TITLE: Dyslexia and Learning Difficulties: Nurse Mentors' experiences of students who struggle to learn in the practice environment

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ABSTRACT

It is thought that dyslexia and learning difficulties affect approximately 10% of the U.K. nursing population. There is a global shortage of nurses which makes a policy of widening participation a prudent recruitment strategy, meaning that this percentage is unlikely to drop even though nursing is now an all degree entry profession.

Nurse mentors are central to the practice learning of student nurses and this equates to 50% of the course requirements. Nurse mentors receive training around disability which incorporates learning difficulties but this tends to be factual. Little is known about how nurse mentors support and work with students who may have a learning difficulty in the clinical setting. The aim of the study was therefore to explore mentors' experiences with students who have, or may have, a specific learning difficulty such as dyslexia.

Using an adapted constructivist grounded theory methodology, 24 nurse mentors were recruited allowing the formulation of a substantive theory to explain mentors' experiences with these students. This is encapsulated by the phrase 'To mentors, dyslexia is just spelling'. Three sub-categories are presented to establish the context in which the theory is set, and these are: 'The practice environment', 'The mentor/student relationship' and 'Dyslexia and learning difficulties'. Extant literature is used as a resource to further explore issues arising within these categories.

Researcher reflexivity contributed significantly to the research process, providing insight into the researcher's thinking and the process of theory production.

The research offers contributions to Higher Educational Institutions, NHS Trusts, all levels of the nursing workforce, and to students who have, or may have a learning difficulty. Recommendations for practice centre on promoting knowledge and understanding of dyslexia and learning

difficulties in the practice environment so that cultures supportive of students with these difficulties are encouraged.

KEY WORDS: dyslexia, learning difficulties, nurse mentorship, constructivist grounded theory.

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CHAPTER ONE: THE RESEARCH DEFINED

DIARY EXTRACT 1: A LITTLE ABOUT ME

I have been a nurse lecturer now for 12 years. My own knowledge of the practice environment as it relates to nursing, means that I am aware of the complexity that exists in terms of some of the contextual, social, relational and cultural factors that contribute to this busy, dynamic and ever changing setting. However, I have not actually worked as a nurse in the hospital environment for over twenty years and my training to become a nurse took place long before the move to teach nursing in higher education institutions and gain academic qualifications. This came about with the introduction of 'Project 2000', the national initiative to move the major responsibility for nurse training along with all academic aspects, into higher education.

The nurse training I experienced, was more akin to an apprenticeship model. As a student nurse, I was interviewed, trained and assessed by hospital staff. I worked on the wards for the majority of my time and occasionally went, with my fellow students, to the 'School of Nursing' (located within the hospital grounds), for a few weeks of theoretical input. I received a wage packet at the end of every month and on this I was described as a 'manual labourer'.

I have also never trained or worked as a nurse mentor as this role came into being after I had become a health visitor. In my role as a health visitor (my last professional practice role before coming into higher education) I did take nursing students out with me for a week at a time and, since becoming a nurse lecturer, I have developed an overview of current nursing and mentoring practice by maintaining links with practice areas and in my role delivering mentor updates, but I do not have hands-on experience myself.

On the one hand, this has been beneficial for the study, as I do not have personal experiences that might cloud the issues discussed by mentors, but it also means that I cannot perhaps fully appreciate the complexities of this role and the practice environment, as it exists today. These personal elements need to be understood as, no matter how reflective and objective I try to be, the interpretations I make are still personal to me. I am on the outside, looking in, which could be argued as being a more objective viewpoint than being involved and in the middle of the action, but I am still influenced by what I see and what I learn from others. I am a key feature of this research and what has influenced me will influence my research.

INTRODUCTION TO CHAPTER

This chapter introduces the study that is reported in the following chapters of this thesis. It begins with background information including an appreciation of the problem and existing knowledge related to the problem

from personal, nursing and learning difficulties perspectives. The aim and the objectives of the study is provided along with the research questions. The importance to this project of reflexive activities is also included in this chapter. The chapter then concludes with an overview of the organisation of the thesis.

CLARIFICATION OF CONCEPTS

Clarification of two concepts is important to this project. Firstly, I sometimes refer to students who struggle to learn in the practice environment rather than to students who have learning difficulties or a specific learning difficulty such as dyslexia or dyspraxia. This is for two reasons. Students who struggle to learn may not have been assessed or diagnosed with a specific learning difficulty as they have adopted strategies to manage their learning needs – both in practice and theory. They may also be awaiting assessment and so may not have a specific diagnosis. In addition to this, even if students have a specific diagnosis, they may choose not to confide this to practice staff. This means that mentors in practice may have supported a student with learning difficulties without realising. It was also thought interesting to see if mentors made any distinctions and connections between students struggling to learn in practice and having a learning difficulty.

This is not to suggest that the name or 'label' given to someone who has dyslexia or another learning difficulty, is not important. Riddick (2000) contests that labels can be positive and negative, formal or informal and can both create and alleviate stigmatisation depending on the user, the context, the culture and the power relationship between communicators. She suggests that the label 'dyslexia' developed from a medical model and that the labels 'specific learning difficulties' and 'learning difficulties' developed from an educational model. She also contests that the term 'dyslexia' in spite of its medical origins, is the preferred label for dyslexics and their families in a social context, as it allows access to a wide range of services and support which in turn helps to facilitate identification with

'the culture of dyslexia' and the start of empowerment for this group (Riddick 2000, p 664).

The choice of label is significant in terms of personal empowerment and power within relationships. Research by Taylor et al (2010) investigated the difference in children labelled either dyslexic or as having a general specific educational need (SEN) in terms of their self- esteem and the children in the 'general SEN' group were found to have significantly lower self-esteem scores than those in the 'dyslexia' group. A control group of children without any learning difficulties was included in the study and no significant difference was found between the self-esteem scores of the 'dyslexia' group and the 'control' group. So the name or label given, can have important implications for those who receive a diagnosis relating to learning difficulties and the label 'dyslexia' appears to have more positive connotations than less specific alternatives.

Secondly, the term practice environment is often used within this study and it is synonymous with the practice setting and the clinical environment and refers mainly to acute hospital settings (mainly wards unless otherwise stated) for all adult and child health mentors and most mental health mentors (only one mental health mentor works in a community setting).

BACKGROUND TO THE STUDY: PERSONAL INVOLVEMENT

In relation to my personal involvement with the subject area, this research topic has grown with me since I became the personal tutor for a very bright articulate student nurse who was diagnosed with dyslexia towards the end of her first year on the Pre-Registration Nursing Course (diploma level) at the university where I teach. I had been a nurse for over 20 years, a health visitor for 8 years and a nurse lecturer for four years; and I thought that I had a reasonable idea about what dyslexia involved. The experiences with this student proved to me that I did in fact know very little about dyslexia, how it affects the individual and what this means for them in terms of their ability and success in studying in higher education and in particular in learning in the nursing environments out in practice.

The student's initial problems were out in practice and I did not, at the time, relate them to dyslexia. She found the hectic and noisy ward environment difficult to adapt to and learn in. She reported that her mentors found her to be 'slow' and 'lacking in confidence'. She did however pass her ward placements without problems – implying that she was more concerned about her progress than the mentors and that she worked extremely hard to meet her learning outcomes. I have since learned how difficult it is for dyslexic people to process information quickly and efficiently when there are is a lot of other distracting sensory data competing for their attention (such as strong neon lighting, background noise and the physical activity of others).

Following difficulties relating to her ability to cope with academic study, a full educational assessment of her learning needs took place at the end of her first year. From this it was diagnosed that she had a wide range of learning difficulties including some visual and memory problems as well as the more well-known problems relating to reading and putting thoughts down on paper. She was also found to have a very high I.Q. An educational support package was put in place for her and in the exam at the beginning of the second year she was given a separate room, extra time and a writer to help her. She received the top mark out of the whole cohort for this assessment and was initially thrilled. An encounter with the module leaders for this exam a little later however, took the pleasure away as, although one congratulated her on her success, the other made the comment that she "... obviously didn't need the extra time after all". The student felt that the lecturer was implying she had cheated in some way and was very upset. She asked me to speak to the lecturer as she didn't want to make a formal complaint but felt the lecturer should know the effect these comments had had on her. The lecturer was very concerned that they had upset the student as this was not their intention, however they did go on to speak of how they found the idea of dyslexia to be

intriguing as they found it hard to know where the distinction between intelligence and dyslexia really lay.

The student went on to pass the Pre-Registration course, taking and passing two modules at degree level in her third year. In practice she succeeded in developing strategies to help her manage the busy ward environment but gravitated towards community placements which she found much less stressful due to differences in the general working environment and the one-to-one nature of the work which better suited her abilities to process information.

My experiences with this student, and some of the beliefs and attitudes I have encountered in the lecturing and mentoring populations for nursing students since these events, have caused me to contemplate the lecturer's and mentor's role in supporting students with dyslexia. How well prepared are we to meet their needs effectively? I only began to think that she might be dyslexic after looking at her written work for a forthcoming essay, even though on her first clinical ward placement she had talked to me about problems and worries that I now, with hindsight, would class as typical learning difficulties associated with dyslexia – i.e. 'getting on the mentor's nerves' (her phrase) because of the need to ask for continual reassurance, problems in coping with what was a busy, noisy environment, including problems with the lighting and answering telephone calls and problems in remembering all of the things that were asked of her by others. It is perhaps not difficult to understand why her mentor might have been a little worried about her competency in practice because without appropriate knowledge or experience of working with students who had these types of learning difficulty, these problems could easily be attributed to lack of confidence, having an anxious personality or being 'not very bright'.

BACKGROUND TO THE STUDY: NHS BACKDROP

In relation to background that is relevant to understand the situation and circumstances in which the nurse mentors and students are working, it should be noted that I have carried out this research at a very challenging time for nursing and the NHS. The practice environment has always been busy. There have always been problems with less than adequate staffing levels on the wards. There have always been conversations – since Project 2000 – that students are being counted in the numbers on wards and fail to be supernumerary. However, since the enquiry into the high level of patient deaths that were attributed to substandard care and nurse failings at two Mid-Staffordshire hospitals between January 2005 and March 2009 (Francis 2013), nurses and nursing have faced reputational onslaughts, being accused of lacking in compassion, competence and losing the ability to care.

The political and economic state of the country has had an impact on the nursing profession. The austerity measures of the last few years have forced NHS trusts to cut back on their budgets and try to find ways to meet patient needs while spending less money. As the NHS workforce is one of the biggest costs to the NHS, employing more than 1.35 million people (Campbell 2013), it could be said that cuts to staffing were inevitable. It was reported in 'The Guardian' in December 2013 that the Department of Health had admitted that 7,060 NHS clinical staff, and specifically 3,859 nurses, midwives and health visitors, had been made redundant since the change of government in 2010 (Campbell 2013).

Due to the increase in workload placed upon those nurses who continue to work for NHS trusts, there has been an increase in the pressures felt by nurses, the vast majority of whom, I believe, still strive to provide a decent standard of care for their patients in very difficult circumstances. Many are not staying in the profession once trained due to disillusionment and burn out. A shortfall in trained nurses employed by the hospital trusts in particular has meant that these trusts have had to resort to other measures

to staff their wards. This includes using a high number of temporary bank or agency nurses – for which the cost of wages is elevated – or going to a variety of other European countries to try to recruit staff. Two local hospitals have made several trips to Portugal to recruit nurses for their hospitals in the last eighteen months but, in spite of this, a significant shortfall still exists.

Running in parallel to this, science, technology and medicine have continually developed and evolved. This has resulted in an increase in the amount of services available for patients. In addition, in-patient stays in hospital have shortened dramatically and patient through-put has increased (RCN 2010). People have come to expect the NHS to deliver free, timely treatments for everyone at the point of service, and so patients' expectations of the NHS and of nursing have risen and continue to rise. This puts increasing pressure on a depleted nursing force to meet the accumulative demands made upon it.

One final thing that has impacted on the nursing profession in recent years is the move for nurse training to become 'all-degree' based. In September 2013, the university I work for, took the step of phasing out the diploma route into nursing in favour of an all degree programme, in line with a national government initiative to bring nurse education in England in line with the rest of the world.

This move was endorsed by professional bodies as a national requirement for nurse education but has prompted criticism from a variety of other sources. Newspapers came up with damaging headlines such as "Too posh to wash" (Carvel 2004). In answer to this, The Royal College of Nursing (RCN) hosted an independent commission into nurse education to review the evidence for this damaging media portrayal. The results of the Willis Commission in 2012 (Willis 2012) found no evidence to support the fears that all degree training for nurses would result in them being 'too posh to wash', however it could be argued that the media campaign has left a

bigger impression on the minds of the public than the Willis Commission Report (ibid).

The move to all degree nursing may be compounding the shortfall in trained and registered nurses as, with the exit of the diploma route into nursing, a large number of people who would have been eligible to apply for the diploma route are having to find other ways of developing a career in nursing. Alternative methods of training people to work alongside the trained and registered degree nurse have been developed and these are hospital based and have mainly taken the form of apprenticeship-type models. This apprenticeship model has only recently been expanded to provide a route for work-based students to progress through foundation degree to full B.Sc. (Hons) status, and it is only with this last step that the student will then be registered with the Nursing and Midwifery Council (NMC) as a qualified nurse. There are only two universities in the country at present, offering this flexible route to full degree status but it appears popular with the Hospital Trusts who will return to a closer relationship with the students they sponsor.

DIARY EXTRACT 2**:** TIMING OF THE STUDY

One question I posed myself was that if I carried out this research five or ten years earlier, or if I carried it out five or ten years in the future, would I get the same or similar results? My feelings are that although there is always going to be an element of contemporary significance that will inevitably date this work, and that the factors that impact on the nursing profession and the nursing environment may change in relation to specific medical, scientific, political and economic initiatives of the time, there will always be a need to train nurses and it is unlikely that there will ever be enough money to do this in a luxurious style. Therefore mentors are always going to experience environmental pressure and stress in relation to trying to meet the competing needs of being responsible for patient care and ward management, whilst at the same time mentoring and supporting students.

The overall picture then is one of a profession under severe stress and this needs to be understood in relation to considering the experiences that

mentors have discussed during the course of this study. Understanding how mentors perceive their working environment and how it translates into a learning environment for their students is necessary in order to understand how dyslexia figures in their consideration of student learning and why perhaps they appear not to prioritise it in terms of thinking about how and why students may struggle to learn in practice.

BACKGROUND TO THE STUDY: DYSLEXIA AND LEARNING DIFFICULTIES

Dyslexia as a 'disability', has derived from two pieces of legislation in the United Kingdom, namely The Disability Discrimination Act (DDA: HMSO 2005) and the Special Educational Needs and Disability Act (SENDA: HMSO 2001). These two acts have since been subsumed under the Equality Act (2010). Classification of dyslexia as a disability could be said to have a labelling effect on individuals, but these two pieces of legislation meant that it was unlawful to discriminate against a disabled person in work (DDA 2005) or in education (SENDA 2001) and organisations must make 'reasonable adjustments' if their arrangements place disabled people at a substantial disadvantage compared with non-disabled people. Dyslexia is also known as a 'silent' disability in that it is not immediately obvious to the general public that someone has dyslexia and this may never become obvious unless there is a need for processing of the written word.

Reasonable adjustments could make a big difference to a nurse student in the practice environment however, what exactly constitutes 'reasonable adjustment' is not specified and this makes it a complex and sometimes contentious area. Sanderson-Mann and McCandless (2005) consider that the size of the organisation and its level of resources; the abilities, experience and expertise of the individual with dyslexia; the terms of employment (part-time or full-time) and the overall cost and amount of disruption the adjustments might require might all need to be considered. This complexity is even more evident when considering what might constitute reasonable adjustments in the nurse practice environment, as student placements can vary greatly in terms of speciality, routine and

expectations of students and mentors alike. The outcome could be that reasonable adjustments have to be changed and be re-negotiated every time the student is assigned to a new placement. The reality, in terms of what I have experienced, is that reasonable adjustments in the nurse practice environment are rarely formerly discussed and documented.

AIMS, OBJECTIVES AND RESEARCH QUESTIONS

AIM: This study aims to identify and explore issues relating to the experiences that nurse mentors have when working with and supporting students who struggle to learn in the practice environment, with a specific interest in those students who have (or may have) a specific learning difficulty such as dyslexia. Objectives and research questions for the study therefore, were as follows;

OBJECTIVES

- To explore nurse mentors' direct experiences of supporting individuals who are dyslexic (or their perceptions about how they might support them).
- To explore the knowledge base of nurse mentors in relation to dyslexia and 'reasonable adjustments'.
- To explore the nurse mentors' confidence in supporting students with dyslexia in practice settings.
- To raise awareness of the issues faced by nursing students who have dyslexia.

RESEARCH QUESTIONS

- How do nurse mentors experience and perceive dyslexic students in the practice environment?
- What do nurse mentors think and know about dyslexia and how does this translate into their work with dyslexic students?
- How well prepared and confident do nurse mentors feel about supporting dyslexic students?

SCOPE OF STUDY

Research into this area is important because there is very little research from the lecturers' perspective into their experiences with dyslexic students and even less into the mentors' perspective. I have chosen to look specifically at the mentors' perspective as it is hoped that the research will provide new knowledge in the field, highlighting aspects of the mentors' role that have not been considered before. Research into the experiences of mentors with dyslexic nursing students in practice could lead to new ways of supporting mentors in their training (pre and post registration) and through mentorship updates. This could lead to an improvement in the confidence and competence of mentors in supporting dyslexic students which would have positive outcomes for students, mentors and also therefore, for patients. Pollak (2005) maintains that any strategy put into place to support a student with dyslexia is also likely to help many other students as well, so there may be positive repercussions in relation to the learning and development outcomes for all nursing students in practice.

It is hoped that the findings will be recognisable to people familiar with the mentor/mentee situation and so be modifiable to similar settings (Hunter et al 2011). This means that the research may have implications not only for pre-registration nursing courses, but for all courses which include practice placements for students, where mentors in practice are required to support students on these placements. Implications would not just be in relation to the institute of Higher Education but also for Hospital and Community Trusts and strategic commissioning groups who are responsible for the employment of mentors.

I am therefore interested in raising awareness of dyslexia and in so doing; helping nurse students understand the mentor perspective and what might be required of them to help promote effective and supportive relationships in practice, promoting greater understanding of dyslexia and learning difficulties amongst health professionals, encouraging mentors to develop

an interest in the needs of dyslexic students so that reasonable adjustments can be more readily negotiated and finally, encouraging Health Education Establishments and NHS Trusts to improve the preparation and support for mentors in their role working with students who have learning difficulties.

INTRODUCTION TO METHODOLOGICAL ASPECTS

The study is guided by a constructivist grounded theory methodology that acknowledges the interpretive nature of social interaction. This approach, which will be explored in depth in chapter 3, is characterised by the search for theory grounded in the data collected. Tenets of grounded theory include theoretical sampling, rigorous data analysis via the constant comparison method and a reflexive approach using reflexivity and memo writing to document the course of analytical thinking and theory production.

During the early phase of this study, where methodological approaches were being considered, grounded theory appealed to me as I perceived it as having the potential for credibility vis-à-vis the more quantitative medical model that I felt nursing aspired to. My thinking on this has changed whilst undertaking this study and I now better appreciate qualitative methodologies for their own merit and ways in which the nursing profession can benefit from them.

This methodology has been adapted to meet the pragmatic requirements encountered during the study and full explanations for decisions made are provided throughout.

REFLEXIVITY AND RESEARCH

DIARY EXTRACT 3: THE NEED FOR REFLEXIVITY

Throughout this project I have been working full time as a nurse lecturer, I have also been a nurse in other roles for over 30 years. I am aware that difficulties can arise due to role conflict in such situations (Newbury 2011, p31). My background as a nurse will definitely have had an impact on this research, not just in terms of knowledge and understanding of the environment, but also in terms of the political, social and feminist values that I have been exposed to over time. Now, as a nurse lecturer, I work with students every day and I have perhaps become more sensitised to looking out for and addressing the needs of those students who struggle to learn in the academic environment – or as I often simplify it, who struggle to put their thoughts down on paper. I appreciate that I am at risk of making assumptions based on my experiences to date, I therefore need to become more aware of what those assumptions actually are. As already stated I am not an experienced researcher and although perhaps aware of the concept, I am also inexperienced in the art of reflexivity. I knew that my professional and personal behaviour, values and beliefs would affect my perspective throughout my research project, so I knew I had to learn to become reflexive.

If, in keeping with the interpretive positioning of this study, I believe that qualitative researchers are not objective observers of social phenomena and that instead they are intimately linked with the research they conceive, plan, design and carry out, then I will undoubtedly influence the process and results of my research in any number of ways. Recognising these influences is a way of enhancing transparency and credibility within qualitative research studies (Walker et al 2011, p 38). One way of acknowledging researcher subjectivity is through reflexivity.

Kaufman (2012, p70) describes reflexivity as '… a process of seeing and a process of being" and states that "To be reflexive requires that we are fully conscious of the lenses through which we view the world" (ibid). Reflexivity has been particularly linked with grounded theory methodologies. Birk and Mills (2015, p 52) define reflexivity as an active process of systematically developing insight into your work as a researcher to guide future actions and these authors maintain that a key strategy in

promoting quality within grounded theory studies is the maintenance of an audit trail that consists of memos and reflective writing. Charmaz (2006, p72) devotes a whole chapter to memo-writing, which includes both reflective and analytical writing, and describes this act as a 'pivotal intermediate step' between data collecting and writing drafts of papers.

There are those who caution that researcher reflexivity can cause an author to be too self-absorbed (Holloway and Biley 2011, Newbury 2011) and Cutcliffe (2003, p 144) criticises reflexivity on the assumption that, in order to be reflexive we need to understand ourselves and it is impossible to obtain a complete knowledge of ourselves because much of our knowledge is unconsciously realised. However, I believe that if the researcher is part of the research they produce then any attempt to understand the researcher's intentions, leanings, emotions and background, even if this is imperfect and partial, can only help the reader of the research to make better sense of what they read and judge for themselves how this may have impacted on what has taken place and in particular on the findings of the study.

The incorporation of reflexive methodologies within research attempts to reconcile us with the idea that even the most diligent of qualitative researchers is still, first and foremost, a human being, relating to other human beings (Skinner 1977 cited in Barnes & Roche 1997). I believe the effect of my existence on the dynamics of what is being observed needs to be accounted for, and the premise is that research findings will be richer for the added insights provided (Kleinsesser 2000, Salzman 2002).

The implication for research activities then is to, on the one hand embrace the subjective nature of the qualitative research process as inevitable, whilst at the same time, trying to maintain a commentary alongside research activities that can be revisited and scrutinised as part of the audit trail and may even become part of the data collected and analysed depending on the researcher's commitment to reflexive processes.

There are no real frameworks or models to help the student master or practice reflexivity however Colyar (2009) asserts that writing is a symbolic system which articulates what we know, but also a tool whereby we come to know what we know. Osterman and Kottkamp (1993, p73) talk about naming our reality through the process of writing. They argue that writing allows us to pause, review, reread and rethink the ideas we are formulating and to capture our thought processes in a way that can be returned to in the future for reassessment.

Writing things down has always helped me to engage with ideas and concepts more deeply so I decided that writing things down would be a good way for me to engage with the art of reflexivity. As part of the memo-writing process, I decided to maintain a reflexive journal during the course of the research process. This journal has become an important part of the research study itself. It has helped to provide me with insight and understanding in relation to many aspects of the research process, and has offered the opportunity for me, time and time again, to reflect not only on what was happening but also on how I was thinking about and processing what was happening. This has been fundamental in helping me to understand the reflexive nature of my role within this research study.

At the beginning, not being used to recording thoughts, ideas and feelings in writing, I used it in quite a self-conscious way. However this became easier over time and eventually became an essential element of the momentum of the study itself. It has also been quite therapeutic to use the first person as a writing medium. It has helped me to identify myself as a source within the work and from there to adopt a more critical perspective on my work.

One of the main principles and procedures of grounded theory relates to memo-writing. An activity that Glaser himself described as the bedrock of grounded theory (Glaser 1978, p83). Although in grounded theory the memos have a distinctly theoretical purpose - to organise thinking about how the data fits together and to help articulate patterns and emerging

links within the data (Engward 2013, p39) – this idea of memo writing also fits in well with the use of a reflexive journal. I kept a separate journal for analytical memos but both diaries and the memo book were invaluable means of scrutinising and developing thoughts and ideas that would otherwise have been lost along the way. I used the diary as a kind of free flow of thought and did not edit or categorise thoughts as my main intention was to commit them to paper as soon as was convenient. Some thoughts were simple and just needed recording and some were more complex and were worked through in the act or writing itself and often when re-visited at a later date. The original thoughts might be useful in their own right but it was the reviewing of what was written that was most valuable in terms of, theory development, reflexivity and insight into personal assumptions and motivation. I have tried to covey some of this in the extracts from the diary that are threaded through the thesis.

LAYOUT OF THE THESIS

Chapter 2 of the thesis presents a basic literature review. In line with grounded theory methodology, the literature review contains only that which was required for the original research proposal. All other extant literature has been incorporated into the Findings and Discussion chapter later in the thesis.

Chapter 3 presents the research design, covering the philosophical and methodological underpinnings of the study along with rationale for the adoption of a constructivist/interpretive approach; discussion of recruitment and selection procedures; and data collection and analysis methods, demonstrating how they relate to the constant comparative model, but also how they were adapted to meet pragmatic necessities of the study.

Chapter 4 presents the findings of the study using extant literature to explore relevant issues in more depth. The findings are organised under headings defined by the three core categories developed during analysis;

'The Practice Environment', 'The Mentor/Student Relationship' and 'Dyslexia and Learning Difficulties'.

Chapter 5 presents the theory emergent in the study; 'To mentors, dyslexia is just spelling'. The theory will be explicated and the theoretical significance of the study will be considered. The chapter concludes with consideration of areas for further theoretical development.

Chapter 6 concludes the thesis by summarising the overall findings of the study and presenting study limitations along with recommendations for future practice.

CHAPTER 2: LITERATURE REVIEW

INTRODUCTION TO CHAPTER

Literature reviews within grounded theory studies should have a different focus to those conducted for other research projects. Adopting a classical approach to grounded theory (Glaser and Strauss 1967) requires the researcher to develop theories from the data collected, using constant comparison analytical methods, rather than begin the research with a particular theory in mind. Conducting the literature review before data collection begins could therefore influence an open minded approach to the data.

On the other hand, it is unusual to encounter research that is carried out by people divorced from any kind of interest in the subject they study or for a researcher to go into the field completely blind and without any knowledge or understanding of the subject area at all. With this in mind the author has chosen to adopt the approach to literature reviews for grounded theory studies, suggested by Corbin and Strauss (2008), whereby the literature review is considered to be a preliminary review which is carried out to enhance theoretical sensitivity. The literature features as part of the analytical approach to the study and therefore will be presented here and as part of the Findings and Discussion Chapter later in the work. In this way the literature can be seen to support emerging theory.

This literature review will therefore concentrate on broad over-views of subject areas that were pertinent to the research project at its proposal stage, namely mentorship and dyslexia.

MENTORSHIP

Literature around adult learning is important to consider in relation to mentoring as the student nurse (mentee) and the mentor, due to the requirements of 'life-long learning', are both adult learners. Also pre-registration and post-registration nursing courses are taught within the

framework of higher education. Understanding the needs of the adult learner is therefore a pre-requisite for successful mentoring and becoming a successful mentor. Some of the issues raised by considering how dyslexic adults learn, are covered in the following section on dyslexia. This section discusses literature that is first and foremost related to mentoring.

There is agreement that the concept of 'mentor' originated from the Greek classical story of Homer's Odyssey, where King Odysseus called upon a trusted friend named Mentor to act as guide and advisor to his young son while he left to fight in the Trojan wars (Gopee 2011, Murray et al 2010, Pellatt 2006). Roman generals were known to have mentors by their side in the field of battle and in mediaeval times the word mentor was linked with master-craftsmen and their apprentices as these men were responsible, not only for teaching of their skill to the apprentice but for their social, religious and personal habits as well (Morton-Cooper and Palmer 2003). Pellatt (2006) and Ali and Panther (2008) also allude to the fact that, in hindsight, Florence Nightingale could be considered as the first nurse mentor because of the relationship revealed through her correspondence with a colleague who was matron at St. Mary's Hospital London.

Professions concerned with medicine, business and law have traditionally been associated with the term mentorship (Murray et al 2010) but not much else was heard about mentoring until a resurgence of interest was generated by a study on adult development by Levinson (1978) in North America, in which a mentor was identified as normally an older person with greater experience and more seniority in the world that the younger person was entering. The business, education and nursing professions were quick to catch on to this idea and in nursing this can be demonstrated by American studies such as Attwood (1979) who carried out a pilot study introducing mentors for student nurses in a children's hospital in San Francisco and Darling (1984) who interviewed a range of healthcare personnel and identified three basic mentoring roles, fourteen mentor

characteristics and three important ingredients for a mentoring relationship. The diffusion of the concept of mentorship from North America to Great Britain was swiftly taken on board by nurse education and became part of the educational language of the Eighties and Nineties (Gray and Smith 2000).

