to have a career… would build that aspect of it."*

The lack of cognitive work as an HCA was clearly an issue for Elizabeth. The prospect of moving from the HCA role to the nursing role is attractive as the scope of knowledge within nursing was anticipated by Elizabeth to be advanced and widened.

In the next extract, Ruth recognises her own potential for nursing and uses learning opportunities close to hand to increase her knowledge i.e. the manifestation of occupational capital in her nursing colleague.

> *"I thought I could do a lot more than just cleaning and feeding… I wanted to do the next step. I started observing the nurse and how she managed the HCAs.. how she did the medication…. Why she was saying certain things"*

Ruth's sense of potential for nursing appears to be self-generated and results in a decision to actively engage with nursing activities, involving knowledge of drugs and the rationale for care. In observing her nursing colleague, Ruth attempts to identify some aspects of the specialist knowledge of nurses. She becomes a critical listener as she looks for a rationale for nursing practice.

> *"they were doing a saline drip… the medicine and the needle. They didn't actually tell me why they were doing it. They should start by saying … 'I'm going to do the saline drip because the patient is dehydrated' "*

This pro-active engagement with a learning opportunity in practice then extended into a critique of the way in which the nurse demonstrated a clinical procedure. Ruth is critical of the lack of rationale provided by the nurse for the saline drip. Although she previously acknowledged in the interview that there is time pressure in practice so nurses may have to exclusively focus on the technique being demonstrated, Ruth is critical of the lack of relevant information.

Motivation to learn is further illustrated in this extract from Gillian. There is a desire to enhance her standing with clients and hence her position and status in the field. Gillian is uncomfortable with what she sees as a lack of knowledge to fulfil her role as an effective carer.

> *"I would go into the treatment room while they dispensed medication and say…'so-and-so is on sodium valproate, what type of medication is that?'…I felt like it's a bit silly being on the ward and having service-users coming to you and saying…'I've got this side effect and I'm on this, this and this… what is it that's causing it?'… and I can't say that I don't know… if you don't make the effort to*

even have a basic knowledge …. then you lose a lot of credibility
because how can people feel confident in coming to talk to you?"

The personal motivation of HCAs to learn is illustrated in this extract where Gillian expresses her desire to know more about the indications and side effects of drugs being prescribed in the unit where she works. Her motivation is, in part, due to embarrassment at not being able to respond to service-users' questions about the nature and side effects of their medication. Despite this aspect of healthcare being beyond the remit of the HCA role, and the medication dispensary being 'off-limits', Gillian explains the need (as she sees it) to have a basic knowledge of pharmacology as an essential requirement for patient care. Her sense of worth on the ward is apparently at stake here as she elaborates on her relationship with patients as a key feature of her rationale.

Discussion

In this final section, I have shown how participants anticipate the boundary that is about to be crossed from HCA to university nursing student. There is a sense of excitement within some HCAs (Pauline) along with a sober expectation of intellectual development commensurate with the registered nursing role (Elizabeth). Participant extracts presented and interpreted in this section illustrate how these HCAs were keen to move on to learning at university for the new knowledge this would bring and to proactively learn in the clinical practice area as a preparation for nursing.

Unfortunately, classical theories of learning tend to overlook any sense of excitement and desire and qualitative studies on motivation for learning are minimal. Thirty years of research on motivation for learning have relied heavily on social-cognitive theories and quantitative methods such as questionnaires, survey and pseudo-experiments (Jenson, 2007). This is unsurprising perhaps, as motivation is a reflection of internal drives and is thus a psychological construct where quantitative methods hold sway.

The sociological construct of agency and a qualitative approach have more to offer in the context of this research. I have shown the effects of agency emerging from participant extracts in an earlier section of this chapter. In this section on knowledge seeking, Ruth and Gillian are shown as operating independently of potential constraints in social structure. These examples illustrate how actors use their environment to achieve their

agentic aims (Biesta and Tedder, 2007) i.e. agency is what people <u>do</u> in their current environment, and not something that people <u>have</u>. According to Biesta and Tedder, actors can (and do) act on their aims in the present, perhaps only minimally and with uncertain outcomes but in order to bring life to that aim. This understanding of agency is only possible if it is accepted that actors operate within a particular environment, a 'context-for-action' (Biesta and Tedder, 2007).

Knowledge is capital and therefore contributes to credibility and status in the field so it is unsurprising to hear of HCAs seeking out learning opportunities while in the field to enhance their store of capital in readiness for the HE course. Of course, these behaviours may also be observed by significant others as evidence of an HCA who has a potential nursing habitus. In all this, a context for action (Biesta and Tedder, 2007) is necessary for the 'frustrated' habitus to engage with opportunities for enhancement of capital. Ruth decided to shadow a particular nurse to learn from her in clinical practice (offering a critique at the same time!) while Gillian entered the medicine dispensary to ask questions on pharmacology. Both seek epistemic knowledge as a rationale for clinical practice.

In Ruth's' opinion, being shown the practical steps on how to assemble a saline drip is not enough. The associated knowledge (with stronger epistemic relations) is required. Gillian enters the medication dispensary, a separate clinical area that usually is limited to registered nurses and thus is laden with symbolic capital and associated status. In wanting to know more about the side-effects of a particular medication, Gillian is attempting to extend her HCA sub-field relationship with patients as social knower (strong social relations to knowledge) into the nursing subfield relationship with patients as epistemic knower (stronger epistemic relations to knowledge). Medicine administration is a nursing responsibility in clinical practice. It has significant symbolic value within the field due to its stronger epistemic relationships to knowledge. Gillian crosses both a physical boundary in the field by entering the treatment room and a legitimation device boundary by seeking knowledge with stronger epistemic relations.

7.6   Summary

The role of knowledge as capital in the field of healthcare has been explored in this chapter. HCAs learn during their work and develop a social

knowing perspective arising from close-proximity patient care. HCAs may also develop an epistemic knowing perspective arising from patient assessments and discrete learning opportunities with nurses. Both these forms of knowledge feed the habitus and develop confidence in the HCA. However, the structure of the field and occupational boundary work by nurses, may limit the expression and operationalisation of this knowledge. Furthermore, although HCAs learn a great deal in their role and the malleability of the habitus can be seen, hysteresis due to tension between field conditions and habitus is also a potential consequence. This may motivate the HCA to seek out nursing as a role where their knowledge may be more fully operationalised.

Although we have seen in the previous chapter that occupational boundary work by nurses may inhibit the expression of HCA knowledge in the field, equally some HCAs are spotted by senior staff as having appropriate attributes for nursing. Their knowledge capital is visible and a nurse or manager who sees this capital emerge in the HCA habitus is effectively saying "you can be like me". For some HCAs, their observations of nurses in practice are an important motivating factor. Seeing and hearing epistemic knowledge being used by nurses is a significant draw.

Some former HCAs fear the academic environment of HE and this may inhibit their application and progression despite having accumulated significant knowledge capital, both social and epistemic. Other former HCAs eagerly anticipate the new knowledge that HE will bring. Once a decision has been made to aim for nursing registration, HCAs may actively seek out learning opportunities in practice to enhance their store of knowledge capital before entering HE.

The next chapter presents findings on participants experiences as they approach HE and during their time in HE. How do participants describe the HE learning environment and their response to it? This is the chapter where knowledge and the status of knowledge come into sharper focus. Former HCAs are moving from the HC field where their role has mainly required a social knowing perspective. Participants may have been exposed to and acquired epistemic knowledge but, once in HE, the social landscape and culture change dramatically. Participants are moving from the profane world of bedside care to the sacred world of the university classroom.

Chapter 8 From HCA to HE: becoming and being a student nurse

8.1   Introduction

The previous chapter examined former HCAs' motivation to become a nurse i.e. the factors involved in their decision to move from the role of HCA to that of nurse. However, the process of transition from the world of the HCA to the world of the registered nurse involves three years at university. To register as a nurse with the Nursing and Midwifery Council (and gain subsequent employment as a nurse) requires an appropriate HE qualification and evidence of competence in patient care acquired though parallel apprenticeship activities in approved clinical settings (wards, clinics, community) (Nursing and Midwifery Council, 2010)

The purpose of the current chapter is to present and discuss relevant extracts to illustrate themes arising from how participants described the time when they approached university and their time as a student at university. In doing so, participants described the lived experience of moving from the world of the HCA in clinical practice to the world of the university student.

The chapter is presented in sections relating to the categories arising from the coding process (see methodology chapter for details).

The chapter is divided into two major sections;

- Approaching university
- Life at university

Each of these major sections is divided into three parts. The section on Approaching University comprises anticipation, perception and preparation. We hear how the reputation of the university and early experiences on the university selection day influence what participants say as they anticipate a relatively alien landscape i.e. the field of HE. Participants' perception of university before and during entry to the field bring issues of cultural capital as forms of knowledge and the doxa of HE into the picture. Friction between habitus and perceptions of doxa of the field produces hysteresis for most participants. Attempts to ameliorate hysteresis through exposure to epistemic knowledge before entry to the field has some success.

The section on Life at University comprises; challenges, responses and outcomes.

For each subsection, participant extracts representative of the coded categories are presented and interpreted in relation to their contribution in illustrating the relevant category. Issues arising from the interpretation are discussed at the end of each subsection in the light of relevant literature.

8.2 Approaching university: anticipation, perception and preparation

Extracts presented in this section illustrate the range of experiences, issues and concerns expressed by participants as they approached the commencement of their university course and during the early part of the HE experience. There are three parts to this section. Participant extracts are used to illustrate

- anticipation of university
- perception of higher education before and after entry
- preparation for the university course.

Anticipation of university

In this part of the section, I present the contrasting perspectives from Adam and Maggie as they anticipate HE from a distance on the reputations of their respective universities and the age-profile of the incumbent student population. Although Adam's transition experience to university was several years before Maggie's, they were both mature students at the time of entry. Both HCAs consider their futures on a three-year university programme and convey differing levels of confidence arising from their early experiences at the interview and on selection day. The combination of institutional reputation and age-profile of their anticipated student peer group prompt completely different comments from the former HCAs as they stand on the threshold of higher education.

For Maggie, the prospect of joining a group of students of a similar age, combined with the anticipation of institutional support for mature students gives her a sense of pleasure and confidence that this important decision was a good one:

> *"based on the interview that I had here … as opposed to* [name of different university] *a completely different set up…. I was very pleased that I got here… they're very supportive of mature students at this university… that made me more confident"*

Maggie describes an informed decision, based on comparison of two universities. Although she does not explicitly state it, the inference is that the alternative university was not supportive of mature students, or at least gave this impression to Maggie's.

However, for Adam, the reverse is the case. His comments are laden with doubt and anxiety. Adam's experience at this pivotal moment is in complete contrast to Maggie.

> *"I found it all a bit daunting... there were a lot of people younger than me…. am I in the right place? I did find the whole thing a bit overwhelming… I had this academia issue in my head.. can I complete this? The huge reputation that* [name of university] *had.. a centre of excellence!"*

The combination of institutional reputation as a centre of excellence and the age-profile of the students produced stress for Adam before he even begun the course.

While Adam's and Maggie's comments reflect their perceptions just before entry, the next part of this section presents participant extracts which illustrate the contrast between expectations and the reality of early life at university.

Perception of higher education before and after entry

The extracts presented in this part of the section on Approaching University illustrate a range of perceptions of the university as an institution and the learning environment of HE. Each of the following three participants (Karen, Bertie, Christine) express shock that their expectations of the course and their previous perception of university do not match their lived experience. The final extract presents a contrasting perspective. Gillian is disappointed that the course does not match her expectations.

In the first extract, Karen confesses a slightly frivolous and dismissive attitude before starting the UG course, followed by shock at the reality of the difference between the NVQ apprenticeship and the demands of HE:

> "I thought it was just going to be like the NVQ3 … a few little scenarios. Part of me thought …'it can't be that hard'… I did take more of a flippant approach… but I never had any idea… this critical thinking and analytical writing and references… all of this came as a complete culture shock!"

Karen's expectation was that the HE course would be similar to her NVQ experience i.e. a task-based, competency approach to learning. The academic demands of HE have brought an abrupt reorientation to what is actually expected of her. This naïve approach to the university course is seen again in the following extract. However, in this case the participant (Bertie) reflects on the learning process as well as the institution. While Karen refers to her NVQ experience, Bertie has his childhood school days in mind:

> "I expected it to run like an adult [version of] school… but it was very different….we'll signpost you in the right direction which way the information is and you can go and learn it! I was petrified… I was thinking… 'what? You're not going to give me everything? You're not going to teach me everything?'... it was a bit of a shock to the system… never had to do this before… it's never been on my head… that I have to learn it myself…"

For Bertie, the reference point is his early experience of compulsory education rather than an NVQ or similar training during his working life as an HCA. The perception is that the institution would 'serve up' everything he needed to succeed as an UG student in a similar way to his earlier experience of learning as a pupil at school. That this is not the case, is more than a revelation. It presents a huge and fearful challenge for Bertie.

In the next extract, however, we see mention of the future potential challenge of HE combined with some self-appraisal. Christine's struggle to succeed with a BTEC diploma delayed her decision to apply for nursing. Although we have no indication whether Christine has proactively investigated the academic demands of the university course to compare with her BTEC experience, there is an awareness (and fear) that the

university nursing course will require development of academic skills that may be beyond her reach:

> *"It probably took me about a year before I decided, I do actually want to be a nurse. What was holding me back? … I didn't think that I was able to do it… I thought I could never do this… I've never been academically minded really… I got through my BTEC diplomas because I <u>just</u> got through them!... [laughter] and I didn't think that I could get any further…I was scared, academically scared"*

Furthermore, although Christine's comments are mainly about herself, there is an emerging sense of the difference between vocational education and higher education in this extract. The juxtaposition of Christine's reference to her lack of '*academic mindedness'* and scraping through the BTEC diploma hints at an awareness that the university course will be more 'academic' than the (vocational) BTEC diploma.

In contrast to the previous three participants, in the following extract Gillian anticipates a demanding university nursing course only to be disappointed that it repeats what she has already learned as an HCA.