The literature of the 1980s and 1990s records enormous interest in mentoring (Cameron-Jones and O'Hara 2003). Many authors since Darling have highlighted the complexity involved in trying to define what mentorship is or should be (Andrews and Wallis 1999, Neary 2000, Morton-Cooper and Palmer 2003, Murray et al 2010). In a literature review on mentoring in nursing, Andrews and Wallis (1999) state that the majority of the literature they found was concerned with defining the concept of mentoring and determining the nature of the mentoring role and they found that there was a general lack of agreement regarding the role and the functions of mentors. Murray (2010, p. 5) refers to a clear definition of mentoring as being 'elusive' over past decades. Many authors provide their own definition in an attempt to introduce some clarity into their work;

Neary (2000, p. 19): *"For the purpose of this book a mentor is someone who assists and supports an adult student taking a pre-registration nursing course."*

Megginson & Clutterbuck (1999, p. 13): "*Our preferred definition of mentoring is that it is: off-line help by one person to another in making significant transitions in knowledge, work or thinking."*

Casey and Clark (2011, p. 933): *"To mentor someone has been defined as: 'To support and encourage individuals to manage their own learning in order that they may maximise their potential, develop their skills, improve their performance and become the person they want to be."*

General definitions of mentoring in the wider literature may be associated with words such as guide, supporter, friend or advisor (Gopee 2011).

However professional definitions have had to become more structured over the years in order to clarify the position and responsibilities of the mentorship role and allow for the inclusion within this role of things such as assessment and evaluation. The current Nursing and Midwifery Council (NMC) definition of a mentor provides some very specific criteria that a mentor must meet:

> ...a registrant who, following successful completion of an NMC approved mentor preparation programme – or comparable preparation that has been accredited by an approved Educational Institute (AEI) as meeting the NMC requirements – has achieved the knowledge, skills and competence required to meet the defined outcomes. (NMC 2008, p. 19)

In relation to discussing the roles of the mentor, Darling (1984, 1985) has been a very influential writer. Her initial research in 1984 identifies three 'absolute' requirements for successful mentoring: mutual attraction, mutual respect and subscription of time and energy. Intrinsic to the requirements, she identifies three basic mentoring roles: inspirer, inventor and supporter. She defined the mentorship role within 14 parameters: role model, envisioner, energiser, investor, standard-prodder, teacher-coach, feedback giver, eye-opener, door opener, idea bouncer, problem solver, career counsellor and challenger (Darling 1984). These roles are still seen as influential today as they continue to be reproduced in contemporary literature (Pellatt 2006, Gopee 2011, Walsh 2010).

Darling (1984, 1985) also coined the phrase 'toxic mentor' by identifying what she refers to as a 'galaxy of toxic mentors' that sub-divide into:

- 'Avoiders' – also referred to as ignorers or non-responders.
- 'Dumpers' – who throw people in at the deep end to sink or swim (sometimes deliberately).
- 'Blockers' – who refuse requests, withhold information or over-supervise
- 'Destroyers / Criticisers' – who undermine confidence, use open and public verbal attacks and arguments to question and

deliberately destroy confidence. Personal, anecdotal evidence from students suggests that these types of mentors still exist today.

In a later study undertaken in Scotland, Gray and Smith (2000) found that students identified poor mentors in the following ways: they break promises, lack knowledge and expertise, have poor teaching skills, have no structure to their teaching and constantly chop and change their minds about things. Poor mentors tend either to over-protect their student by allowing them to observe only, or were unclear on the students' capabilities and 'threw them in at the deep end' (Ibid). They also acknowledge that students had all experienced a 'good' mentor in at least one of their placements and valued this experience. In this study, students identified good mentors as feeling genuine concern for students as individuals and being nurses who actually wanted to be a mentor. They described them as being approachable, confident in their own ability, good communicators, professional, organised, enthusiastic, friendly, possessing a sense of humour, caring, patient and understanding. This study is again influential as it is cited in detail in more contemporary work such as that by Anderson (2011).

Virtually all studies explore the traits needed by a mentor in some way. Although there is some distinction between the categories used to describe mentor traits there is also much overlap. Walsh (2010) refers to them as 'Qualities', Eleigil and Yildirim (2008), Anderson (2011) and Andrews and Wallis (1999) call them 'Characteristics', Morton and Palmer (2000), NMC (2008) and the RCN (2007) place importance on 'Roles', Ali and Panther (2008) refers to them as 'Essential Attributes', Ness et al (2010) calls them 'Skills' and Clutterbuck (1998) considers them in terms of 'Behaviours'. Traits that are common throughout these accounts are good communication, approachability, being good at giving constructive feedback, being supportive, being professional, being competent, being a good teacher and prioritising the student's learning. Some literature couches the role of the mentor in terms of their responsibilities (Pellat

2006, NMC 2008, RCN 2007) and issues around their role in supporting learning, teaching and assessment of students feature highly in these accounts.

The research literature has often produced contrasting findings from mentor and mentee perspectives in relation to the evaluation of the mentoring role. Earnshaw (1985) examined mentorship from the students' perspective and identified that students saw mentors as having a specific role in their clinical learning. Students in this study identified the role of supporter as a key role for the mentor and felt that mentors had a significant role in shaping their views on how they themselves would act as mentors, thus highlighting the significance of the role-modelling aspect. In a study on students' opinions and expectations of clinical nurse mentors, Eleigil and Yildirim (2008) found that students felt mentors should be able to communicate without prejudice, give positive feedback, have empathy, require students to do their own research and offer information when appropriate.

In contrast to the above, a longitudinal study of students' perspectives on the qualities of an effective mentor, Gray and Smith (2000) found that students quickly lost their idealistic view of their mentor and over time develop an insight into the qualities they perceive are required in an effective mentor. Students quickly became aware of the importance of choosing good role models and learning about their mentor's specific likes and dislikes as they realise that this impacts on the outcome of their assessment. As they move into branch programmes and become more confident about their overall competence, there is a gradual distancing from their mentor.

Gopee (2011) suggests that some of the problems students experience includes lack of opportunity to work with their mentor, lack of interest on the part of the mentor, lack of knowledge about the student's course, lack of research/evidence based practice evident in mentors' practice, hierarchical approaches by mentors who lack a team approach, not

acknowledging the student's previous experience, negative attitudes on the part of the mentor and a reluctance to change their practice.

From the perspective of the mentor, two studies, one by Wilson (1989) and one by Aitkins & Williams (1995) had similar findings. Despite mentorship being viewed as a positive activity, there were difficulties relating to role conflict and lack of time to achieve optimum mentor supervision. The potential for mentoring to foster personal and professional development was also identified. Ali and Panther (2008) identify challenges for mentors including limitations on time, dual responsibilities of patient care and student teaching, high workload, the mentor's own personality, the student's level of learning, the number of students allocated to a mentor and the high level of commitment required, collaborating with student teachers, the need for knowledge concerning theoretical aspects of learning, the need for knowledge about learning theories and ways of providing positive feedback. Walsh (2010, p. 4) lists many benefits of mentoring including increased job satisfaction, increased professional role, involvement with the higher education provider, being updated and learning from students, developing teaching skills, adding to personal profiles and C.V.'s, being able to use mentoring skills in other areas such as management, receiving the gratitude of students, increased self-esteem, being responsible for maintaining the standards of the profession and protecting the public.

A theme that many authors consider within their work is the relationship between the mentor and the student. Walsh (2010) considers that achieving this one initial, important goal will solidly underpin every other aspect of mentorship and Andrews & Wallis (1999) state that the nature and quality of the mentoring relationship is fundamental to the mentoring process. Gardiner (1998, p77) puts forward arguments for a humanistic approach to this association referring to it as a 'professional friendship' that relies on a range of human values such as warmth, genuineness, reliability, support, honour, empathy, rapport, honesty, loyalty and being

non-judgemental. Beskine (2008) sees this much more as a 'working relationship' and stresses the professional aspects of the partnership. Ali and Panther (2008) relate the mentor/student relationship to the quality of the learning achieved by the student and consider that if the mentor/student relationship is based on mutual respect and a sense of partnership, students' learning is enhanced. Morton-Cooper and Palmer (2000) review theories relating to how the mentor/student relationship develops over time and passes through various stages, namely an initiation stage a working stage and a termination phase. A multitude of factors impact on this relationship and on the transition from one stage of the relationship to the other (which can be almost unnoticeable).

One of the main issues in the literature over the last decade started with the research by Duffy (2003) who explored the factors linked to mentors' reluctance to fail students. In an NMC funded study Duffy (ibid) found that mentors were failing to fail students on their placements because, either they did not want to fail a student early in their programme, or because they did not want to jeopardise the student's future, or because they inadvertently did not follow procedure correctly. So the students were, in all cases, given the benefit of the doubt and signed off as safe to practice. Duffy (2004) states that this has consequences for future mentors and may ultimately have professional consequences. Failing to fail a student early in their course may be detrimental for the student, as they are denied the chance to put things right in good time and may continue through the course with false assumptions about their competence. Mentors who had had experience of failing students found the experience extremely traumatic, underlining the need for more appropriate and timely support for mentors with this difficult aspect of their role.

Carr et al (2010) review Duffy's work and summarise the key issues by listing the fears experienced by mentors when faced with a failing student. They state that mentors may feel they lack confidence or the skills to address the issue of failure. There may be an impact on the mentor's

caseload – e.g. the time spent addressing and processing the failure. They may fear consequences for the student nurse in terms of their future career and prospects. There may be personal distress involved for the mentor in failing the student – especially if the student is seen as a likeable person who has tried hard and who might be dependent on passing the course to improve their life chances. There may also be fear that the academic institution may not be supportive or may challenge the decision made. In summary a question may be asked by the mentor as to whether the distress is worth it.

Jervis & Tilki (2011) have more or less repeated the theme of Duffy's original research by asking the question *"Why are nurse mentors failing to fail student nurses who do not meet clinical performance standards?"* They state that students are more likely to have training discontinued for failing academic work than for clinical performance. They feel that although the NMC's Standards to Support Learning and Assessment in Practice (NMC 2008) may have addressed many of the underlying problems identified in Duffy's research by identifying specific requirements for mentor preparation and support, it is easy to underestimate the confidence, assertiveness and interpersonal skills involved in assessing performance. Mentors spoke of having to balance objectivity and intuition when dealing with upset or angry students, those who were popular or those who tried hard but did not perform adequately. The similarities in findings between Duffy (2003) and Jervis & Tilki (2011) suggest that the situation has not changed a great deal in the intervening years and mentors continue to feel under stress when confronted by a failing student.

Two important and influential pieces of literature concerning mentorship for nursing in the United Kingdom come from professional sources. These are the *Nursing and Midwifery Council* (*NMC) Standards to Support Learning and Assessment in Practice* (NMC 2008) and the Royal College of Nursing *(RCN) Toolkit: Guidance for Mentors of Nursing Students and Midwives* (RCN 2007). These two documents clearly detail the roles and

responsibilities expected for professional competence in the mentorship domain.

The NMC document (NMC 2008) defines the knowledge and skills that nurses (and midwives) need to apply when acting as a mentor and supporting learners in the workplace. These learning outcomes are described under eight domains;

- Establishing effective working relationships,
- Facilitation of learning,
- Assessment and accountability,
- Evaluation of learning,
- Creating an environment for learning,
- Reviewing the context of practice,
- Evidence based practice and leadership,
- Leadership.

Each domain has a range of individual learning outcomes and these provide clear and explicit standards that mentors should demonstrate and against which their performance can be measured. There are also five underlying principles that apply to all mentors who make judgements about whether a student has achieved the required standards of proficiency for safe and effective practice and they are:

Nurses must;

1. Be on the same part or sub-part of the register as that which the student is intending to enter,
2. Have developed their own knowledge, skills and competency beyond that of registration through CPD (continual professional development) – either formal or experiential learning – as appropriate to their support role,
3. Hold professional qualifications at an appropriate level to support and assess the students that they mentor,
4. Have been prepared for their role to support and assess learning and met NMC defined outcomes, achieved in practice and where

relevant in academic settings, including abilities to support inter-professional learning in addition,

5. May record their qualification on the NMC register when they have completed the NMC approved teacher preparation programme.

Since September 2007, the only route to becoming a nurse mentor is by undertaking an NMC approved university course, so understanding the NMC requirements is very important. Before becoming a mentor a nurse needs to be registered for at least one year and once qualified, in order to keep their name on the live register of mentors, mentors need to attend yearly mentor updates, mentor at least two students over the three years and at the end of every three years complete a 'Triennial Review' at which competencies are signed off for the following three years (Veeramah 2012).

A toolkit to help nurses do this has been produced as a resource for mentors by the RCN in the form of *Guidance for mentors of nursing and midwives: an RCN Toolkit* (RCN 2007). This document is designed to introduce mentors to the NMC requirements but also to provide a variety of helpful background information and some creative suggestions as to how to achieve the competencies required. It includes such things as a placement checklist for mentors (ibid, p. 12), advice on helping students get the best from practice placements (pp11-14) and suggestions as to where mentors can seek support for their role (ibid, pp. 15-17). Both of these documents can be easily downloaded via the internet.

Veeramah (2012) conducted a cross sectional survey of 346 mentors who had successfully completed one of the new NMC approved mentorship courses and found that, overall respondents felt adequately prepared for their role as mentor and were more confident in their ability to support pre-registration students in practice. However a significant number of respondents received little protected time away from clinical duties to complete the theoretical and practical components of the course and many

indicated the need for more input on the practice assessment document used for assessing pre-registration students.

DYSLEXIA AND LEARNING DIFFICULTIES

The original view of dyslexia comes from the medical profession (Pollak 2005) and much of the literature on dyslexia concentrates on the continued attempts of the medical profession to pin down the cause of this condition. Numerous medical and biological theories exist; (e.g. 'Deficit in left hemispheric processing' (Galaburda 1989); 'Cerebellar impairment/deficit hypothesis' (Fawcett and Nicholson 2007); 'Magnocellular theory' (Stein 2001); 'Phonological processing difficulties' (Snowling 1997,)) and these differing opinions perhaps account for the extremely individualistic collection of symptoms that a person with dyslexia might present with. There is as yet no agreed biological or genetic explanation for dyslexia and this could mean that there are many different explanations or that the overall unifying theory has not yet been identified.

Educationalists became interested in dyslexia as the effects of dyslexia are most notable in aspects of the individual's abilities to learn (Fawcett and Nicholson 2007). During the course of the twentieth century the assessment and support for dyslexia has come from educational and related professions. It is, for example, the educational psychologist who is mainly responsible for the diagnosis of dyslexia, and educational specialists who are employed to support individuals with their learning, both at school and in establishments for further and higher education e.g. see the Professional Association of Teachers of Students with Specific Learning Difficulties (PATOSS 2010).

There is much literature available in the form of practical guides to dyslexia which are designed to support educators, parents and families, and adults who have dyslexia. As examples of these, I have concentrated on those that focus on adult learning and learning in higher education e.g. Hornsby (1997), Hunter-Carsch and Herrington (2001), Lee (2003) and Price and Skinner (2007). All of these guides address issues such as identification of

the individual with dyslexia and assessment and support for these students once a diagnosis has been made. These texts are all valuable for the educator from an operational point of view but they tend not to give attention to what it is like to teach dyslexic students or study in mainstream education with a diagnosis of dyslexia.

More recently still, and particularly this century, there has been interest in the lived experiences of dyslexic students. Nursing research has sought to understand the dyslexic nurse's experiences from a professional perspective as well as an academic one. Clinical experiences of student nurses with dyslexia (Morris and Turnball 2006), an exploration of the working lives of nurses and healthcare assistants with dyslexia (Illingworth 2005), the reluctance of student nurses to disclose their dyslexia in clinical practice (Morris and Turnball 2007), problems dyslexic student nurses have in developing clinical competence (White 2007) are all qualitative pieces of research that seek to understand the dyslexic nurse, or dyslexic student nurse's experiences and perspective .

These studies all found that participants managed their dyslexia in highly personalised ways and that there was an almost uniform reservation about disclosing information relating to their dyslexia which was attributed mainly to the possibility of negative attitudes from colleagues. Dealing with information and administering drugs, particularly in stressful situations were highlighted as particular areas of stress for dyslexic nurses (Illingworth 2005, White 2007) but a heightened sense of self-awareness, hard work and an increased effort on the part of the dyslexic nurse often meant that patient safety was not compromised. Several of the articles suggested ways in which the dyslexic nurse could be supported in clinical practice and these included working in less acute clinical environments (e.g. out patients or community nursing rather than A&E or ITU) (Morris and Turnball 2006, White 2007), writing up of clinical documents in a quiet, undisturbed area (Morris and Turnball 2006), appropriate attitudes and supportive responses from colleagues and mentors (Illingworth 2005,

Sanderson-Mann and McCandless 2006, White 2007) or use of assistive technologies (Illingworth 2005, White 2007). One of the things highlighted by all four pieces of research was the need for increased awareness of dyslexia in the hospital setting both at management level and amongst fellow professionals.

To date, in the literature two pieces of research stand out as especially important in terms of identifying teachers' or lecturers' views of students who suffer from dyslexia (Pollak 2005 and Guernan-Jones and Burden 2009).

In his book *"Dyslexia: The Self and Higher Education"* Pollak (2005) gives his attention to the social and emotional factors associated with the lived experience of dyslexia and is interested in how people with dyslexia have coped with education and life in a society that celebrates the ability to read and write and perceives disability in negative ways. In carrying out this piece of in-depth qualitative research, the author's stated intention was to increase understanding of dyslexia and produce insights which help universities to work with dyslexic students (Pollak 2005, p141). His approach was to collect the 'personal histories' of 33 students from four different universities in England. He is concerned with these students' sense of identity, their self-esteem and the coping strategies they use to deal with the academic challenges of higher education, but also with the academic environment itself. He talks of universities having 'visions' of good practice and having intentions to promote inclusion and meet the aspirations of a diverse student body. However he describes the model of support for dyslexic students at university as a 'disability model' which even though it offers the student an explanation for their 'problems', it also requires a medicalised, diagnostic assessment which is something that, along with learning support, takes place in isolation with little or no liaison with course tutors. Funding for students with dyslexia in universities is an issue in itself (Wright 2005) but the possible lack of communication

between learning support staff and lecturers/tutors/mentors might have a direct effect on how students with dyslexia are perceived and supported.

The perspective of university nurse lecturers is not addressed in Pollak's research (2005). This research pursues how the 'vision' of good practice referred to above is interpreted by nurse mentors and achieved on a day to day basis out in the practice environment.

Gwernan-Jones and Burden (2009) surveyed 500 primary and secondary Post Graduate Certificate in Education (PGCE) students about their attitudes towards dyslexia and their confidence in their ability to support dyslexic pupils. The results of the research highlighted that there was little change in prospective teachers' attitudes towards dyslexia and their confidence in supporting dyslexic students during the year of their course. A vast majority of students highlighted positive attitudes towards the prospect of teaching dyslexic students, although many highlighted the need for further post qualification training around the subject. At the point of writing the literature review (2012), no research had been found that investigated the perspective of the nurse mentor towards nurse students who suffer from dyslexia.

MENTORSHIP AND LEARNING DIFFICLUTIES

Finally the issue of how learning difficulties such as dyslexia are addressed in literature relating to nursing and mentorship will be considered. Three pieces of literature addressed the issue of mentoring students with dyslexia or other learning disabilities. These were:

- The *NMC Standards to Support Learning and Assessment in Practice* (NMC 2008)
- *Guidance for mentors of nursing and midwives: an RCN Toolkit (RCN 2007)*
- Elcock & Sharples (2011*) "A Nurse's Survival Guide to Mentoring".*

The NMC Standards document (NMC 2008, p. 14) makes the following recommendations: that all mentors should receive disability equality training, that placement areas should be prepared to support students with

disabilities, that these students should also be prepared for the demands of the placement, and that the environment will not engender discrimination if specific needs are disclosed by the student. The issue of reasonable adjustments (adjustments that can be reasonably achieved within the environment to help accommodate the disability identified) is seen to be the province of programme providers (i.e. the academic institution and the NHS Trust) rather than in the hands of mentors.

The RCN Toolkit (RCN 2007) provides much more background and information around issues relating to student disabilities and specifically names dyslexia as one of the more common disabilities, devoting a large section of the chapter on 'Students with Disabilities' (RCN 2007, pp18-22) to the topic of dyslexia. Although this document precedes the NMC Standards Document reviewed (NMC 2008) it actually follows as a result of the first edition of the Standards (NMC 2006) that came into force in 2007. It was therefore the NMC who initiated the consideration of student disabilities within the mentorship role and the RCN who expanded on this with further clarification.

The book by Elcock and Sharples (2011) is a very practical approach to supporting mentors and picks up on two of the issues discussed within this review which it covers in some depth. Individual chapters are included on 'Mentoring Students with Disabilities' (Elcock and Sharples 2011, Chapter 11, pp. 185-208) and on 'Supporting the Failing Student' (Elcock and Sharples 2011, Chapter 8, pp. 127-148). These three works together demonstrate that considering students who fail and students with learning disabilities such as dyslexia is something that has only really come into sharper focus in recent years and perhaps accounts for the relative lack of research available on the subjects.

From an overview of the literature there appear to be some reasonably well defined developments in relation to mentorship that are chronologically related. Firstly, mentoring before the 1970s which was not related specifically to nursing. Secondly, in the 80s and 90s, following the

resurgence in the interest in mentorship, mentoring began to be adopted by the nursing profession when the need to support learners who were no longer going to be part of the workforce was identified. Thirdly, the development of a more formal mentorship role, which has followed the introduction of Project 2000, along with the implementation of super-numerary status for pre-registration student nurses. Although informal mentorship programmes were evident prior to the initiation of Project 2000, they became integral to pre-registration nursing education in the latter part of the 1980's as the new programmes were introduced. By 1997 all nurse students had some form of mentorship throughout the clinical placement elements of the course. Over the last ten years the NMC have tried to clarify and formalise the mentoring role and generally it appears that in contemporary practice mentoring is seen as an important role that every nurse will assume, formally or informally, sooner or later, in their professional life.

CHAPTER SUMMARY

This literature review has presented an overview of what was known in relation to mentorship and dyslexia to the point where I began data collection and analysis. Both subject areas are continually evolving and new literature has been included in the study to explore issues that emerged in the data.

Aspects of the literature search that are important to this study centre around the acknowledgement of issues relating to dyslexia and learning difficulties within the nurse practice environment. Learning difficulties have been shown to effect a wide range of data processing skills and are highly individualised which can make it difficult to identify and support students with standardised approaches. Dyslexic nurse students report a fear of experiencing negative attitudes from practice personnel and not being accepted in the clinical environment. This impacts strongly on their willingness to disclose their learning difficulties in practice.

Nurse mentors receive training for their role and this includes some input in relation to learning disabilities. There is evidence to suggest that the scope of the mentors' role is wide ranging and there are competing priorities for the mentors' time. Positive and negative approaches to the role of mentor are highlighted that impact on the student experience of learning in the practice environment. The mentor/student relationship is stressed as being fundamental to the mentoring process and investment in this role is one of the reasons why mentors find it difficult to fail students in practice.

These findings led to the research questions:

- How do nurse mentors experience and perceive dyslexic students in the practice environment?
- What do nurse mentors think and know about dyslexia and how does this translate into their work with dyslexic students?
- How well prepared and confident do nurse mentors feel about supporting dyslexic students?

Chapter 3 demonstrates how these questions were addressed.

CHAPTER 3: METHODOLOGY, METHODS AND DATA ANALYSIS

DIARY EXTRACT 4: CHOICE OF METHODOLOGY

I am an experienced teacher and I teach research but I am not an experienced researcher and I do not have a wealth of knowledge and understanding out 'in the field'. So perhaps by concerning myself fully with the methodological side of research, I am playing to my strengths – doing what is comfortable and easy for me – staying within my comfort zone.

As a nurse first and foremost, I am interested in human beings and all the complexity of the individual's response to the world around them. Life is complex. Humans are complex social creatures. Communication processes within social environments can be, at the same time, common yet subtle and multi-layered. Nursing as a profession deals with people in various states of vulnerability and communication is one of the main tools of the nursing trade, thus a level of complexity is likely to be involved in all situations that the nurse becomes involved in. As a nurse researcher, quantitative methodologies, that measure, equate and generalise would not offer me the opportunity to explore and investigate the things I am interested in, which is the depth of people's experience and an individual's responses to the world around them.

INTRODUCTION

This chapter will begin in Section 1, by presenting the research methodology and detailing how ethical approval, consent and confidentiality were achieved. This will be followed in Section 2, by consideration of recruitment, data collection, theoretical sampling, focus groups and individual interviews. The chapter will finish with presentation in Section 3 of data analysis techniques, focusing on the use of the constant comparative method.

SECTION 1: METHODOLOGY

INTRODUCTION

Research methodology has been described as a bridge between theory (ideas) and method (doing), offering consistency and coherence throughout the whole research process and serving as a "strategic but malleable guide throughout the research experience" (Hesse-Biber and Leavy 2006, p36). In its broadest terms, research methodology links both the ontological and epistemological beliefs of a study and focuses on the best way of acquiring new knowledge (Kramer-Kile 2012). In this chapter I will present and defend the philosophical and methodological stand-points that underpin the approaches I have taken within the study to answer the research question.

JUSTIFICATION OF A QUALITATIVE, GROUNDED THEORY METHODOLOGY

Qualitative research helps us understand how people cope in their every-day settings because it attends to the contextual richness of these settings (Yin 2016, p 3). It is used to explore the meanings individuals give to the social phenomena they encounter in their natural context (Grossoehme 2014, p109). Qualitative methodologies are appropriate for this research as they are ideal for exploring and making sense of complex social situations, gaining insights into phenomena, constructing themes to explain phenomena and ultimately fostering deeper understanding of phenomena (Smith et al 2011)

I initially had concerns about the credibility of qualitative research and the response of the quantitative research community to such research. Sandalowski (2008) points out that qualitative research often suffers from being compared to quantitative research and that in such comparisons, qualitative research tends to be presented as 'what it is not' which can make it appear 'less than' quantitative methodologies. The nature and pervasiveness of this value judgement is such that, even though as a teacher of research methods, I made bold claims backing the value of

qualitative research, it hasn't been until undertaking this doctoral research project that I feel I have actually begun to fully understand and appreciate what this value entails.

A qualitative methodology is appropriate for this study as the aim is to explore the lived experiences of nurse mentors in relation to their work in practice with students who may struggle to learn in the practice environment. To do this, I wanted to consider what being a mentor entails from the perspective of the mentors themselves. Quantitative approaches stemming from the positivistic tradition, do not attend to the processes of data production, ignoring the social context from which data emerge, the influence of the researcher and the interactions between the researcher and their participants (Charmaz 2006, p131). Therefore, quantitative methodologies were inappropriate for this study because I was not interested in collecting statistical data, I wanted rich in-depth personal data that could "get beneath the surface of social and subjective life" (Charmaz 2006, p13) and provide insight into the experiences of nurse mentors.

Once a qualitative methodology had been decided on, the next step was to decide exactly which methodological approach best fits the aim and the research questions relating to the study whilst resonating with my own beliefs and values. Grounded theory is a methodology that is interested in the social context of relationships between human beings and was considered to be an appropriate approach for a variety of reasons. According to Griffiths and McKenna (2013), grounded theory offers rigour in terms of data analysis – the idea of thorough and systematic consideration of the data using iterative techniques and constant comparison processes would help to bring credibility to the work. Also, the opportunity to go beyond description of data and move towards interpretation, explanation and theory production, although more challenging, was felt to be more rewarding and useful. This research study does not seek to verify a previous hypothesis. Instead it seeks to build

inductively an understanding of the participants' realities making it more than just a descriptive exercise.

Griffiths and McKenna (2013, p21) maintain that grounded theory is a valuable methodology for developing theories directly from the data and in doing so is held in high regard by qualitative researchers and is very much a part of contemporary enquiry. Being derived from the social sciences, grounded theory encourages exploration of issues that are relevant to the human condition which makes it appropriate for nursing situations (Birks et al 2006a). The emphasis is on the process of interaction between people and the way they understand their social roles (Holloway and Todres 2006); which makes it an appropriate methodology to explore the way mentors view their roles in relation to students who struggle to learn in practice. Importance is placed on the context in which people function and share their social world with others (Holloway and Todres 2006) and it is assumed by the researcher that the context in which the mentor supports the student nurse is central to the experiences of both mentor and student nurse.

Finally, Grounded Theory offered an opportunity to use creativity and intuition along with attention to detail and other researcher skills. Grossoehme (2014) points out that perhaps more than any other qualitative methodology, with Grounded Theory, the person, the investigator, is the key. The extent to which the investigator notices subtle nuances in the data and responds to them with new questions for future participants, or revises emerging theory is an aspect that particularly appealed to me.

Therefore grounded theory methodology was chosen as the approach for the study. Before articulating what is understood by grounded theory as a methodology and in particular constructivist grounded theory, it is pertinent to consider some underlying philosophical foundations. The main ones that have significance for this study are symbolic interactionism and constructionism.

SYMBOLIC INTERACTIONISM

One of the main philosophical foundations associated with grounded theory is symbolic interactionism. Birks (2006) identifies the traditions of pragmatism and interactionism within the contributions of Anselm Strauss, who along with Barney Glaser were the first exponents of grounded theory (Glaser and Strauss 1967). However, Moore (2009) points out that it is a misconception to say that the early beginnings of grounded theory were imbedded in symbolic interactionism and she cites Hammersley (1989) as being the first to compare grounded theory with Blumer's interactionist approach, which is discussed in more detail below.

Symbolic interactionism is a theoretical perspective relevant to qualitative research (not just grounded theory) that focuses on human experience (Licqurish and Siebold 2011, p12). It asserts that people are active and dynamic, giving meaning to their environments instead of simply responding to them (Hall et al 2013). The idea of meaning being given to the environment implies that the social circumstances in which people find themselves is significant and will have significance for mentors in the practice environment.