> *"I was expecting it to be really intensive … the way that some nurses have been so over-protective of their qualifications, I expected it to be very difficult* [but] *going over stuff I already knew… I don't think that I am any further forward now than I was when I started the course".*

A potential explanation for the disappointment expressed here by Gillian is that, as a graduate, she has previous experience of the learning culture of HE. However, Gillian does not refer to this, instead referring to her recollection of nurses guarding their status by using their qualifications as a status symbol. Implicit in this extract is a sense of 'so now I am here, what is the big deal about the university nursing qualification?'

Preparation for the course

The four extracts presented in this part (Jenny, Karen, Ruth, Olive) on Approaching University illustrate participants' experiences of preparation for the university course. Many participants referred to an Access (to HE) course as a valuable pre-cursor to their university nursing course.

Jenny's situation is typical of many students entering university for nursing. Jenny's extract reflects a concern that many students have, both before and during their nursing course, that their previous education has little or no bioscience and there is an expectation that this subject will be a necessary and significant feature in the UG preparation for registered nursing.

> *"Unfortunately, my background before wasn't anything science oriented … I went out of my way to study to understand it …so when I came in here with my Access biology it helps me with the parts of the body and the systems, how it functions…"*

Jenny's use of 'unfortunately' indicates a sense of regret that she lacks a science preparation and an awareness that this could be a potential problem. However, she made a conscious decision to be ready for HE by taking an Access course and her investment paid off. Jenny's Access experience appears to have benefited her at least with the bioscience component.

In the next extract, Karen goes as far to declare that an Access course or similar should be made a pre-requisite by universities for the UG nursing course. She reports that many of her student colleagues had taken an Access course before entry to university and therefore had essential prior knowledge. Bioscience emerges again in this extract for special mention.

> *" a lot of the girls did Access to nursing which is phenomenal!… they seem to sit there and know it… it's like a foundation… whereas I came in not having a clue what a blinking cell was! I think they should not let anyone do this course* [university degree] *unless they've got that background because it does really help…"*

Cell biology is frequently the first topic to be covered in the bioscience element of most UG nursing courses and Karen feels excluded due to lack of knowledge. Her frustration and embarrassment that fellow students were comfortable with this while she was ignorant leads to a declaration that universities should create a level playing field by making Access a prerequisite for entry.

Essentially, Jenny and Karen are saying that intending HE students need to go out of their way to prepare for HE nursing. However, the personal cost of taking an Access course before the UG nursing course is an important

issue for applicants. Ruth's extract below illustrates the commitment and determination of some HCAs to maximise their chance of success at the selection stage and to prepare for the UG course.

> *I pursued an Access course… to get into university... it was hard because you're working and you're studying… it is extremely demanding"*

Ruth's use of 'pursue' is significant as it indicates a sense of sacrifice and persistence despite the difficulties of combining work and study.

While Access to Higher Education offered by community colleges is the preparation most frequently referred to, there are alternatives to Access preparation for HE and Olive's extract below illustrates this. Olive's experience with the Open University (OU) is in the context of her employment as a receptionist at the local health centre and GP practice. Although Olive had not yet decided to apply for nursing at this point, and had considered *"English literature or something like that",* she opted for a health-related OU short course because she thought this would be more valuable in her employment.

> *"The first one I did was the* [Open University short course] *molecules, medicines and drugs… a lot of the students are struggling with just the terminology and the basic dynamics of pharmacology… and I just sit there and it's like a refresher course and I just think…this is great! I do actually understand what you're saying!"*

Olive is very affirming of the value of preparation as she extols this preliminary learning. Consequently, once at university, unlike her student colleagues she is familiar with the specialist language and the underpinning concepts of this difficult topic.

Discussion

Interpretation of extracts in this first section of the chapter illustrate how cultural capital in the form of qualifications, previous education experience, forms of knowledge and the doxa of fields, interact with and may produce hysteresis in participants as they approach a new life at university.

In the first part of this section, participants talk about their *anticipation* of making the transition to university. Participants look at the early and visible manifestation of the conditions operating in the HE field. Adam's reaction to his approaching entry to university can be interpreted as hysteresis even before he enters the field. He recognises the academic reputation of the university, the impending environment of epistemic knowledge imbued within the field and senses that he does not have the necessary attributes (cultural capital) to succeed or even survive! In contrast to Adam there is no detectable hysteresis in Maggie's account. She knows there is support for mature students. Whatever the field conditions she encounters, there are resources from within the field to reduce any hysteresis she may subsequently experience.

In the second part of this section, as participants describe their *perception* of HE before entry and compare this with their reflections on their lived experience of the field, the role of qualifications, forms of knowledge and experience of independent learning emerge as important contributions to the cultural capital resource of participants. Karen and Bertie exhibit hysteresis due to lack of appropriate cultural capital for comfort in the field, Christine indicates some awareness of the field conditions and delays her entry while Gillian exhibits no hysteresis as she has previous experience of the HE field. Furthermore, and in contrast to other participants, Gillian is critical of nurses during her time in the health care field for using knowledge practices originating in HE to enhance their symbolic capital and maintain their status boundary with HCAs .

Karen displays an element of naivety as she approaches the field and subsequently exhibits hysteresis due to lack of appropriate cultural capital. NVQ and BTEC qualification credentials are more strongly classified and framed in terms of social relations to knowledge, they have weaker classification and framing of epistemic knowledge. Bertie's sense of hysteresis arises from his lack of cultural capital in both understanding and meeting the requirements of the HE field doxa of the educational process, i.e. independent learning and prioritisation of knowledge.

However, Christine appears to be aware of the doxa of the HE field i.e. that her BTEC qualification and previous education would not provide her with the appropriate cultural capital for success. Her 'anticipatory' hysteresis

inhibited her entry to HE until such time as she felt ready to embark on the move into what was, for her, an alien field.

In contrast to Karen, Christine and Bertie who have no previous experience of the HE field, Gillian comes to nurse education as a post graduate student and therefore with awareness of the doxa of the HE field. Not only does Gillian not experience hysteresis as a result of culture shock arising from the doxa of the HE field, she refers to the use of knowledge practices by nurses in their performance of occupational boundary work with HCAs. She came to the HE field with an expectation that nurses' language of legitimation that she previously experienced as an HCA would be borne out by a university course that matched the language of legitimation within nurses' knowledge practices. Instead, she finds that this is not the case. The HE course is not as demanding as nurses had indicated.

In the third, and final, part of this section, where participants talk about their *preparation* for the HE field, (or lack of preparation), the role of forms of knowledge as significant cultural capital emerges. Participants recognise the epistemic knowledge requirements of the field and endeavour to remedy their perceived lack of this capital resource. Of the four participant extracts considered in this part of the section, three have anticipated the requirement of HE for epistemic knowledge (Jenny, Ruth, Olive) while one (Karen) comes to this realisation only when she experienced hysteresis arising from lack of cultural capital in the HE field.

Jenny is aware that she needs the epistemic knowledge of bioscience before entering the field. UK health care discourse is largely predicated on biomedicine and Jenny has realised this. Similarly, Ruth seeks out the knowledge and skills of an Access course that will furnish her with the appropriate attributes for success in HE. The combination of epistemic relations to knowledge, strong classification and framing, and the semantic density of the terms within the phrase *'molecules, medicines and drugs'* has huge cultural capital value for Olive. There is no hysteresis here. Olive's attributes are in alignment with the field doxa of HE nursing and she is able to relax.

In contrast, Karen observes the capital attributes of her colleagues in the evident epistemic knowledge arising from their Access course experience.

The term *'cell'* has epistemic significance and strong semantic density. Her expression of hysteresis is therefore unsurprising.

8.3   The university experience: challenges, responses and outcomes

Extracts presented and discussed in this section illustrate several challenges for participants during their HE experience and their actions to deal with these challenges. Although many of these are typical of the issues faced by other groups of students during their higher education, these former HCAs offer their unique perspective on the transition to HE. The section also presents participants' reflections on the outcomes for them of the university experience.

There are three parts to this section. Participant extracts are used to illustrate

- the challenges of university
- response to the challenges
- some outcomes of the university experience.

Challenges of university

Five discrete areas of challenge were identified by participants and are represented in the extracts which follow. These challenges are:

- academic demands of the course
- language and writing
- the learning culture of HE
- tension between practicing care and managing care
- what counts as knowledge?

Each of these challenges are presented and discussed in sub-sections below.

Challenge: Academic demands of the course
In the first part of this section, extracts from Elizabeth and Ruth illustrate how participants talked about the academic demands of the HE course as a significant challenge for former HCAs. Elizabeth recalls student colleagues who left the programme due to academic failure:

> *"They* [former HCAs] *had general on-the-job experience over a number of years… altogether half of them dropped out… it was the demands of the course … the academic requirement of the assignments… it was full on… I think for people who hadn't done that* [before] *it could be quite a challenge".*

Elizabeth identifies these former HCAs as entering university with healthcare experience but leaving due to no academic preparation. Although Elizabeth does not mention in this extract the potential role of the university in ameliorating this situation for former HCAs by offering appropriate support for such students, later in the interview she indicated that the university could have done more for vulnerable students.

In the next extract, Ruth identifies a similar challenge for former HCAs who entered university without the benefit of an Access course preparation. However, in this case the university is providing early academic support in an endeavour to bring all students to a point where they can engage with an essay. Although Ruth has herself previously benefitted from preparation on an Access course, she is still highly appreciative of this strategy by the university:

> *" … there's a lot of HCAs* [without Access] *… they* haven't *got the writing ability as yet so they're* [university] *trying to build everyone up to the same level and then we can start doing that essay…they're going through everything so everyone's got an equal* [chance]*… there's a lot of support… I'm really happy with the way they're doing things."*

This difference in the experience of Elizabeth and Ruth may be due to the passage of time between their respective HE experiences. Ruth was a current UG in year one while Elizabeth had completed her nursing course several years earlier. However, this difference in their experience may be attributable to their respective HE institutions. Elizabeth attended a Russel group university where the institutional expectation is that students arrive in a state of academic readiness. In contrast, Ruth attended a post-1992 university, known for their support of a wider constituency of UG students.

Challenge: Language and writing

The risk of failure seems ever-present. In the next two extracts, Maggie and Bertie describe their struggle with writing in a style deemed appropriate by the university. Maggie had previously worked as a journalist and expected her experience to help meet HE requirements. A sense of vulnerability emerges as she realises that she may not be able to meet the requirements. Maggie identifies and describes sources of pressure and injustice arising from her early experience of HE.

> *"When I started here that was a big, big shock… big shock! I thought I was a confident writer* [as a former journalist] *but that proved not to be the case. It's a huge amount of pressure… knowing that you could be thrown out at any time, having given up your career, your paid job"*

Maggie refers to loss of employment and the income that goes with it as the sacrifice that she has made to become a nurse. In doing so, Maggie seems to be portraying the university as an impediment to what might otherwise be a relatively smooth process of transition to registered nurse status. We have a sense of the 'imposter-syndrome' at work here as Maggie describes how she erroneously thought that her previous experience would stand her in good stead. While Maggie describes her experience right now as an UG student, Bertie echoes this sentiment from a distance of several years. He recollects a singularly stressful episode when success in an exam depended on his use of an appropriate form of language. Bertie describes how close he came to leaving the HE course due to similar difficulties with language and writing:

> *"I really had to work hard because of the terminology … you had to write in a particular way and use certain words… for instance I used the word 'contribute' instead of 'determine'…I had to repeat the exam… that was one of the most stressful periods at university. I'll never forget the relief when I got the pass mark!"*

Challenge: The learning culture of HE

That the university learning culture represents an alien landscape for former HCAs is illustrated in the next two extracts. Both Olive and Steve articulate the requirement for independent learning in HE. However,

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whereas Olive has accepted this approach as an integral part of the learning culture of HE, Steve is distinctly challenged by the lack of didactic teaching.

> *"I struggle with being at university. A lot of the time it's quite frustrating. They* [other students] *seem to need to be spoon-fed quite a lot. I don't think they've quite grasped what university is meant to be. In university learning you get a lecturer to give you the basics, or an idea of what you need to read around, to go away and read around it, to develop your own education and knowledge. It does help if you read proper sort of nursing and medical journals and articles. You do get an idea of sort of how to speak, 'cos it is a different language and it is a different way of constructing sentences. They do expect it to be like school still and we never had any explanation in the first few weeks of what university teaching is and what is expected. So, I think it's a bit of a shock for some people" (Olive)*

Olive's struggle with university is a combination of irritation with the inability of her student colleagues to understand that they are now in a new educational landscape and a sense of disappointment with the university for not setting out exactly what the students could anticipate at university and how to develop the appropriate skills. The reference to 'spoon-feeding' and the students' expectation that university is an extension of school life is particularly telling here. Although Olive herself is a first-year undergraduate student and therefore a novice, with no previous experience of higher education, she is able to contrast her own understanding of the university's expectations with what she asserts are the naïve perceptions of her colleagues. There is an unambiguous acknowledgement that the university provides the framework and direction for learning and the student needs to proactively build upon this to progress.

Olive offers her own rationale for this approach to learning by the university and the value of the HE process to the student in terms of providing a model of '*how to speak*' and write in the university. It seems that students need to a) recognise that it (university) uses a different language and b) to know how to speak this language. Olive elaborates on this issue by discriminating between '*proper nursing and medical journals'* and, by

implication, those sources that are not 'proper'. There is an element of self-realisation of how to learn in HE arising from a position of a former OU students. Olive concludes this extract by mitigating her earlier judgement of student colleagues' shock response to the learning culture of HE. How can they know how to learn in HE if the university has not provided an explanation of the university's expectation of its undergraduate students?

In contrast to Olive's recognition of the value of independent learning in HE, there is a sense of cynicism and disillusionment with this approach in the next extract from Steve; cynicism with a system that requires people to attend HE to reach qualified nurse status along with the disillusionment with the educational reality of being a student:

> *"It was like self-directed learning and I thought, I'm not sure if I like this… I felt like I wanted to be taught, like… but it was learning yourself sort of thing… after a while, I kept thinking, I could just not bother doing the training, I could just look through the books and carry on doing what I'm doing* [as an HCA]… [Laughter]*… I was just getting the recognition of being a student and that's the way to qualify as a nurse… it felt like I hadn't been taught and I was teaching myself and just trying to learn as I went along". (Steve)*

The self-directed learning of HE is clearly a challenge because of Steve's expectation that the university would 'teach' him how to be a nurse. As Steve compares his life as a student nurse with his previous life as an HCA, he concludes that there was not much difference for him, he could have carried on as an inquisitive HCA, observing phenomena and learning from them. However, there were clear boundaries between the practice domains of the HCA, the nurse and the doctor in his previous practice setting (ICU and HDU) and, although he acknowledges that there is a difference between HCAs and nurses, he feels that it is the responsibility of the university to teach him. Learning for this student nurse in HE is the responsibility of the individual in much the same way as when he was a self-motivated HCA, frequently asking questions of medics and referring to pathophysiology texts. The label of 'university student' has given Steve the recognition for what he was doing anyway, solving his own learning problems while in practice as an HCA.

Challenge: Tension between practising care and managing care

The next two extracts (Karen and Lynn) illustrate differences in participant views of their preparation for nursing and tensions between direct patient care and management of care. In the first extract, Karen reflects on the difference between her experience of the comfort zone of her part-time HCA employment and the discomfort of university life:

> *"I'm not enjoying my second year at all … how hard it is… when I work at the weekends and as soon as I get my list and I'm back in my patients' houses… then I'm happy… but to get where I want to be, I've got to get through this pain barrier of uni…they leave you to self-direct which I think is mean but I can understand it… because you can't be carried as a nurse… you've got to make decisions and stand on your own two feet…"*

Karen looks back to her previous life as an HCA and, similar to Steve, expresses a sense of abandonment by HE. However, unlike Steve, Karen indicates her understanding of the rationale for self-directed learning. She looks forward to her future as a nurse and the responsibilities of the independent nursing role that require thinking for yourself. Despite the difficulties associated with university, this is a necessary path for Karen to reach her destination.

Lynn, however, offers a cautionary voice to the tension between practice and management. She views the HE preparation for nursing as a means to separate nurses from their original and true role:

> *"It's frightening because… the teaching sessions… it's all about management of patients and I find that maybe the nurse training is at fault here. They're teaching us to become managers … it's neglecting the fact that you're a nurse. I think that could be contributing to the attitudes on the wards about health care assistants do basic nursing care and nurses just manage".*

Lynn's use of language as she refers to roles of HCAs and nurses in practice indicates the value she places on each. According to Lynn, HE has its priorities wrong. The university course needs to be more focused on direct patient care rather than ('just') nursing management. Apparently, the division of labour in care settings and the associated responsibilities are

due to the HE nursing curriculum. However, now she understands that the attitudes of nurses to HCAs she previously experienced are due to HE teaching students how to be managers of care rather than practitioners of care. While Lynn acknowledges that management is a feature of healthcare, she emphasises that this is not the primary role of the nurse.

Challenge: what counts as knowledge?

The final participant extracts (Olive and Frances) in this section further illustrate the difficulties experienced by HCAs during HE. There are clear tensions for former HCAs between skills developed while working in health care practice and the evidence underpinning these skills in an HE setting. In the extract below, Olive refers to the development of communication skills as a natural part of everyday life. Also, her use of the word *'somehow'* indicates a lack of awareness of what she has learned during her years working as an HCA. Furthermore, her disparaging comment about the role of HE in development of communication skills adds to this lack of awareness and lack of respect for the HE process. There is a contrast here between the high value she places on previous learning of OU pharmacology while a receptionist at a health centre and the communication skills learned experientially during this time. A sense of 'anti-intellectualism' emerges as Olive relegates the development of communication skills to 'common-sense' knowledge. The word *'anyway'* appears twice in quick succession, indicating a 'taken-for-granted' and dismissive attitude. Laughter at the conclusion of the extract indicates a release of tension for Olive as she challenges the university for having communication skills in the HE curriculum and the time devoted to it.

> *".. you can develop communication skills anyway while you're out on placement… I think you develop those throughout your life anyway… which is probably why being an HCA or just working in the public sector somehow helps… speaking to different people from different backgrounds… they* [university] *like to do the communications skills for weeks on end… they think they can teach people common sense in a classroom… I don't think you can…*(laughter).

In the next extract, Frances also contrasts experiential learning from healthcare practice with the theoretical content of the university course. The example she uses is dramatic but serves well to illustrate her point:

 "You don't need to know some of these things to be a good nurse. I think that if you are in front of a psychotic patient who is effing and blinding and is about to punch you on the nose. Saying… 'did you know that the amygdala and the whatever, is making you do this?' That doesn't matter. What matters right then and there is something that you can give them to calm them down to make them be okay… And that's not scientific, that's something on another level which….. I've nowhere near mastered but I know a bit about".

For Frances, knowing the neurological origin of aggressive behaviour is unnecessary when facing a violent patient. Of course, it is pointless to attempt to explain to a psychotic patient that a certain part of their brain way may be contributing to their aggressive behaviour. It serves no useful purpose and may even enflame the situation further. The point for Frances seems to be that this piece of information is an example of unnecessary academic knowledge. She does not explicitly attribute this knowledge to her university course but it seems likely that this is the case given the context of her argument. Her inference is that the university course is providing irrelevant knowledge when what is needed in the heat of the situation is an intervention that will work to reduce the aggression.
This knowledge may be part of the thinking of an 'academic' nurse but for Frances it is irrelevant knowledge for nurses grounded in the reality of practice. Dealing with the immediate threat of the situation is the primary concern for Frances and, by inference, all right-thinking (*'good'*) nurses.

Frances rejects this knowledge as unnecessary for effective nursing in this situation *('you don't need to know some of these things to be a good nurse').* At this critical moment, the essential requirement is an intervention strategy for an aggressive psychotic patient that will immediately calm the situation. While it is true that this obscure brain structure does form a part of the neurobiological basis of aggression and violence, knowing this does not offer a practical solution to the immediate problem. Although the pharmacological intervention that Frances refers to would be mediated by receptors within the amygdala, proficiency in practice skills is more

important for Frances than the theoretical underpinning knowledge. Frances is making a distinction between science and artistry in healthcare practice. There is almost a mysterious quality to the practitioner skills that cannot be taught and the essential quality of a 'good nurse' is not the epistemic knowledge of psychobiology but the intuitive and tacit social knowing that comes from experience in the field.

Response to the challenges

Three extracts (Anne, Bertie, Brenda) are presented and discussed in this section to illustrate the main findings. Despite the range of challenges that participants identified in the previous section, forming an HCA support group was the major response of participants to life at university. The findings show that there are two broad reasons for this. HCAs have a shared experience of a previous life in the NHS and the opportunity for support, guidance and sharing resources.

In the first extract below, Anne describes how former HCAs could assist each other with their HE experience from a position of a shared identity. Anne's use of language is not neutral here. Implicit in the phrase *'what we are all going through'* is a sense that the course and/or the institution was arduous. Although Anne does not refer to this phenomenon as group counselling, it seems there was comfort to be found in the presence of other former HCAs and a shared resource.

> *"…you tended to form more of an alliance with other HCAs… because there was an understanding of what we were all going through… you tended to get a lot of learning from the healthcare assistants…"*

In the next extract, Bertie also cites the value of mutual support through group work because he and his HCA colleagues were in unfamiliar territory. There is a willingness to collaborate until they are confident.

> *"some of us hadn't been in a learning environment for quite a while. We would study together… work as a unit…until we got the hang of being able to do it ourselves…"*

Brenda and her HCA colleagues give an additional validation of why they have formed an alliance.

> *"We calculated one day how many years' experience we had in the NHS and it was something astronomical!"*

The extract conveys a sense of insecurity as the HCAs attempt to counter the intimidation they feel by being in the university. We can imagine the scene as the former HCAs discuss how *'You (the university) may have all that, but we have all this! (years' experience)'.*

Some outcomes of the university experience

Seven extracts are presented and discussed in this section to illustrate the main findings. Four participants (Bertie, Brenda, Anne, Adam), who had completed an HE course and worked as registered nurses for several years, identified and described outcomes of independent thinking, evidence for practice, formal writing skills and reflection in practice. Three participants (Lynn, Frances, Gillian), who were currently on an UG course identified similar outcomes. However, there were also some comments about lack of meaningful progress from participants who were currently taking an UG course.

> *"I sometimes, ignorantly used to think, the only thing you do differently when you qualify as a nurse is give medication… once I was at uni into the second year… I started to look at the role a whole lot differently. It changed my look on things… I kind of grew up and I kind of understood that it is making me aware of the responsibility I'm going to have…., it's serious you know, you need to learn stuff. I just think that with the higher education… you need to do a lot more reading ….and research yourself… you learn more that way …because it's not given to you up on a PowerPoint"* (Bertie)

In this extract, Bertie describes how the HE experience is a catalyst for change and how a more critical view of the difference between the nurse and the HCA emerged as a result of being in HE. On entering HE, Bertie had a self-declared lack of awareness of the nurse's full role and how HE contributes to the preparation for nursing practice. A faulty belief about the

singular difference between HCAs and nurses in giving patient medication illustrates this gap in his understanding. Bertie previously believed that the only difference that being a registered nurse with an HE qualification made was to legitimate and provide the authority to give medication.

It is not until the start of year 2, when the foundation programme (Level 4) gives way to the Diploma (Level 5) course, characterised by application of knowledge and analysis that Bertie starts to realise the full and wider role of the nurse. Awareness of change occurring and an anticipated shift to the impending responsibility of the full nursing role as a result of the HE course is expressed using the metaphor of 'growing up'. The seriousness of the enterprise in terms of the responsibility and having to learn 'stuff' reflects a self-declared changing attitude. This responsibility for learning is elaborated upon as a requirement and stimulus to read more and to research. At first, this appears to have an instrumental quality as it is expressed simply in terms of passing the course. However, there is also a rejection of the notion of the student as passive consumer of the education process epitomised by the PowerPoint presentation. The value of the HE experience is in the encouragement of independent 'detective' activity for location of what the student needs and the enhanced learning arising from this. The requirement, compulsion even, to locate the information and learn from it is identified by Bertie as the way in which HE encourages change in cognition.

In the following extract, Brenda also identifies a significant change in her thinking and attitude as a result of the HE experience. However, this is illustrated by reference to the knowledge required for healthcare practice.

> *I think it's given me that evidence base in the sense of… You know, I don't quite trust or agree with things unless I see the evidence for it, and I never used to think like that… I was a complementary therapist and I was just like, well it works!…* [Laughter]*… I know it works, I can see people (who) tell me it works* [spoken ironically]*… I've moved from that completely which has been a bit strange because I hang out with a lot of people who are osteopaths and homoeopaths… 'Well you know, we need to go on evidence don't we?'* [spoken sarcastically] *I was never like that, so it has changed my thinking a lot!*

Framed as a sense of trust in evidence and agreement with claims to knowledge, the contrast between this new position and the beliefs and attitude held during her previous occupation as a complementary therapist has become a source of amusement. In addition, the ironic tone to Brenda's voice as she related her previous conviction in the efficacy of complementary therapy, even citing other people telling her it works as a 'source of evidence' from her previous life, illustrates her revised attitude to knowledge claims. The sense of amusement at her own trust in complementary therapy, despite the lack of empirical evidence, coupled with the ironic expression of her use of anecdotal evidence to justify this trust captures the distance of travel in her understanding of the role of evidence and the HE experience in achieving this new position. In her role as graduate nurse, we hear that 'hanging out' with osteopaths and homeopaths is now an opportunity and a challenge to extol the cause of evidence as the true foundation for knowledge and practice.

In the next extract, with an initial declaration of becoming a more 'academic' person, Anne illustrates the role of HE in changing self-perception.

> *"I think it made me more academic … making me think about writing critically and analysing research and being able to use that skill further if I had to write documents or write a report for my manager and I think …. looking at themes in the clinical environment and thinking… ok this is happening in this clinical environment, how would you put that on paper academically using evidence based work? That helped me a lot".*

The relevance and application of academic skills derived from HE to the domain of clinical practice in general and with writing in particular, is explained by Anne in terms of the cognitive challenge of transferring the experience of clinical activities into passages of writing. Critical analysis is declared by Anne as an important feature of the writing process for documents in clinical practice and reports to be read by managers. The critical process has become embedded in what she does and Anne is being critical here as she talks about what she is thinking. Things are happening in the clinical environment that require description, explanation and interpretation and this challenge is met by using evidence to support the

writing. Making the link between clinical practice and theory is raised here as a problem that exposure to HE has helped to resolve. There is a sense that the HE experience has almost 'forced' a change in thinking and approach to a writing challenge in clinical practice, with the role of the HE tutor specifically identified as encouraging thinking about writing.

In the next two extracts (Lynn and Adam) we see the value of reflection identified as a significant outcome of the university experience.

Lynn articulates a particularly reflexive and mature approach in her sensitivity to the reflective process. She affirms that it is nursing practice that is the focus of the reflection. The reflection is not on the person doing the reflection but on the practice of the person doing the reflection. There is a sense that Lynn is reminding herself (and me) that she knows what reflection is. When Lynn declares that *'…it's not all about you, you know?'* she is qualifying and affirming the purpose of reflection. Furthermore, the language appears carefully chosen, with clear signs of praxis emerging from the conjoined phrases *'on practice, in practice':*

> *"I think reflection is a very powerful tool, but you had to remind yourself it's not all about you, you know? When you're writing reflections, reflecting on practice, in practice, I think that's the most powerful thing I've got from the university… reflecting on your own practice" (Lynne)*

Adam also affirms the value of reflective practice.

> *"The one thing I remember when I was doing my nurse training was, you know, they constantly talk to you about reflection and I remember thinking, why do they keep banging on about reflection. And now, my wife says to me…' You don't have to reflect on everything, Adam'… And it is so valuable, reflection for me is the key".*

The power of reflection as a tool provided by the HE experience is central to the development of reflective practice which, in turn, is central to Adam's practice. Although initially appearing to question the point of reflection during nurse training, the reflective process seems to have permeated areas of life other than nursing practice. There is a suggestion that

reflection has almost become a personal 'mantra' and has reached slightly irritating levels in personal relationships.

Frances uses two metaphors in the next extract ("… *working that muscle….*" and "… *reversing the car….*") to illustrate her experience of the differences between working and learning as an HCA and the HE preparation for nursing.