Symbolic interactionism is attributed first and foremost to George Mead (1815-1872), an American philosopher, sociologist and psychologist. Meade regarded humans in naturalistic terms asserting, after Darwin, that our development was part of an evolutionary process; but he went further than Darwin and claimed that language and the power to reason gave us the ability to interact socially to our benefit (Griffiths and McKenna 2013).

Herbert Blumer, a follower and interpreter of Mead, coined the term 'symbolic interactionism' and put forward an influential summary of the perspective that people acted toward things based on the meaning those things have for them; and these meanings are derived from social interaction and modified through interpretation. Symbolic interactionism is a theory of 'group life and human conduct' where;

> Human beings act towards things on the basis of the meaning things have for them. The meanings of such things arise out of social interactions with one's fellows; the meanings are handled in, and modified through an interpretive process used by the person in dealing with the things he encounters. (Blumer 1969, cited in Licqurish and Seibold 2010, p12)

Symbolic interactionists presume that someone else's sense of meaning is interpreted through social interactions, and the communication and understanding of verbal and non-verbal socio-cultural symbols such as language (Charon 2007). This again has relevance for the study as the processing of such symbols – particularly in the context of learning difficulties may have particular significance.

CONSTRUCTIVISM

To explore the idea of the constructivist approach to grounded theory it is first important to clarify the distinction between 'constructivism' and 'constructionism'. These two theories are connected and tend to be used interchangeably, but there are some subtle differences. Constructivism is a theory of knowledge that argues that humans generate knowledge and meaning from an interaction between their experiences and their ideas. The theory of constructivism is generally attributed to Jean Piaget (1896 – 1980), a Swiss developmental psychologist and philosopher, who suggested that knowledge is internalised by learners through assimilation (incorporating it into their knowledge framework without changing the framework) or by accommodating it (a process which requires re-framing of the knowledge framework itself – for example when we learn from our mistakes). Its main thrust was to describe how children learn but it had much to say about how we learn in general and particularly how we construct learning and therefore meaning through and in social situations. Constructivism is often associated with pedagogic approaches that promote active learning, or learning by doing. It is a theory describing how learning happens, regardless of whether learners are using their

experiences to understand a lecture or following the instructions for building a model airplane. In both cases, the theory of constructivism suggests that learners construct knowledge out of their experiences.

Social constructivism not only acknowledges the uniqueness and complexity of the learner, but actually encourages, utilizes and rewards it as an integral part of the learning process (Wertsch 1997). The social constructivist paradigm views the context in which the learning occurs as central to the learning itself (McMahon 1997).

Constructionism was inspired by Constructivism, has connections with experiential learning and builds on Piaget's epistemological theory. The main exponent of constructionist views is Seymour Papert (Papert 1980), a pioneer of artificial intelligence, who considered that individual learners construct mental models to help them understand the world around them, particularly when they are taking part in real world (i.e. social) situations. This then is a more applied version of the constructivist model and it is cited more frequently in the literature as one of the main theoretical influences on grounded theory (Licqurish and Siebold 2011).

Licqurish and Siebold (2011) maintain that constructionism is as an epistemology in its own right. For them, it underpins a number of qualitative research approaches and, unlike the post-positivist epistemologies that underpin many quantitative approaches, assumes that people construct their world and make sense of experiences during interactions in it. Meaning is constructed when an individual engages with the world around them. In order to accommodate for this, truth becomes relative and meaning has to be flexible. With this in mind, truth and meaning will be subject to change and individuals will continually try out new versions in their social environments (Charmaz 2006). Nursing practice itself is an evolving and ever-changing environment and nurse mentors would have to be adept at being flexible in their approaches to practice issues.

CLASSIC VERSUS STRAUSSIAN GROUNDED THEORY

All versions of grounded theory stem from the original work of two sociologists Barney Glaser and Anselm Strauss in the 1960's which culminated in their book "*The Discovery of Grounded Theory"* (Glaser and Strauss 1967). However, following this joint endeavour these two exponents of grounded theory moved their theory in different directions, in line with their own personal and differing ontological and epistemological paradigms (Ghezeljeh and Emani 2009).

Glaser's background had been mainly until this point in quantitative research and his world view has been classified as a 'critical realist' (Annells 1995), a 'modified objectivist' (Ghezeljeh and Emani 2009) and a 'positivist' (Charmaz 2000). He wanted to investigate the social world with the same diligence as he had the natural world. He saw the researcher as a neutral observer who discovers data in an objective and neutral way, independent from what is researched. His version of grounded theory is often referred to as 'Classical' (Moore 2010, Hunter et al 2011a) or 'real' (Cutcliffe 2008) and his later works continued along the same lines as the original book.

Prior to his work with Glaser, Strauss had been aligned to The Chicago School and the field of symbolic interactionalism and his later work was done in conjunction with a nurse educator Juliette Corbin. Together their work, referred to as 'the reformulated grounded theory' by Charmaz (2000), took a more 'relativist' and 'subjectivist' position aligning it more closely to a post-positivist paradigm which claims that, although reality exists to be uncovered by enquiry, it is never perfectly apprehensible (Ghezeljeh and Emani 2009, Griffiths and McKenna 2013).

THE ADOPTION OF A CONSTRUCTIVIST APPROACH

There are two other well defined versions of Grounded Theory outside of the traditional Glaser, and Strauss and Corbin models; constructivist grounded theory (Charmaz 2006) and postmodern situational analysis or critical grounded theory (Clarke 2005). Each has its own unique take on the

original elements outlined above. Alongside these, Parahoo (2009, p 4) suggests that "a plethora of adaptations has caused a blurring of ideological underpinnings and a divergence of methodological approaches within grounded theory which make it very difficult for the novice researcher to understand and stay true to one particular version". However Parahoo (2009) also feels that, due to the flexible and responsive nature of qualitative research, some blurring may be inevitable and if strategies to suit a particular research environment and phenomenon need to be modified then the rigour of the research itself does not have to be at risk as long as the reasons for taking a particular decision or action are explained and the implications explored. This is an important point for this study as modifications were needed during the course of this study to accommodate for time restrictions and the experience of the novice researcher. These modifications will be presented in the course of the thesis, along with rationale and justification for the decisions made.

Parahoo (2009, p 5) states that, in terms of students choosing a model of grounded theory, "By and large, students choose what they are comfortable with". My choice as to what was 'comfortable' evolved with the project. As Edmonds and Gelling (2010) point out, inexperienced researchers often learn how to do research from the many methodology books that are available on the subject. This was the reality for me. The more I read around the literature concerning grounded theory, the more I found myself drawn to the constructivist approach. Charmaz (2006) writes simply and convincingly about her perspective on grounded theory and her conceptualisation of the social world as being constructed by individuals fits with my personal interpretation. As a teacher I find that sometimes I can say one thing to a class of students and their responses demonstrate that individuals have perceived it in a variety of ways. This reinforces the idea that there are multiple realities which relate to the individual's responses and interpretations of the world. If this is the case, then subjectivity in research is inevitable. I see the researcher as interpreting

data gathered rather than being objectively and scientifically distanced from the study. I believe that we as researchers cannot fail to be subjectively involved in our work and so must work with subjectivity along the way.

It took quite a while to come to terms with the different approaches to grounded theory and to fully differentiate one from another, and then longer still – in actuality whilst working through the project – for a real understanding of which approach best fitted my personal beliefs and value system. Accompanied with this was a real need to understand more deeply what I was trying to achieve by using this methodology within my study. Glaser appeared to have an open book approach to research that was appealing but his overtly positivist theoretical underpinnings and his view of the researcher as removed and objective did not fit with my beliefs and values about research.

Corbin and Strauss (2008) were appealing as they provided several analytical tools that could help guide a novice researcher, however the criticism that their approach could end up with researchers 'forcing' theory from their data (Glaser 1992) by being overly bound by rules (Melia 1996) did not sit well with my belief that there should be a creative and intuitive side to the research process. In addition, the fact that these same tools have been described as having 'procedural affinity with positivism' (Age 2011, p1601), appeared to be taking me away from the more interpretivist and subjectivist ideals that I had come to align myself with.

Apart from the constructivist approach, there was also a very practical reason which drew me to Charmaz's (2006) interpretation of grounded theory – I understood more clearly how she was envisaging managing the data in order to achieve credible analysis and interpretation. It was therefore later in the study, when contemplating how best to proceed with data analysis and the notion of constantly comparing data that constructivist methodology sealed itself for me as the best fit for this study and for me.

This may cause concern for those who feel that all eventualities should be considered from the very start of a project, however Walls et al (2010) argue that there are no absolute rights or wrongs in qualitative research and Edmonds and Gelling (2010) offer reassurance to the novice researcher when they say that the priority for researchers should be to adopt pragmatic approaches to answering research questions. They feel that adhering strictly to methodological guidelines does not help researchers and can over-complicate research for those new to qualitative methods, an approach supported by Yin (2016) who promotes the option of an adaptive approach to qualitative research and the need to develop practical approaches in terms of getting the research done.

This does not allow a researcher to free fall through their research. If strategies are changed or modified to suit a particular research environment or phenomenon being studied, the reasons for taking a particular decision or action should be explained and implications explored (Parahoo 2009). Kramer-Kile (2012) maintains that analysis of the data collected can sometimes stimulate researchers to re-think their methodological approach in order to remain sensitive to the relationship between their emerging data, initial research questions and theoretical framework. Therefore, on reviewing where I ended my methodological journey, I would say that this study followed a grounded theory approach, influenced by a constructivist methodology.

ETHICAL CONSIDERATIONS

INTRODUCTION

This section of the thesis covers the ethical issues around consent, confidentiality, anonymity and the safe storage of data for the study. Some other ethical issues are considered at relevant points later in the chapter.

RESEARCHER INTEGRITY

Research integrity means that the researcher and their data can be trusted to represent reliable positions and statements (Yin 2016, p 44). Part of this

can be judged by the way a study is designed and presented however proving research integrity can be challenging due to the flexibility of the qualitative research approach. The use of reflexivity can support researcher integrity by providing access for the outsider to the researcher's thinking and reasoning. Yin (2016, p 45) considers being unsure at times about an aspect of your research as being 'more truthful' and the excerpts from my reflexive diary included in the study, refer to some of my reservations, demonstrating awareness of conflicting positions that often had ethical implications.

ETHICAL APPROVAL

Ethics approval was sought from the School of Lifelong Learning Ethics Committee at the university and proved to be quick and straight forward, requiring only two minor revisions before full approval was given. The journey through NHS ethical approval however was much longer and more complicated. Although all research participants are in some way vulnerable, the level of vulnerability of the nurse mentors is not considered, by the NHS, to be as high as it would be for some participants, e.g. patients and their carers, because nurse mentors are professional people (DOH 2011). This meant that full NHS Ethical approval was not necessary for this project. IRAS/Research and Development approval for each site used for the project was required and subsequently obtained.

The full process of NHS site approval was not something that could be read about, so finding out that things were missing on my list of pre-requisites for site approval happened frequently – e.g. needing a research passport, having to attend an ethics course to gain certification for research on NHS sites. Choosing to interview on four sites complicated the process further as accessing relevant Research and Development personnel – particularly from the private company who had just taken over the Community Trust organisation – was a lengthy process. Also changes to the proposal suggested by one Trust's Research and Development team meant that revisions had to be re-submitted to the other Trust teams. Finally,

accessing specific people who would be able to support the process was complicated due to job changes, annual leave and part-time working arrangements of staff. Recruitment and data collection began once full site approval, on three sites (minus the community Trust) had been achieved.

One of the most complex parts of applying for ethical approval for this grounded theory research proposal is the fact that at the start of the project, outside of the request for ethical approval for the focus group and the individual interviews, due to theoretical sampling, the exact number of participants, the extent of participation requested from any particular participant and further possible research interventions were not known. Re-course back to the ethics committee for updates and minor changes occurred once during the project and was without incident.

Whilst at all times it was my intention that this research would be of benefit to participants, both in terms of a positive experience of the research process itself and in terms of improvements in the support they receive for working with dyslexic students, a range of possible ethical situations were considered before the commencement of data collection, and contingencies were prepared-for prior to group and individual interviews taking place. However, no participant became distressed at any time during the course of the focus groups or one-to-one interviews; no participant disclosed unprofessional behaviour during the course of the focus group or individual interview; there were no heated confrontations between individuals within focus group discussion and nobody requested to quit the interview before its naturally occurring end-point. Participants were reassured that they were free to leave the study at any time without needing to give an explanation and that they would be supported in this and that in no way, and at no time would this adversely affect them.

INFORMED CONSENT

The process of informed consent was taken very seriously during this research study. According to Parahoo (2006, p 469), informed consent is: "The process of agreeing to take part in a study based on access to all

relevant and easily digestible information about what participation means, in particular, in terms of harms and benefits."

Informed consent means that participants have adequate information regarding the research, are capable of comprehending the information, and have the power of free choice enabling them to voluntarily consent or decline participation in the research (Oliver 2010, p 28). Nurse mentors were considered to be professional people who had achieved a reasonable level of education which meant that they would be competent to understand the information given in the Participant Information Sheet and on the Consent Form. These forms were written in easy-to-understand language avoiding jargon.

Copies of the 'Participant Information Sheet' and the 'Informed Consent Form' can be found in Appendices 1 and 2 respectively. Researcher contact details and research supervisor details were included on both forms so that the participants could make contact if they wished, to ask for further information or arrange an oral explanation of the research project. The participants' rights to confidentiality, full information concerning the research study, the potential benefits and harms of the study, and their right to withdraw at any time without repercussions or the need to give an explanation, was explained in these forms and again verbally before participants were asked to sign. Clinical Practice Facilitators (CPF), experienced, qualified nurses who had been mentors for several years and were employed specifically to support student and mentor education within each trusts, mediated the initial recruitment process so that individuals did not feel under any pressure to take part in the research study.

The researcher was careful to revisit information about the study and consent at each meeting subsequent to the focus group, although signed consent was only gathered at the initial focus group as it covered inclusion in a face-to-face interview at a later stage of the study.

As explained in the Methods section of this thesis, although the Participant Information Sheet was available on-line or in hard copy format from CPF's for at least two weeks prior to the mentor update/focus group, many mentors arrived on the day unaware that there was a research element to the mentor update. The researcher allowed time for the mentors to read the information sheet before commencement of the focus group/update and reassured them that they did not have to partake in the focus group section but would still be credited with having attended a mentor update if they attended the rest of the session outside of the research group activity and discussion.

COLLECTION AND STORAGE OF DATA: ANONYMITY AND CONFIDENTIALITY

Collection and responsibility for all data was the sole responsibility of the researcher. A secure location at both the researcher's place of work (lockable personal filing cupboard) and at home (lockable desk drawer) was used for storage of research data and all data and evidence was kept under lock and key in one of these two locations at all times when not in use. The security, confidentiality and anonymity of participants' evidence was, at all times, a key component of data collection and storage measures. An assurance of confidentiality and participant anonymity was given to participants regarding the researcher's treatment of all data and those participating in the focus group discussion were asked to maintain the confidentiality of the discussions.

All interviews were digitally recorded and then transferred onto CDs. The digital recordings were then erased. The researcher transcribed the data personally, using paper and pen which assisted the confidentiality of participants as there was no risk of on-line access by uninvited persons. CD's and hard copies were kept in locked storage areas as described above, when not in use. All participants were referred to using codes in all transcriptions to protect participant anonymity. Participants were assured

that all data collected from participants would be destroyed at the end of the project.

SUMMARY

This section of the chapter presents rationale for choices made in relation to choosing an appropriate methodology that fits the research aim and answers the research questions. It also details how my personal philosophical inclinations have been considered as part of the decision-making process. Details of the process of seeking ethical approval for the study were also included. This study uses a grounded theory methodology based on the constructivist approach detailed by Charmaz (2006) to meet the aim of the study which was to explore nurse mentors' experiences of supporting students who struggle to learn in the practice environment. The following sections will consider the methods used during the study and the process of data analysis.

SECTION 2: METHODS

DIARY EXTRACT 5: THE RESEARCHER AS INTERVIEWER

Elmir et al (2011, p 13) believes that the way to develop a good rapport involves giving as well as receiving information in a two-way process between researcher and participant. This approach appeals to me as I see it as acknowledging the co-construction of knowledge between interviewer and participant and it therefore has the potential of minimising the power differential between myself as researcher and the participant. I have never conceived of myself as the expert in this project but more someone who wants to learn from the experiences of others. It is hoped that the participants get something out of the process too. This is a chance for them to have their views listened to and attended to, and it may help them to think about their students in a different light that will benefit them as a mentor as well as the student. As a shared process and with the interests of the participant always at heart, the interview could be beneficial to both researcher and participant.

INTRODUCTION

This section will consider the methods used within the study to recruit participants and collect data. Silverman (2014, p54) defines methods as 'specific research techniques' and describes them as being more or less useful depending on how well they match the requirements of the study. Grounded theory does not prescribe specific methods for data collection but Charmaz (2006, p14) states that the methods we use must allow us to see the world from the perspective of our participants – from the inside. Topics to be covered within this section will be; exploration and justification of recruitment and selection decisions; presentation of recruitment and selection methods used within the study and exploration and justification of data collection techniques including theoretical sampling.

Once the main methodology for the study had been decided, the next decisions related to the exact methods that would best fit this methodology and answer the research questions for the study. At the start of the project, with no real idea what the issues and experiences of mentors in practice might be in relation to supporting students who struggle to learn in the practice environment, I felt it was important to use methods that would provide data about what the nurse mentors thought and felt about their work with students who struggle to learn in practice. Observation was discarded as extended time in the field would have been prohibitive for a full time nurse lecturer. Also the fact that I was a nurse lecturer, and had been a nurse lecturer for many years in the locations where the study would be based, would mean that I could potentially be recognised by students, and others, in the practice environment, and this too may have impacted on the data to be collected (Nelson and Frontczak 1988). This could have made people inquisitive or more self-aware meaning that their behaviour would not be representative of what would normally transpire in the practice environment and thus skewing the data collected.

THE FIRST WAVE OF DATA COLLECTION: FOCUS GROUPS

I decided to begin the study with focus group interviews because they are an appropriate method of qualitative data collection if the generation of ideas and the exploration of issues need to be those shared between participants (Breen 2006, p 465; Acocella 2012, p 1126). Finding out what mentors felt the issues were in relation to supporting students who struggle to learn in practice *from their perspective* was important to the study so this made focus groups a good method for the initial data collection phase. Acocella (ibid) also points out that focus groups are particularly suitable for pointing out unexpected aspects of a social phenomenon as it concentrates more on the frames of reference of the group analysed than those of the researcher.

Focus groups may be considered to provide data with less depth and detail than individual interviews however they are good for collecting multiple perspectives (Roller and Lavrakas 2015, p 104; Yin 2016, p 149). Members of a focus group need to be individuals with a shared experience and Powell and Single (1996) advise that for best effect, they should be strangers to each other. The rationale for this is that they won't be inhibited or deferential to each other in terms of occupation or seniority which should make for a more honest sharing of opinion and experience. Nurse mentors definitely have a shared experience and in general they would not be expected to know each other but in one focus group, where only two mental health mentors attended, it was obvious that these two women worked together and knew each-other quite well. This was not considered to be detrimental, as they provided an intimate quality of discussion that enriched the data collected rather than hindered it.

DIARY EXTRACT 6: FACILITATING FOCUS GROUPS

Although a novice interviewer, I felt at home with the focus group approach as I have facilitated a lot of group work over the years and these skills had some resonance for working with focus groups. Engaging the group and supporting them to share their experiences whilst trying to remain relatively neutral was not new to me, as was managing outspoken members of a group, being inclusive to as many voices in the group as possible and using silences effectively (Bloor 2001, Del Rio-Roberts 2011, p313). I am not saying that I did this perfectly and I needed to maintain a reflexive self-awareness at all times (i.e. I had to keep reminding myself of my role as a researcher) in order to minimise my influence on the groups or individual's responses, however, I was familiar with the role and so was able to maintain a relaxed approach which hopefully helped participants to feel more at ease.

RECRUITMENT TO THE FOCUS GROUPS

The focus groups were designed to be part of the 'group work' section of a mandatory 'mentor update'. This is part of the normal mentor update framework which is part of mentors' professional development and so would not entail any extra time or effort on the part of the mentors. The Nursing and Midwifery Council Standards to Support Teaching and Learning in Practice (NMC 2008, p 15) states that nurse mentors must attend one of these every year in order to maintain their registration as a mentor. Incorporating the focus group within the mentor update was considered to have benefits for both the research study, the mentors and the practice environment.

From the perspective of practice, it was envisaged that there might be difficulties in relation to releasing staff from practice to attend a research focus group which could be perceived as a low priority activity and this had been verified on numerous occasions in relation to the ability of practice partners to attend educational support roles at the university where I work. So a format that incorporated the focus group into an existing

requirement would mean that the amount of time mentors would need to be away from their practice area would not change.

From the perspective of the mentors, two extra dates for mentor updates were provided in each Trust which gave the mentors added opportunities and more flexibility to meet the NMC requirements. It was also hoped that mentors would benefit from the discussion with colleagues around issues relating to the support of students who struggle in practice and finally they were not being asked to give up their own free time which would be the case if the focus groups were separate from the update.

From the perspective of the research it would help to ensure that enough mentors would attend the planned research focus groups. Breen (2006, p 466) and Powell and Single (1996, p 501) both advocate for providing incentives for attendance to focus groups to help ensure that people will indeed turn up on the day. These two sources are practical rather than analytical in their approach to focus group interviews but they both make the point that providing an incentive is advisable and sometimes desirable. From an ethical point of view, the nature of this incentive should always be carefully considered. A reimbursement so that participants are not out of pocket for travel costs may be appropriate and show gratitude for attendance, but anything more than this, especially in monetary terms could be considered as inappropriate for many types of research.

In relation to this study, the incentive was to make sure that participants were not 'out-of-pocket' in terms of the *time* they committed to the focus group. The benefits to the mentor were seen to be fitting and proper at the time of planning, although in reality many mentors turned up for the mentor update not having realised that there was a research element attached. The researcher accounted for this by making sure that these mentors sat quietly prior to the commencement of the mentor update/focus group and read through the information sheet before committing to signing the consent form and taking part in the session.

It could perhaps be argued, that mentors' attendance at the focus groups was achieved under false pretences as they came primarily in order to achieve their mentor update and their interest in the research would have therefore been minimal, however the group sessions fulfilled both purposes without causing any extra burden and mentors were reassured that they would be facilitated to achieve the mentor update without attending the research activities. No mentor chose this latter option. Informed written consent was achieved before any participant was allowed to continue with the session so it is hoped that the mentors, as professional people, would have taken this seriously and given consent knowing that the focus group was part of the mentor update provided.

NUMBER OF FOCUS GROUPS

Another important aspect of the recruitment process was how many focus groups to hold in order to achieve a breadth of opinion to inform the next stage of the research process. Bloor et al (2001, p 28) states that the number of focus groups should not be decided using a statistical calculation but should rather fit with the overall plan for the research. As breadth of opinion was a key influence on the decision-making process here, and in order to achieve reasonable representation from mentors due to the fact that attendance for focus group activities is infamously unreliable (Power and Single 1996, p501), I decided that a range of nursing sites and fields of nursing would be targeted. Two acute hospital trusts were selected, along with the local community nursing trust and the local mental health nursing trust. Two focus group/mentor update sessions were planned for each site because the number of actual attendees would not be known until the day of the update. Time issues might have been a concern if only one update was put on at each site and numbers of attendees were low.

NHS SITE APPROVAL

A prolonged period of trying to achieve NHS site approval for the Community NHS Trust without success, led to delays in progressing with

the project. Time was the limiting factor and a pragmatic decision had to be made to proceed with three sites instead of four; the two acute hospital trusts and the local mental health trust. This obstacle undoubtedly changed the scope of the results for the project. A gap exists in the data relating to how community nurse mentors perceive their experiences with students who struggle to learn in the practice environment existed, although one of the mental health mentors did work in a community setting. This in turn means that any theory derived from the data had little opportunity to be explored in the community setting which is a very different nursing environment to the acute hospital adult, child or mental health setting. This in turn means that any theory that evolved from the data would need to be explored further in terms of community nurse mentors at a future date in order to account for any differences in experiences and any similarities and before it could be generalised to this setting.

GATE KEEPERS FOR THE RECRUITMENT PROCESS

The lead nurses for education in each NHS Trust were contacted and dates were agreed for the focus group/mentor updates to take place. Trusts were particularly interested in holding the focus groups/mentor updates before September of that year as mentors needed for the first time to complete Triennial Reviews (the three yearly assessment of mentor update activities that allows mentors to remain current on the mentor register and support students in practice (NMC 2008)) before this date. This meant that the focus groups/mentor updates were all held within a four week period during July/August that year. Clinical Practice Facilitators publicised these extra focus group/mentor updates within their respective trusts, supplying Participant Information Sheets and Consent Forms to any nurses who showed an interest in attending. Mentors however, were not required to sign up for the focus group/mentor update and could attend on the day if practice pressures allowed. The researcher's contact details were provided so that any questions could be answered and more detailed information

given if required. Nobody contacted the researcher prior to attending one of the focus group/mentor updates.

FOCUS GROUP ATTENDENCE

Six focus group/mentor updates were held in all. A total of 24 mentors attended over these 6 sessions with the highest number attendees at one session being 12 and the lowest 1. The Demographic questionnaire can be seen in Appendix 3 and a full break-down of the focus groups and tables of demographic data can be seen in Appendix 4.

In relation to what is the ideal size for a focus group, some authors are quite prescriptive in relation to recommending the number of participants that they should aspire to. Powell and Single (1996) assert that 6 to 10 participants are generally sufficient whereas Krueger and Casey (2009) advise that for an effective group 4 to 12 participants are needed with the ideal size being 7 to 10. Breen (2007) recommends 10 to 12 members as an average in order to achieve analytical saturation. What is not apparent here is what happens if there are multiple focus groups. The dimensions of the data collected from one focus group of 12 members could be very different from three focus groups each with 4 participants.

The focus group where only one person attended proceeded in the form of an interview but using the same format as the other focus groups. There was also the group of 2 participants at one of the mental health focus groups sessions and once again this group went ahead identically to the rest in terms of overall format. I have therefore continued to refer to these sessions of data collection as focus groups (even though the numbers of participants suggests that in the strictest terms they did not constitute a 'group'). Grounded theory considers all relevant data to be useful for further theoretical development (Charmaz 2006, p 16) and the purpose of this part of the study was to identify potential issues for further investigation in later stages.

ANALYSIS OF FOCUS GROUP DATA

Holding six focus groups in quick succession (four weeks in July/August 2013) had an unforeseen effect in relation to the amount of data collected within a short time frame. Time available for analysis between focus groups was not enough to allow for more than a cursory review of data collected. Full analysis of this first phase of data collection could not be conducted until all six focus groups had taken place. The data from all six focus groups was therefore considered together as one unit of data collection. This became known as the first wave of data collection which was followed by in-depth analysis and theoretical sampling to determine where and how data would be collected next. This is in keeping with a grounded theory approach and will be explored in more depth in Section 3 of this chapter.

SETTING AND ENVIRONMENT

The setting is an important aspect to consider when organising a focus group as the environment can have a big influence on how the participants behave and interact during the group session (Breen 2006, p467). It also needed to be somewhere that was convenient for participants as they were coming straight from practice and possibly returning to practice after the focus group / mentor update finished. Focus groups therefore took place in educational facilities on each trust site. Rooms of suitable size were chosen and it was felt that these facilities provided convenient and comfortable locations where mentors were familiar with their surroundings but away from the busy practice environment. The timings for focus groups / mentor updates kept within the 1 hour 30 minutes usually allocated for a mentor update and the focus group element lasted between 33 minutes and 54 minutes.

FOCUS GROUP INTERVIEW SCHEDULE

Breen (2006) advises that an interview schedule is a good idea, not just because there is a lot to remember but also to ensure a level of consistency

across groups. The interview schedule for the focus groups can be found in Appendix 5. Following introductions and a brief overview of the aims and focus of the research, participants were reminded of their role and their right to withdraw at any time without prejudice. Consent forms and demographic survey forms were then filled in, signed and collected. The focus groups all began with a group activity that was completed without researcher participation. This was followed by discussion around what had been explored during the group activity and then the issue of students with learning difficulties was introduced. The final area covered was around mentors' understanding of what learning difficulties entailed and their confidence in supporting students who have, or might have a learning difficulty.

An activity was chosen to start the focus groups as it was envisaged that a group task would help group members interact with each-other and stimulate discussion of ideas which would be beneficial for the research (Bloor et al 2001, pp 42–48). They were asked to do this without the facilitator being present at the table to encourage discussion which would not be influenced directly by the researcher (although it must be noted that the researcher remained in the room and was therefore exerting some form of indirect influence). This approach with groups can also be seen in some types of Participatory research where the ideas of the group members are given the greatest importance (Robinson-Pant 2002).

This approach worked well and an example of the resultant images produced can be seen in Appendix 6. The group work was organised in two stages. The group were initially asked to collectively discuss and write down things they felt impacted on students' learning in the practice environment. Once the group had written their thoughts down on paper, they were asked to assign a measure of importance to individual issues by placing beans by the side of issues they felt were most important. Each participant had one white bean and ten red beans; white indicating the most important issue and red indicating other issues they felt were

significant. The actual placing of beans remained anonymous unless the participant offered their choice as part of the following discussion.