> *"I would have to think long and hard about what I've learned theory-wise… at the university … the longer that I'm away from the wards the more de-skilled that I feel because I'm not working that muscle… the jump from band 3 where you are right in the thick of it to this… you take a huge step back… band 3 is that way and a registered nurse is that way… you have to reverse the car and go back along that route…(then) you have to catch up again…"*

Despite the fact that this interview extract was recorded while Frances was in the university phase of the course, she could not immediately recall any learning relevant to her progression as a nurse. Distance from the clinical environment due to attendance at university is clearly a problem for Frances as she cites the loss of clinical practice skills. In doing so, Frances paints a picture of atrophy and loss. As a band 3 HCA she was immersed in the clinical environment. Now she finds herself in a learning environment where theory is neither easy to recall nor particularly relevant. The relevance of the HE curriculum to practice is invisible to her.

For Frances, preparation for nursing appears to have gone into reverse since embarking on the university course. It seems that band 3 support work and registered nursing are some distance apart and in different directions. The university course requires putting the '*car'* into reverse and retracing the route. Once the destination of nursing registration has been reached, Frances anticipates additional effort to re-establish her skills. The clinical skills 'muscle' will need working up to full strength once Frances is qualified, registered and employed as a nurse.

Gillian continues in this vein in the extract below where she compares her current learning at university, which she describes as minimal, with the great extent of learning that she experienced as an HCA:

"I don't think that I'm any further forward now than when I started the course… I was taught so much on the ward that I came from… the (HE) *course is aimed at people who have no nursing knowledge and have never worked in this environment… you just have to be quiet and listen"*

It seems that the university course is contributing very little to Gillian's development as a nurse because, according to Gillian, it is pitched at a level that is appropriate for students without any prior knowledge or experience in healthcare. She seems to place more value and emphasis on acquired knowledge and finds it difficult to accept that the course may need to start with basic knowledge and concepts. This is frustrating for Gillian when she is in university. Not only does there not appear to be an acknowledgement that students may have knowledge acquired from previous healthcare experience, Gillian indicates that a declaration by students of previous learning would not be welcome.

Discussion

Having previously described and explained their anticipation, perception and preparation for university life, participants now reflect on the lived experience of the HE field. Interpretation of extracts in this second section of the chapter have illustrated how participants talk about the challenges of life at university, some of their response to these challenges and some outcomes arising from their experience of HE.

Throughout this section, the role and importance of cultural capital in the HE field as a form of knowledge, its relevance to clinical practice, communication skills (both verbal and written) and independent learning is evident. A sense of hysteresis emerges in many passages as participants talk about their experience of moving into the field of HE. The interpretation of extracts has illustrated how the prevailing doxa of the HE field and tension between epistemic and social knowledge represents a significant challenge for many participants. In the first part of this section, the role of forms of knowledge contribute greatly to this tension. The lived reality for participants is that epistemic knowledge pervades the field and represents a dominant form of cultural capital. Previous learning that has its roots in social relations to knowledge has low cultural capital value in the HE field.

Students feel threatened by this as they may be required to leave if they do not adjust to the new and alien field doxa.

However, HEIs may differ in their cultural capital expectations and support of students. Elizabeth relates how the high attrition rate of former HCAs student colleagues from a Russell group university, was due to lack of the requisite epistemic cultural capital. Their social knower capital was insufficient to cope with the doxa of the field conditions in the particular HEI. In contrast, the HEI that Ruth describes seems to recognise that the field doxa of HE will disadvantage students with cultural capital predicated on social relations to knowledge. Furthermore, communicating epistemic knowledge using terms with high semantic density is a skill requiring considerable preparation and practice before competence is reached. UG students entering HE with these attributes are equipped with the appropriate cultural capital for success in the field. This HEI recognises that many students do not have the appropriate cultural capital for communicating epistemic knowledge and provides relevant support.

Formal writing is thus a significant part of the doxa of the HE field and lack of relevant cultural capital contributes to hysteresis on the part of students and risk of ejection from the field. Maggie's journalistic experience may have equipped her with writing skills for SR knowledge with a tendency to semantic gravity (person, time, place) but in HE this form of cultural capital has minimal value. Bertie makes specific reference to language and describes his experience of hysteresis arising from his inability to employ terms with the appropriate semantic density.

Independent learning is also an important element of the learning culture of HE and a doxic expectation of the field. However, interpretation of extracts has illustrated a variation in participants' recognition, understanding and acceptance of this particular doxa of the HE field. While Olive, as a current first year undergraduate student, is relatively new to the field, Steve reflects on his HE experience from a distance of several years. Olive entered HE with relevant cultural capital arising from her experience with the OU. She has had exposure to distance and independent learning and we have previously seen that she recognises the epistemic nature of the HE field and the semantic density of the language. This represents significant

cultural capital to inform and develop her habitus such that her experience of hysteresis, now she is in the HE field, is low. In contrast, Steve's recollection of his HE field experience is not a happy one despite his previous experience of self-directed learning as an HCA. He recalls the doxa of independent learning in the HE field as a source of stress. His expectation was, and still is, that HE should be more didactic, giving students the relevant epistemic knowledge for eventual registration as a nurse.

Further hysteresis is expressed as participants compare the field conditions of HE and healthcare in terms of practicing and managing care. Karen is comfortable working as an HCA, her habitus is aligned with the field but the university field doxa of self-directed learning brings discomfort. However, there is some recognition of the eventual value of the HE doxa to her preparation for nursing as Karen explains and rationalises the relevance of this to her future practice.

Lynn, however, identifies the preparation of nurses by HE to manage the healthcare field as a challenging aspect of the HE field doxa. Lynn's hysteresis stems from a change in doxic conditions as she moves from a HCA field position, where social knowing represents important cultural capital, to HE where epistemic knowledge is more highly valued. Lynn resists the changing field conditions of healthcare, where nurses are replaced by HCAs for personal care, and the rationale for care and its management is increasingly based on epistemic knowledge, more highly classified and drawing on language with high semantic density.

This tension between the role of epistemic and social knowledge in the healthcare field emerges again as Olive and Frances articulate that they value social knowing above epistemic knowing in the context of communication skills. Olive and Frances apply their HCA criteria derived from social knowledge in everyday life and clinical practice to define good nursing practice. There is a clear resistance to epistemic knowledge. Why are communication skills in the HE curriculum when this is common-sense everyday knowledge (Olive)? And what is the point of knowing the name of an obscure brain structure involved in aggressive behaviour when what is needed is a common-sense solution (Frances)? These extracts illustrate

the tension between theory (sacred knowledge) and practice (profane knowledge) in this particular knowledge domain.

In the face of these challenges, former HCAs discover that they are not alone in the HE field. Extracts illustrate how the individual experience of hysteresis can be ameliorated when HCAs share their discomfort and pool resources to deal with the challenges of the alien HE doxa. HCAs formed social learning groups in the new field, drawing upon collective cultural capital imported from the healthcare field and sharing insights from the new HE field, until the challenging doxa of HE was more fully revealed through shared experience, and sufficient new capital had been accrued such that individual hysteresis had diminished. A sense of defiance is nicely captured when Brenda adds up the total social capital of her HCA support group and compares. She is effectively saying, *'HCA capital (social knowing) derived from years in healthcare may be different but it is still valuable'*.

Expressions of hysteresis disappear in the interpretation of extracts where participants are talking about some outcomes of the university experience (Bertie, Brenda, Adam, Lynn, Anne). Participants' language illustrates the value of epistemic knowledge and acceptance of the value of the HE field to the acquisition of important cultural capital such as independent learning (Bertie), use of evidence in clinical practice (Brenda), criticism of social knowledge and the value of epistemic knowledge in thinking about experience in clinical practice. Furthermore, knower code approaches to clinical practice are enhanced by application of knowledge code thinking (Adam, Lynn). It is even possible to achieve an elite knower code position when epistemic knowing is combined with social knowing (Anne).

However, with the exception of Lynn, all these participants are nurses looking back several years to their experience of the HE field. Participants who rejected the value of the HE experience to their development as nurses (Frances, Gillian) were both current students taking the PG accelerated course to nursing registration. Frances remains unaffected by exposure to any epistemic knowledge from HE while Gillian describes the university as trying to compensate for most students not having a social knowledge code position due to lack of exposure to the healthcare field. These expressed views of the value of HE may change over time once Frances and Gillian have occupied the position of RN for several years.

Their current view of nursing is affected by the proximity of their life as an HCA.

8.4   Summary

The participant extracts presented, interpreted and discussed in this chapter have illustrated the experience of former HCAs as they approach the field of higher education and experience life at university. A sense of culture shock at the experience of a new and alien world is the main conclusion to be drawn from both sections of the chapter. In Bourdieu's terms, the hysteresis arises due to participants' lack of capital appropriate to the field. Lack of cultural capital, both perceived and actual, play a role in the stress experienced by participants as they approach and enter HE. At least, this is the experience of those participants who had no previous experience of HE. Postgraduate students have previously experienced the HE field so there is no expression of hysteresis from these participants.

There is a mix of awareness and naivety in the data. Preparation for the demands of the course by some participants reduces stress and enhances confidence. Others report being completely overwhelmed by the HE experience. Do HEIs have a role to assist students' preparation for HE, before the course and in the early stages, to ameliorate the culture shock? Tension between a social knowing and epistemic knowing perspective emerges where participants express difficulty and frustration as they move further away from the everyday and mundane world of the HCA and further towards the esoteric and sacred world of the nurse.

However, we see in the latter half of the chapter how participants draw upon their own resources by forming support groups of former HCAs to meet the challenges of life at university. Outcomes of the HE experience are seen in beneficial terms by former HCAs who had been nurses for several years. However, these responses may have been expected as only participants who had been nurses for several years were asked this question. The responses given by participants are a reflection of their position now having operated as nurse for several years. Nursing is much more than the legal responsibility for medication. It involves assessment of evidence to inform practice, critical thinking and an academic writing style. Reflection on practice is a skill advocated by both a current student and nurse participant.

However, lack of personal impact and progress arising from the HE course is articulated by two participants (both current students). It would be interesting to follow up these participants when they have been in practice for a few years, to assess their views on the impact and relevance of the HE course. It may be that the value of epistemic knowledge from HE becomes apparent with the passage of time.

In the final findings chapter, we hear how former HCAs experience the HC field afresh, now as nursing students from HE. What do participants say about their return to the HC field having been exposed to the HE field and sacred knowledge?

Chapter 9   From classroom to clinical practice: the 'HCA within'

9.1   Introduction

In the previous chapter, we heard how participants described and explained their experiences during the move to university and transition to the HE field. For most participants, the process involved culture shock (hysteresis) as the doxa of the HE field was anticipated and then experienced. Participants discovered that epistemic knowledge, its application and means of communication represented the forms of cultural capital most valued in the HE field. The social knower perspective of former HCAs was of minimal value.

In contrast to HE, cultural capital derived from participants' time spent as an HCA in the HC field emerges as an important feature as participants return as nursing students to the clinical areas for their practical training. This capital comes from the typical close-body and personal care work of HCAs with patients and participants' understanding of the doxa of the HC field. However, participants are now operating in the HC field as students from HE. They are visible in the HC field as social agents from HE and yet they have the habitus and capital of the 'HCA within'. They are required to perform the role of the HE nursing student in the field of HC with previously acquired knowledge of intimate patient care and the doxa of the HC field.

This chapter is presented in two sections.

- Confidence in practice and the dilemma of disclosure
- Learning from practice as a student nurse

The first section presents, interprets and discusses selected participant extracts that illustrate the contribution of prior experience as an HCA to participants' sense of confidence as they move from the HE field to the HC field. However, confidence in the HC field brings its problems for former HCAs in terms of whether to inform nurses of their previous experience.

A similar treatment is given to selected participant extracts in the second section. However, in this section, participants describe and explain their learning experiences in clinical practice placements. Of particular interest is

how participants talk about the learning opportunities in practice and their previous experience as an HCA to make links between theory and practice.

9.2   Confidence in practice and the dilemma of disclosure

In contrast to their experiences in HE, participants describe how their previous experience as an HCA represents and offers useful cultural capital in the HC field. The social knower perspective of former HCAs is aligned with the doxa of the HC field and thus reduces the level of hysteresis experienced by participants that may otherwise have occurred without participants holding this form of cultural capital.

However, there is a problem for former HCAs as they return to the HC field. One consequence of previous caring experience is that nurses identify the social knower capital in the behaviour (habitus) of the student nurse and may attempt to exploit the student for routine care activities. For participants, this may lead to a dilemma of whether to disclose their former life as an HCA. Participants are aware of this possibility and respond accordingly.

Confidence in practice

In the first part of this section of the chapter, five participants describe how their previous experience as HCAs gave them confidence during their clinical practice placements. This is presented by participants in contrast to their student colleagues in practice who had not previously worked as HCAs.

An extract from Deborah's summary observation of the difference between those students without prior HC experience and her own HCA experience, sets the scene of this section.

 "They struggled more with the programme than those that had (been an HCA) … for lots of people it was a very steep learning curve whereas for me it was much more gradual because of my previous HC assistant experience…"

Her metaphor illustrates the advantage, in terms of learning, of having been an HCA before starting the HE programme.

In the next extract, Jenny adds to and elaborates on this feature by describing the anxiety expressed by other clinically naïve students at the prospect of clinical practice placements.

> *"Most people were frightened, nervous and worried. I wasn't quite as nervous and worried as I was in the classroom. It was the academic and essays … that was frightening. I know the environment of the clinical area having been an HCA so it wasn't frightening for me.*

In contrast for Jenny, it was the academic experience which prompted feelings of vulnerability and fear. Although this sentiment towards HE was reported by participants in the previous chapter, this is the first time a participant make this direct contrast between these discrete cohorts of HE nursing students i.e. those with fear of HE (former HCAs) and those with fear of clinical practice placements (students without previous caring experience).

The next extract from Anne illustrates some of the specific difficulties that were faced by students without prior HC (HCA) experience. Although students were 'excused' from direct patient contact by virtue of their supernumerary status in clinical practice placements, this was not the view held by nurses.

> *"… we were in a minority.. a lot of them (students) hadn't had any experience… and it didn't help them …because there were mixed messages…. the university were saying that you were supposed to observe… and when you don't know anything about the clinical environment… about working with people … and with patients… you are going to observe aren't you?...* [laughter]*…it caused rifts for people at the beginning because the nurses were expecting us to learn by doing… some of the students were saying…'no, I'm not doing that…I'm only here to observe, that's what the university tells me'… those who've worked in that environment just naturally fitted in…"*

Anne recounted how, in the early days of Project 2000, tensions arose between students and nursing staff on the role of students in clinical practice. Despite their official status as supernumerary, derived from the shift of nursing education form local hospital schools of apprenticeship to universities feeding a much wider group of hospitals with students, Anne

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conveys the sentiment that there was lack of clarity and therefore confusion about what nursing students were expected to do. She also stated that some students were effectively 'hiding' behind their supernumerary status to avoid the difficulties and stress associated with direct patient care.

I had the sense that Anne was being sardonic and perhaps even scornful of these students who either could not or would not contribute to the practical tasks of nursing care. The nursing staff may have made these judgements of the new generation of HE students partly due to their familiarity with the apprenticeship style of nurse training before Project 2000 and partly due to their observations of practice competency in those nursing students who were former HCAs. Although Anne stated that she and her former HCA student colleagues were spread thinly in clinical practice placements, their very presence coupled with confidence in practice may have undermined the supernumerary strategy of Project 2000.

Adam's comments in the next extract about his skills and competencies as a former HCA affirm and develop this point. Only when he arrived in the practice placement as a student, did Adam come to realise the extent of his knowledge.

> *"my first placement was an acute ward … I didn't find it daunting at all… I thoroughly enjoyed it … I quickly realised that my HCA role had given me a pack of tools… a couple of first year colleagues came onto the same acute ward … and they were absolutely terrified … I was thinking.. 'what is the issue here?'… so I took a lot for granted…"*

In this extract, Adam describes the value of his previous HCA experience to his self-confidence during the first clinical practice placement of the undergraduate nursing course. It is significant that Adam remembers this specific event after the passage of many years and explicitly acknowledges the contribution of his previous role as an HCA to his sense of confidence. In complete contrast to his own experience in the first clinical placement of the undergraduate programme, Adam describes the reaction of student colleagues to the clinical environment as fearful. Adam explains that initially he was perplexed. He did not seem to understand how the working environment of an acute mental health ward could be anything other than comfortable and straightforward. However, for novice mental health nursing

students, this working and learning environment would have presented an alien landscape populated by people with varying degrees of challenging behaviour. Their lack of previous experience was immediately apparent and their inevitable response to this vulnerable position were expressions of stress and fear.

This section ends with an extract from Bertie which further illustrates the advantage that former HCAs felt they had in clinical practice placements compared to 'clinically naïve' students. However, the additional dimension from this passage is that it gives a voice (albeit vicariously) to nursing students in practice who had not previously worked as an HCA.

> *"I felt an absolute 100% advantage. On the wards some of my student colleagues would assume it was all light and fluffy… and if they [patients] aren't well they just come and tell you. But I was trying to say 'it's not like that, sometimes it's quite distressing and it's loud and sometimes … violent'. The students said…'you're just so natural at doing this and I used to say 'it's because I was an HCA first. I was on the shop floor the whole time so I'm used to this kind of interaction between people'.*

Taken at face value, Bertie's use of metaphor to convey his recollection of some students' beliefs about life in clinical practice illustrates their inexperience and naïve attitude. However, there is also here a sense of amazement, incredulity and disdain from Bertie. How would anyone think that a mental illness ward would be anything other than challenging, and why would patients necessarily volunteer their state of mind?

Bertie uses this example of an interaction to show the extent of his understanding of life in clinical practice. He knows that he has a depth and breadth of knowledge derived from years of experience as an HCA in mental health practice and he employs comments from student colleagues to evidence and augment the contrast. There is also a sense that Bertie enjoys the attention and acknowledgment of his ability from student colleagues who likely came to nursing education via the more traditional school or college route with A levels, rather than an NVQ. So, despite his perceived difficulties with academic aspects of nursing HE, this is an area (for him as a former HCA, perhaps the most important area) in which he can excel.

The dilemma of disclosure

In this part, participants describe and explain their responses to the situation of being a former HCA and yet finding themselves back in clinical practice as a student nurse. The four extracts presented and discussed illustrate the range of participants' experiences and responses. Each of these extracts is from a participant who was an UG student on an HE nursing course at the time the study was conducted. The eight participants who were registered nurses, having completed their HE nursing course several years earlier, could not recollect this level of detail from their student experience.

The first extract from Karen captures the experience of former HCAs as they re-enter clinical areas, but this time as student nurses.

> *"They could tell… they said that I was just too confident in going to patients… it didn't bother me wiping their bums and stuff like that… I don't think that I did myself any favours because I got myself too involved as an HCA and I ended up being treated as an HCA… you're supposed to go around and shadow and observe… you're supposed to be supernumerary… on my third placement I didn't want to do it again…. I think I came across as being a little bit… not aloof but … not involved as much whereas I would automatically go and do it… I had to keep holding myself back…"*

Karen's actions in practice placement immediately conveys to nurses that she had previously worked in practice as an HCA. Personal and intimate care does not faze or deter her. Karen is in her comfort zone as she provides a service to patients. However, she knows that the expectation of the university is for her to learn from the nurses. The dilemma for Karen becomes clear as she describes how she knew what she had to do but could not resist the immediate needs of patients and the doxa of the field. Finally, she decides that her HCA approach to clinical practice placements cannot continue if she is to become a nurse. Karen decided on her third placement that she must stop being an HCA and become a nursing student. However, this decision seems to replace one source of discomfort with another i.e. suppressing her natural inclination to provide care when patients need it.

In the next extract, Pauline describes how former HCAs collaborate as they prepare for their next clinical placement. The dilemma for these students was whether to inform their placement supervisors that they were former HCAs and therefore had previous experience of patient care. The issue at stake for these former HCAs was how the staff in the clinical area would respond to this information. Would it be a liability or an asset? Would they use the students as supplementary carers and simply 'dump' the routine work on them or would they adjust the learning activities to suit the previous experience and knowledge of the HCA students.

> *"…we had a discussion about this… should we tell them?... some people said it might go against you because they might think…'oh, just get on with the obs'… and some people said 'yeah, tell them and then they know what your baseline is… they won't start teaching you from scratch'…I didn't tell anyone for a few days…. I just wanted to see what it felt like being a student nurse…and they notice that you're just getting on … that you're a bit more confident doing things… people would see me as an HCA…. I didn't want to take that risk… I wanted to be a student nurse… a fresh slate…"*

Pauline decided to wait for the placement staff to identify her as a former HCA. She knows this will happen anyway as she goes about her work as a student nurse, that she could not hide her previous experience from the nursing staff. There is the sense that Pauline wants to control her outward appearance, her identity, for as long as possible. She does not want her placement supervisor or ward manager to immediately exploit her previous HCA experience or to assume any previous knowledge on her part. Pauline wants the placement to treat her as they would any other student nurse.In the first half of the extract, Pauline sets the scene by describing and explaining the dilemma. She knows in the end that she will be discovered. But she wants the staff in the placement to form an opinion of her before she 'comes' out' as an HCA.

For Lynn, in contrast, there is no dilemma. In this extract, we hear how Lynn states knowing the role that she must play in order to succeed.

> *" I just act the way that they want me to act… it's all a performance really isn't it?... you don't want to be too cocky… too sure of yourself or the nursing staff don't like that… so you have to go into*

performing the role that they want you to be as a first year, second
year, third year…"

Lynn shows remarkable insight into what is required. She adapts her
behaviour to suit the prevailing circumstances of the placement and her
assessment of the expectations of the clinical staff. In her previous role as
an HCA, Lynn would have worked alongside nursing students during their
clinical practice placements and would therefore have developed some
insight into the clinical learning activities relevant to each of the three years
of the UG nursing course. She observes, learns and then projects herself
accordingly.

Discussion

Interpretation of participant extracts has shown how previous experience as
an HCA may benefit the nursing student in the HC field while lack of any
experience may be a disadvantage. Hysteresis arising from lack of capital
resources and the requirements of the prevailing doxa of the field is
identified in the interpretations of the first three extracts of this section.
Deborah values the social knowing perspective that she acquired during
her time working as an HCA and recognises the difficulties faced by student
colleagues who lacked this capital resource. Jenny's form of language is
more indicative of hysteresis as she describes the stress of students
without prior experience of HC as they anticipate and move into this alien
field.

In contrast, Jenny's own sense of hysteresis comes from her experience of
the HE field. While the interpretations of Deborah's and Jenny's
descriptions of hysteresis in the HC field are contemporary accounts, the
interpretation of Anne's description of student hysteresis in HC comes from
the early period of Project 2000. The interpretation of Anne's description of
the tension and conflict experienced by HE nursing students as they moved
into the HC field was more to do with the resistance of students to the
expectations of nurses that they would learn according to the
apprenticeship model that the nurses had experienced in their own nurse
training i.e. this was the prevailing doxa of the HC field at the time of
Project 2000. However, these new HE nursing students were 'importing' the
doxa of the HE field into the HC field. The hysteresis seems to have been

experienced by nurses as the conditions in their previously secure field were being challenged by novice nursing students.

The benefit of cultural capital acquired as an HCA in mental HC is described by both Adam and Bertie. The HC field, experienced as an HE student, is familiar territory; the doxa of the field is transparent and the value of occupying a position in the field informed by social knowing cannot be underestimated.

Adam appears at first to have overlooked the significance of his learning as an HCA and the associated cultural capital. It is only when he sees the hysteresis in other HE students who lack this capital that he fully realises the importance of his HCA experience. Other students in clinical practice who may have entered nursing education with prior epistemic knowledge, do not have the social knower perspective that comes with prior HCA experience but Bertie does have this knowledge! He seems to enjoy the feeling that he has powerful knowledge derived from his HCA experience in the mental health HC field. In contrast to the dilemma of disclosure articulated by some former HCAs, as they returned to the HC field as an HE student, other participants describe the benefits of their HCA capital resources.

However, I have also shown how the decision to disclose a previous life as an HCA on entry to the HC field is fraught with difficulty. Participants had difficulty in not following the inclination of their habitus on return to the HC field as an HE nursing student. The doxa of the HC field does not challenge former HCAs and also seems too powerful for them to resist its 'pull'. Participants feel comfortable as an HCA, they are a 'fish in water' (Hardy, 2012) and there is no risk of hysteresis. However, nurses in the HC field quickly identify the HCA attributes of the HE student and may exploit this as an opportunity to have another care worker on a busy ward.

Suppression of the HCA habitus and a decision to align with the doxa of the HE field while in clinical practice is difficult and may itself bring a struggle against their natural inclination to follow the HCA inside (Karen). This issue of the HCA within the nursing student trying to operate in the HC field can be a problem for former HCAs. Participants are aware that their HCA capital attributes are visible when they enter the HC field. The decision to disclose these HCA attributes at this point represents a dilemma. How will

nurses respond to being presented with a student in practice who has HCA experience and the associated capital resource? Will this be exploited to complete the routine work or will the HCA capital be valued as foundation knowledge for development as a nurse? Pauline knows that her attributes will be noticed. She cannot disguise her capital derived from HCA experience because she has been socialised as an HCA and this informs her habitus.

A potential solution to this dilemma is to employ capital attributes from both fields (HE and HC) to achieve a smooth passage as an HE nursing students in the HC field. Lynn does exactly this as she recognises the doxa of the HC field at each stage of her clinical training and acts accordingly. She has acquired sufficient capital from each field (HC and HE) and she adapts her behaviour to fit the expectations of the nurses in the HC field. She recognises the rules of the game in the HC field and knows how to play it for maximum personal benefit.

9.3   Learning from clinical practice

The first section of this chapter examined issues arising from the consequences of participants operating in the HC field as an HE nursing student with attributes of an HCA and whether to disclose their identity as a former HCA. This section examines how participants describe and explain their learning from clinical practice as a student nurse. I previously (chapter 5) examined how former HCAs talk about their learning from the HC field from their HCA role, whether their knowledge was recognised and, if so, how? Now I examine how participants describe their learning experience in the HC field with their new identity as student nurses from HE.

Four extracts from three participants (Anne, Adam, Maggie) are presented to illustrate how participants talk about their learning from clinical practice as an HE nursing student and specifically their experience of linking theory with practice. Two participants (Anne, Adam) were nurses at the time and recall their experiences from several years previously when the HC field had minimal exposure to and influence from social agents in the HE nursing field. The doxa of nursing in the HC field was largely created by nurses who had received an apprenticeship training and no exposure to HE.

In contrast, one participant extract (Maggie) is used to illustrate how former HCAs describe their experience in clinical training as a contemporary

nursing student. The HC field and the prevailing doxa are now different in that nurse in the HC field have all experienced the HE field and are diplomates or graduate nurses. Interpretation of these extracts illustrates the role of social agents in the construction of knowledge and learning in the HC field. Thus the nature and value of different forms of nursing knowledge comes into focus in this section. We see how participants negotiate the HC field, now as a student, and attempt to make sense of forms of knowledge (epistemic and social) differentially recognised and valued.

The first extract presented in this section is from a participant who experienced life as a student nurse in the early period of Project 2000 when preparation for nursing had moved into HE and a new generation of students were arriving in practice placements for the clinical training. In this extract, Anne talks about how she and her contemporaries were received by nurses in clinical practice placements:

> *"We were seen as academic people who were privileged to get that academic side… we were very annoying people. We were seen as people who know it all … that we were trying to be the experts… bringing all this academia in and asking questions, ….we've been told about this research or that research… undermining or devaluing their experience or their knowledge… the nurses who hadn't been trained as project 2000… they didn't get it… 'I don't know what you're talking about, we didn't do it that way… <u>we</u> do it this way'…[laughter]… I tried to tone that down a bit really … cos it got in the way of your learning clinically".*

Anne reports how student nurses were perceived by registered nurses as, at least an irritant and at worst, a direct challenge. These student nurses were seen as representing the university and the embodiment of a different approach to nursing rather than the apprentice nursing students that clinical training areas were accustomed to before Project 2000. This was evidently a problem for the nurses responsible for the clinical training of this different cohort of students. There is a sense in this extract of excited nursing students from HE arriving on the wards and clinics, keen to engage with learning, only to have their questioning approach dampened and thwarted by current nurses who had no previous experience of HE.