Once the activity was complete, a semi-structured approach to the discussion part of the focus group was adopted. A semi-structured interview approach is recognised as appropriate for a grounded theory methodology that recognises symbolic interactionism as the underlying philosophy (Lambert and Loiselle 2008, p 229). Open ended questions were used where possible to introduce subject areas and then probing questions were used to help follow-up on specific issues raised. Some of the probes were part of the Interview Guide but others occurred naturally as points of clarification or to encourage a participant to further explore their experiences. As a general rule, I tried to say as little as possible while still promoting discussion amongst the group.

The discussion started by asking the group to talk through what they had put down on their sheet. This enabled the group to start talking and contributing more easily and helped them to disregard, as much as possible, the microphone. Discussion naturally ensued around issues raised during the group work and as much as possible the group were allowed to discuss amongst themselves until they had either come to a natural close or gone off track from issues relating to the research study.

The second part of the discussion phase began by asking participants to share their knowledge and understanding of dyslexia and learning difficulties. Mentors were encouraged to contribute their knowledge and feelings about these issues and wherever possible, quieter members of the groups were brought into the conversations to stimulate a breadth of opinion. The session finished by asking generally if anyone had anything else they wished to say or contribute and following this they were thanked for their time and contributions.

THE SECOND WAVE OF DATA COLLECTION: INDIVIDUAL INTERVIEWS – EXPERIENCED MENTORS

DIARY EXTRACT 7: INDIVIDUAL INTERVIEWS

Individual interviews were more challenging as this is a much more intimate process. Once again I feel that prior experience – this time the experience of being a nurse for many years – was useful to me, although I acknowledge that I needed to remind myself that I was a researcher and not a nurse during these encounters. For nurses, building relationships with their patients becomes second nature and adapting the self to best fit the needs of the person you are with is not a new concept to me. A chiropodist once commented on how I changed my approach with every patient we went to one afternoon and this included a whole range of aspects such as speech, attitude and body language.

INTRODUCTION

Some aspects of interviewing groups or individuals are shared, such as the skill of listening deeply (Yin 2016, p 142), respecting participants' views and maintaining a focus on the needs of the research (Arksey and Knight 2001), but the two approaches have significant differences that require different skills from the interviewer. In-depth interviewing of individuals, according to Roller and Lavrakas (2015, p 50), provides "a deep understanding of what people are doing and thinking" which fits with the requirements for this study. Charmaz (2006, p 28) refers to this as 'intensive interviewing' and states that;

> Intensive qualitative interviewing fits grounded theory methods particularly well. Both grounded theory and intensive interviewing are open-ended yet directed, shaped yet emergent and paced yet unrestricted.

She is relating here to one-to-one interviewing and in particular the semi-structured interview approach. She does not specifically speak of focus groups but she does say that this intensive individual approach

complements other methods and advocates for the researcher to choose methods that are shaped by the research question with ingenuity and decisiveness (Ibid, p 15).

Josselson (2013, p 12) states that the idea of the "neutral interviewer is a myth" supporting the idea of the interviewer as an active participant in knowledge production rather than a neutral bystander. She counsels that as interviewers we must pay attention to the relational and emotional factors that are inherent in all interview exchanges. This implies a humanistic approach to the interview process and an ability to perceive and interpret the nuances and intentions of the participant rather than just the words. Interviewing from a constructivist perspective entails uncovering the participant's definition of terms and situations as well as identifying their "… assumptions, implicit meanings and tacit rules" (Charmaz 2006, p 32). Building a good relationship with the interviewee is therefore implicitly central to obtaining good data for a study.

One way of building this relationship is to keep the tone of the interview conversational. As Arksey and Knight (1999, p 98) counsel, "It is important to remember that qualitative interviews are intended to encourage people to speak". They refer to the interview as a detailed and guided conversation best accomplished when the framework is flexible and not rigid. Other research books concur (Roller and Lavrakas 2015, Green and Thorogood 2014) portraying the qualitative interview as a type of conversation that simulates a more natural flow to the sharing of information which therefore stimulates inclusion. I would describe the interviews I carried out as being a form of 'professional conversation' that was guided by the issues the researcher needed to cover, but where, as much as possible, power relations within the conversation were equalised and the interviewee was respected as the expert in relation to the knowledge shared.

THEORETICAL SAMPLING

Once issues had been highlighted through analysis of the focus group data, mentors were selected for individual interview based on their increased experience of the mentorship role and their ability to help further exploration of emerging theories. Lambert and Loiselle (2007) conducted a reflexive analysis of the combination of these two qualitative data collecting methods and found that they were well suited for use together as they felt the focus group model created an initial model of conceptualisation of phenomenon and guided exploration of individual accounts and successive individual data served to enrich this conceptualisation whilst producing enhanced trustworthiness for findings. This works for a grounded theory approach, although here there is an added requirement for the collection of data to support and develop theory.

A series of four in-depth interviews were planned with participants from the focus groups. Participants who had several years of practice as a mentor to draw on were considered to be appropriate for this next phase. They were also participants who had highlighted issues within the focus groups that suggested they would have experiences that would be useful in terms of exploring the categories that were emerging in the data in more depth. A breadth of experience was included in relation to the final four mentors chosen as one mentor was child health trained, one was adult trained (both from the acute hospital setting - one from each hospital trust), and two were from the mental health trust (one acute hospital setting and one community setting).

RECRUITMENT OF MENTORS FOR INDIVIDUAL INTERVIEWS

In the original plan more time was allocated between each potential interview to allow for analysis that could inform questions in subsequent interviews. Contacting and booking mentors for individual interviews however, took more time than anticipated and the time left for analysis between interviews was once again reduced. At this point it was decided

to combine the four interviews into a second wave of data collection and analysis whereby all four interviews would be analysed at the same point and then compared to the focus group data.

Participants were contacted first via work e-mail accounts provided as part of the demographic questionnaire. Nobody replied. Letters requesting participation were then delivered to the work places of participants and this was followed up by telephone calls on numbers that had once again been supplied as part of demographic data. The original Participant Information and Informed Consent had both described and asked for permission to contact them again in the future for follow-up individual interviews. All had agreed to this process on the consent form however consent was sought once again before individual interviews took place.

INDIVIDUAL INTERVIEW GUIDE

An interview guide for the one-to-one interviews can be found in Appendix 7. Individual interviews began with re-visiting the issue of consent and their right to withdraw at any time without prejudice. Areas covered within the interview were their views on the role of the mentor, their views on working with students who struggle to learn in practice and their knowledge and understanding of learning difficulties and reasonable adjustments. A final question asked them to consider why only two of the initial six focus groups considered learning difficulties as an issue in practice.

All four interviews were carried out within a two week period, so, once again due to the short time span involved, the data from all four interviews was analysed at the same time. Codes identified from the individual interviews were then compared with those from the focus group stage which led to revision of these codes in the light of the new data and the identification of emerging categories. This became the second wave of data collection and analysis and further theoretical sampling ensued. This will be covered in more detail in the data analysis chapter.

THIRD WAVE OF DATA COLLECTION: INDIVIDUAL INTERVIEWS - MENTORS WITH A LEARNING DIFFICULTY

Following analysis of the individual interview data and comparison and refinement of codes by comparing with focus group codes, three main categories were emerging in the data, the importance of the practice environment, the relationship between the mentor and the student and the lack of importance that mentors appeared to give to issues around dyslexia and learning difficulties. In order to explore these issues from a slightly different perspective I decided to conduct two more one-to-one interviews, this time with mentors from the original focus groups who both had a learning difficulty. One participant had acknowledged that she had dyspraxia and the other had confided that she had dyslexia. The final two interviews were conducted in December 2014. Once again consent was re-visited before interviews began and the constant comparative approach to analysis was applied after both interviews had taken place. This became the third wave of data collection and analysis.

INTERVIEW GUIDE

The interview guide for the one-to-one interviews with mentors who had a learning difficulty themselves can be found in Appendix 8.

Once again their views on the role of the mentor and their views on working with students who struggle to learn in practice and their knowledge were sought. These areas of discussion remained the same to allow for comparisons to be made. The next area looked at their specific experiences of being a nurse and mentor who had a learning difficulty in the practice environment and explored their perceptions of how these experiences had impacted on how they work with students themselves. They were then asked to speculate, based on their experiences, what could be done to better support students with learning difficulties in the practice environment. The final question was the same as with the general individual interviews and asked if they were surprised that so few people had mentioned learning difficulties in the original focus groups.

Analysis of this third wave of data collection used the constant comparison method to compare and contrast between data from these individual interviews and the previous round of individual interviews and with the data from the focus groups.

SECTION 3: DATA ANALYSIS

DIARY EXTRACT 8: RESERVATIONS ABOUT ANALYSING DATA

> *To begin with, I was very fearful of the data analysis process. Never having done this before I felt overwhelmed. What if I couldn't make any sense of this data? What if the sense I could make was flawed, inconsistent or unacceptable to other researchers with much more experience and knowledge than I? This led me to do a considerable amount of reading around the data analysis process and unfortunately, the more I read, the more I became fearful and confused. This confusion is recognised by those who try to teach research to the novice student 'would-be' researcher, such as Silverman (2014, p110) who likens beginning qualitative analysis to exploring an unknown territory without a clearly understandable map. It appears that many students coming to data analysis for the first time share these feelings of being overwhelmed by the data they have collected and unequipped for the data analysis process ((Mauthner and Doucet 2003, p 414). Reading about data analysis may be necessary, but Frankham et al (2014) believes that 'doing' data analysis is the key to learning about it and identifies 'serious limitations' in research manuals* that set out to 'model the process' (p87).

Rapley (2011, p 274) states that the aim of the qualitative researcher is to develop 'a qualitative analytic attitude' which incorporates a working, hands-on, empirical, tacit knowledge of analysis. The only way of achieving this is to do it. Many researchers provide a set of rules or guidelines for novice researchers to follow (e.g. Corbin and Strauss 2008, Silverman 2014). Silverman points out that everyone, when they start analysing qualitative data, needs a 'ladder' to help them access higher levels of analytical development and that this ladder can be thrown away once the

researcher becomes confident in what they are trying to achieve. Charmaz (2006) gives a clear breakdown of her approach to data analysis in grounded theory which includes the gathering, coding, theoretical sampling and memo-writing processes and it was her work that guided my initial analysis.

CHRONOLOGICAL SEQUENCING OF THE DATA COLLECTION/DATA ANALYSIS PROCESS

WAVE 1: FOCUS GROUPS

1. All focus group data was considered as one data collection event and became the first wave of data collection.
2. Focus group activity data was coded and then categorised into areas sharing commonality.
3. Focus group interview data was transcribed by hand, page and line numbered and photocopied several times for further work to be done by hand (See Appendix 9 – Example 1).
4. Transcripts were read and re-read and listened to for familiarisation.
5. Line-by-line coding was commenced but this was replaced with passage-by-passage coding which was less time consuming and gave me a better overview in terms of categorising main issues (this approach was used for all subsequent transcripts – (See Appendix 9 – Example 2).
6. Codes and categories from focus group activity were compared and contrasted with those from focus group interviews and refined into more abstract categories that better represented the larger data set (see Appendix 10).
7. Notes were kept continually throughout the process in both the Reflective Diaries (Appendix 11 – Example 1) and the Memo-book which was invaluable for tracking ideas and theoretical notions through each stage of the process (Appendix 11 – Examples 2 & 3).

8. Colour-coding was used to help track categories through transcripts.

WAVE 2: INDIVIDUAL INTERVIEWS – EXPERIENCED MENTORS

1. Once all categories had been refined, theoretical sampling was used to identify mentors who had more experience with students who had learning difficulties and who had experience that would help further develop theoretical ideas.
2. Four mentors were subsequently interviewed and this was considered as one data event and became the second wave of data collection.
3. Stages 3, 4 and 5 repeated as for Wave 1.
4. Codes and categories from the individual interviews were then compared with those from the focus group activity and the focus group interviews and the combined categories derived from the first wave.
5. Further refinement and of the overall categories was carried out to better represent the full data set so far (See Table - Appendix 12).
6. Notes continued to be made in the Reflexive Diary and memo-book relating to development of theoretical possibilities.

WAVE 3: INDIVIDUAL INTERVIEWS – MENTORS WITH LEARNING DIFFICULTIES

1. Once all categories had been refined, theoretical sampling was used to identify that 2 mentors within the sample had learning difficulties and these were chosen for individual interview to provide a unique perspective on the issues arising and test out burgeoning theory.
2. Stages 3, 4 and 5 were repeated from Wave 1.
3. Codes and categories from these individual interviews were then compared with those from the focus group activity and the focus group interviews, the four original individual interviews, the

combined categories derived from the first wave and the combined categories derived from the second wave.

4. The final refinement of categories (Appendix 13) set the context for and supported the theory developed and proposed in this thesis: 'For mentors, dyslexia is just spelling!'

HOW DATA ANALYSIS EVOLVED WITHIN THE STUDY

For me, initial steps in data analysis were quite formulaic. The line-by-line coding adopted initially (Charmaz 2006, p 50) took time, and I felt that I was following a path with blind faith, not knowing exactly what I was hoping to achieve. I was becoming familiar with the data but did not feel I was making any progress in terms of the analysis. I was perhaps being impatient but looking back on this period of the project, it coincided with a particularly busy and stressful time at work, and I perhaps did not have enough spare capacity or time, to bring the required amount of focus to the data analysis process at this time.

I believe that the researcher can never be an objective bystander in the analytical process as the whole point of interpreting qualitative data is found in the relationship the researcher develops with the data itself. I transcribed all my data and conducted my data analysis by writing out by hand, without the use of a computer, choosing to do so partly because back problems made long stints of sitting at the computer prohibitive at this time and partly because I originate from an era before computers became common and I still have a preference and feel closer to the written word. Maclure (2013, p230) echoes my own feelings when she describes the qualitative data analysis process as follows:

> I enjoy that part of the research process that involves pouring over the data, annotating, describing, linking, bringing theory to bear, recalling what others have written, and seeing things from different angles. I like to do it 'manually' too, with paper and pen, scribbling

a dense texture of notes in margins and spilling over onto separate pages.

RESERVATIONS ABOUT THE CODING PROCESS

Providing evidence of how and why conclusions are arrived at, and how findings are an honest representation of what participants intended is important, but I was not at first convinced that codes and categories gave a full and adequate picture. St. Pierre and Jackson (2014) consider that one of the reasons why coding and categorising is so popular within qualitative data analysis, is because it is very hard to teach other approaches. In their words, "… we teach analysis as coding because it is teachable" (Ibid p745). They go on to argue that coding data can attempt to reduce words to numbers – perhaps in order to get closer to a scientific ideal of what research should achieve and aspire to. Mauthner and Doucet (2003, p 415) suggest that codes and categories along with computer aided programs for qualitative data analysis try to confer an air of objectivity on something that is intrinsically a subjective and interpretive process.

Grounded theory however, has a different approach to coding that I was slow to understand. Charmaz (2006, p 71) defends the coding process, describing it as 'flexible', enabling the researcher to go forwards and backwards through the data analysis process, using codes not to count events but to highlight theoretical possibilities. This idea of using codes to highlight theoretical possibilities became more and more important to me as the analysis progressed. Although I found the ritualistic process of coding and categorising initially laborious, I realised slowly how it helped me to create meaning from the data. I use the word 'create' intentionally as in helping me to engage with, sort and organise my data, the coding and categorising process slowly became the main source of analytical and theoretical development within the study. I also recognise that I became subjectively involved with the data on a personal and emotional level. This is why, for me, the reflexive process has been so important throughout this study. Even as the project has progressed, the way I have come to think

about things has changed. In time and in the future, I am sure that I will review the project differently once again. There is also a tension between musing over the more philosophical aspects of the research process and the practicalities of getting the project done and due to the fact that in all the reading I did in preparation for analysis, I did not come across anything that was able to provide clear procedures to teach my brain how to engage with and think about the data, I had to eventually learn by doing.

Time for data analysis within this research study was limited due to the delay in getting NHS site approval and although this was frustrating at the time, Silverman (2014, p111) comments on what he calls the 'sad fact' that there is little time for the data analysis itself within the demands of a research project and cites problems with ethical approval as one of the offending issues, which implies that I was not alone in feeling there were time constraints imposed on this important aspect of the work.

EXPERIENCING THE DATA ANALYSIS PROCESS

I decided to replace this line-by-line process with a broader approach that looked at chunks and passages of data (a point in time that also coincided with a more relaxed period at work). It was at this time and during this process that the data started to 'talk to me'. Thoughts and ideas came thick and fast and these were recorded in the reflexive diaries and memo book. I had a feeling of 'going with the flow'. I ceased to continually doubt myself and let the process itself take over. For this reason I continued with passage-by-passage coding for all three waves of analysis.

These periods were where inspiration and creativity was at its highest and I describe the feeling as joyful. The challenge was to provide evidence that what I was coming up with and out with was not just in my head but was grounded in the data. Finding a way to provide evidence for my interpretations kept me in constant touch, not just with the codes and categories but the actual data itself and I found that I was 'constantly comparing data' as a matter of course and not just because a book suggested that this was a good way to proceed.

For me, there had been a challenge in relation to the activity of data analysis. How to be rigorous and thorough without being constricted by a particular model or framework that dampens down the researcher's ability to use their own powers of interpretation and creativity to help make sense of the data in front of them. I feel I overcame this challenge by allowing myself to engage and interact with the data at times in an unrestricted manner whilst at the same time keeping track of my thoughts by way of the reflexive diaries and memo book. This then allowed me at a later date to review the product of my creative spells by re-engaging with the data in a more formal structured way.

> The problem with grounded theory, … , is that it is a one-sided hermeneutic; it is looking at and doing things to the data, it is not a thinking with the data or an engagement through the data with the process of analysis. In its tendency to itemise, grounded theory also atomises and the relationships between the parts and the whole are ignored. (Franklin et al 2014, p90)

In this way I was able to, in the words of Franklin et al (ibid) 'hang on to the notion of 'groundedness'' whilst at the same time allowing for engagement.

ADAPTED USE OF THE CONSTANT COMPARISON METHOD

Data analysis is a process of breaking down data into its constituent parts in order to reveal characteristic elements, patterns, relationships, influences and structures. The way this is done needs to be systematic and rigorous, but it also involves the use of the researcher's perceptions, experience and intuition. In keeping with the grounded theory approach to this research project, it was envisaged that theoretical sampling and constant comparison of data would occur from the moment that the first data was collected, however adaptations to this approach were necessary to accommodate the needs of the part time researcher and the needs of the practice environment where the patient and the daily running of the wards has to come first for nurse mentors.

One of the major challenges faced during this project, was the inability to engage consistently with the data collection/data analysis process over time. The hope had been to run a focus group, transcribe and analyse the data from it and then, through theoretical sampling, move on to the next data collection activity. Unfortunately, due to scheduling issues for the focus groups, this was not possible – and perhaps there had been a little naivety on my part to assume that this would be without problems. My work commitments, at this time, did not allow me to stay in the field for this entire process. Also, there was a distinct window of opportunity to access mentors for their mentor updates as they needed to complete their updates by Sept 1st 2013 in order to stay on the NMC mentor register and by the time I was ready to collect data it was July/August of this year.

Data collection/data analysis was therefore achieved in three waves. The first wave entailed collection of data from focus groups, followed by analysis. Analysis at this point revealed that there was a wide variety of experience between the mentors who attended the group sessions, with the mentors who had the most experience being able to provide more specific insights into working with students who struggle to learn in practice. Therefore, in line with theoretical sampling techniques, in order to explore these experiences in more depth in relation to the issues arising from the focus group data, the second wave of data collection involved in depth, face-to-face interviews with four mentors who were identified during the focus groups as having more experience with students in practice. Issues raised in the focus groups were followed up in these one-to-one interviews. This once again was followed by analysis. At this point it was decided that there was a need to focus more specifically on dyslexia and learning difficulties and two mentors were identified within the group, who revealed that they had learning difficulties themselves. The third wave of data collection therefore, entailed collection of data from these two mentors, once again followed by analysis. In line with the constant

comparison method of data collection, throughout this process, all data was constantly revisited to test out assumptions and possible theories

ISSUES ARISING DURING THE DATA ANALYSIS PROCESS

There were many times that the researcher's focus was taken away from the research project, sometimes for many weeks. Reflection on this has pointed to benefits as well as limitations. Limitations include a disruption in the flow of ideas and process of analysis. Becoming immersed in the data can take some time and when this process was working well there was a real feeling of engagement and connection with the stories and feelings of the individuals. At this point however, although ideas can come thick and fast, reflexivity is probably at its minimum. Periods away from the data allow time for reflection and consideration from a greater distance. There were times I had to make sure I carried my reflective journal around with me so that ideas could be captured on paper for consideration at a later date.

The philosophy of grounded theory implies that the researcher needs always to be aware of these thoughts and musings so that they can be tried and tested back with the data – being always mindful that it may be possible to find an example of virtually anything we think of within the data – to make sure that the thought comes first and foremost from (i.e. is grounded in) the data itself. This for me was part of the micro perspective, the 'up close and personal' relationship with the data.

Long periods away from the data mean that the research project lost momentum and threads may not have been followed up and therefore have been lost altogether. But it does help to come back to the project and data after a spell away with fresh eyes and perhaps slightly more objectivity (at least for a time). It is a time when things that we did not pick out previously can emerge. Other ideas that were previously exciting and calling out for more attention may now seem only vaguely important. It is also a chance to analyse our own thought processes in relation to the

analysis and analytical process itself with more clarity; to evaluate progress and direction from more of a macro perspective.

RESEARCHER SENSITIVITY TO THE DATA

Final thoughts about the data analysis process relates to my sensitivity to evidence for the intensity of feeling and meaning contained in the nuances, timings and silences of human speech, transcribed in the data. Interpreting words and phrases of participants carries with it a level of subjectivity but interpreting what a silence means, means conjecturing about what is going on inside the head of a participant and this moves interpretation to another level. Once again I found that I became more sensitive to the nuances in the data as I progressed through the analysis process. A lot of what was said during interviews when specifically relating to dyslexia or learning difficulties, appeared to be said mindfully, and this often made the flow of speech slightly halted with lots more 'umms' and silences than elsewhere. An example of this is presented within the category 'Walking a fine line' (see pages 138 – 145 in Chapter 4 on Findings and Discussion). I would find it very difficult to provide concrete evidence to support the fact that some of the candidates were uncomfortable when considering certain aspects relating to students who have, or may have, Dyslexia or another learning difficulty but the overall impression given supported this idea.

THEORETICAL SENSITIVITY

In reviewing this process I can see ways in which I strayed from the classical grounded theory model. Although there was an element of theoretical sampling, this could (and perhaps should) have been a stronger force in terms of the directions the research took. Eliminating strands that were not central to the research question earlier, might have focused the study more specifically on issues around dyslexia and learning difficulties at an earlier stage. However, as a novice researcher it took time to build confidence in my ability to analyse data and I can see that I spent precious time seeking verification for what I thought I had already found, rather

than seeking out evidence that would have helped towards developing and defining theory within the study.

SUMMARY OF DATA ANALYSIS

The process of data analysis within this study was based on theoretical sampling, constant comparison method and coding and categorising of data. It is based on a grounded theory approach although changes were made for pragmatic reasons as the study progressed.

Three waves of data collection were followed by three waves of data analysis. The constant comparison method of data analysis was used between each wave of data collection to refine codes and inform theoretical categories. Focus groups were the initial method of data collection to try to establish what the issues were from the perspective of the mentors. This was followed by individual interviews with four mentors who had more experience and might be able to help with the exploration of emerging theories. Two more individual interviews of mentors with a learning difficulty were then undertaken to explore the different and appropriately unique perspective of someone who had experience of not only the mentor role but that of the student with a learning difficulty.

CHAPTER SUMMARY

This chapter has looked at the research design for this study, splitting it into 3 sections. Section 1 looked at methodological issues, Section 2 covered research methods and Section 3 presented the data analysis process. My role as researcher has been examined at strategic points throughout this chapter to help clarify how this has impacted on the study and elucidated reasons behind decisions made.

The approach taken within the study led to the formation of three main categories that feed into an emerging theory which seeks to explain why mentors appear to fail to prioritise dyslexia and learning difficulties in their work with students in the practice environment. The next chapter will

discuss the findings that resulted from this data analysis and includes discussion using extant literature to further the analytical process

CHAPTER 4: FINDINGS AND DISCUSSION

DIARY EXTRACT 9: Thinking About Credibility

"We may think our words capture the empirical reality. Yet it is OUR view: we choose the words that capture our codes. Thus we define what we see as significant in the data and describe what we think is happening."
(Charmaz 2006, p 47)

Thinking about this quote reminds me that my findings are just that – 'My Findings'. I still sometimes think about the belief that I recognised at the start of this project (and beliefs are quite ingrained within us and therefore hard to change); that qualitative research may not be as good as quantitative research. Taking this a step further; that a piece of qualitative research such as mine (small scale and carried out by one researcher) may be even less respectable. I recognise too that this belief has changed. I now understand and believe that qualitative research is important in its own right but I still feel it may not be received by others on an equal footing.

Getting used to the idea that what I think is happening may be useful has taken some time, but maybe it is because I have taken the time and trouble to do the thinking and work through the process that there is value in what I have achieved and produced. It may not be possible for another to exactly reproduce these findings but I have tried to challenge myself and my assumptions throughout the process. I may be a novice researcher, and I might well do things differently if I was to start all over again, but the findings I present will be honestly and diligently offered as my interpretation of the data I collected. Nothing more, nothing less and that is okay.

INTRODUCTION TO CHAPTER

This chapter will explore the findings of the study relating to the core categories; 'The Environment', 'The Mentor/Student Relationship' and 'Dyslexia and Learning Difficulties'. These sub-categories are important as they provide context, and outline dimensions and properties that inform the theory proposed by this study.

The Tables in Appendix 13 give transcript, page and line number references to demonstrate how all codes and later categories originate from the data In grounded theory, each level of coding raises the conceptual level of the theory and a visual interpretation of the journey from data to theory for this study is provided in Appendix 14. Use of the constant comparison method helped to ensure the findings and the theory are grounded in the data. Aligning myself with a constructivist methodology means that I acknowledge the analytical lens or focus of the researcher as being an important part of the research process, and the reflective approach I have taken helps to provide insight into how I have progressed through each stage of the study to produce these findings.

The chapter will begin by considering the importance of the practice environment as a backdrop to all practical and social interactions between mentor and student nurse. Areas covered include, the importance of time as a crucial resource in the practice environment; a consideration of issues that make the practice environment a daunting prospect for students, including the impact of poor staffing levels; the effect of ward cultures on the student experience and exploration of the differences between practice learning and academic learning.

This will be followed by consideration of the relationship that develops between the nurse mentor and their students as this relationship is central to understanding how mentors relate to and interact with their students on a professional, social and personal level in practice. This section will look at issues around how mentors perceive their role, their beliefs and value systems, how they work with students in practice and how they perceive students who are struggling. The final section of the chapter considers findings relating to dyslexia and learning difficulties, exploring issues around mentors' knowledge and understanding of dyslexia and learning difficulties, the concerns they have about dyslexia and learning difficulties, disclosure and the way that mentors often appeared to be

aware that dyslexia and learning difficulties were sensitive subject areas and sometimes they were thoughtful and careful about what they said.

The findings of this study are presented along with discussion because Grounded theory is different from other methodologies in the use of extant literature within the study. In most other approaches a literature review precedes fieldwork. In classically based grounded theory studies this is not advised and the researcher is directed to go into the field without consultation of the literature so that they are not clouded or persuaded by other theories and ideas and can concentrate fully on the data as the source of concepts and theory (Walls et al 2010, p 9; Charmaz 2006, p 6). A preliminary literature review is required for doctoral studies, but literature in grounded theory has another purpose and can be used as a source of data in its own right to help with cross referencing and analysis of ideas, and the building of theory (Glaser and Strauss 1967, p 163). Consultation of extant literature is used within the Findings and Discussion Chapter of this thesis to help increase the analytic abstraction of the emerging theory by challenging and refining concepts. It also demonstrates where concepts evident within the study are supported by pre-existing research and where new knowledge has been identified. This is consistent with both classic and constructivist approaches to grounded theory (Breckenridge 2010).

SECTION 1: THE PRACTICE ENVIRONMENT

INTRODUCTION (Appendix 15 presents this Category with the codes feeding into it)

The nurse practice environment is an important factor within this study as it encompasses a place of work, a social milieu and a place of learning for mentors and their students. This section considers how mentors perceive this environment and how it impacts on their work as nurses and mentors in practice. For the purposes of this section of the study, the practice environment is synonymous with the practice setting and the clinical

environment and refers mainly to acute hospital locations (mainly wards unless otherwise stated), for all adult and child health mentors and most mental health mentors (only one mental health mentor works in a community setting). This section will begin with a brief consideration of how the practice environment is perceived in extant literature. This will be followed by consideration of issues around 'Time' as a valuable resource in the practice environment, issues that make the practice environment a difficult place to work and learn such as staffing levels, length of student placements and finally the impact of the ward culture on the student experience in practice.

THE NURSE PRACTICE ENVIRONMENT

The nurse practice environment is dynamic and ever changing and it is hard to pin down exactly what the chief characteristics of this environment are. It comprises more than just the spatial and practical elements such as buildings, resources. Duffield (2009, p245) considers such things as nurse variables (staffing, skill mix, job satisfaction), workload (patient acuity, Patient dependency, patient turnover) and working environment (environment complexity). Environment complexity is (interestingly) not broken down further but could perhaps include elements such as ward atmosphere and relationships between staff (Chuan and Barnett 2012) and leadership skills, communication and clinical competence of staff (McNamee et al 2013). The practice environment has also been considered as an organisational environment (Norman 2013, p1577), a psychosocial environment (Papathanasiou et al 2013, Malloy and Penprase 2010) and most frequently, a learning environment (Hegenbarth et al 2015, Van Bogaert et al 2013, O'Mara et al 2013, Smedley and Morey 2009, Bjork et al 2014). The nurse practice environment is also the subject of discussion from papers throughout the world (from above – Greece, Norway, Canada, Australia, Malaysia, U.K. and the U.S.A.).