Anne acknowledges in this passage that the new generation of nursing students had an advantage by virtue of their different and special route into nursing. However, the established nurses were not only perplexed but, according to Anne, felt deskilled in the process. Anne's laughter reflects her recollection of the tension arising from this clash of cultures.

In her own practice as a student nurse, Anne realised the personal cost of antagonising her placement supervisors in this way and charts a more diplomatic route to maximise her learning in practice. There was no indication from Anne on how students were guided by their university about how to manage these issues in practice placements. The challenge for Anne is that in her previous role as an HCA she was responsible for the day-to-day care of patients and was not required to think about the rationale for this care, indeed, in a previous extract, Anne identified this aspect of her working life as a source of frustration and then motivation to pursue nurse training. Now Anne found herself in the position of nursing student rather than HCA and she was meeting nurses who did not want to hear questions about the rationale for their care. Anne and her student colleagues are shadowing nurses, trying to engage them in conversation about their rational for care and being rebuffed in the process.

In the next extract, two former HCAs talk about the strategies they used in an attempt to make sense of the theoretical concepts they were being exposed to at university. Anne explains how her previous experience and learning as an HCA helped her to make sense of otherwise complex terms and phenomena. For Adam, theory acquired in HE was a revelation in understanding practice. However, he does not accept theoretical concepts without question. Instead, he uses an analytical approach to compare his own and colleagues' practice knowledge with the knowledge coming from his HE experience.

> *"I quickly understood that the classroom and the theoretical part of what I was being taught was key to everything that you pick up on the wards… you start shifting your brain… this is more what evidence based nursing is telling you as opposed to experiential nursing or learning from your peer group… I was able to sit in lectures and pull bits and pieces out and think…'that's not what happens when I'm working on the ward…so I was able to go to a*

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> *ward… and throw it out there, this piece of information… to debate about … how relevant that is or not… some nurses will say, 'that's a load of rubbish that you're learning at university'… and some will be very open to new ideas"*

The figure of speech that Adam uses in this extract …*'you start shifting your brain'* conveys a change in Adam's thinking associated with a discord between learning from HE and learning from clinical practice. Adam does not initially seem to identify any difficulty with the association between theory and practice. The connection seems to be immediately apparent to him as the value of the *'theoretical part'* is explicitly stated as the *'key to everything'*. However, this is a prelude to a more pro-active assessment of the value and relevance of the new theory that he is being exposed to. The difference between knowledge derived from research described as *'evidence-based nursing'* and that derived from practical experience *'experiential nursing or learning from your peer group'* emerges. Adam compares what he is hearing in HE to what he experiences on the ward and subsequently selects items that he believes are controversial for testing with nursing colleagues when he is in practice. He is actively compares theoretical ideas in the university setting with his own ward experiences as an HCA and tests these ideas with colleagues in practice.

The cognitive dissonance for Adam arising from the tension between his own ward experience as an HCA and nursing theory derived from research is a cue to action for Adam. It is almost as if he cannot quite trust this new way of thinking about HC phenomena without having the benefit of the opinion of colleagues in practice. There is the sense that Adam wants to test the value of the new and different HE knowledge he is being exposed to. He embarks on his own investigation by *'taking an idea… and throwing it out there to debate'*. There is no definitive answer though. Adam is left to choose between those nurses who denigrate the university preparation of nurses and those who are positive.

In the next extract, Anne describes the connections she made between theoretical concepts being presented to her in HE and the experiences she had as an HCA in a mental health setting.

> *"… the academic helped me understand my experiences as an HCA… I thought 'that's why this patient behaved this way'…. the*

experience was there to join the dots… it (HCA experience) didn't make me stand out academically … it would help you to grasp the learning a bit more… especially in mental health…you're talking about clients who've had hallucinations… and side effects… it's hard to visualise what that means for that person….especially with all the technical names… but then you can go back to what you've experienced as a healthcare assistant …"

The relationship of learning seems to operate in both directions. On the one hand, Anne was able to employ 'academic' learning to assist her understanding of some clinical experiences in mental health. Her choice of metaphor at this point is interesting. Anne's HCA experience was useful to link mental health nursing theory to clinical practice. However, her clinical experience as an HCA had a limited effect on her academic performance.

On the other hand, Anne states that an example of the particular value of her HCA experience in mental health settings is in the meaning of hallucinations and side effects (of medication) for patients. Without revisiting life as an HCA, how would the student otherwise make sense of relevant theoretical concepts? The complex language adds to the difficulty in understanding how what is learned in HE can be applied within the context of patients.

In the next extract, however, the rationale of the university in Maggie's situation is clear. Student nurses who are former HCAs should be aware of the potential to be drawn to other HCAs as this may be their natural inclination. The university makes a clear distinction between the role of HCA and nurse, and guides students accordingly.

"… it was made very clear that you were a supernumerary student nurse… you're not a HC assistant so don't get involved in any of that work…you're training to be a nurse and that's what you're learning to be so you must shadow the other nurses… don't shadow the other HCAs… because you're not learning the skills that you're supposed to be learning"

Two reasons for this can be inferred. Firstly, the university knows the landscape in wards and clinics has changed over the twenty years since the inception of Project 2000. All nurses in practice placements will now be graduates or, at least, diplomates from HE. This means that student nurses'

clinical supervisors will have had a similar preparation for nursing and student nurses are unlikely to experience incredulity towards their questioning approach.

Secondly, the university will be aware of the dilemma faced by former HCAs when they commence their clinical practice placements, i.e. whether to emulate the HCAs employed in the placement or to join the nurses.

Discussion

Interpretation of these extracts has illustrated how the experience of former HCAs moving from HE back into HC as a student nurse can shed light on the role of epistemic and social knowledge in the construction of roles and identity in the HC field. As former HCAs, participants' occupational capital is derived from their experience as a support worker in the HC field. Knowledge is derived from close-proximity care work with patients. It is thus social in nature and will therefore give a social knower perspective to these students in clinical practice placements.

However, participants have now spent some time in HE exposed to epistemic knowledge and the doxa of the HE field. They return to the HC field, familiar with the HC doxa and a social knower perspective but now with a new identity (HE student) and bringing epistemic knowledge from HE into the HC field. The experience of Anne and Adam shows how, during the period when nursing education had recently moved into HE, the clinical training of students, now coming into the HC field from HE, posed a challenge for nurses working and contributing to the doxa of the HC field at the time.

It is the nurses in the HC field who exhibit hysteresis as the doxa of their field is challenged by student nurses from HE. Students are curious, asking questions derived from their exposure to epistemic knowledge in HE. Participants say that most nurses denied and resisted the value of this knowledge to the HC field as they experience and understood it.

During the early years of Project 2000, when a new generation of nursing students appeared for clinical training in wards and clinics where the nurse mentors would have come through the apprenticeships route to nursing registration, the doxa of the HC field was challenged by epistemic

knowledge arriving with nursing students from HE. These students were early agents of change in the HC field.

Anne and Adam respond to this reaction from the HC field in subtly different ways. Anne describes how she held back from overt displays of epistemic knowledge to protect herself from the negative reactions of nurses whereas Adam's strategy was to test the HC field with epistemic knowledge as a means of helping him to establish the veracity of his HE experience. The interpretation of Anne's and Adam's experience in returning to the HC field as HE nursing students illustrates how former HCAs try to adjust to the transition and make sense of competing forms of knowledge and learn from the process. We can speculate that, in these extracts, they were recounting their earliest manifestations of the elite knower code which come from a synthesis of both epistemic knowing and social knowing.

The value of social knowing to understanding epistemic knowledge emerges from the interpretation of extracts. Social knowing involves the context and semantic gravity (knower code) whereas epistemic knowing involves the object of knowledge and semantic density (knowledge code). Knower code capital may not contribute to performance in the HE field (Anne) but it does provide the context of semantic gravity to makes sense of epistemic knowledge and semantic density of the associated language.

The interpretation of Anne's second contribution to this section illustrates the synergy that is possible between a social knowing and an epistemic knowing perspective. Her metaphor *'joining-the-dots'* works both ways. There are dots to be joined in both the epistemic knowledge domain and the social knowledge domain. Each plays a reciprocal part in joining the dots in the other.

Fast-forward twenty years to the present time and the field conditions in HC have changed. Most nurses have experienced the HE preparation for nursing and hold a diploma of HE or a first degree. The HC field is now populated with agents who have brought epistemic knowing into the field. The doxa of the HC field has changed accordingly and staff in HE know this. Hence the advice to contemporary nursing students to shadow nurses in their clinical practice placements. Maggie's HEI specifically advised against following HCAs, perhaps because the HE staff were aware that students and particularly former HCAs may do this. HEIs view current

HCAs as not having the appropriate cultural capital to convey to student nurses, further evidence for former HCAs that their experience and social knowing is not valued.

9.4   Summary

Participant extracts examined in this chapter illustrate the role and significance of cultural capital within former HCAs as they operate in the HC field as an HE student. The benefits to participants emerge from the social knower perspective acquired from their previous life as an HCA in the HC field. Their experience of close-proximity care of patients and immersion in the doxa of the HC field provides a valuable resource for former HCAs to draw upon.

However, this is not without its problems. It may be tempting for clinical areas to exploit this 'imported' capital for direct patient care when staffing levels cannot cope with high patient demand. We have also heard how there is tension for former HCAs when the drivers of personal habitus, social knowing capital and the doxa of the HC field pull the former HCA to direct patient care away from the need to fulfil the learning required by their new role as HE nursing student.

This chapter has also explored how participants describe some aspects of the process and significance of their learning while in clinical placements. Cultural capital acquired from previous experience as an HCA is also useful for participants in the context of their learning. Former HCAs are already familiar with the doxa of the HC field and take a critical approach to practice arising from the recent exposure to epistemic knowledge and the doxa of the HE field. Participants who experienced the transition from the HE field to the HC field during the early phase of university nursing education (Project 2000) identified this as much of a challenge to the nurses in the HC field as it was for them as former HCAs returning to clinical practice as an HE student.

Chapter 10   Conclusion

10.1   Introduction

The aim of this study was to explore the status of knowledge during the transition of former HCAs to registered nursing.

The research questions were:

How do former HCAs articulate their knowledge acquired as an HCA?

What is the role and status of knowledge as former HCAs describe their transition to registered nurse?

How is knowledge involved in the relationship between HCAs and nurses during transition?

The project was motivated by the UK government policy of encouraging the enrolment of former HCAs to nursing education in order to remedy the national shortage of nurses. The study is also an attempt to address the lack of rigorous research on the experience and impact of this transition and to engage with the debate about the knowledge required for nursing.

The major purpose of the concluding chapter of a thesis is to position the findings against the issues identified in the original rationale for the study (Silverman, 2010). Following a brief summary of findings and a commentary on the research process, this conclusion will seek to demonstrate how the study contributes to issues that are relevant to the context of the research.

10.2   Summary of findings: the power of knowledge

In broad terms, my research has revealed the importance of knowledge in the process of transition described. The interviews collected showed that former HCAs have much to say about what they have learned from the role and about what others in the healthcare field say what HCAs know. The defining status of knowledge in the perceptions of and relations with others at work and in the expression of statutory differences in the health sector has been exposed throughout this thesis.

I have shown how knowledge plays a part in the reasons that people give to enter the healthcare field as a support worker and how it is an important factor in the decision of HCAs to apply for nursing higher education. Former

HCAs describe how observing nurses using knowledge in their practice stimulated their desire to learn more by becoming a nurse themselves. Some expressed their frustration with the statutory limitations imposed on HCAs' use of their knowledge. However, others described how nurses sometimes recognise them as having attributes appropriate for nursing and encourage them in the process.

The value and power of knowledge also transpired in discourses about the nursing course and the university experience. Once in the university, knowledge formed the backdrop to various challenges encountered by former HCAs and when returning to the NHS Trust as a student nurse from HE, their knowledge derived from an HCA experience, was seen as an asset by some and as a problem by others. This ambivalent nature and recognition of knowledge in the sector was further illustrated when the first cohorts of former HCAs taking the new HE diploma started to re-enter clinical areas as students.

10.3   A reflexive commentary on the research process

The findings of this study emerged iteratively, from its original conception rooted in my occupational history, and through development of my thinking during the data analysis, wider reading and my encounter with the legitimation code theory (LCT). Like much qualitative research, it has evolved over time (Silverman, 2010). While my aim has consistently been to explore with former HCAs what kinds of knowledge they say they have and how they reflect on this knowledge in the context of the transition to RN, specific research questions were difficult to articulate at the outset. Although I did not want to be overtly influenced by the literature, the five studies on HCA transition to nursing, emerging from my wide trawl of the literature, added to my sense of purpose. The wider HCA literature offered substantial and largely descriptive commentary on the role of HCAs in practice, on the regulation of HCAs' role, and on the education and training of HCAs. However, there was no exploration of the knowledge of HCAs, or of the perceptions of HCA knowledge, of their actual cognitive and social experience of HE or of their relationships with nurses before and during their own professional training.

Since the inception of Project 2000 and the shift of nursing education into HE, nurses in general and academic nurses in particular have become

almost obsessed with the socialisation of students into the 'profession'. It is no coincidence that this heightened interest occurred at the same time as nursing was attempting to take root as a legitimate discipline in universities across the UK. The long-standing and thorny issues of the credentials of nursing for its position in the academy and the knowledge and skills required for nursing practice both became hot topics for debate.

My personal scepticism about use of the term 'professional' morphed into full criticism after reading about Bourdieu's view of professional practice as a folk-concept *"which has been uncritically smuggled into scientific language"* (Pierre Bourdieu speaking in Bourdieu and Wacquant, 1992) that could be recast as a form of symbolic capital (Schinkel and Noordegraaf, 2011). I became convinced that Bourdieu's thinking tools of habitus, capital and field would be an excellent alternative to the limited concepts found within the nursing socialisation literature and would be a much more productive way of thinking about the dynamics of former HCAs negotiating their way through the fields of healthcare and higher education. While other studies had used Bourdieu's theory of practice to examine the transition experience of mature and working class students (Crozier et al, 2008: Reay et al, 2010) and secondary school students (Davey, 2009) into and through higher education, illustrating the potential value of this model to my study, none had explored the role and status of knowledge as a form of occupational capital from work experience in the transition to HE.