The nursing student's perspective on the practice environment as a learning environment is particularly sought after (Hegenbarth et al 2015, Bjork e al 2013, O'Mara et al 2013, Decker and Shellenbarger 2012, Papathanasiou et al 2014) and one of the main overall concerns of this literature is the training and retention of nursing staff. This is perhaps due to what Burtson and Stichler (2010) refer to as a 'global nursing shortage' (Ibid, p1820). In a review of the literature, Norman (2013, p 1577) concludes that negative perceptions of the working environment predict intent to leave nursing and reduce commitment to the profession. The views of trained nurses about the practice environment in the literature, tends to reflect this overarching interest in staff retention as they focus on such issues as workload and burn-out (Duffield et al 2011, Van Bogaert et al 2013), but they also consider aspects in relation to and the effect the environment has on the caring role of the nurse and patient outcomes (Burston and Stichler 2010, Norman 2013).

The frequency with which issues relating to the practice environment occurred throughout the data provides evidence of how important mentors perceive this to be in relation to the work they do supporting students and supports findings from previous studies (Allan et al. 2011, Burtson and Stichler 2010, Chuan and Barnett 2012, Duffield et al. 2011, McNamee et al. 2013, Papathanasiou et al. 2013,Van Bogaert et al. 2013). The Practice Environment figured consistently throughout all three phases of the study however, the focus group phase was particularly important because the data collected at this point set the scene for further investigation suggesting what the main areas for investigation might be. During the activity part of the focus group sessions, only one of the 23 mentors placed a white bean (the sign for what was the most important issue for them individually) next to an issue relating to the practice environment. Out of the 228 red beans available (the sign for important areas), mentors placed 54 next to practice environment issues. Sixteen practice placement issues were written down but had no beans placed by

them at all. In total, the practice environment was mentioned 71 times. In terms of number of overall mentions, the practice environment was the second largest area identified.

This indicates that although the practice environment was seldom experienced as the most important aspect of the students' learning, it did have an important role to play, especially in terms of the mentors' perceptions of things that impact on student learning. This concern with the practice environment continued throughout all three waves of data collection and analysis. The nursing environment was a continual backdrop to all other elements of the research study. Its presence and its influence on other important aspects, such as the mentor/student relationship and the mentors' experiences of dyslexia and learning difficulties was found to be pervasive and therefore cannot be ignored if issues around how mentors perceive and work with students who have learning difficulties is to be understood.

THE IMPORTANCE OF TIME

One of the most frequent issues raised by mentors throughout this study, was in relation to 'time' and this perhaps reflected concerns with a range of issues regarding their feelings of not having enough time for students due to the pressures of workload and the stress experienced when there were not enough staff or mentors in the practice environment to support the number of students allocated. Once again this supports findings form other studies (Huybrecht et al. 2011, McIntosh et al. 2014, Snowden 2008)

Issues around 'time' appear in all 6 focus group (19 references overall) and all 6 individual interview (29 references).

> *"I've put one down on … time constraints because obviously it's … that's quite a big factor. If a student does need extra support … ummm … you know, the ward time constraints can be limiting."* **(FG 2 Adult Female)**

"Yes … if a student wants to learn something and it's obvious you don't have the time to stand there and do it … and its making the time or finding that time at the end of the shift, but if, you know, you've actually slogged your guts out for 7 ½ hours, are you gonna spend another half an hour at the end of the shift going through something with the student? Probably not …" **(LD 1 Adult Female)**

"Lack of time …… there are times when you're so, so busy. You just don't get the chance to … to explain rationale, or why you're doing what we're doing." **(GI2 MH Male)**

Throughout this study, time was related to a variety of aspects that go to make up the mentors' role in the practice environment. Sometimes they related to the general workload of the ward – of which supporting students played a significant part. Sometimes it was about mentors having enough time to do what they felt was a good job when supporting their students. Four mentors expressed feelings of regret and occasionally guilt when they were unable to give a student the support they would like to give and it was usually due to feeling that they do not have enough time for these students.

" … ummm … and I think it's time … and letting them down because I haven't been able to give them … what I think they .. should … they deserve … you know, what they need." **(G 1 MH Female)**

"Time – whether you've actually, physically got enough time to spend as much time with the student as you would like to." **(FG 6 – Adult Female)**

Pressures on the mentors' time can make their role as mentor very difficult and the more senior the nurse, the more difficult it was to create time for students. This often resulted in them having to rely on associate mentors and other members of staff to support students alongside themselves.

"And you get so many interruptions, so many calls on your time. So I'm trying to look after a group of patients, I'm trying to support my staff. I'm trying to deal with shortages of staff. I'm trying to deal with audits. The doctors tend to come to someone who's wearing a blue dress rather than go to someone else … and then I have a student as well, who also needs me there for them. So I find all those things … sort of crowding in on me. It can be overwhelming at times … and that … that is why I feel sometimes I might fail my student … because I … I can't focus on them sometimes". **(GI 3 Female - Adult).**

There is a sense of frustration and distress in this comment and a picture of nurses working as hard as they can but being unable to achieve what is being asked of them to the standard they would like. This impacts on outcomes such as 'job satisfaction' for the nurse mentor. In a survey of newly qualified nurses in America (Unruh and Zhang 2013), job difficulty and job demand were significantly related to a lower commitment to nursing and a greater intent to leave nursing. It could be argued that nurse mentors are more senior and more experienced, however similar results were found in other studies. In Belgium (Van Bogaert et al 2013), a range of nurses were surveyed and the nursing environment was found to predict variables of burnout, job satisfaction and intention to stay in nursing. For the participants in this study, the frustrations highlighted, often centred on the tensions between wanting to do their work with patients well and being a good mentor to their student. Time as a factor in this, will be revisited when considering the relationship between mentors and their students later in this chapter. It also comes up in many other quotes throughout the findings chapter as a part of other issues being presented.

Lack of time for the mentorship role figured highly in the findings of several other papers outside of this study, reinforcing the relevance of this particular code. In a U.K. survey by Hurley and Snowden (2008), three

themes emerged; lack of time to perform the mentorship role due to patient care workload, lack of opportunity to update knowledge and skills and lack of familiarity with the programme of study (which is updated every five years to comply with NMC regulations (NMC 2010). In a mixed methods study from Belgium, (Huybrecht et al 2011), workload and time were also identified as two significant barriers to performing the mentor role. A third study. Again from the U.K., McIntosh et al (2014), found that time, competing demands and paperwork emerged as the three main challenges faced by mentors in the practice environment. In a survey, report for the Nursing Strategic Collaboration Committee (Bough and Shaw 2014, cited in Winterman et al 2015), time was only one of the numerous difficulties reported by mentors; 60% of respondents cited workload as a barrier to mentoring, 36% reported a lack of staff and 29% said that patient dependency was a barrier to the mentorship role. It is interesting to note that these studies are all relatively recent, which demonstrates the amount of interest and concern that this subject is generating at this time. All of these issues were apparent in accounts by the mentors in this current study and acknowledging the scale of complexity evident within the nurse practice environment is important when trying to understand the challenges nurse mentors face in their role of supporting nurse students in practice and particularly, understanding why dyslexia does not appear to be a problem from the mentors' perspective.

TIME OUT AND PROTECTING TIME FOR STUDENTS

In this study, participants identified learning as having to happen alongside the day to day running of the ward;

> *"And the environment itself, because if it's a noisy and busy environment … and It's like you don't always get a quiet* space *to go and sit and have a conversation. There's usually something going*

on and a lot of the time it's … learning is as you go isn't it?". **(FG 4 MH Female)**

There are two aspects to this comment as the mentor is identifying that there is a need for time and quiet to absorb information and make sense of the environment with a student, whilst at the same time acknowledging that learning in practice is inextricably linked to the actual work that is carried out on the wards and as such, mentors need to be on the wards with their students in order to experience and benefit from it. Again, the reference here is made about students in general but for some students who have a learning difficulty, the pressures of 'learning as you go' may be increased.

Five mentors appreciated the benefits of being able to leave the ward environment with their student to reflect on learning experiences and opportunities:

"You disappear … You go over and sit in the school room. So we're here, but we're not here, and that's an … awfully good opportunity to be able to … to review things, because you're entirely away from the clinical area." **(GI 4 Child Health Female)**

One participant resorted to coming in on her own time to make time for filling in student documentation with them:

"Sometimes I … I feel I have to just go away from the ward, or even I've come in on my own time and said "Right we'll go to Timeout (Hospital Café) to have a cup of coffee and we'll just go through the paperwork. If I'm not actually supposed to be at work, they shouldn't bother me, theoretically, so I just go and hide." **(GI 3 Adult Female)**

Another participant makes a link between time constraints on the ward and the need to find time for students who are struggling in practice, intimating that this presents the mentor with a difficult dilemma.

"I've put one down on time constraints because it's … that's quite a big factor … if a student does need extra support … ummm … you know, the ward time constraints can be very limiting … for them so it's obviously making them aware that if they do need extra support you need to take time away from … the ward. And it can be difficult." **(FG 2 Female Adult Female).**

Taking this a step further, one mentor contemplates how working with a student who has learning difficulties might complicate the practice environment even more.

"So you work with them (students) and you have conversations amongst the group, and you may have varying experiences of the actual learning environment … and some people don't learn so well … and especially if they've got a learning difficulty on top of everything … you know, if … added to the pressure of the … environment…" **(GI 1 Mental Health Female)**

This issue demonstrates perhaps how dyslexia and learning difficulties might be seen as one more pressure for mentors to cope with in the practice environment. When asked if there was anything in the practice environment that could be changed to accommodate students with dyslexia or specific learning difficulties, the participant below, found it difficult to identify what could be changed, apart from giving extra time:

"No, it's just giving them time ... you know … But there's nothing within the environment that can be changed." **(GI 2 MH Male)**

Another mentor replies to the same question;

"Why would the practice environment have to change?" **(GI 4 Child Female)**

It is interesting to contemplate why these mentors feel that the practice environment either can't or shouldn't change. Both of these mentors have

years of experience behind them and perhaps there is a feeling that the practice environment has always been a difficult partner to manage and manipulate in any one particular way or another. Or perhaps they feel that it is part of their role as a health professional to adapt to the environment and change services and approaches to care rather than for the practice environment to make changes to accommodate for them. This issue will be re-visited in relation to reasonable adjustments in the practice environment for students with learning difficulties.

PRACTICE IS DAUNTING FOR STUDENTS

Several mentors in this study raised issues about the practice environment in relation to the impact it can have on students. Issues under this heading were raised in all 6 individual interviews and in 5 out of the 6 focus groups and included; fear and lack of experience on the part of the student, the busy, fast paced, ever changing nature of the wards; lack of staff and low staff morale, and the general effect of particular ward cultures which made the student feel unsupported or unwelcome. As this participant points out:

> "*They may have been at the end of their first year but may never have set foot in an acute hospital setting before, so that is quite daunting to begin with.*" **(FG 5 Adult Female)**

THE IMPACT OF STAFFING LEVELS

This study's interest in the practice environment is mainly as the psychosocial setting for the relationship that nurse mentors build with the student to support their learning. It cannot be ignored however, that there are inherent political and economic forces impacting on how the environment is perceived by nurse mentors. Variables such as shift patterns, staffing levels, skill mix, workload, nurse/patient ratios and nurse mentor/student ratios, were all identifiable issues raised by mentors.

"Especially now we have these long days. There's not enough staff necessarily all the time to support them (students). So then it's a question of finding somewhere for them to go … to keep them safe." **(FG 5 Adult Female)**

"… staffing levels are dropping again and quite often, you know, you end up with two or three students and, you know, sometimes they have to sit in the office and maybe do some … errr … research or course work on the computer (coughs) because there isn't sufficient to take them out on visits." **(GI 2 MH Male)**

Staffing levels of nurses, on hospital wards in particular, has been a feature of healthcare over many years and this is reflected in the literature. In 2010 the RCN published a report entitled 'Guidance on safe nurse staffing levels in the U.K.' (RCN 2010). This was in answer to growing concerns following inquiries into the Mid-Staffordshire NHS Hospital Trust by the Healthcare Commission between 2005 and 2008. This was the first of a number of reports by the RCN, focusing specifically on the nurse staffing crisis within the NHS (RCN 2012, RCN 2013). In this initial report, the RCN expressed grave concerns about the implications of sub-optimal nurse staffing levels on patient outcomes.

> Nationally the number of nurses in the workforce has risen in recent years. But capacity increases in the NHS have absorbed much of this additional workforce. Bed occupancy and patient throughput has increased dramatically over the last 20 years. There is no evidence to suggest that NHS ward level staffing has improved (RCN 2010, p 5).

The National Institute for Health and Care Excellence (NICE), who produce evidence based information for health and social sciences, produced guidelines in July 2014 around safe staffing levels for in-patient adult wards in hospital environments (NICE 2014). These guidelines take a wealth of information around patient and nursing variables into account to

produce a comprehensive and perhaps complicated framework that is designed to help both the organisation and the nurse, assess and plan staffing levels to accommodate for patient need on any particular ward in any one 24 hour period. The amount of variables taken into consideration within this document, to calculate what appropriate and safe staffing levels should be, indicates once again that the practice environment is complex and difficult to pin down.

However, perhaps one of the most interesting points from all of these reports is that the role of the registered nurse as mentor is virtually absent. In the RCN 'Guidance on safe nursing levels in the UK' (RCN 2010, p 28), the report briefly includes mentoring as one of the 'Other elements of nursing workload', stating that 'current systems capture only a fraction of the total volume of nursing work and overlook elements of workload'. The NICE Guidelines (NICE 2014, p 18) refer to 'the requirement for registered nurses to support and supervise healthcare assistants and page 19 gives a brief mention of 'nursing activities and responsibilities, other than direct care', but once again there is no specific consideration of the work that goes along with being a mentor. This may be due to the 'supernumerary status' of nurse students which dictates that their presence on the wards cannot be accounted for as part of staffing numbers, however the effect of their presence on the workload of mentors is not formally being factored into any equation relating to required staffing levels in practice. Staffing levels and mentor workload will have a direct effect on the time and support mentors are able to give to their students and this will have implications for the mentor/student relationship (section 2 of this chapter) and their attitudes and experiences with nursing students who have learning difficulties (section 3 of this chapter). When asked what they thought were the biggest factors impacting on the student's learning experience in the practice environment, one mentor said;

"I think that … err … might be … umm … mentor's motivation, and time and staffing levels." **(GI 1 Mental Health Female)**

Achieving adequate nursing staffing levels does not just incorporate appropriate and accurate assessment of the environment. The shortage of suitable trained and untrained staff referred to in the journal literature affected mentors in all practice environments accessed for this research project. As a final comment, one mentor pointed out that having more staff may not necessarily resolve the problem and allow more time for their role as mentor;

"That's what it comes down to all the time isn't it? But if we had more staff, we'd probably have more beds." **(FG 3 Mental Health Female)**

The idea here is that demand for NHS care is always likely to outweigh capacity available which means that nurses will always be working to capacity as the needs of patients always come first.

Although 'time' is not mentioned specifically in any of the documents relating to nurse staffing levels, nurse/patient ratios etc. mentioned above, it could be argued that the main impact of these shortages on the work of the qualified nurse and the nurse mentor is that there is less time available for everything they do. This incorporates their work with patients and their work with nurse students. If supporting patients is the trained nurse's prime responsibility and this is seen as a challenge due to less than adequate staffing levels then their ability to support nursing students is going to be equally challenging.

THE EFFECT OF WARD CULTURES ON THE PRACTICE ENVIRONMENT

Much of what mentors commented on within this study relates to the more practical elements of the nursing environment, staffing levels, numbers of students allocated to mentors and the lack of time available to support students adequately, but there was also evidence of how the

practice environment impacted on students in relation to being a negative and sometimes even hostile environment to learn in. Mentors in 4 out of the 6 focus groups and 2 out of the 6 interviews recognised that some students were fearful of the practice environment and this fear impacted on their ability to learn.

> *"I think if they are scared, they kind of back off, don't they? They don't really get involved as much as they need to, to be able to learn ….. they just go back into their little shell."* **(FG 3 MH Female, Female).**

There are a variety of reasons for this fear. Students can lack experience of the practice environment itself. It is my experience as an Admissions Tutor for many years and supporting first year student nurses, that those students who do not have experience of the practice environment before starting on the course often feel more apprehensive than those students who have worked in the practice setting already as, for example, a health care assistant. Those without experience also tend to be younger and therefore lack life experience which would help them to adapt to the practice setting. Finally, due to their younger age, they may have further to go than their older counterparts in relation to developing personal confidence in new and varied situations and settings. All of these things may contribute to a student nurse feeling anxious about practice placements. As one participant said:

> *"They're also quite anxious (students new to the ward) … like you know … it's quite scary when you start … come onto that ward isn't it? The first time you meet new people, and that's whatever placement it is. Starting a new environment is pretty daunting so … you've just got to be really supportive …"* **(FG 1 Adult Female)**

This mentor works on a general adult ward. Fear of the environment may be increased when the students are placed in more specialist adult areas such as theatres and critical care (Williams and Palmer 2013). In these

more specialised placement settings, even more advanced, more experienced students may initially experience fear or a lack of confidence. A participant who works on an oncology ward had this to say;

> *"They're always, when they come to us … very unconfident … because of the area we work in. They're always frightened about cancer. They're always frightened about the patients because they think they're all going to die. So every student, or 90% of students that come to us, isn't that confident."* **(LD 2 Female)**

Six mentors had experiences and stories of things that happened to them when they were students which helped them to understand and relate to the fears they identified in their students and this mental health mentor appreciated that their environment could be particularly frightening.

> *"Yeah we get chucked in there after a couple of weeks of college, don't you …I got left in the office on my first day when … ummm … somebody was kicking off outside. They locked me in the office with another student … We didn't know what to do. There was all these patients knocking at the door, asking for things. It was awful (laughs)"* **(FG 3 Mental Health Female)**

Working in the mental health ward environment is understandably different from working on adult wards, perhaps most significantly because a great deal of the focus for mental health nurses is on communication with patients, with less emphasis on providing practical care. However the patients on mental health wards are also very different and working with people who are psychologically unwell, sensitive and sometimes volatile may be understandably scary for inexperienced student nurses. This is perhaps what the participant is picking up on above. In my experience as an admissions tutor for pre-registration nursing, students who embark on the mental health nursing course do tend to be slightly more mature than those wanting to follow the adult nurse pathway and although the added life experience may help when it comes to fortitude and resilience in the

face of challenging placements and situations, the understanding and support given by the experienced and trained staff, and particularly the mentor might be pivotal in terms of how the student copes with such circumstances.

A slightly bleaker consideration is that the learning environment can perhaps be a hostile environment for nurse students due to the attitudes and culture that exist in some placement areas. Decker and Shellenbarger (2012) discuss how social interactions and cultural traditions between people in the practice environment can lead to the following states; horizontal violence and hostility, and vertical violence and hostility. Horizontal violence and hostility is defined as any act of subtle or overt aggression perpetuated by one colleague toward another – be it verbal, physical or emotional (Long 2007). Horizontal hostility is aggressive behaviour between individuals who hold the same level of power but which is designed to diminish or devalue or control a peer or group (Bartholomew 2006). These can be unkind and disrespectful behaviours which amount to a form of bullying. They may not be directed at the student nurse, but the resulting culture will have a profound impact on the student's ability to learn and progress.

Vertical violence and hostility describes the relationship between individuals of differing levels of power. This can be any manner of abusive, disrespectful behaviour, either overt (name-calling, fault-finding, intimidation, gossip, humiliation, chastising in front of others) or covert (sarcasm, eye-rolling, ignoring, sighing, isolation, refusing to help). Nursing students have been particularly identified as being susceptible to these kinds of behaviours from those they work with in practice (Levitt-Jones and Bourgeois 2007).

In this study, one participant speaks very strongly about a mentor she had during her training, who epitomised some of the behaviours and approaches mentioned above;

"My first placement in my third year was orthopaedic and my mentor was a cow ... and she was saying "you're in your third year and you don't understand how a giving-set works?" … and the more she tried, the more her attitude got "Why for God's sake can't you do this?" and the worse it got in my head. In the end, I avoided doing it … because I thought I can't … It, it was knocking my confidence." **(LD 1 Female Adult)**

There were other comments from participants reflecting that they appreciated some placement cultures were not as positive for students as others:

"They might have had a poor experience in a previous learning environment." **(FG 5 Adult Female)**

"If everybody on the ward believes your student is the tea-maker … do you know what I mean? They kind of fall into that role." **(FG 4 Mental Health Male)**

"… but people were saying "Can you just send a student to pharmacy?" Well I'm not THE STUDENT. My mother gave me a name and it wasn't 'the student', so I don't have that." **(FG 6 Child Health Female)**

These cultures are likely to impact on both the relationship that mentors build with their students and ultimately how much the student will be able to learn in that environment. Some students may even leave the course due to negative aspects of the nursing environment (Unruh and Zhang 2013, O'Mara et al 2014). This also has significance for the student with a learning difficulty as they may not feel able or confident to disclose their learning needs in environments that are not perceived as being supportive.

THEORY/PRACTICE GAP

The 'theory/practice gap' has a very complex nature and this makes a comprehensive definition difficult, however Monaghan (2015, p. e1) refers to this concept as an inability to relate and implement ideological knowledge gained in education with the realities of the practice environment. Matching textbook descriptions of clinical situations with the realities of practice is an ongoing problem (Scully 2011, p. 93) and according to Maben et al (2006, p. 466) appears to be a global phenomenon. There is a wealth of literature that considers this phenomenon, both from a nursing perspective (Scully 2011, Monaghan 2015, Haigh 2008, Maben et al 2006, Allan et al 2011), but also from a varied professional perspective, as any profession that has separate academic and practice elements could qualify (Rothe et al 2014, p. 552).

Scully (2011, p. 94) describes the 'theory-practice gap' as a distancing of theoretical knowledge from the practical dimension of nursing and goes on to argue that it is the most important issue in nursing today given that it challenges the idea of evidence-based practice which forms the basis of the nursing profession as a whole. This idea of distancing is echoed by Monaghan (2015, p. e2) who considers that the distances, both physical and psychological between nursing theory and practice are ever growing. This implies that there is a gap not only between the practical manifestation of theory in practice (e.g. adoption of correct manual handling procedures in practice (Swain et al 2003)), but also in the minds of nurses themselves. Therefore, beliefs and values of clinical nurses about academic knowledge and beliefs and values of academic nurses about clinical knowledge are likely to contribute to the perpetuation of this 'theory/practice gap'.

Haigh (2008, p. 1), insists that the 'theory/practice gap' does not have to be a bad thing and in one context could be taken to mean that a discipline is changing and evolving, challenging accepted norms and moving forward. However, she also describes theory and practice as separate disciplines and

although these disciplines are populated by the same professional – fundamentally the nurse – she sees a lack of collaboration between what she describes as 'academics' on the one hand and 'clinicians' on the other which she feels is one of the perpetuating factors of the 'theory/practice gap'. It was identifying this apparent disparity in the types and approaches to learning in academia and practice within the data that lead me to consider the issue from the perspective of a 'theory/practice gap'.

My experience of the role played by theoretical learning in the practice environment is that it can be contentious. As a nurse lecturer I have much experience of students complaining about having to write academic essays and read research articles because they do not appreciate how this academic learning is relevant to the practice area. This has particular importance for this study, as Dyslexia is often viewed as an academic issue by participants and is not seen as the responsibility of the practice environment. Mentors tended to situate themselves almost exclusively as clinicians in the practice environment and as such, separate from the academic and theoretical side of nursing. This participant would go straight to the academic institution for support when looking after a student who had dyslexia:

> *"I think … I'd go to talk to someone – the reason why I don't feel confident looking after a student with dyslexia because I don't even know much about dyslexic … how can I help, that's the reason. Yeah, I think I'd have to ring the university to seek, you know, where I could get some advice from, or what I should be looking out for and how to help them really."* **(FG 1 Adult Male)**

Identification and assessment of the student with a potential learning difficulty is something that is traditionally carried out in educational institutions and the cost of professional assessment and diagnosis may also be prohibitive in terms of the practice setting becoming involved.

Information about diagnosis of learning difficulties and reasonable adjustments is shared more readily and more routinely within the

academic environment and it has often been my experience, anecdotally from students and mentors that many students who struggle to learn in theory are often held in high esteem on the wards, especially by patients. This would back up some of the claims of the research that dyslexia and learning difficulties are not a problem in the practice area.

Participants in this study were not viewing academia in a negative fashion, but they were identifying it as a different environment with different expectations, different responsibilities and different practices. Within this study, being 'academic' and being a 'good nurse' were often referred to as being completely separate things.

> *"When I was a student nurse, one of the things I was good at was the academic side. So I wrote a good assignment … umm … regardless of whether I performed in practice or not."* **(FG 3 M4 Mental Health Male)**

> *"I've mentored student nurses who've got degrees but they cannot nurse. They've got no interpersonal skills whatsoever."* **(FG 3 M2 Mental Health Male)**

This implies that the skills needed to be successful in academia were seen as being very different from those a student needed to be successful in the practice environment. Not only that, but the skills needed for success in practice were considered as much more important.

> *"I think personability is such a big thing. If you can't talk to people … If you can't be empathetic, if you can't kind of communicate in an effective manner … umm … to me you're on a losing battle."* **(FG 4 M4 Mental Health Male)**

This is an important perspective, because if dyslexia and learning difficulties are being associated with academia and the science of nursing, and practical nursing skills are associated with practice and the art of nursing, then issues about dyslexia and learning difficulties are less likely to be considered as a problem in the practice environment.

"Caring, competence … caring for the patient is a different thing. Their attitude is right. What they want to do is right, but they have difficulty in writing. It should not really matter … I mean the spelling … one or two spelling here and there and … but if they've done what they're supposed to do, I think it should not matter." **(FG 6 IP3 Adult Male)**

The contemporary nursing literature is most concerned with the 'theory/practice gap' in relation to nursing students and to how they make the transition to newly qualified staff nurse (Maben et al 2006, Allan et al 20011, Monaghan 2015). Maben et al (2006) carried out a longitudinal study in three educational establishments in the U.K., over a three year period. The overall findings of the Maben et al (2006) study were that although candidates started their life as qualified nurses with a coherent set of values and ideals that largely reflected current academic theories and approaches to care, such as patient-centred care, holistic care, the need for quality care and the importance of evidence based care, they were unable to put their ideals into practice. This was due to what Maben et al (2006, p. 468) refer to as 'organisational and professional sabotage'. Organisational sabotage arose from the pressures and constraints of the working environment – much of which was referred to in relation to lack of time – and professional sabotage resulted from the influence individual colleagues and their approach to practice which was, in turn, strongly influenced by organisational sabotage factors.

Maben (ibid) saw existing staff in practice as *messengers* who, possibly unconsciously, were socialising the new nurses into a way of practicing at odds with their academic bred ideals and values. This socialisation process is likely to apply not only to newly qualified staff but also to students who spend 50% of their course time in the practice environment. The mentor may possibly be able to compensate for the impact of this socialisation process for the student, if they are a good role model and if they are not subconsciously affiliating with the covert socialisation process themselves.

The way mentors in this study referred to academic issues appears to support the idea that there is a subconscious but prevailing attitude in practice that the work of practice is more important than the work of academia. At the end of the day, as this participant points out, the needs of the patient always come first:

> *"But we've got another responsibility as well … We've got our role in our clinical area … ummm … sometimes the students don't always come first and that's quite difficult."* **(FG1 – Adult Female)**

If this is the case, it provides further evidence to support the idea that as dyslexia is seen as an academic issue, it lacks relevance and impact in the mind of the mentor in relation to assessing the ability of a student to learn in the practice environment.

Reasons for this situation were considered in my Theoretical Memo Book. I used this book alongside reflective diaries as part of the reflective approach taken within the research. I kept notes of theoretical issues and ideas deriving from the data and this helped me to analyse, reflect and compare them throughout the analytical process (see appendices 11a, 11b and 11c). Grounded theory particularly advocates the use of such diaries and memo-writing to evidence the thought processes of the researcher (Charmaz 2006, pp 72-94; Glaser and Strauss 1967, pp 108-111; Birks and Mills 2015, pp 39-47). Considering why students with learning difficulties were often appreciated in practice, caused me to consider learning in the practice setting and how and why this might be different from learning in academia. Issues around processes, assessment, success and the values and beliefs of those supporting students in the two areas were included. My personal reflections on these areas are presented in Box 1. This Box is presented as a reflection of my analytical thinking about the issue. Following this, and to qualify for inclusion within the thesis, mapping back to data was carried out to demonstrate that these ideas were indeed grounded in the data.

Ideas on the Practice side of the table came from working with the data and I contrasted them with my experience as a nurse lecturer along with views I have encountered from students and practice staff about the academic environment.