Although Bourdieu and Bernstein were both relevant to my research, they had differing ontological positions in relation to the social world. However, Maton's (2014) synthesis of their respective theories into Legitimation Code Theory (LCT) using a social-realist approach gave me the best of both worlds. I could now think of knowledge as capital with its status negotiated between social agents in the field **and** as a real phenomenon with emergent and valid properties of its own. The contradiction between Bourdieu's and Bernstein's position on the role of knowledge was not only resolved for me by Maton's LCT (Maton, 2014), it gave greater analytical purchase on the data and provided a higher level of abstraction to the study. I was able to interrogate the data for expressions that reflected the status of knowledge i.e. the extent to which the participant responses reflected relations to epistemic knowledge or relations to social knowledge.

I realised that there was epistemological convergence between how former HCAs talked about knowledge during their transition experiences and the inability for nursing to position itself satisfactorily in the academy due to enduring tensions between nursing scholars on the nature and form of nursing knowledge. Is nursing best represented in the academy and in healthcare by strongly classified and framed 'sacred knowledge' found within the singular disciplines of *scientific nursing*? In contrast, is nursing best represented by the more weakly classified and framed 'profane knower' perspective of *nursing science* which draws upon patients' lived experience for its legitimacy? What started as a naïve interest in what HCAs learned from their role and how this might be interpreted for nursing education developed into a study with wider implications for the status of nursing knowledge in the academy and in healthcare practice.

10.4   Former HCAs have a unique perspective

My study has shown that former HCAs have a unique perspective on nursing and nursing education through their previous experience in healthcare practice. Although they are relative outsiders (Wenger, 1998) and the social power of epistemic knowledge in HE accentuates this, former HCAs hold a store of knowledge as occupational capital derived from their HCA role. Although this knowledge has low status due to its profane origins, it self-evidently means that former HCAs entering HE are not at the naïve starting point assumed by Fitzpatrick et al (1996) in their study of students' socialisation into nursing.

Participants in my study described in some detail what they had learned during their time as an HCA, how this knowledge contributed to, and was viewed by others during their transition to RN. The assumption by the Department of Health (2006, 2010) that former HCAs represent a pool of potential candidates for nursing education due to their valuable knowledge and skills is borne out by the words of the participants in my study. My work represents the only research to date that has directly sought the views of former HCAs on their knowledge and skills for healthcare practice.

In using LCT, my study illustrates the way in which knowledge derived from work experience is articulated by former HCAs themselves and powerful others in the field. My findings contribute to the wider HE transition literature and may help to ameliorate the significant gap in the literature

about the transition of VET students to HE identified by Heyward et al (2008) and Barber et al (2015). Specifically, my study has shown that former HCAs enter university with a store of mixed mundane and esoteric knowledge acquired from their experience in healthcare.

However, although the status of knowledge in the transition of HCA to registered nurse is the primary focus of my study, most HCAs are women and many have working class origins (Kessler et al, 2010). Issues identified in my study could therefore reflect the occupational social class gradient that operates between representations of the 'working class' HCA role and the 'professional' role of the nurse. While social class has been largely overlooked in studies of gendered phenomena (Skeggs, 1997), the role of social class and gender in the transition process cannot be ignored here. Brief consideration of some key authors and studies illustrates this but also indicates that knowledge is evident within the context of social class and gender.

For example, in an examination of the moral codes that historically construct working class women as 'chaotic and excessive', Skeggs and Wood (2007) showed how working class women are frequently depicted in the media as inadequate and requiring improvement. On the premise that certain bodies are inscribed with certain characteristics, Skeggs argues that a discourse has emerged where the 'respectable' middle class woman knows more and is pitted against the 'rough' excessive working class woman in order to 'maintain standards' (Skeggs, 2009).

In a study of students taking vocational courses, Wheelahan (2007) drew upon Bernstein to illustrate how differences between mundane working class knowledge and middle class esoteric knowledge prevents working class students from entering HE. However, my study has shown that, rather than completely 'locking out' HCAs from HE (Wheelahan, 2007), the knowledge that HCAs bring to HE is framed as the wrong kind of knowledge in order to justify the transformative effect of transition to graduate nurse. Although knowledge is central to this process, knowledge derived from 'dirty work' typical of the HCA role is devalued for lacking the level of abstraction valued by both HE and disciplinary regions of professional and 'scientific' nursing knowledge. Furthermore, despite the almost universal gendered nature of emotional labour in society (Reay,

2004) and its association with close proximity caring, now the province of HCAs rather than nurses, my study has illustrated how this form of occupational capital held by HCAs also seems to have reduced worth in the fields of healthcare and higher education.

However, differentiation of occupational roles into profane and sacred, framed in terms of social class, is not an inevitable and universal consequence for HCAs and nurses. In contrast to the UK situation, Norwegian nurses have attempted to retain the personal and intimate care work historically performed by nursing assistants, the Norwegian equivalent of the HCA. The Norwegian Nursing Association (NNA) in 1989 drew the occupational boundary between nursing assistants and state registered nurses at a much wider point than in the UK such that Norwegian nursing assistants would no longer provide personal and intimate care (Dahle, 2003). Instead, their role would be limited to general housekeeping tasks while nurses focussed on all aspects of direct patient care. The rationale of the NNA was that, although personal and intimate care (the 'dirty' jobs) are seen as simple and routine tasks of low prestige, only nurses have the relevant competence and theoretical knowledge derived from a university preparation to perform this work. Inevitably and unsurprisingly perhaps, given the cost implications of this strategy, the Norwegian Ministry of Health ignored the NNA rationale for including basic care in the professional remit of nurses. Instead, the NNA was advised to respect the valuable contribution of nursing assistants in performing close proximity care and to support their vocational preparation for this role.

This brief consideration of social class and gender issues and the contrast between the UK and Norwegian situation illustrates differences in the treatment of knowledge underpinning nursing practice, in the context of social class and gender, by nurses, managers, HE and governments. Notwithstanding the competing arguments between advocates of a scientific disciplinary and 'sacred' approach to nursing education and advocates of a personal, intimate and 'profane' approach, boundaries between sacred and profane roles (the esoteric and mundane) are not fixed and immutable, but negotiated in the field of practice with status of knowledge central to the process. Thus, knowledge and its relation to status in the fields of HE and healthcare has formed the core focus of this research. My study has provided evidence that HCA knowledge is devalued

in a transition process where knowledge serves as an instrument of discrimination, classification, empowerment and distinction.

10.5   HCAs at the 'eye of the storm'

Whatever else nursing is, it involves the care of the body and, in this respect, HCAs have unique experiences to draw upon. HCAs assess breathing and heartbeat. They feed the body when it cannot feed itself. Direct assistance with defaecation, micturition and suppurating wounds while communicating with the person of the body, all fall into the remit of HCA work. Merleau-Ponty's phenomenology of perception envisages how it is possible that another's body is experienced in much the same way as the carer's experience of self (Merleau-Ponty, 1962). This is more than the 'downloading' of proprioceptive data to the human cerebellum of learned routine activities such as blood pressure and pulse rate monitoring. It is the complete identification with the other in their experience of the moment. Close-body care inevitably involves activities that elicit disgust in most people, hence its classification as profane and mundane. However, in all the profane human body functions that involve the HCA, there will be biological, psychological and social issues involved, whether the HCA recognises this or not. Its potential for classification as activity with epistemic relations to knowledge is latent and yet to be disclosed as *scientific nursing* once the former HCA is in the university. The lived experience of the person being cared for has unique, subjective and ethical qualities, making it *nursing science* (Northrup et al, 2004) with a characteristic holistic and subjective focus.

This distinction reflects the continuing debate in the UK on the form of knowledge required for contemporary nursing practice and the legitimation of nursing as a disciplinary region in UK higher education. During the early sorting of my data and ensuing analysis using the Watts (2014) approach, the significance of what participants were talking about and how they were talking about it, took on a new meaning. What participants said about the knowledge arising from the learning in their role had features which aligned with the debate in the nursing literature on how nursing defines itself in the academy and in healthcare practice. The binary conception of knowledge underpinning this controversy has a long history in the sociology of education from Durkheim to Bernstein (Young, 2008b), leading to the

present day when nursing struggles to find its place as a discipline in the academy and negotiate a new image and identity in society (Beck, 2002).

A premise of my study is that former HCAs making their way through HE and clinical practice placements as HE students are, in many ways, at the 'eye of the storm' of this controversy. On the one hand, they represent the caring or 'mothering' discourse (Apesoa-Varano, 2007), widely recognised in society as the hallmark of nursing due to their role in personal and intimate bodily care, the everyday, the social, profane and the mundane. However, their journey through HE to RN status requires assimilation of appropriate academic knowledge, the sacred, the esoteric, the epistemic knowledge of a university discipline. Furthermore, HCAs inevitably derive knowledge beyond their immediate role in bodily care resulting from their immersion in the HC field and performance of clinical activities previously the remit of registered nurses (James et al, 2010). While all nursing students have eventually to construct an identity commensurate with being a graduate nurse, former HCAs face a unique challenge in their learning trajectory, of reconciling and merging the profane knowledge derived from their HCA experience with the sacred knowledge from exposure to HE. Melia (1984) has succinctly captured this continuing dilemma for nursing students as doing it the 'ward way' or the 'college way'. However, former HCAs in my study describe how knowledge derived from experience is given minimal recognition both within HE and the healthcare field. Perhaps former HCAs are ignored in the current climate of nursing education and its epistemological crisis because they are the 'wrong kind of knower' (Maton, 2004). Former HCAs bring contamination into an academic environment (Watson and Thompson, 2004) where nursing scholars are struggling to create a unique nursing identity premised on more esoteric forms of knowledge.

10.6   'Hot-housing' HCAs for progression to nursing

Since the commencement of my study in 2012, Health Education England (HEE) commissioned a pilot programme for people interested in nursing to spend twelve months as an HCA before embarking on the UG nursing degree (HEE, 2015). The purpose of this pilot study was intended to test the recommendations of the Francis report (2013) that aspiring nursing students should spend up to one year working as an HCA to develop

appropriate skills, knowledge and a caring attitude, and to allow participants to make their own independent judgment about nursing as a career option. Publication of the report shows that while caring, behaviours and attitude formed the greater part of the programme, again, the role of knowledge in HCA work was not discussed or addressed.

A further criticism of this pilot is that the 37 recruits joined the programme on the premise that they were already being considered for nursing, that they were in a supportive environment and considering the potential for nursing as a career option. Effectively, these individuals were being 'hot-housed' for nursing, when at the same time throughout the UK, hundreds of formers HCAs, similar to my research participants, would be joining UG nursing degree programmes as part of the annual cycle of student enrolment. The HEE pilot programme could have investigated what was happening in the field already. These former HCAs come to UG nursing for a variety of reasons, other than simply to 'test the water' in a highly supportive and rarefied environment, and would have a more valid and organically interesting story to tell about the value of being an HCA before nursing higher education.

The pilot programme has also been criticised for high cost, feasibility, being a cynical public relations exercise and as a 'cover' for the management failings at Mid Staffordshire NHS Trust (Ford, 2013). This pilot programme has received significant media coverage, leading to the false impression that nursing education was the main problem at Mid-Staffordshire. Yet it arose from a single Francis recommendation from a total of 273 recommendations, most of which arose from management failings.

10.7   Other implications of my study

In contrast to the DH strategy of creation of high-profile 'show-case' examples of widening participation to UG nursing, the findings in my study give rise to other recommendations. Department of Health funded research on the knowledge and skills of current HCAs (not those specifically hired for testing the route to UG nursing) would be money well-spent. The vast majority of HCAs are locally resident to the NHS Trust where they work already and therefore have the 'bonus' of additional community knowledge. If supported for nurse education, they are more likely to stay in the Trust as they have family and social roots in the local area. The Kessler (2010)

study has shown that many HCAs do the job as a proxy for nursing and my study has given a voice to former HCAs on what value they attribute to the learning and knowledge that arises from HCA work. The DH and NHS Trusts implicitly acknowledge that HCAs learn from their role and therefore acquire a mix of social and epistemic knowledge. Both need to be identified and recognised for their contribution to HCA progression. Only further research and focussed educational support will achieve this.However, in healthcare, nurses may actively diminish the value of HCA knowledge in occupational boundary work. We have seen how nurses use languages of legitimation to justify the superior nature of their work and to maintain their occupational boundary with HCAs. While this may be a common feature of power structures in healthcare (van Beveren, 2003), it does not diminish the potential negative affect for those on the receiving end. Does this amount to symbolic domination, or even symbolic violence? The healthcare field, like any other field, is subject to unequal division of labour as a major structuring force and leads to a lack of opportunity for subordinate groups of workers (Sayer, 2014). If symbolic domination due to unequal field structure is a given feature of healthcare, then the active denial by powerful others of HCA experiential knowledge takes this beyond domination.

Bailey et al (2013) have explored the significant emotional labour performed by HCAs in their highly-personalised care of people with dementia. They describe the reciprocity of communication and affection achieved by HCAs with patients despite their challenging behaviour. Biomedicine explains the debilitating effects of dementia as loss of cholinergic neurones in the cerebral cortex but currently has little else to offer. In the meantime, HCAs who comprise most of the staff on dementia wards offer invaluable and close-proximity intuitive care arising from experientially learned perception and embodied knowledge of the person and situation (Merleau-Ponty, 1962).

Research on development and transference of tacit skills and knowledge in the workplace is limited despite their relevance and wide recognition. However, Evans and Kersh (2004) have shown how occupational and learning biographies can be understood, modelled and made more explicit so that workers and others can articulate their value and relevance. Similar research needs to be performed in the context of HCAs' close -proximity care of patients so that embodied knowledge, tacit skills and intuitive

learning can be recognised (and rewarded) by NHS Trusts and theorised by nursing scholars for accreditation on entry to HE.

Furthermore, recognition by HEIs that former HCAs enter the academy with valuable knowledge derived from experience in the workplace, both social and epistemic, would contribute greatly to the democratisation of the curriculum. While enhancing the transition process for individual students, the acknowledgement of embodied knowledge and the recognition of powerful learning, arising from the chaotic situations inevitable in healthcare practice, may revitalise the undergraduate pre-registration nursing curriculum. Former HCAs entering the academy have come from an environment where they are at the centre of their own learning. '*Heuta'* derives from the Greek for 'self' and, in contrast to both *peda-* and *andro-*gogy, the heutagogical approach (Bhoyrub et al, 2010) is premised on the notion that humans experience powerful learning in complex and challenging situations that stretch their capabilities to the full. More than simply recommending an extension of RPEL (Recognition of Prior Experiential Learning) for former HCAs entering nursing education, my research project advocates a wholesale re-evaluation of the role of experiential learning in healthcare support work and the relationship between forms of knowledge for nursing higher education.