BOX 1: DIFFERENCES BETWEEN THEORY AND PRACTICE LEARNING

THEORY – Personal Perspective	**PRACTICE**
High value on the ability to read, memorise and write things down **(FG 3 M4 MH Male)** **(FG 3 MH Female)** **(GI 4 CH Female)** Lower value on practical ability and personal skills	High value on communicating and how to behave properly in the practice environment **(FG 4 MH Male)** **(GI 4 CH Female)** Lower value on writing skills **(FG 6 Adult Male)**
TYPES of LEARNING Book learning Planned learning Cognitive ability Critical analysis Model and theory based Classroom / Library / Computer **(FG 3 MH Female)** **(FG4 Adult Female)** **(FG 6 Adult Female)**	**TYPES of LEARNING** Experiential Opportunity based Contemporary Practice based Problem solving **(FG 1 Adult Female)** **(FG 2 Adult Female)** **(FG 4 MH Female)** **(GI 1 MH Female)** **(GI 2 MH Male)** **(GI 3 Adult Female)**
LEARN BY Book learning Planned learning Cognitive ability Critical analysis Model and theory based Classroom / Library / Computer **(GI 2 MH Male)**	**LEARN BY** Watching Listening Practicing Reflecting Communicating **(GI 2 MH Male)** **(GI 1 MH Female)** **(FG 5 Adult Female)** **(LD 2 Adult Female)**
WHAT CONSTITUTES SUCCESS? Passing Assignments Passing Exams Being present during classroom activity **(FG5 Adult Female)** **(FG 3 MH Male)**	**WHAT CONSTITUTES SUCCESS?** Enthusiastic Pro-active Confident Competent skill level Able to 'get on with' patients and help meet their needs

	Able to 'get on with' staff and contribute to the functioning of the team. **(FG 1 Adult Female)** **(FG 3 MH Male)** **(FG 3 MH Female)** **(FG 4 MH Male)** **(FG 6 Adult Male)** **(GI 1 MH Female)** **(LD 1 Adult Female)** **(LD 2 Adult Female)**

The idea that learning was indeed different in theory compared to practice may appear to be self-evident but acknowledgement of this phenomenon helped to clarify and explain some of the issues arising in the data. It explained why students who struggle in theory are often successful in practice and it provides insight into why some mentors identified a division between their work in practice and the work of nurse academics in the university. This idea could have been developed further in terms of building a theory in its own right, however as it only addresses some of the issues that were identified in the findings, it does not fully explain mentors views of struggling students (the over-arching aim of the study) and so it remains something that could be pursued in future research more specific to the 'theory-practice gap'.

This research study supports previous research in relation to there being a distance in the minds of nurses between academic learning and learning in the practice environment (Monaghan 2015, Scully 2011). It also supports research around the impact on student nurses as they make their way towards qualification and beyond (Allan et al. 2011, Maben 2006, Monaghan 2015). The area of new knowledge comes from implications within the findings that the 'theory/practice gap' could have specific implications relating to the student with dyslexia or a learning difficulty. If mentors are distancing themselves from academic learning when working with students who struggle to learn in the practice setting and identifying

academia as having responsibility for these students, they are failing to appreciate the practice based significance of dyslexia and learning difficulties.

SUMMARY OF ENVIRONMENTAL ISSUES

The practice environment then, is busy, dynamic, ever-changing, stressful and not always an easy place for mentors to work with their students and support them with their learning needs. The variety of placements, the length of time that students spend on a placement, staffing levels, morale, lack of time and supernumerary status of students are all issues that impact on the mentor/student relationship which is the next section of this chapter. As a continual backdrop, the practice environment will therefore exert a considerable influence on this relationship as it is both the location and the context in which this relationship develops.

SECTION 2: THE MENTOR/STUDENT RELATIONSHIP

INTRODUCTION (Appendix 16 presents this Category with the codes feeding into it)

The mentor/student relationship forms and develops in the practice environment and therefore needs to be understood in the context of all the challenges that have previously been highlighted. Much of what mentors speak about in the data is based on the relationship they have with their students and therefore, understanding this relationship helps in relation to understanding how they make sense of their experiences with students who have (or may have) learning difficulties. The data presented in this section helps to contextualise mentors' discussions around learning difficulties which are presented later in this chapter. It is also an important theoretical category that feeds into the overall theory presented in chapter 5. This section will cover issues relating to the role of the mentor, mentors' beliefs and values and how mentors work with their students.

The category of 'Mentor/Student Relationship' originated in the focus group activities where mentors prioritised it highly in terms of the number of white beans placed against issues relating to how they worked with students in practice. This interest in how they perceived their role with students was followed up in the individual interviews.

THE ROLE OF MENTOR

The role of mentor is regarded as a key factor in the development of student nurses by professional bodies associated with nursing. The requirements for mentors and mentorship are articulated in the NMC 'Standards to Support Learning and Assessment in Practice' (NMC 2008). Nurse mentors have to produce evidence of yearly updates and, in order to remain on the live register of practicing mentors, they have to demonstrate to their employers through a triennial review how they have maintained their ongoing competence. In their toolkit for mentors of nurses and midwives (RCN 2007), the RCN had this to say;

> The importance of the role of the mentor and quality of the mentorship offered in practice cannot be over-emphasised; learning experienced in the clinical setting ensures that the nurses and midwives of the future are fit for practice and purpose. The mentor is a key support to students in practice; this is where students apply their knowledge, learn key skills and achieve the required competence for registration. (RCN 2007, p. 3)

All mentors who had face-to-face interviews were asked about what they considered the role of the mentor to be. The most popular answers to this were around the mentor being a role model, a teacher or educator, someone who listens and supports, someone who is welcoming and includes the student in the team and someone who is interested in the student as a person.

The NMC (2008, p. 28) outline the key responsibilities of the mentor's role as:

- Organising and co-ordinating student learning activities in practice.
- Supervising students in learning environments and providing them with constructive feedback.
- Setting and monitoring achievement of realistic learning objectives.
- Assessing total performance – including skills, attitudes and behaviours.
- Providing evidence as required by programme providers of student achievement or lack of achievement.
- Liaising with others to provide feedback, identify any concerns about the student's performance and agree action as appropriate.
- Providing evidence for, or acting as, sign-off mentors with regards to making decisions about achievement of proficiency at the end of the programme.

These responsibilities form the core around which the role of the mentor needs to revolve. However there are a variety of ways that these responsibilities can be discharged. Some participants in the study saw helping the student to grow and develop as being just as important as teaching new skills. Although some more traditionally academic approaches are highlighted in the data, such as instructing, teaching, questioning, explaining, there is much more in the accounts of mentors that relates to the all-round development of the person (all be it the professional person) rather than just teaching. The In Vivo code (a code that is directly taken from the spoken words of a participant) 'Enablement' came to represent a mentor's overall approach to supporting students in practice. The emphasis here is on encouraging, guiding, role modelling, nurturing and 'giving the student a voice'. This is encapsulated by the following participant:

> *"It's a role model really … and I think, and a guide. Ummm, I think … I think just someone who … ummm … I think a mentor … you aim to show how, you know, you wish things to be … or hope things will be done. But it's also about being a support, a guide … to enable*

that person to find out who they … how they want to be as well. I've got, you know, as I said, I've got four students – all very different people and so I can't make them (into) myself, but I can support them to be the best of what they can be …….. You know, a guide. A resource as well, a mentor. Somebody who supports, who listens, who understands and can empathise and point you in the right direction. **……** *I think its hopefully a listening ear and … ummm … yeah, an educator, a health promoter (laughs) … and all that side of things … and you know, and a teacher … I suppose … definitely yeah because you are teaching – but you're also trying to … ummm … you know, sort of like ummm … criticism in a constructive way so that they can learn from it … and actually … realise themselves why they need to do certain things. Not necessarily a dictator, but an enabler."* **(GI 1 MH Female)**

Mentors then, perceive and interpret the role of mentor in different ways. It appears that there is a need for flexibility within the role and the role itself is complicated because of all of the things that the practice environment expects of qualified nurses. Considering what motivates mentors within their role can help provide some understanding of how they work with students and has implications for the student with learning difficulties as they are likely to need more time and effort from the mentor concerned.

MENTORS' BELIEFS AND VALUES

Data from the study suggested that mentors' motivations to be a mentor varied but, in spite of all of the difficulties identified. Five out of six individual interviews and one focus group expressed overtly positive sentiments towards the role:

"I love having students. I'd have one every day, all day." **(LD 2 Adult Female)**

"… and I've been a mentor since forever and I really like it. I really, really like it." **(FG 6 Adult Female)**

Another participant who enjoyed the mentor role, also acknowledged that this was not how all mentors felt:

"I think it's because I'm a … umm … a highly motivated mentor. I really like mentoring. I like the relationship that you establish between students and learners … and because I really enjoy it, I struggle to understand why other people don't." **(GI 4 Child Health Female)**

Huybrecht et al (2011) found that for mentors, the benefits outweighed the drawbacks of the role and even with the difficulties of practice notwithstanding, they still felt able to transfer enthusiasm to their students. Walsh (2010, p 4) lists 10 reasons why nurses may wish to become a mentor;

1. Increased job satisfaction
2. Increased professional role
3. Involvement with the higher education provider
4. Being updated by and learning from students
5. Developing teaching skills
6. Adding to personal profile / C.V.
7. Mentoring skills useful in other areas – e.g. management
8. Gratitude of the students, increased self-esteem
9. Opportunity to impact on curriculum and nurse training
10. Maintaining the standards of your own profession/protecting the public. (Walsh 2010, p. 4)

Intrinsic and extrinsic motivational forces are likely to be involved with all of the above behaviours. Some might have a more extrinsic focus – e.g. adding to a personal profile or C.V. or receiving gratitude from a student. Some might be inherently more intrinsic by nature such as being updated and learning from students. Mentors in this study presented a variety of

rationales for being a nurse mentor and these fell broadly into two categories. Firstly, reasons that revolved around feeling responsible for the production of the next generation of nurses (two mentors):

> *"And I try to explain to them, the patients, that the reason I'm a mentor is to enable the next lot of nurses coming through … you know so they treat you like they should do ... support you like they should."* **(GI 1 MH Female)**

Secondly, a more intrinsic rationale where mentors appeared more motivated by what they get out of the mentoring role on a personal level. For some this might be increased job satisfaction from the experience of mentoring itself (six mentors). As this participant puts it:

> *"Oh … it's … I love being a mentor because you get all these new, fresh people coming in, and it's an opportunity to show them the real side of nursing. You know, to get out there on the coal face sort-of-speak … and teach them the right way of doing things … and also … to … for them to teach me."* **(GI 2 MH Male)**

Motivations expressed by mentors in this study revolved mainly around numbers 1, 4, 8 and 10 of Walsh's list above. They tended to be more focused on the day-to-day, more personal aspects of being and working with a student, rather than the longer term, overarching aspects that link mentoring in with the bigger educational picture of pre-registration nursing courses. Once again Huybrecht et al (2011) had similar findings, concluding that benefits for mentors were not materially based (i.e. extrinsic) and were more concerned with the personal rewards of following up on new developments and the actual activities of teaching and sharing experiences. In a descriptive and cross-sectional survey study by Kantek et al (2015), the motivation of 326 nurses was explored and findings suggested that being 'appreciated' generated the highest score over all factors. This matches with the idea of intrinsic motivation explored above.

In spite of the challenges of the practice environment outlined in the previous section, one participant found that the additional requirement of having a student was a motivational force in itself:

> *"It's quite difficult to be motivated, to be fair, when your staffing levels are low, when morale's low on the unit. I actually like having students for that reason, because if I'm feeling like it's getting a bit mundane, they almost kind of make me … sit up a bit. … They remind me why I came into nursing in the first place."* **(LD 1 Female – Adult)**

Motivation can also come from internal mechanisms such as beliefs and values. Wang et al (2009) conducted a study of mentors and mentees around attachment theory, mentors' experiences of mentoring and the approach taken by mentors with their mentees. It should be stated that this piece of research was not done with nurse mentors and their students but with mentors and mentees from a large service organisation in a major city in southern China. Adjustments need to be made therefore from economic, political and cultural perspectives, however the premise is interesting even if the results might be difficult to justify in terms of generalisation to nursing here in the U.K.

Within the study, Wang et al (2009) identify two variables from research around attachment theory which they identify as continuums and along which the attachment style of the mentor can be assessed: anxiety and avoidance. Anxiety is said to assess the extent to which individuals worry about being rejected by others as they believe that they are unworthy of the positive attention of others. Avoidance measures the degree to which they are uncomfortable with closeness, which would limit their interdependence with others. By measuring applicants against these variables and including a measure of the mentor's experiences, the authors' aim was to predict a mentor's willingness to mentor in the future.

Wang et al (2009) argue that it is appropriate to consider the mentor and mentee in terms of attachment theory because mentoring relationships

can be considered to be close relationships that occur at work. Individuals learn about providing support in part, through personal experiences of attachment. They argue that attachment styles are linked to attitudes and beliefs about caregiving and serving as support workers, concluding that willingness to mentor can be considered a type of caregiving because it relates to intentions to provide support for less experienced individuals (Ibid, p. 246)

The mentor student relationship in nursing is a close interpersonal experience that takes place in the psychosocial practice environment. It is less a classical mentoring relationship which is very informal and takes place over a long period of time, and more a formal mentoring relationship which Morton- Cooper and Palmer (2000, p. 46) describe as 'facilitated mentoring'. This type of mentoring is created for a specific purpose, is determined by an organisation and focuses on specific supporter functions. The idea that mentors relate to their students depending on how securely they were attached as children with their parents, coupled with how well the students were attached to their parents, gives a different perspective on how and why things go well, or go badly.

Participants in this study appreciated that some relationships between the mentor and the student are likely to be more effective than others. This has good outcomes if the relationship works, but poorer outcomes if it doesn't. As one participant points out:

> *"What really impacts … was sometimes the students are very happy with the mentor, they get plenty of support, talked through things. But each individual is different. The mentor is different and the student is different as well. Sometimes it's a personality clash maybe, like … even if not in a very high degree."* **(FG 2 Adult Male)**

The idea of a personality clash here, could be considered as a simplified way of trying to understand why the mentor/student relationship isn't working. What is being highlighted as a personality clash may well include elements influenced by attachment theory. A mentor who has high

avoidance tendencies may be paired with a student who has high anxiety levels due to, according to Wang (2009), how securely or insecurely they were attached to their parents as children. This would mean that a mentor who is uncomfortable with closeness and limits interdependence with others is paired with a student who lacks confidence, worries about being rejected and accepted by others. This situation could cause frictions within the mentor/student relationship. This point has resonance in Section 3 of this chapter, where the pairing of mentors with mentees was suggested as being an under explored way of perhaps providing a measure of reasonable adjustment for a student with learning difficulties in practice.

In this study, attachment theory could also be reflected in the idea that the mentor's relationship with students was a highly individualised affair. One participant puts it this way:

> *"I think the most important thing is recognising that everybody is individual. You know, you can have 3 third year students and they don't all perform to the same … or in the same way. You know they can be very different in the way they can perform and the way they conduct themselves even … ummm … and the way that they communicate with patients and with staff."* **(FG 5 Adult Female)**

The study by Wang (2009) could also shed some light on the way some participants in this study described their feelings about mentoring students. The authors, (Ibid, p. 246), maintain that the formal and informal mentoring functions that mentors provide for their mentees are similar to the 'safe haven' and 'secure base' provided by parental figures. In this current study, four mentors took the nurturing element of their role very seriously and expressed the sentiment of feeling protective towards their students. One mentor saw this as a kind of 'fostering role' (GI 3 Adult Female). Another takes it a step further:

> *"So it's … it's like … it's literally like three years of raising a baby to a teenager. Actually … it is isn't it? You know, when your … when your baby is very small, you feed it and as it gets older you do less*

and less and less ... and it's the same. It's about their emerging confidence and competence really" **(GI 4 Child Female)**

One mentor, who is the educational link nurse for her clinical area and has the responsibility for allocating students to mentors in her clinical setting, acknowledges that she takes a very strong parenting approach to students:

"I keep an overall eye ... a bit like a mother figure. It's awful, I want to mother all my students. I'll be honest, I want to mother them all (laughs) … and I'm very protective of them … whether they've got problems, whether they're young or old, whatever. I get very protective of all my students. Not just the ones I'm mentoring." **(LD 2 Adult Female)**

It could be argued that this is not the best way to mentor students and other authors advise a more professional approach to the mentoring of students. Gardiner (1998 IN Downie and Basford 2003, p. 86) guides the reader towards the idea of a 'professional friendship'. She sees this as inherently different from an informal friendship, having clear boundaries and special purposes and goals that relate to the contract setting. She describes it as a 'special relationship' where interrelated elements of friendship are utilised within the context of professional objectivity. Nurturing is not outside the boundaries of this relationship, however professional objectivity dictates that a degree of self-awareness is essential to ensure that professional boundaries are maintained.

One of the main reasons for a more objective and professional approach to the mentor/student relationship is the need for mentors to assess their students and this cannot be done well if a subjective relationship has evolved. Mentors mentioned assessment mainly in line with the idea of failing students in practice. Only 3 participants had actually been responsible for failing a student and they all found the experience to be distressing and stressful. This reflects the findings of Duffy's (2003) seminal work on mentors' reasons for failing to fail students and more recent research (Brown et al 2011, Jervis and Tilki 2011) which supports Duffy's

(2003) original findings. Those who coped best with this situation were those who worked closely with other members of their practice team and with the link lecturers from the university faculty to support the student through the process such as this participant:

> *"Much easier … than to say … "You're just not good enough … I'm gonna have to speak to someone about this." Then you speak to the line manager. Then you speak to someone at the school. Then you arrange a meeting with everyone. It's … it's a difficult process."* **(GI 2 Mental Health Male)**

WORKING WITH STUDENTS

One of the principle ways of working with students reported by participants in this study, be it during a student's formal initial, mid-point or final interview, or be it a reflective discussion on an issue from practice, took the form of some kind of conversation. This gave rise to the code 'Conversations with Students'. Although occasionally mentors mention conducting a teaching session or making use of someone else's teaching, the principle way of imparting knowledge, assessing understanding, or just supporting the student was in the form of a conversation or discussion as this participant explains:

> *"Umm … it's conversations all the way. It's asking about "Is there anything I can do?", you know … and help them … umm … and … and supporting them to make decisions. It's about … umm I suppose … giving them directions really, for certain things …… It's trying to find out what the person knows about it … and what I know. There might be a big gap, so then we … sort of like … have a conversation about it. And maybe it challenges ... We both go off and find information out and come back and share it. So it's a shared … it's a shared … sort of like … sort of learning process."* **(GI 1 MH Female)**

Conversations took a variety of forms but always implied a two-way process. Mentors were often keen to find out more about a student in terms of what was working or not working for them as illustrated by the participant below:

> "*I needed to have a conversation just to see, you know, it could have been a problem with myself. It could have been a problem with the ward. It could have … I just felt there was something not quite working for her. Ummm … and that was the time that she said she'd been having problems and that … and she'd failed her exam and she just … you know … and it's because of her dyslexia"* **(FG5 Adult Female)**

Sometimes they wanted to find out about the student's expectations in relation to the placement and whether they were having any problems:

> *"I was very fortunate that I was able to have a … umm … conversation with her quite early on in the placement and I recognised that there was a potential problem."* **(FG 6 Adult Female)**

Only one of the mentors in the study worked in a community setting but the idea of having discussions and conversations with students appears to translate well into this different environment as driving to and from clients' homes gives the mentor and their student an ideal opportunity to discuss cases and reflect on what has happened.

> *"Obviously we have to drive back (from visiting a client) to the office … so we discuss in the car on the way back. "What did you gain from that? Would you have done anything differently? Why did you think I said this instead of saying this?" You know … and then get them to find out the rationale behind everything that was said or done whilst with the client."* **(GI 2 MH Male)**

These conversations appeared to have a strong reflective content, reflection being a recognised and effective tool for learning in the clinical

environment (Walsh 2010, p. 157). Reflection is the process of exploring experiences in order to learn from them and it has been accepted as a tool for professional learning through the work of people such as Donald Schon (1983, 1987). Reflective learning involves using deliberative, cognitive processes which actively set out to explore an experience to discover what can be learned (Jasper 2007, IN West et al 2007, p. 30). It essentially involves describing an event or experience in some detail and evaluating and analysing the thoughts, actions and beliefs that are revealed. This can be done alone but, as a nurse tutor, I have observed students struggling to learn a good technique and found that they often benefit from an outside, more experienced individual to help them reflect in a way that allows them to appreciate alternative perspectives. The mentor is ideally placed to fulfil this role. Walsh (2010, p. 157) believes that one of the hardest aspects of mentoring students is finding time for reflection and discussion. Codes relating to 'time' covered earlier in this chapter support this claim.

A lot of what has been covered in this section is about the mentor's approach or preferred style of mentoring. This style is likely to be influenced by a range of factors, their age, their years of being a mentor, the style of training they undertook, the mentors and nurses they chose as role models and wider influences such as social background and personal values and beliefs. The mentors chosen for the individual interviews were deliberately chosen because they had more years of experience mentoring students. It could however be said that this introduces a form of bias to the data as these mentors will have undergone a very different training to that which is offered today. They will have trained in the years before Project 2000 was introduced and before the NMC introduced their 'Standards to support learning and assessment in practice' to guide mentorship training (NMC 2008). Training for these older mentors would have been more like an apprenticeship model and very different from the current model. One mentor who was of this 'old school' approach talked about how he supports students and the phrase he used 'sitting by Nellie',

an old fashioned term aligned with the apprenticeship style of support, was used to describe how learning on the job occurred.

> *"Sit by Nelly, I think they called it … where you're showing them how to do it … yeah … 'Sitting by Nelly', just showing them how to do the job … errr … without saying 'Read this chapter, read this chapter, it'll give you a good idea'. No it won't. If we do it like this, and then we do this, and then that … then, you know … you try it. You do this, this and that. Yep, that's it but try doing it this way. Yes that's fine. You've got the idea. Now try and do it – see if you can do it without my input. Yep … that's how to do it. That's brilliant. Well done you know – and then they remember that."* **(GI 2 MH Male)**

This demonstrates a way of building the student's confidence by role modelling, demonstrating and working alongside the student to help them achieve success. Although perhaps a little outdated in light of today's mentoring approach and nursing rhetoric, which calls for a much more complex and flexible approach to supporting students, there are aspects of this mentor's approach that reflects elements of Vygotsky's framework of guided participation (Vygotsky 1986). Social development theory argues that social interaction precedes development and that consciousness and cognition are the end product of socialisation and social behaviour. He also referred to the 'More Knowledgeable Other' (MKO), which is someone who has greater understanding or a higher ability than the learner. This MKO is often perceived as being a teacher or coach and therefore the mentor would fit this role well. The final element of Vygotsky's theoretical framework involves the 'Zone of Proximal Development' (ZPD) which is the distance between the student's ability to achieve a task with the supervision of the MKO compared to the ability of the student to do so independently. This is the zone where Vygotsky claims learning occurs.

The mentor in the above quote fulfils the requirements of the MKO and with his support, the student is encouraged to push their boundaries in a supportive way into the ZPD so that they achieve the set task. Working in

this way with students helps them to become more self-confident and self-sufficient in their practice and moves them towards practising more independently of their mentor.

Some mentors had a more pragmatic approach to moving their students towards practicing more independently, and were more structured and challenging in their approach; challenging the student to fulfil potential, practice new skills or develop a leadership role. Challenging is one of the 14 roles identified by Darling (1984) and it was something that several mentors identified as an important part of their work to support students with their learning. As one participant explains:

> *"And the third years, they're the ones that I would start then to challenge. So, okay … so this is the scenario we've got. What would you like … what would you do about it? How would you react? What do you think … you know, what policies would you align to this? What anatomy and physiology would be relevant? How often would you give this medicine? So they'll be feeding the stuff back to me."* **(GI 4 Child Female)**

West (2007 IN West et al 2007, p.20), points out that the right level of challenge is something that students actually wanted. She maintains that having their skills and understanding challenged helped students to value the theoretical component of the course. She also remarks that those mentors who were seen as 'too nice' or 'reluctant to embarrass students' were not held in as high esteem. Those students who had been exposed to regular questioning from mentors in practice found it made them think and read to find out more. Challenging does not just relate to questioning students, but no matter how a mentor challenges their student, getting the balance right for each individual student may be hard to achieve at times as this participant points out:

> *"Don't push too hard … but don't let them sit in the background. You know, let them (coughs) take a lead for as much as they feel confident in … and maybe just a little bit extra. So that they're not*

just coasting. Although I like them to have a pleasurable experience with the team, I want to push them just a little bit." **(GI 2 MH Male)**

One mentor puts getting this balance right down to a form of intuition:

"You get a sixth sense … is this person ready to take the next step forward, or do we need to hang onto the reins a little bit longer … and go and give them extra support and more support." **(FG 5 Adult Female)**

During the focus groups/mentor updates, the mentors were asked to think about student attributes that help or hinder learning in practice. Motivation and enthusiasm of students was frequently picked as the most important student trait in the focus group activity. Four mentors used white beans to indicate enthusiasm as the most important student attribute in relation to learning in practice. Thirty-one red beans were also placed on aspects relating to this issue. Of all the issues highlighted in the focus group activity, enthusiasm related issues had one of the highest all round mentions and was highlighted in 5 out of 6 focus group discussions. Three out of the 6 individual interviews also picked up on this issue as important. Mentors were mainly referring to *student* motivation when they talked about motivation and enthusiasm but as this mentor points out it can be inter-related or it can come from the mentor's side. Either way, it is likely to have implications for the mentor/student relationship and how mentors work with their students. One participant explains:

"Student motivation … I mean, if they're not motivated to learn, it's the most difficult thing to teach. You cannot teach a student motivation. If they're not willing to be where they are, to do what they're doing, they're just … it's like … walking through mud trying to teach them something. But that can have an effect on the mentor's motivation. You know, if the mentor's not got their heart in it, they're not gonna teach properly. Now saying that, there's a lot of mentors … you know, they … have just been a mentor because they've been told, you know, you're a band 6 or band 5, you need to

be a mentor …"Well I don't really want to be … but yes I suppose I will." They're just not enthusiastic about it." **(GI 2 MH Male)**

One participant pointed out that there may be some confusion between a student who lacks enthusiasm and one that lacks in confidence.

"I'm not sure if that is a lack of enthusiasm rather than a lack of confidence. If a student is learning … they should be increasing in confidence. Some students might not put themselves forward and ask questions about what they are experiencing … Some might not volunteer information for fear of failure." **(FG 1 Adult Female)**

Trust between the mentor and the student was another issue that several mentors highlighted both within focus groups (2 out of 6) and individual interviews (4 out of 6). 'Trust' became a code in its own right and was also linked strongly to the act of disclosure when discussing issues around dyslexia and learning difficulties which will be followed up in the next section. Trust was seen by some as the bedrock upon which the whole mentor/student relationship was founded, as the following quotes indicate:

"I put mine down as trusting mentors because I think … if you don't have the trust there and they don't confide in each other, we're not going to be able to help each other. I'm not going to be able to help them and they're not going to be able to … able to help me and so I think it's quite a strong one for me." **(FG 2 Adult Female)**

"It's like any relationship, if you don't trust the person you're with … then then I don't think you can have a relationship. So there needs to be that student / mentor rapport. There needs to be that trust. There needs … the student needs trust that you're going to teach them ... correctly. That you are gonna put effort into it. Ummm … the mentor needs to … there needs to be a level of respect … with the mentor and the student. You need to respect their ability. They need to respect yours. Th … th … it's almost like … well it's like it is

in any relationship, there needs to be respect, trust, commitment from both sides." **(LD 1 Adult Female)**

Daykin (2007 IN West et al 2007, p. 74) suggests that the mentor/student relationship should be fundamentally based on genuineness, trust, acceptance and empathetic understanding. Genuineness on the part of the mentor is about presenting oneself as a real person and displaying normal reactions when you are with students rather than trying to be an ideal version of a mentor. Trust and acceptance is about avoiding being judgemental about students and treating them as a real person. This approach is suggested as being honest and therefore more likely to engender trust between mentor and student. Trust however can take time to achieve and clinical placements are relatively short. It can also be hampered by the past experiences of both students and mentors and is thus not always easy to achieve

SUMMARY OF THE MENTOR/STUDENT RELATIONSHIP

Overall, the conclusions about the mentor/student relationship, based on the data collected for this study, points to the fact that even though a mentor's life may be pressurised and stressful, they still value the work they do with students. They recognise that not all mentors are enthusiastic about the mentor/student relationship, that not all students are easy to mentor and that the practice environment presents them with challenges to their mentoring role on a daily basis, however they take the role seriously and try to do a good job. This is something to remember in relation to how they feel and react to issues relating to students who may have dyslexia or some other learning difficulty, or may just be struggling in practice for other reasons.

SECTION 3: DYSLEXIA AND LEARNING DIFFICULTIES

INTRODUCTION (Appendix 17 presents this Category with the codes feeding into it)

The two previous sections on the findings from this study have set the scene for how mentors view the environment in which they work with patients and students, and how they view the relationship they build with students in the practice environment. Both of these areas have significance for how they view issues relating to dyslexia and learning difficulties. This section looks at findings related specifically to mentors' experiences with students who have, or may have, a learning difficulty and their understanding of what learning difficulties and reasonable adjustments involve.

For the purpose of this section of the findings, unless specifically differentiated, dyslexia, specific learning difficulties and learning difficulties are all used to signify problems with data processing which may include writing, reading, spelling, memory, and organisational skills. Mentors tended to use these names interchangeably as there was often a lack of detailed knowledge about what the precise differences between these terms actually involved. Dyscalculia and Dyspraxia are names of two specific learning difficulties that mentors were aware of and therefore they will be referred to by name. Although mentors rarely volunteered discussion around dyslexia and learning difficulties when talking about students who struggle to learn in practice, once the topic had been raised for them there were some significant similarities in terms of mentors' approaches and opinions.