10.8   Dissemination of the research

This research will be offered for publication in journals specialising in nursing education and the sociology of education. I have contacted the universities and the NHS Trusts, who permitted me access to potential research participants, to offer a seminar presentation on my research for staff and students. I hope to present the project at UEA in the School of Education and Lifelong Learning and/or the School of Health Sciences. The work will also be offered for presentation at national and local conferences e.g. Access to Higher Education, Royal College of Nursing, The Open College Network, Forum for Adult and Continuing Education.

Ideas for potential future research

I have learned a huge amount during the UEA EdD programme and I now feel like I am a social scientist! Here are a few ideas for future studies I would like to undertake.

A project with similar aims and design to explore the perceptions of registered nurses (not former HCAs) and other health professionals on the knowledge of HCAs.

A similar study with HCA participants who are currently working as support workers.

An ethnographic study of HCAs in practice (non-participant observation) to investigate the development of embodied knowledge of HCAs.

List of acronyms

A level	Advanced level (GCSE)
BSc	Bachelor of Science (degree)

BTEC	Business and Technical Education Council
º C	Degrees Centigrade
CSW	Clinical Support Worker (Scotland)
DH	Department of Health
DHSS	Department of Health and Social Security
DSDP	Dangerous and Severe Personality Disorder
ECG	Electrocardiogram
ER	Epistemic Relations (to knowledge)
FE	Further Education
GP	General Practitioner
HCA	Healthcare Assistant
HE	Higher Education
HEI	Higher Education Institution
LCT	Legitimation Code Theory
mm Hg	millimetres of mercury
mmol/L	millimoles per litre
NHS	National Health Service
NMC	Nursing and Midwifery Council
NVQ3	National Vocational Qualification (level 3)
OU	Open University
PG	Post Graduate
RCN	Royal College of Nursing
SR	Social Relations (to knowledge)
TA	Teaching Assistant
UEA	University of East Anglia
UG	Undergraduate
UK	United Kingdom
UKCC	United Kingdom Central Council (for nursing and midwifery)

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Appendices

Appendix 1 Participant recruitment email for registered nurses working in NHS Trusts

Do you have a story to tell about life at university as a health care assistant on the way to becoming a nurse? Research is under way to investigate the experience of qualified nurses who were previously health care assistants. The aim of the study is to find out what former HCAs think about their time at university. It is hoped that this will lead to a greater understanding of the challenges and rewards of higher education for this group of NHS staff. Taking part in the study will involve having a discussion with a researcher. Volunteers will receive a £20 M&S voucher. If you are interested in finding out more about what it would mean to take part, please contact Kevin Bryant on 020 7848 3551 or by email kevin.bryant@kcl.ac.uk. (This study has received ethical approval from the University of East Anglia)

Appendix 2 Participant recruitment flyer for registered nurses working in NHS Trusts

Were you a healthcare assistant

before becoming a nurse?

If the answers is 'yes', would you consider taking part in my research?

I am interested in finding out about your experiences at university.

This would involve a discussion that would last for about one hour.

If you would like to know more (without obligation), please contact

Kevin Bryant

on 020 7848 3551

or by email kevin.bryant@kcl.ac.uk

Volunteers will receive a £20 M&S voucher

(This study has received ethical approval from the University of East Anglia)

Appendix 3 Participant recruitment flyer for undergraduate student nurses

Were you a healthcare assistant

before becoming a student nurse?

If the answers is 'yes', would you consider taking part in my research?

I am interested in finding out about your experiences at university.

This would involve a discussion that would last for about one hour.

If you would like to know more (without obligation), please contact

Kevin Bryant

on 020 7848 3551

or by email kevin.bryant@kcl.ac.uk

Volunteers will receive a £20 M&S voucher

(This study has received ethical approval from the University of East Anglia)

Appendix 4 Participant recruitment email for undergraduate student nurses.

Do you have a story to tell about life at university as a health care assistant on the way to becoming a nurse? Research is under way to investigate the experience of student nurses who were previously health care assistants. The aim of the study is to find out what former HCAs think about their time at university. It is hoped that this will lead to a greater understanding of the challenges and rewards of higher education for this group of NHS staff. Taking part in the study will involve having a discussion with a researcher and possibly other student nurses who were previously HCAs. Volunteers will receive a £20 M&S voucher. If you are interested in finding out more about what it would mean to take part, please contact Kevin Bryant on 020 7848 3551 or by email kevin.bryant@kcl.ac.uk.

Appendix 5 Participant information sheet

Title of project

An exploration of the transition experiences of former healthcare assistants through higher education to registered nurse status.

My name is **Kevin Bryant** (KB). I am a lecturer in the school of nursing and midwifery at King's College London and a doctoral student at the University of East Anglia, Norwich. The research project described here will form the basis of my thesis for the award of Doctor of Education. My research supervisor is Dr Yann Lebeau in the School of Education and Lifelong Learning.

You are invited to take part in a research study.

This study is about healthcare assistants' (HCAs) experience of university. You may be a former HCA who is already on a nursing degree course or you may be a former HCA who has completed a nursing diploma or degree course in the UK. I am interested in finding out what your experiences have been.

What is the purpose of this research?

The purpose of this research is to investigate the social and academic experiences of former HCAs who

- are currently studying for a nursing degree at university

- have completed their university nursing course in the UK.

I hope the findings will help to improve the experience of future HCAs who wish to study for a degree in nursing.

What happens if you decide to take part?

If you decide to take part in this study, you will be invited to an individual interview with the researcher (KB). The interview will take place at your work site if you are a qualified nurse and at the university if you are a nursing student. The interview will last approximately one hour. It will be recorded and I will take notes as we talk.

The topics for discussion at the individual interview will be about

- what you learned as an HCA and your route into university

- the challenges, difficulties, rewards and successes that you may have experienced while at university

- how your previous education or life experience may have helped or hindered your progress to university and your experience on the degree course

- how your HCA experiences have influenced your learning at university

- what part your university and HCA experience have played in your transition to nurse

What should you do if you are interested in finding out more about the study and possibly taking part?

If you are interested in taking part in this study, you can contact me (Kevin Bryant) by phone on 020 7848 3551 or by email at kevin.bryant@kcl.ac.uk

I will answer any questions that you may have and explain in more detail what will be involved in the individual interview process. You can then decide whether you want to take part in the study. If you agree to take part, we will agree on a mutually convenient date, time and location of the individual interview. You will be required to sign a consent form and to abide by the conditions of participation in the study. You will receive a copy of the consent form.

What if you do not wish to participate or if you change your mind and leave the study?

Participation in this research study is completely voluntary. You may decide not to participate. That is fine and no one will know that you expressed an interest. You may also change your mind and leave the study at any time without giving a reason. Your involvement in the study to that point will not be shared with your employer or university. Complaints about any aspect of the research should be sent to Dr Nalini Boodhoo (Head of School of Education and Lifelong Learning, University of East Anglia) N.Boodhoo@uea.ac.uk.

What about confidentiality if you take part? Who will know that you have taken part in this study and what will happen to the information that you give?

I am the only person who will know that you have taken part in this study. All information that you provide during the course of the study is strictly confidential and will not be shared with anyone. Only I will listen to the tape recordings and type-up the discussion. My research supervisor (Dr Yann Lebeau) will read parts of the typed-up discussion (the transcript). Your name and any other identifying features will have been removed from the typed transcript.

All tape recordings, hand-written notes and typed-up transcripts will be kept securely in a locked cabinet and will be destroyed at the end of the research period. Your name will be removed in the transcript during the typing-up process so that your contribution will remain anonymous. You will receive a summary of the interview analysis. I will be interested to hear your comments and feedback at this stage.

Where will the results of the study be presented? How can you find out the results?

The results of this study will be presented in my doctoral thesis. The findings may also be presented at research conferences and in journal publications. I will send you a summary of the final research findings. The

information that you provide as part of the study will be anonymised and so will not be attributable to you. The findings may be of interest to NHS Trusts and to universities who wish to maximise the success of former HCAs who are sponsored to a university nursing course.

Appendix 6 Participant consent form

Name of participant

Title of project: An exploration of the transition experiences of former healthcare assistants through higher education to registered nurse status.

Name of researcher:	Kevin Bryant
Contact details:	020 7848 3551 (office)
	07850 928687 (mobile)
	kevin.bryant@kcl.ac.uk
	Room 1.29 James Clerk Maxwell Building
	Florence Nightingale School of Nursing and Midwifery
	King's College London
	57 Waterloo Road
	London SE1 8WA

Research supervisor:	Dr Yann Lebeau
	University of East Anglia

Agreement to participate

I agree to take part in the research project described in the Participant Information Sheet.

My questions about the research have been answered.

I understand that

- I will take part in an interview at a date, time and location to be confirmed

- The interview will be recorded

- I can ask questions about the research at any time before, during and after the interview

- I can withdraw from this research study at any time and for any reason (without giving a reason if I don't wish to)

- A summary of my interview will be provided to me for comment and feedback to the researcher

- A final summary of findings will be provided for me at the end of the study

- My contribution to the study will be confidential and anonymous

- I must respect the confidentiality and anonymity of all other participants in the study.

I agree to the researcher processing the information that I have provided as part of the study.

Name of participant (print)…………………………………

Signed ……………………………………………

Date……………………….

Please return this consent form at the interview. Thank you.

Appendix 7 Ethical approval

RE: Ethics committee 10 April EdD

Dear Kevin,

Your application was reviewed by the EDU research ethics committee today. I'm pleased to let you know that it was approved with two small provisos.

Please would you make two small changes to the information and consent documents? The information sheet should state that any complaints about the research should be sent to the Head of School, and give the name and email contact details. And we recommend that you remove the witness signature from the consent form as this is not needed.

Provided these small amendments are made, your application is approved and you can begin your research.

With best wishes, Jackie.

Dr Jacqueline Watson
Chair EDU Ethics Committee
School of Education and Lifelong Learning
University of East Anglia Norwich Research Park
Norwich NR4 7TJ, UK

Email: Jacqueline.Watson@uea.ac.uk
Telephone: +44 (0)1603 592924

Appendix 8   Semi-structured interview guide

Say a little more about me…

Teacher at FNSNM

Background in science/biology

I'm not a nurse

I'm learning how to be a social scientist

Have always been interested in how people make their way to university and their experiences when there

Hence this project!

Refer to the participant information sheet… any issues or questions?

Refer to the consent form… read out the key points… possible focus group…you can ask questions at any time… you can withdraw at any time….you will receive a summary of your interview and a summary of the study findings …. your contribution will remain anonymous…

Is the form signed and dated?

Some of my questions may seem a little obvious or basic.

….this is an early stage for me… so it may seem a little disjointed at times as I refer to my questions!

There are no 'right or wrong' answers. Please answer how you feel / think.

Some questions may seem intrusive. Please tell me if you are not happy about answering any questions.

Start from the present…

What is your role now?

Now I want to go back in time…

Could you tell me more about your role as an HCA?

How did you become an HCA?

What kind of things did you learn while you were an HCA?

What did you need to know to be an effective HCA?

Could you describe your route into university?

Can you remember when and how the idea of doing a university nursing course first occurred to you?

What motivated you to embark on the course?

What were the encouraging factors?... and the discouraging factors?

What did you think that university life would be like?

Was it how you thought it would be? If so / not….how?

What strengths did you feel that you brought with you to university?

Did your previous HCA experience help or hinder your progress at university? If so, how?

What kind of demands did you think that the university would make on you?

Did these demands actually materialise? Or were the demands different to what you expected?

Can you remember how you felt on the first day?

Did the university give you a sense of welcome?

What was the general atmosphere during ….the first week?... the first term?

Did this change as time went on? If so, how?

Did you need to adjust in any way? If so, how?

How did you view nursing before university?

How do you view nursing now?

How did you view nursing after university?

If (name) the HCA in (1987 / 2010) could see (name) the nurse/ university student now, what would s/he say?

Can you remember / describe your first feelings about the academic demands of the course?

Did this change as time went on? If so, how?

What was your earliest recollection of university life?

What was the most significant thing that happened / that you can remember?

What was the most challenging aspect of the course?

What was the most rewarding aspect of the course?

What was the most important thing that you learned during your time at university?

What did you enjoy about university?

Were there any aspects or issues of university life that you struggled with?

How did you deal with the assessments at university?

Did / do you know any other former HCAs on your university course?

Did you collaborate in any way during the course?

If so / not, how and why?

Can you remember any particular high points / low points during your course?

Could you describe / elaborate / explain?

How did you relate to HCAs who were working on wards and departments while you were on clinical placement as a student?

Are you working with HCAs now?

How would you describe the relationship between HCAs and nurses in general?

When you were an HCA?

When you were a student?

Now?

How did you see yourself when you emerged from university? What impact has the university course had on your life / who you are?

What do you think are the issues now for HCAs who want to become nurses?

Have I missed anything? Is there anything that you would like to add?

Appendix 9   Themes arising from the coding

Experience of HCA	Motivation for nursing	University experience	Relationship between HCA and nurses	Experience of clinical placements	Role as nurse (if registered)
Route into care work	Influence of nursing role model	Collaboration with student colleagues	Staff nurses look down on HCAs	The shock of clinical practice	Attitude to HCAs once registered
Role of HCA	Frustration with limited role of HCA	Anticipation of university	Staff nurses value HCAs	Disclosure of former HCA role	Value of combined HCA and nurse in one person
Learning as HCA	Senior staff identify potential attributes	Relationship with other students	Former HCAs value current HCAs	Linking theory with practice	Former HCAs support development of current HCAs
Knowledge of HCA	Desire to learn (knowledge seeking)	Challenge to learning	Teamwork between nurse and HCA	Experience of non-HCAs	Responsibility in current nursing job
Previous education	Desire for status and responsibility	Outcome of university experience		HCA experience gives confidence in practice	
Responsibility as HCA					
Training as HCA					

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