This section will begin by looking at mentors' knowledge and understanding of dyslexia and learning difficulties. It will then proceed to consider their concerns in relation to documentation and medication. Issues around disclosure of learning difficulties in practice will be explored and the final section will reflect on the contributions made by mentors in the light of political correctness.

KNOWLEDGE AND UNDERSTANDING OF LEARNING DIFFICULTIES

The demographic survey (Appendices 3 and 4) demonstrated an overall trend for mentors to have less confidence in supporting students who have a learning difficulty than supporting a student who 'struggles to learn' in practice and mentors with more years of experience had more confidence in both categories. This suggests that mentors thought 'struggling to learn' was different to having a 'learning difficulty' and poses questions about their knowledge and understanding of learning difficulties. The use of the phrase 'struggling to learn' was used to include those student nurses who had either chosen not to disclose their learning difficulty or who had not been officially diagnosed with one. If, as Pollock (2005) contends, any strategy implemented for students with dyslexia would have benefits for all students, the distinction between struggling students and students with a learning difficulty should perhaps be negligible.

When participants were asked during focus groups and individual interviews about what they knew about dyslexia and learning difficulties and how confident they felt about supporting students who have, or may struggle in this area, there were mixed reactions. Five mentors expressed sentiments of feeling unconfident such as those of the participant below:

> *"I don't think … no … I don't think I … I'd do the best I could but I'm not sure if I could … if I'm helping them in a way they need to be helped."* **(FG 2 B1 Adult Female)**

The trepidation here could be viewed in a positive way as at least the mentor is acknowledging the unique nature of learning disabilities in that they are very much specific to the needs of the individual person involved. There is also a feeling that this mentor does not feel familiar enough with the realities and practicalities of supporting students with these difficulties.

Some mentors appeared to understand the idea that there were different possible degrees to which people were affected by dyslexia such as this participant: *"I'd want to know the degree of it … cos there are, there are*

varying degrees of dyslexia …" **(FG1 A1 Adult Female)**, but all interviews and focus groups, even if they acknowledged that a continuum existed in relation to the severity of learning difficulties, were specifically concerned with issues relating to writing, reading and spelling:

> *"Dyslexia is, as my understanding … they might, when they write something, it might be letters backwards, or not read as well as we could or anyone could. They might stop and start words. … … They add on words and take words away and put sentences back to forward or front."* **(FG 6 Adult Female)**

This reinforces findings by Tee and Cowen (2014) who evaluated an interactive resource to help nurse mentors understand the needs of nursing students who had a disability. They found that while most of the mentors in their study had a *basic* understanding of *some* of the areas which might be associated with dyslexia, they tended to focus on issues around reading, writing and spelling. They also found that mentors had a poorer knowledge of the less well known aspects associated with dyslexia such as organisation, working memory and automaticity which were areas that they felt were "more likely to cause difficulties in a clinical setting" (Tee and Cowen 2012, p 9).

AWARENESS OF LEARNING DIFFICULTIES

Mentors tended to attribute reasons for struggling to learn in practice to explanations such as those of the participant below:

> *"I think sometimes, you know, they're struggling … It might be lack of confidence or … umm … they're doing the same thing every day and not challenging themselves … … … Sickness is a big one for us."* **(GI 1 Mental Health Female)**

Lack of confidence figured highly in these explanations. Three out of 6 individual interviews picked up on this aspect and 4 out of 6 focus groups. Avoidance and sickness were also mentioned several times; four out of 6 focus groups and 2 out of 6 individual interviews referred to sickness as a

method used by students to avoid issues in practice. It appears that the behaviour of a struggling student is picked up on consistently, but the reasons for the behaviour are not always clarified. Students struggle in practice for a variety of reasons and not just because they have dyslexia. A student with dyslexia who is struggling may not be identified at this point in practice and could be considered to have other problems unless either they disclose, or the mentor has insight due to specific knowledge and understanding of dyslexia.

Some people aren't always aware that they have a learning difficulty and have managed by working extremely hard and employing coping mechanisms that they have developed over many years. A very interesting exchange took place between two mentors who worked together in practice in relation to identifying someone in practice who might have a learning difficulty. One of these mentors had already come to my notice in terms of learning difficulties due to the way she spoke about the academic side of the pre-registration nursing course she did. She had a very specific approach to supporting students who found written work from the university difficult;

> *"READ IT and read it – one hundred and fifty times if you've got to, but get to what they want, you know. Make sure you know what you're supposed to be writing about."* **(FG3 Mental Health Female)**

For me, this reflected an area of difficulty she had identified for herself whilst on the course. This specific mentor talks about finding the academic work for her nursing course really hard and having to spend a long time doing assignments, admitting that she was really bad at spelling. At one point in the interview, her colleague and friend challenges her;

> *"You're asking me how to spell all sorts of things. Does that mean that you're dyslexic?"* **(FG 3 Mental Health Female)**

Her response is followed by her friend laughing loudly;

> *"I don't know, I was never tested."* **(FG 3 Mental Health Female)**

This exchange is intriguing as it appears to be the first time either of them has considered the prospect that A10 may actually be dyslexic. A11 concludes that this shows that she would not be able to spot someone who has, what both of them conclude to be the possibility of mild dyslexia. A10 has a son who she describes as being severely dyslexic and she does not equate her problems with writing and spelling with his diagnosis but reflecting on her own issues with academic work did make her review the possibility;

> *"I've seen what my son went through. I don't put letters back to front or things like that. It's just …umm … I don't know really."* **(FG 3 A10 Mental Health Female)**

She did however, definitely feel that having a son with dyslexia helped her in her role of supporting students in practice. When asked about this, she replies;

> *"Yeah (quietly, thoughtfully) … umm … being aware, I know something about how they feel. I've got more understanding."* **(FG 3 A10 Mental Health Female)**

Once again the idea of 'understanding' is considered to be most important where issues relating to learning difficulties is concerned, perhaps because it is in understanding that attitudes and beliefs are challenged, which is something that may not be as powerfully addressed by more factual approaches to education on the subject.

REASONABLE ADJUSTMENTS IN PRACTICE

Within this study, there was a lack of in-depth knowledge and understanding of what reasonable adjustments in relation to supporting students with learning difficulties in practice might look like. Elcock (2014, p 758) maintains that it is the word 'reasonable' that often leads to the most debate and discussion as it cannot be pinned down in definite terms. Reasonable adjustments would therefore be different for each student and not always transferable from one practice setting to another.

In this study, 5 focus groups and 5 individual interviews considered reasonable adjustments in some way and 6 out of these 10 references were made about adjustments of academic origin and associated with the educational side of the course such as coloured glasses and overlays, extra time in exams, the use of electronic gadgets such as computers and phones. The contribution from the participant below was a typical response:

> *"So like, if you were having something to do with an exam you would have somebody to scribe for you. Things like using overlays, special glasses. Using a computer rather than writing by hand."* **(FG 6 Adult Female)**

Mentors talked about adjustments incorporating coloured glasses and overlays and computers as being transferable to the practice environment without too much difficulty. The only other possibilities offered, were time and matching students to mentors more carefully.

Time was often identified as a reasonable adjustment that could be made in the practice environment. Five out of 6 individual interviews and 4 out of 5 focus groups highlighted the fact that time would be an important issue when considering the support for students who had a learning difficulty. As this participant points out:

> *"Allowing extra time for things … sometimes they might need a bit of extra time to complete a task that somebody without dyslexia might do a bit quicker. But it wouldn't mean that they can't do it. They just need a little bit longer."* **(FG1 A Adult Female)**

However the logistics of this seemingly simple idea are complicated by all of the issues relating to lack of time identified in Section 1 on the 'Practice Environment'. Time is a precious commodity on the ward and there is only so much time in a day, as this mentor explains:

> "*Time's not married to the student's needs is it? The time is pre-set and I know that, you know, you can't kind of plan the timetable*

around individuals' needs particularly, but that is an issue isn't it?" **(FG 4 M4 Mental Health Male)**

Participants appeared to value their role of supporting students and identified this tension between wanting to do a good job supporting their student but not being able to because there was a lack of time to do so. The participant below acknowledges the dilemma of wanting to spend more time with a student but is also aware of the general lack of time available:

> *"If I had a student with dyslexia, I would like to be able to try to spend more time with them because when we're doing care plans … and writing notes and stuff … you know, I whizz through it … because I haven't got the time to spend ages on it …"* **(FG 3 A11 Mental Health Female)**

Matching students more carefully with mentors was also offered as a form of reasonable adjustment that could be accommodated in the practice environment. Two participants suggested placing a student who has dyslexia with a specific mentor who would be able to meet their specific needs. When asked if he had ever considered reasonable adjustments for students in practice, the participant below said this:

> *"I think a lot of things I've considered – not who is my student nurse, but who is that student nurse best placed with? Like if they're completely opposite to me as a person, in terms of personality, in terms of the way they learn and the way I teach … umm … Am I really the best person to be their mentor? Is there someone else who could do a better job? ……. It's not always kind of … it's not always explored like that. It's kind of normally explored on who has the capacity to take this student. But, you know, it's probably a bit of an ideology that you marry the student to the mentor."* **(FG 4 Mental Health Male)**

This suggests that the shortages of staff and mentors in practice might make this option more difficult to follow through than it at first seems.

The participant below appeared receptive to the idea of applying the basic principles of reasonable adjustments to the practice environment;

> *"You can use them (reasonable adjustments) in practice as well can't you? If you've got somebody that you suspect, or has been diagnosed, they can just bring them with them. It's not a problem, otherwise I suppose it wouldn't be too difficult to make adjustments to accommodate people."* **(FG 6 IP1 Adult Female)**

However, others were more sceptical about how reasonable adjustments would work in the practice environment. Four out of 6 individual interviews and 2 out of 6 focus groups put forward the idea that practice would have problems changing to accommodate for reasonable adjustments. When asked what might be changed in the practice environment to accommodate students with learning difficulties and dyslexia, two mentors interpreted this as actually trying to change the nature of the practice environment, rather than perhaps introducing accommodations for the student:

> *"Why would the practice environment have to change?"* **(GI 4 Child Female)**

> *"No … it's just giving them time, you know? But there's nothing within the environment that can be changed. No."* **(GI 2 Mental Health Male)**

This idea that the practice environment cannot change may be understandable in terms of the size and scope of the way the NHS is run – particularly in the acute hospital sector – but severe failings in the NHS over the past years have challenged this way of thinking. It is perhaps accurate to say that the number, the type and the dependency of the patient is not likely to diminish – and this is perhaps how the question was interpreted by some of the mentors in the study. Change may be difficult

to implement in the current climate, but innovation is promoted by the NHS and included in pre-registration nurse curriculums when considering issues such as service improvement.

At the end of two of the focus groups, mentors commented on the fact that they would welcome more knowledge and understanding of the problem and one or two asked for more input regarding learning difficulties in mentorship programmes and on mentorship updates.

> *"Within our mentorship training maybe we should have a bit more emphasis on, you know, dyslexia and how to look after these ... particular needs. I don't think in my mentorship there was a great deal of … being a good mentor to someone who, you know …. struggles to learn … yeh."* **(FG 1 A7 Adult Female)**

Where and when a mentor trained for their mentorship qualification may be an underlying factor, however, the NMC promotes the idea of acknowledging disability within programmes designed to train mentors (NMC 2008) and all mentorship training programmes should include content on equality, diversity and disability. On mentorship programmes over the last ten years at the university training nurses and mentors for the settings used in this research, a whole day is spent on issues around disability. Equally, the mentor update for 2014 - 2015 (these are changed yearly and all mentors must access them every year) was built around issues specifically relating to students who may have a learning difficulty.

Feedback from mentors on this update highlighted that they did not appreciate why they were having this content when there was so much else to discuss about the mentoring role. This situation led me to consider why this educational input did not appear to be valued, remembered or internalised in any way that was meaningful in relation to supporting a student with learning difficulties in practice.

Although theoretical input appeared not to translate into meaningful knowledge and understanding for many mentors, there was still evidence

that knowledge and understanding existed amongst them – even if their confidence in this knowledge was poor. All 6 focus groups and 4 out of the 6 participants who provided an individual interview knew someone who had a learning difficulty. Ten mentors had experience of working with a colleague who had dyslexia and it was only when they began to consider the problem in relation to how this person struggled or coped that they were able to make more sense of what they knew and what the actual problem might entail. Two examples from participants are below:

> *"We have one of our own staff nurses has dyslexia and her writing is quite creative at times … but we've got used to her and we can actually read what … what she's trying to say."* **(GI 3 Adult Female)**

> *"Actually, I said I didn't know anybody before, but I do now thinking about it – a member of staff who … you're working alongside … and suddenly she sort of … picks herself up on every little thing that she feels she could have done better."* **(FG 5 Adult Female)**

It is perhaps interesting that this mentor could not initially think of anyone she knew with dyslexia and it wasn't until later in the interview that she made the comment above. The implication is that many people with dyslexia may go under the radar and their condition does not register with those they work with. There is also the possibility, relating to the discussion around disclosure of learning difficulties in practice below, that nurses with dyslexia may go to some lengths to remain under this radar on purpose. This again could contribute to the possibility that dyslexia is not considered to be a problem in the practice area.

Relating this to the idea put forward earlier that formal education or training around issues of disability did not appear to have helped mentors understand the needs of these students, it could be argued that factual knowledge of disability and learning difficulties was not sufficient and did not translate easily into knowledge that was useful in the practice environment. This could be seen to have detrimental consequences for nurse students with learning difficulties and was commented on by

students from other research studies. In a study by Evans (2013, p e44) of 12 students with learning difficulties, one participant was quoted as saying that a "bit of ignorance" prevailed generally amongst staff in practice.

In a study to evaluate a method of promoting understanding of the lived experience of students with dyslexia amongst mentors, Tee and Cowen (2012) used the stories of student nurses with disabilities to promote discussion and debate amongst mentors about this lived experience. They found that mentors were very positive about this approach feeling that these stories helped them understand the needs of disabled students and would enable them to take more positive actions towards supporting them in practice. The study also challenged mentors to face their possibly unrecognised attitudes and unhelpful approaches.

> They indicated that the stories made them *"realise the challenges"* disabled students face and how their reactions can enable or inhibit student learning. (Tee and Cowen 2012, p 9)

It is interesting that this study aimed to 'promote understanding' of issues around the disabilities that student nurses have, amongst mentors in practice. It does not claim to teach or train. The idea of encouraging understanding through practical simulation (Wadlington et al 2008) or through discursive interactive sessions (Tee and Cowen 2014) may be worth considering as more legitimate and appropriate approaches to working with mentors around issues of disability in practice.

DOCUMENTATION AND MEDICATION

Mentors associated dyslexia and learning difficulties fundamentally with reading, writing and spelling and tended to make a distinction between a student's competence to read, write and spell and their actual abilities and skills related to practically caring for patients in the clinical setting as this participant points out:

> *"I think dyslexia is … people…* umm … *probably understanding what is going on, but they are not able to express it in writing. … … But if*

you ask them to do it, they do it perfectly alright." **(FG 6 IP 4 Adult Male)**

In spite of the general consensus amongst mentors that students who have dyslexia or another specific learning difficulty do not struggle in terms of the practical element of the course, the topic of documentation and medication came up a lot throughout the interviews. Four focus groups and 5 individual interviews raised concerns about documentation and the student with dyslexia and 4 focus groups and 4 individual interviews raised concerns about medication and the dyslexic student. Documentation and medication are important areas of accountability for the nurse in practice, as they have both professional and legal implications in relation to poor practice and patient safety. The significance of this concern, is that mentors associated these two important areas of nursing practice as being specifically concerned with reading, writing and spelling and therefore, students experiencing problems in these areas, might be suspected of being dyslexic and students known to have dyslexia were likely to be more closely supported in these activities.

"Well practically they may, you know, shine in practice, you know, and it's difficult … It's not until they sort of come down to documentation and things like that and they're talking about their assignments and how they're getting on that you might become aware that there might be issues." **(FG4 B3 Adult Female)**

So there was an underlying tension in some respects, as having dyslexia was 'not a problem' but documentation and medication were highlighted as areas where potential problems could exist. However, no literature or research has been found that demonstrates that students with dyslexia are unable to carry out their duties competently (supported by Ridley 2011, p 36), or that patient safety is compromised as a result of dyslexia (supported by McPheat 2014, p 45). Even so evidence from participants demonstrates that there still appears to be some anxiety amongst mentors relating to

aspects of a dyslexic student's practice relating to documentation and medication.

DISCLOSURE

Four out of 6 individual interviews and 4 out of 6 focus groups raised the issue of disclosure. On all 8 occasions, mentors expressed the wish to know whether a student had a learning difficulty or not. Two of the mentors involved said that they wouldn't ask a student outright. Feeling unable to identify students with learning difficulties meant that the only way mentors in this study could be sure if a student had a learning difficulty or not was down to whether the student chose to disclose this information to them. Disclosure of a learning disability in practice is a complex issue. Howlin et al (2014, p 571) found that disclosure was challenging and difficult for students with a learning difficulty due to environmental issues and personal characteristics. They point out that disclosure for student nurses is not a single event, but rather a series of disclosures are necessary with new staff in each new practice placement. Experiences gained was seen to impact on future decisions to disclose or not.

In a study of 12 nursing students with learning difficulties, nine of whom chose not to disclose their learning difficulties in practice, Evans (2013) identified a continuum relating to disclosure. The categories identified within the study were 'Embracer' at one end of the continuum, to 'Resister' at the other, with some students sitting between these two positions referred to as 'Passive Engagers'. In practice, it would be the 'Embracers' that would be most likely to disclose their learning needs in practice.

Six participants in this study referred to students or colleagues with learning difficulties who were open and honest about their learning difficulties, in positive terms. When students were confident with their learning difficulty and had coping mechanisms in place they were considered by these mentors as having no problems in the practice

environment. In one focus group three out of the four mentors present, identified a student or colleague in this category:

> *"I've had one … she was quite open really. She came out and said, you know, I've got this, this is what I do. I have this to help me. I have extensions on my … and that's it really."* **(FG 2 B2 Adult Female)**

> *"I trained with a gentleman who had some problem. He couldn't say, pick up black on white. I say, but if he had it on yellow paper then to him that was fine. …… He was quite open with everyone and the other … that he needed to have … his handouts and everything on yellow paper."* **(FG2 B4 Adult Male)**

> *"I had this student who had dyslexia but she … umm … had everything in place … So she just said to me … I've got a computer and I just need to do this … and she got on with it and she was absolutely fine."* **(FG2 B1 Adult Female)**

One of the mental health mentors identified a distinct difference between how she works with a student who has dyslexia (implied as being someone who discloses) compared to a student who is perhaps unaware or in denial about their needs:

> *"So … so … I think with learning difficulties … especially diagnosed … the person themselves will have a way of managing it – hopefully. Or an understanding of what they find difficult, so they can … they can guide you as much as anything else. But with the other side of it … when people don't understand or the comprehension is off … I think that's a bit more difficult … and that's about supporting a person. 'How do you find… you know, learning?', 'Has it been difficult?' … you know … 'Is it hard?' … umm … 'How do you retain information? Is there any way that you've found that really helps you?' And then supporting it from there really."* **(GI 1 Mental Health Female)**

This mentor has a flexible and inclusive approach to supporting students who may struggle to learn in practice and although she still focuses mainly on written difficulties, she appears experienced in ways of working around the disclosure issue. Lack of disclosure to her appears to centre on lack of insight on the part of the student but students have also been shown to understand their learning needs well but still decide not to share this information with their mentor (Evans 2014, Morris and Turnbull 2006, Ridley 2011).

Alternatively, when students were not confident in dealing with their dyslexia and weren't open about it in practice, the picture was sometimes different. Evans (2014, p 384) points out that avoiding disclosure can potentially have an ongoing effect on the competency of the student and the quality of health care they are able to provide, stating "A student must be up front and open about his or her dyslexia, if avoiding to do so presents health and safety considerations for either his or herself, colleagues and patients."

When asked how much dyslexia was part of the problem for a student who was failing her final placement, one participant commented:

> *"I think it was … a huge part … because umm … it was complete avoidance … of … not only her academic but also her practical placement work, because she … felt that she was … she was always … (short quiet laugh) … (pause) … just swamped … I think absolutely swamped. Umm and the more she got swamped … the bigger the problem became."* **(FG5 Adult Female)**

This student only chose to disclose her dyslexia when her ability to pass the placement was under severe threat. Disclosing only when there are serious issues at hand is what Evans (ibid) calls 'back to the wall' disclosure and in this situation, issues of competency and learning difficulties can become very tangled and hard to separate.

Reasons for being guarded in relation to disclosing dyslexia or other learning difficulties are varied. Morris and Turnbull (2006) identified negative perceptions of dyslexia in healthcare settings and Ridley (2011) found that nursing students were reluctant to disclose their dyslexia for fear of discrimination. Evans (2013) found that students were reluctant to disclose for fear of being classed as 'stupid' and also because they didn't want to stand out amongst their peers. All studies found that it was the nature of the practice environment and the relationship with the mentor that had the biggest impact on a student's decision about whether to disclose information or not. A lot of these issues were identified in this study. Participants recognised that students may not wish to disclose because they may be stigmatised or labelled:

> "*Yeah – not wanting to disclose. Not willing to disclose in case they're … I don't know … judged. I don't know (quietly) … I probably would feel like that."* **(FG2 Adult B2 – Female)**

This mentor makes the distinction between not wanting to disclose and not being willing to disclose. In other words, a student may want to disclose but decide not to for fear of some kind of negative consequence. Another member of this focus group identified later that students may not want to disclose for fear of what others might say behind their backs – this may not necessarily be for fear of being labelled as 'stupid' but because it would make them stand out amongst their peers:

> *"I think it could also be like … so-and-so got an extra need that's been identified and … that whispering … caught in ear-shot you know … and it's like they've been stigmatised."* **(FG2 B4 Adult Male)**

The length of time a person has been diagnosed with dyslexia was suggested by one participant as also being relevant in terms of how willing they were likely to be, to disclose their condition:

"And I also wonder if it's like … when they've been diagnosed, as to how long … you know, if they're like newly sort of diagnosed … they might not want to admit that. Whereas if they've had it for a long time … or they've been diagnosed for a long time …" **(FG2 B1 Adult Female)**

This is supported by Evans (2013, p 368) who found that his 'embracer' group of students reported gradually embracing their dyslexic identity over a period of time and all recalled earlier periods in their nursing experience when such an outgoing and positive position would not have been possible.

From a slightly different perspective, one of the reasons put forward by another mentor for wanting to know that a student has dyslexia or a learning difficulty was in relation to how the student might be perceived by staff on the placement, if this knowledge was **NOT** disclosed;

"I think it would be better to know ahead of time if there was a potential problem that a student might struggle … with the learning … and … and also what we could do to help out … that student. Umm … I wouldn't want to label them as being a difficult student and "Oh we've got to make extra effort with this one because …" If you know they're (dyslexic) *… that's … that's got to be helpful all round – hasn't it?"* **(GI 3 Adult Female)**

This also implies that stigmatisation and prejudice around a student's general ability can exist without the label of 'dyslexia' and may actually create a worse environment and atmosphere for the student to learn in. Riddick (2000) contests that people can be stigmatised for not being able to read, write or spell and refers to these as 'informal labels' (p 661). She suggests that these labels can be more detrimental than a formal label such as 'dyslexia' because the assumptions behind them are implicit and therefore rarely open to public scrutiny or debate.

Disclosure implies a lot of trust between the mentor and student, not only in confiding the learning difficulty, but in working with the mentor in a way that is perhaps different from the usual mentor/student dynamic. Issues pertaining to trust were discussed in some depth in one of the focus groups when discussing issues around disclosure:

> *"Unless they're open and honest and tell you, then you wouldn't know. But that comes down to trust, doesn't it. If they trust in you then they'll probably say … expand and say tell you more about themselves.* **(FG 2 B4 Adult Male)**

He goes on to consider that perhaps some of these students have had poor experiences in the past in terms of disclosure and this will impact on their confidence to be open with mentors:

> *"If you've had a bad experience, it always does make you that little bit more … reserved, you know."* **(FG2 B4 Adult Male)**

For this disclosure to happen students need to feel that they will be treated positively and supported if they disclose their learning difficulties, however evidence from research by Morris and Turnbull (2006), White (2007) and Illingworth (2005) suggests that students with dyslexia did not view the practice environment positively in relation to how the disclosure of their learning difficulties would be received. Mentors who had positive attitudes towards the subject of learning difficulties would be likely to encourage disclosure and help with the acceptance and integration of a student with dyslexia onto the ward but could not perhaps guarantee that the attitudes of others would be the same. The limited time a student has on a practice placement may also impede disclosure as the student may need time to decide whether to disclose on any particular placement and in the absence of overt positivity to the issue may decide not to disclose, even though negative staff attitudes have not been observed.

On the eight out of the 21 occasions that disclosure was raised as an issue within the study, participants expressed the feeling that they would like to

know if a student had a learning difficulty and they recognised a tension in terms of what they would like to know about a student's learning difficulties and what they felt students might feel happy to share with them. There is a gap in the outside research around this point. Six mentors in this study specifically recognised that disclosure was a confidential matter and it was up to the student to share or not share this information, however they were often keen to know as much about the student as possible and 4 felt it would be helpful if a student was open about having dyslexia or another learning difficulty. The participant below suggested that it would be beneficial if they were informed about a student's learning difficulties before they arrived on the ward:

> *"Having some information from the practice facilitators (*qualified experienced nurses whose role is to support mentors and students on the wards*) might … they might … umm … tell you that there's a student coming with say … extra needs. They would say hopefully that's been identified say at induction, or even at interview, the selection process, and there's things that need to be put in place."*
> **(FG 2 B4 Adult Male)**

Once again, this comment also suggests that the identification of a learning difficulty is perhaps seen to be the role of academia and not practice. When asked to sum up her final thoughts about the subject, this participant said:

> *"It's a student's choice, obviously, whether they disclose, but I think that it, certainly as somebody supporting the person in the learning environment … it's very hard if you're not privy to that information isn't it – to support them? Umm … and I know its confidential and you can't do anything about that, but it's umm … You know, I'd like to think that students, if they have … if they're struggling, were able to share that information … because it's , you know, not only for the person who's supporting them, but for the whole … everybody working with them you know .. because it's something that you can*

actually address … I think if … if you're given knowledge on how to do it. … Otherwise you're in the dark really". **(FG5 Adult Female)**

This implies that the mentor is happy to adjust and makes changes to accommodate the needs of the dyslexic student but it is up to the student to lead the mentor and this means that the student needs to be aware of their condition and able and confident enough to discuss and articulate their needs. Making the practice environment a place that students with learning difficulties feel is safe, receptive and supportive for their disclosure was something that was identified by Halligan and Howlin (2011) as being a fundamental requirement for improving disclosure of learning difficulties in practice. However this is likely to be a complex, ongoing process in such a big, evolving and varied organisation as the NHS.

WALKING A FINE LINE – SENSITIVE TO SENSITIVE ISSUES

Referring back to the discussion in the data analysis section of Chapter 3, which considered how it is not always 'what' is said or 'how many times' it is said, but the 'way' something is said that creates meaning in the mind of the researcher, the idea of participant sensitivity to the sensitive issue of dyslexia, is something that is difficult to prove is present in the data collected. Intonation, pauses, stumbles, laughter, may all be part of the communication style of the mentor generally but sometimes it appeared that some of the candidates were uncomfortable when considering certain aspects relating to students who have or may have Dyslexia or another learning difficulty.

In answer to the question "How big an issue do you consider Learning difficulties to be in practice?" one candidate said this:

"I think … I think … because of … just … times have changed and it's recognised more easily. I think it's still an issue because that's … because you want to enable … make sure you're supporting the person correctly." **(GI 1 Mental Health Female)**

This candidate did have the tendency throughout her interview, to stop and restart sentences and spoke very quickly suggesting that she was thinking as she spoke, but it is difficult to detect what might be behind the hesitancy here. My interpretation was that she wanted to make it clear that she was not prejudiced towards students who might have a learning difficulty, but it was the way she said these words that implied that she recognised the need for professional appropriateness within her answer. She begins by saying that it is still an issue – and recognises that this might be interpreted as prejudiced and so ends the sentence by making it clear that highlighting it as an issue is actually for the student's benefit. In the following extract the participant demonstrates a similar kind of dilemma in terms of wanting to identify students who have a learning difficulty but not wanting to single them out as different or 'special':

> *"I'd like to think we'd be supportive of … of anybody's learning, whether they have … ummm … a recognised learning difficulty or whether they just …just find it a bit tough going. Ummm … I … I think I just ummm … treat everybody as an individual …"* **(GI 3 Adult Female)**

In this quotation, there are again a lot of elongated pauses and the mentor appears careful of content and about how what is said comes across. One mentor appears to recognise the professional and ethical implications of the question "What aspects of the nurse's role do you think might be difficult for people who have a learning difficulty?" and struggles to answer the question at all:

> *" … (pause) …….. That's a tricky question …… (pause) …….. I've no idea …… (pause)…… (laughs) I don't want to give you some old nonsense that's just come off the top of my head, (laughs). (Long pause) ……. So that could be absolutely huge couldn't it? …… No I'm not going to be able to answer that one, I'd just have to think about it for a bit longer."* **(GI 4 Child Health Female)**

The greatest difficulty with these extracts is in the interpretation of the pauses, the paralanguage and the laughter. It is impossible to guess accurately what is going on in the minds of candidates when they pause and apparently think and reflect on their answers. To some extent this is something we all do and is therefore not always related to not wanting to say the wrong thing. However for nurses, there is a professional code of conduct to consider (NMC 2015).

During research of this kind, candidates are perhaps never fully oblivious to the fact that what they are saying is being recorded and this is likely to have an impact on what they say and how they say it. At the very beginning of this project, I happened to comment casually to a colleague that I was most interested in what participants really thought about the issues around the study. My colleague suggested that I would not get the truth from them for precisely the reason stated above. So as a researcher, I have to acknowledge the point that I am only likely to get a particular version of what the participants think and feel about the issues I raise – the version that they feel is politically and professionally correct. The participant below specifically acknowledges the possibility of prejudice and stigma:

> *"I suppose it goes back to the question we were talking about before – you know, the link between academic ability and learning difficulties. Perhaps the majority of people consider that to be academically able, you can't be academically able if you've got a learning difficulty. Prejudice … absolutely, not almost."* **(GI 4 Child Health Female)**

This idea that educators may believe that there is a link between a learning difficulty and a person's I.Q. was one of the original starting points for this research following the conversation with a fellow academic highlighted in the Introduction. The point being made at that time was where do learning difficulties stop and intelligence begin? Questions relating to this aspect were asked during all 8 individual interviews to try to understand mentors'

conception of what learning difficulties entailed. Seven of the 8 participants were emphatically positive that there was no causal link between the two. The 8th participant proposed that there was a lack of clarity in terms of how people understood the two terms and as such there could be instances where the two terms were confused. Prejudice can be seen to stem from beliefs that relate intelligence with learning difficulties and this was a big part of the findings of Evans (2013) who found that being considered as 'stupid' had a pervasive link to the dyslexic identity of students. Referring to a student who was later diagnosed with dyslexia whilst on the course, one mentor said:

> *"When she used to do the fluid balance charts, they never made any sense and I know a few people said "I'm sure she's a bit thick!" because the totals were never right. And it was only at the end of her first year that they found she was dyslexic. Then a few of us thought "Ooh maybe we were a bit harsh there. She wasn't aware that she was doing it at all and I think she was doing her assignments and things and somebody picked up on it. But badly dyslexic as well … I'm surprised they didn't pick up on it at school."*
>
> **(FG1 A1 Adult Female)**

This comment suggests that people on the ward were actually more intolerant of a struggling student when they were unaware of a learning difficulty than they were of the learning difficulty itself. In other words the diagnosis of a learning difficulty helped to explain why the student was struggling and thus helped them to understand what the student's difficulties were. It also perhaps suggests that the actual diagnosis of dyslexia is considered to be the responsibility of other people and not practice staff. One final aspect of this quote is that the original reference to the student being 'thick' was attributed to others but the latter comment about being a little 'harsh' was presented as 'we'. This suggests that the mentor in question may also have subscribed to the initial assessment of the student as 'stupid' in some way, even if she

subsequently identifies this as being unfair. Self-awareness around personal attitudes and beliefs can be difficult and it is sometimes not until our prejudices are challenged that we become more aware of them.

One mentor appreciated the difficulties associated with identifying that a student has learning difficulties and how this might be perceived as a 'problem' by practitioners in the practice environment. Her overall attitude however is positively in favour of appropriate support for these students, indicating that she does not feel that learning difficulties should be perceived in practice in this way. In fact she appreciates some of the positive traits that might be associated with someone who has a learning difficulty;

> *"I feel a little bit prejudicial really, to think that someone that has learning difficulties we might have problems with. Cos I'd like to think that we'd be supportive of … of anybody's learning, whether they have … umm … a recognised learning difficulty, or whether they just … just find it a bit tough going. …….*
>
> *I think if you have a learning difficulty … you … you've got to be pretty intelligent to overcome it haven't you? If … umm … if someone couldn't read for instance … umm … they've got to be really quite … imaginative … to get through life without that."* **(GI 3 Adult Female)**

Being politically correct may also be reflected in the way that some mentors, although they might want to know, would not ask students directly if they had a learning difficulty. When asked by another student how they might know if a student was dyslexic and whether he would ask the student directly, the mentor relayed his reply as;

> *"No I don't* (emphatically) *… we've just got to observe and see if we can pick it up."* **(GI 2 Mental Health Male)**

This reluctance to ask a student directly if they had a learning difficulty but wanting to know is a difficult position to be in for the mentor. In itself, this

suggests that they identified learning difficulties as being a sensitive subject area where prejudice might be identified and where the confidentiality of the student was therefore an important priority.

SUMMARY

This section of the findings has looked at issues around mentors' knowledge and understanding of learning difficulties and reasonable adjustments. It has highlighted mentors' concerns around medication and documentation and it has considered the issue of disclosure and political correctness. The overall conclusion is that dyslexia is a complex issue to pin down in the practice environment.

A lack of specific knowledge and understanding about learning difficulties is likely to impact on mentors' confidence to support students with dyslexia in practice. It is also likely to impact on their ability to recognise and identify students who may have a learning difficulty. If mentors did have knowledge and understanding, they often gained it through the experience of working with a colleague who was dyslexic but they failed to transfer this knowledge to considering aspects of their work with students who struggle to learn in practice.

Issues relating to disclosure of learning difficulties in practice meant that mentors were often not aware when a student had a learning difficulty and they were therefore felt unable to identify and plan learning appropriately for these students. The sensitive nature of the subject itself means that mentors do not always ask students direct questions relating to learning difficulties. Current education about learning difficulties does not appear to be effective in encouraging understanding of the issues from the mentors' point of view and alternative methods perhaps need to be considered that help the mentor to challenge their own attitudes and beliefs by helping them to understand the problems faced by students with learning difficulties and foster a more positive view of these students capabilities.

CHAPTER SUMMARY AND CONCLUSION

Findings, along with discussion, have been presented in this chapter around three categories significant to the theory to be presented in Chapter 5; 'The Practice Environment', 'The Mentor/Student Relationship' and 'Dyslexia and Learning Difficulties'. The section on the 'Practice Environment' presented evidence to demonstrate how time is considered to be an important resource for the nurse mentor and lack of time adds to the pressures of the ward which, along with staff shortages and ward culture can make the environment daunting and difficult for students. The idea of a theory/practice gap was introduced to demonstrate how learning is considered differently in practice than in the academic environment. The section on the mentor/student relationship highlighted mentors' beliefs and values about their role working with students and looked at some of the ways mentors envisaged and enacted this role such as having conversations with students and enabling them. Several issues highlighted as important to mentors included trust, confidence and intuition. The final section looked at mentors' knowledge and understanding of dyslexia and learning difficulties and how this impacted on their ability to identify and work with students who may have a learning difficulty. Issues important to mentors in this section included disclosure of learning difficulties and being sensitive to, and about a sensitive issue. Mentors' were aware of the sensitive nature of the issue and also aware that they were being recorded in an official capacity that required professionalism at all times.

Findings from this study indicate that mentors appeared overall to be positive about students who had or may have had a learning difficulty although the acknowledgement that dyslexia could be a sensitive subject could mean that some participants were reticent about discussing attitudes and beliefs in case they said something that was considered to be unprofessional. Reports from student nurses and qualified nurses in other studies (White 2007, Morris and Turnbull 2007) who felt that they were judged by others and experienced stigma in practice suggests that there is

an undercurrent of prejudice and ignorance that would need to be addressed if this situation is going to be improved.

The nature of the clinical environment means that time is a premium commodity and patient needs often have to come before the learning needs of students. Mentors may not prioritise learning difficulties as an issue for students as the pressures of time and workload mean that other aspects of their role tend to take precedence. One of the over-riding findings from the research was that the practice environment was the main defining factor in how mentors worked with their students. What they would like to do and how they were limited in what they could do with students all came down to how busy they were and how well staffed their clinical area was.

More needs to be done to encourage acceptance of learning difficulties as a legitimate and more main stream issue in the practice environment so that it is more openly talked about and more widely accepted that students can have a learning difficulty while still being able to perform their nursing role safely and competently. If the culture of the practice environment became more friendly and supportive of students with learning difficulties, students who had specific learning difficulties might feel more confident to disclose their needs and happier to work honestly and openly with staff on the wards.

CHAPTER 5: THE THEORY

DIARY EXTRACT 10: MENTAL GYMNASTICS

In discussion with a colleague and fellow research student the other day, we spoke about ontology and epistemology, deciding that although we had studied these words and concepts many times, we both still had to make our brains focus quite hard to appreciate exactly what these terms mean. I often speak to students about making our brains hurt a little when we think about philosophical ideas and reassure them that this is good for us as it is in this that we begin to appreciate things that are perhaps outside of the way we use our brains on a daily basis. I believe we grow and develop our ability to analyse and think in the abstract when we participate in such activities. I sometimes refer to this activity as 'mental gymnastics'.

Developing theory for this study has challenged my brain to do just this – think in the abstract and break new ground in relation to how my brain normally functions. I have already spoken of how rewarding I have found this activity to be however, thinking about theory in terms of ontological and epistemological assumptions may have benefits for the methodological relevance of the theory in terms of its underlying philosophical nature, but for me I also need to perceive the theory in terms of its practical application and importance. If there is no practical application, then for me, it fails to achieve relevance as a theory from a professional perspective. As I write this down I recognise that this in itself will have an influence on the final theory developed and on how I present it in writing. I like to clarify things for students and present them in a form that can be easily understood and so I am likely to present the theory in lay terms and simple language.

INTRODUCTION

The three sections of Chapter 4 outlined the findings relating to the core categories that fed into the theory presented here. This chapter will begin by considering briefly the role of theory within a grounded theory study and then the theory, 'For mentors, dyslexia is just spelling' will be presented and explored in relation to evidence that has been gathered

during the course of the study. An outline of the theory with respect to issues with specific relevance to its properties and dimensions will be discussed and this will be followed by consideration of theoretical significance and limitations. The chapter will conclude by consideration of areas requiring further theoretical development.

THEORY IN GROUNDED THEORY STUDIES

One of the main tenets of grounded theory is that the generation of theory is central to the methodology and this is a very different activity to verification of existing theory or description of events (Glaser and Strauss 1967, p28). Silverman (2014, p 112) argues that theory is a composite part of all data analysis as all analysis depends on theory-dependent concepts however, the difference with grounded theory, is the importance given to, and the central focus on, theory generation throughout the whole course of a research study.

From a positivist perspective, theory tries to explain or predict what is happening. Glaser and Strauss (1967, p 24) espouse this idea of theory whereas Charmaz (2006, p 126) argues that methodological differences mean that the definition of theory can be more fluid and offers an interpretivist definition that sees theory as trying to understand social phenomena rather than explain it. Her definition gives priority to showing patterns and connections rather than seeking causality and showing linear reasoning. As with other aspects of the methodology, my sympathies lie with the interpretive view, and so it will be Charmaz's criteria for grounded theory studies of credibility, originality, resonance and usefulness (Charmaz 2006, p 182-183) that will be used to evaluate the study in Chapter 6.

NAMING AND EXPLICATING THE THEORY

The theory developed over the course of this study is encapsulated in the phrase:

> 'For mentors, dyslexia is just spelling'

This is not meant to portray a totally dismissive approach by mentors to dyslexia and learning difficulties in the practice environment as legitimate reasons were presented why mentors do not prioritise dyslexia and learning difficulties higher on their agenda. Also participants often emphasised their non-judgemental approach and belief that students with dyslexia and learning difficulties were just as good as other students. They generally felt that the difficulties identified in relation to documentation and medication were not insurmountable and people could still function competently in their role as a nurse, or student nurse, with appropriate support.

DYSLEXIA AS A PRIORITY ON THE MENTOR AGENDA

Dyslexia is repeatedly identified by mentors as not being a problem in the practice environment and is rather a simple state that relates uniquely to the ability to read, write and spell (except where documentation and medication are involved). This is not seen to impact on their ability to think and work as a nurse. Unless specifically prompted about learning difficulties or dyslexia, mentors repeatedly left them out of their discussions about the student who struggles to learn in practice.

Evidence for this began to surface early in the study and was followed through in subsequent waves of data collection and analysis. One of the initial things to arise from the focus group data during the first wave of analysis, was that in spite of the fact that the mentors had been given an information sheet outlining the scope and rationale for the research and a verbal introduction from myself, only one of the groups introduced dyslexia as an issue during the group activity, as a reason for students struggling to learn in the practice environment. At this early juncture, based on focus group activity data and focus group interview data, it raised questions around why this might have happened. Practical explanations could include the fact that mentors' primary motivation for coming to the session was perhaps to achieve one of their mandatory mentor updates

and that the research element did not fully register with them. The participant information sheet was available from the point of initially advertising the Focus Group/Mentor Update, but was generally not read by candidates until asked to do so, by the researcher, prior to commencement of the Focus Group/Mentor Update itself. This could mean that the importance of the dyslexia aspect was missed. Further information was sought throughout the individual interviews to help clarify this situation.

Mentors did not prioritise dyslexia and learning difficulties as issues due to the wealth of other challenges they faced every day in the practice environment. Evidence from the study suggested that dyslexia and learning difficulties did not register in the minds of mentors as an issue for a variety of reasons. Section 1 of Chapter 4 provides evidence relating to pressures within the practice environment such as prioritising patient care and lack of time for the mentoring role that may complicate issues for mentors when faced with a student who is struggling in the practice environment. In one of the face-to-face interviews, when asked if she was surprised that dyslexia had seldom been raised by the focus group activity as a reason that a student might struggle to learn in the practice environment, the mentor with dyspraxia said she was not surprised.

> *" … … Ummm … no … I think if you had a student who was underperforming, you wouldn't necessarily … the first thing in your head was that they had a learning difficulty of some sort. I don't think that would come into your head. You're more likely to look at this and think … what else is going on?"* **(LD 1 Female Adult)**

The nature of the practice environment and particularly the importance of time, plays a significant role in terms of how mentors work with their students and impacts on what they are able to do to support these students. Time is specifically mentioned in relation to working with students who have dyslexia as a form of reasonable adjustment that could be accommodated for in the practice environment.

KNOWLEDGE AND UNDERSTANDING OF DYSLEXIA AND LEARNING DIFFICULTIES

Mentors felt that they did not have enough knowledge and understanding of dyslexia and learning difficulties. It was highlighted in Section 2 of the findings chapter that mentors did indeed have some appropriate knowledge and understanding, often obtained from working with colleagues who had dyslexia, but did not appear to refer to this knowledge or have confidence in it. Mentors considered reasons why a student might struggle in the practice environment, however these were usually around issues outside of the course and mainly centred on problems in their personal lives. Their main criteria for judging whether a student was struggling was around avoidance behaviours such as sickness and being reserved. Mentors commented that they work with students on their weaknesses and sometimes use action plans as a formal way to help guide the support they give, but they do not appear to consider that these weaknesses might be caused by a specific learning difficulty. Mentors felt able and confident to pick up on students who were struggling in practice and described a variety of ways that this was accomplished, most of which were informal and included things such as having a 'sixth sense' 'intuition' and through observing the 'little things':

> *"Going back to the struggling student, sometimes it's not actually what they do. You pick up on alarm bells. Maybe it's an intuition thing – something … innate in you that you pick up. I don't know what it is, but sometimes you know."* **(FG1 Adult Female)**

> *"Yeah, it's a combination of a lot of little things, but it sort of comes to you bit by bit and … umm … you sort of go round certain things and ask them in a round-about … not straight to them … but a lot of little things add up."* **(FG 6 Adult Female)**

Very rarely did any mentor relate to the student not meeting the competencies laid down in their Practice Assessment Document (part of the formal process of assessing a student's performance in practice), unless the student was at risk of failing the placement. Instead, they identified a range of issues and behaviours that they associated with a student who was struggling to learn in practice and these very rarely included any mention of dyslexia or learning difficulties until specifically asked.

> *"I think sometimes, you know, they're struggling … It might be lack of confidence or … umm … they're doing the same thing every day and not challenging themselves … … … Sickness is a big one for us."* **(GI 1 Mental Health Female)**

DYSLEXIA IS NOT PREVELANT IN PRACTICE

Another aspect of this problem is that dyslexia is not really considered by mentors to be very prevalent in the practice area, even though 10 mentors knew of a colleague in practice who had, or may have had, a learning difficulty. In relation to students who they had mentored, the mentors who had been qualified for longer (sometimes 20-30 years) felt they were only referring to one or two students through the whole of their mentoring careers who they knew to have a diagnosis of dyslexia. One such participant had this to say:

> "*But I haven't had many coming through with umm … the learning … learning issues recently though. It's been a while since I've actually had people who've had a … sort-of-like … diagnosis … I think."* **(GI 1 Mental Health Female)**

One mentor considered the idea that students who have a learning difficulty may not be easy to identify in practice, suggesting that they may not come onto the mentor's radar because they may have become very good at coping and hiding their learning needs in practice:

> *"I think it's probably bigger than we know. I think the majority of students are umm academically very able … and have developed*

social skills over a long time to be able to … umm … hide, you know, got a bit of front. Umm and I think there's more out there that have got (learning difficulties) than we realise." **(GI 4 Child Female)**

Mentors may have had concerns about some of their students in relation to their learning skills, but rarely were these suspicions strong enough for them to have a specific recollection of them in terms of learning difficulties. GI 2 (Mental Health Male), had been a mentor for nearly 30 years and in all of that time, he thought he had only *knowingly* had a dyslexic student twice. The more recently qualified a mentor was, the more unlikely they were to have supported a student with dyslexia. The implication of this is that mentors feel that they rarely encounter dyslexia and are therefore unlikely to be looking out for it. This would make them less likely to consider dyslexia as a reason for a student struggling in practice, as this participant points out:

"You know, if it's not blatantly obvious, a lot of nurses are just so busy. You know, they're just sort of filling out paperwork and just signing things off … and you know … you might not pick up something like dyslexia or anything like that. So it's something that is probably out there. Probably not in a high percentage. You know, it's gonna be a very low percentage. You know, they don't wear a badge saying 'I'm dyslexic' so sometimes you just don't notice it.' " **(GI 2 Mental Health Male)**

DYSLEXIA IS AN ACADEMIC RESPONSIBILITY

Dyslexia was seen as an academic issue and was therefore not the responsibility of the practice environment. Support from academic colleagues is one of the first places mentors go when they have a student who is struggling in practice.

Outside of documentation and medication (which is perhaps in contradiction to the above views and is discussed in more detail below), Dyslexia is perceived as something that is more of a university issue since

reading, spelling and grammar are associated primarily with academic learning rather than learning in practice. It is in the university that the assessment of students for learning difficulties is seen to take place rather than in practice and where identified reasonable adjustments, such as extra time in exams and for assignments, and scribes etc. are seen to be applicable.

Mentors spoke at times of school being the place where children were usually identified and assessed for learning difficulties and this association carried on to the role of higher education to fulfil this role. One mentor suggests that students should be screened at the interview stage for the course which is again a university responsibility.

DISCLOSURE OF LEARNING DIFFICULTIES IN PRACTICE

Mentors would very much like to know if students have any specific learning difficulty so that they can better support these students in practice. However they appreciate that disclosure is the prerogative of the student and therefore, in order to be politically correct, they avoid asking questions relating to this subject. Mentors identify students who disclose that they have dyslexia as doing well in terms of learning in the practice environment. These students are often those who are pro-active and confident about being Dyslexic and have a variety of coping mechanisms and reasonable adjustments already in place (e.g. computers and coloured glasses/overlays).

Failure to disclose learning difficulties and avoidance of activities that might cause a student problems due to their learning difficulties are suggested as being inappropriate coping mechanisms for students with dyslexia and most likely to result in poor practice (Evans 2013, p 384, McPheat 2014, p 46). However, the complexity, impact and consequences of disclosure from the students' perspective mean that they are likely to perceive the option of disclosing their learning difficulties with much more fear and trepidation than the mentors appreciate.

WALKING A FINE LINE: SENSITIVE TO SENSITIVE SUBJECTS

There appeared to be a degree of political correctness or professional appropriateness in the responses of mentors when being questioned on the subject of dyslexia and learning difficulties which sometimes made them hesitant in the answers they gave to questions directly related to the issue. Section 3 of the findings chapter demonstrates how the paralanguage relating to some of the participants' contributions caused me to consider what they were thinking as well as what they were saying. Although it was pointed out that my interpretation of these contributions could be contested, it still raises the question of how much of the data collected had been internally screened by participants before it was verbalised.

Dyslexia is sometimes called an 'unseen' disability and the label or stigma it carries with it has been alluded to at various points within this thesis. It could be argued that the professional status of the nurse and mentor should protect against this prejudice effecting the relationship between the student and mentor and I acknowledge that a lot of the mentors went to lengths to assure that they were non-judgemental and in some cases positively supportive of students who had or might have a learning difficulty. However, whether the label is perceived as positive or negative, I feel the influence of this possibility of prejudice and stigma in relation to the theory, needs to be explored further.

LEVEL OF THEORETICAL SIGNIFICANCE OF THIS STUDY

Some studies claiming to be grounded theory have been criticised for failing to generate theory (Becker 1998, Silverman 2014, p 125) and some are accused of being descriptive (Birks and Mills 2015, p 109). Charmaz (2006, p 133) points out that more researchers have used grounded theory methods than profess to have constructed substantive or formal theories. This study does not claim to reach full substantive theory for two main reasons;

Firstly, theoretical saturation was achieved for the sample used for this study however time restrictions meant that only the data collected from mentors who were part of this original recruitment drive which lead to three rounds of theoretical sampling, along with extant literature, has been used to define the theory and explore its potential. Further theoretical sampling across a wider range of nursing environments is needed to provide more scope, and more depth for the theory before it could legitimately be called fully substantive. Glaser (2001, p 183) acknowledges that perhaps this could be true of all research studies when he says that ultimately sampling:

> "… must come to an end, usually based on human limits, with an appeal to future research to give directions for a subsequent grounded theory researcher."

Secondly, the researcher developed theoretical sensitivity as the study progressed but this was lacking in the early stages of the study and therefore progression towards identifying and exploring the theory were slow. Theoretical sensitivity on the part of the researcher is an essential element of grounded theory and important to the analytical process. As a novice researcher, I believe this sensitivity has grown throughout the course of this research project. By the end of the time I had to complete this study I was only just getting to grips with what 'generating' theory really means (Glaser and Strauss 1967, pp 21-43). This has implications for the study itself as the point where I am writing up the study is the point at which I have recognised how I needed to focus more on the pursuit of theory from the very beginning. This is not to say that ideas for theory have not surfaced during the course of the analysis but lack of theoretical sensitivity in the early stages of the study resulted in slow progress in terms of theory recognition and development. Once again, this is a state of affairs recognised by other researchers. Breckenridge (2010, p 241) acknowledges that

"It is important to acknowledge that, in the early stages of one's career, the breadth, depth and comprehension of multiple theoretical codes may have been limited."

Therefore, this does not mean that the findings from this study are invalid. I believe the theory as it stands includes valuable insights into the experiences of mentors and their work with students who struggle to learn in the practice environment and that these insights are useful both in terms of generating understanding of issues faced by mentors when supporting these students, and in terms of making recommendations for future practice. Analytical abstraction has been used in the formation of categories and work has been done to demonstrate their relevance to the theory presented. However, further work on the study is needed to give more substance to the theory in terms of detailing its characteristics, dimensions and properties, giving it more resonance and making it more useful, and conceptual scope could be enhanced by exploring different contexts. Breckenridge (2010, p 240) insists that new ideas and new data do not refute a theory but increase the density and scope by adding variation. Future work could produce substantive theory that relates to nurse mentors' work with students who have learning difficulties, and possibly other mentor/student relationships, or formal theory that considers the view of disability within the workplace relating to the social model of disability.

AREAS FOR FURTHER DEVELOPMENT

DOCUMENTATION AND MEDICATION

There is a recognisable tension within the data in terms of how mentors view potential problems with learning difficulties in practice. On the one hand, they feel that dyslexia is not a problem but on the other hand, many mentors had reservations when it came to considering issues around documentation and medication. Mentors associated dyslexia and learning difficulties fundamentally with reading, writing and spelling and tended to

make a distinction between a student's competence to read, write and spell and their actual abilities and skills related to practically caring for patients in the clinical setting.

As pointed out in Section 3 of the findings chapter, documentation and medication are important areas of accountability for the nurse in practice, as they have both professional and legal implications in relation to poor practice and patient safety. The significance of this concern, is that mentors associated these two important areas of nursing practice as being specifically concerned with reading, writing and spelling and therefore, students experiencing problems in these areas, might be suspected of being dyslexic and students known to have dyslexia were likely to be more closely supported in these activities. Further research into this dichotomy might therefore lead to revision of the theory so that the following caveat is added:

"To mentors, dyslexia is just spelling and not a problem in practice, UNLESS it involves documentation or medication."

This is then an example of where the theory requires more consideration and further work. Attempting to access mentors' beliefs and assumptions about dyslexia and learning difficulties would not be easy as there could be increased reluctance to share opinions due to the possibility of professional consequences for highly inappropriate responses. However encouraging self-awareness about personal prejudice could lead to changes in attitudes and a more supportive culture for disabilities on the wards. This point links with the following consideration of political correctness or professional appropriateness.

WALKING A FINE LINE: SENSITIVE TO SENSITIVE ISSUES

Evidence was presented in Section 3 of the findings chapter that mentors may have interpreted dyslexia as being a politically and professionally sensitive issue. This aspect of the findings requires further investigation as it could have implications for how the theory is developed. Within their

interviews, mentors were sometimes interpreted as being careful about what they said and how they said it and this may interfere with an accurate understanding of how they perceive dyslexia and learning difficulties in the practice environment. Once again, more work is needed in order to refine the theory in light of this possibility.

COMPARISON OF NURSING ENVIRONMENTS

Within the study, there has been little comparative analysis between the adult and the mental health participants in terms of exploring how their approaches were similar and how they differed. This is partly due to the slow development of theoretical sensitivity mentioned above but perhaps also because this objective was not identified in the original aims for the study. A breadth of experience was considered as important for the sample but the importance of looking specifically at how approaches varied has only been identified as being important since considering the dimensions and properties of the theory.

It could be argued that a comparison of nursing environments would have given rise to a different study but I still feel analysis of this aspect would prove informative in relation to delineating dimensions and properties of the theory. Exploring how the type of patient, the type of skills developed by students and the differences in the practice environment impacted on the mentors' approach to a student with learning difficulties could be beneficial in understanding the scope of the theory itself. Some of these aspects have been alluded to but I feel they would benefit form more detailed analytical attention.

SUMMARY OF CHAPTER

This Chapter has presented the theory;

'To mentors, dyslexia is just spelling'

Following clarification of what constructivist grounded theory should look like, six fundamental statements relating to this theory were presented and

then explored in relation to how they contributed to the understanding of mentors' perceptions of dyslexia and learning difficulties within their practice environments. Issues around prioritisation of learning difficulties, mentors' knowledge and understanding of dyslexia and learning difficulties, prevalence of learning difficulties, disclosure of learning difficulties in practice, the academic associations of learning difficulties and the political correctness/professional appropriateness with which the subject area is considered were all discussed in relation to their significance and impact on the theory. Theoretical limitations were then presented along with areas for proposed development of the theory in the future.

Ideas and concepts formulated during the course of this study have highlighted insights and areas of interest in relation to the experiences of nurse mentors with students who struggle to learn in the practice environment, which have culminated in the theory: 'To mentors, dyslexia is just spelling'. High level theoretical development was not possible within the scope of the work due to time limitations and researcher inexperience meaning that theoretical saturation was not achieved. Further research needs to be carried out in relation to defining the scope, dimensions and properties of the theory so that full substantive theory can be claimed.

CHAPTER 6: SUMMARY AND RECOMMENDATIONS

DIARY EXTRACT 11: WHERE I ENDED UP

I do not describe myself as an 'expert researcher'. I am learning as I go along and because of this my perspective is changing all of the time; growing as I actually start to experience the things I am reading about. There is no substitute for background reading – the ideas and opinions one reads helps to inform the mind, directing and re-directing the focus we bring to what we are trying to do. I often think that I wish I had known what I know now, when I was younger but I wouldn't be where I am now without the experiences, the challenges, the mistakes and the moments of joy and triumph that have been part of my journey. In the same way, my research would not be what it is if I had not made a similar, but more formal journey through the research itself. Having started out being committed to the rules and procedures I had considered to be so important in creating a worthwhile and credible piece of research, I have found that it is just as much in the creativity of the analytical mind that the research evolves and progresses. I was so determined to be 'objective' and 'rationale' at all times, I was at first disappointed and deflated that I couldn't maintain the perfect piece of research. Through supervision and wider reading, I have come to embrace the interpretivist perspective within research and understand that the journey itself is part of the research process and the researcher is integral to this research process. Being human and understanding that life and work are things that will always get in the way of being 'perfect' opens up prospects for the research rather than closing them down.

INTRODUCTION TO CHAPTER

Chapter 5 has provided a discussion of the theory relating to nurse mentors' experiences with students who struggle to learn in the practice environment. In this chapter I will provide a summary of the thesis and revisit the aim and objectives. The theory will then be evaluated using the criteria provided by Charmaz (2006, pp 182-183); credibility, originality, resonance and usefulness. Conclusions will then be presented to draw

together the major points of previous chapters, emphasising the implications of this study's findings for nurse mentorship, nursing practice, nurse education, organisational knowledge and issues around theory and research. The study's limitations will be acknowledged and recommendations for practice will be presented. In the final section of this chapter some final observations from the researcher will be offered.

SUMMARY OF THE STUDY

This study has used a constructivist grounded theory approach and methods to explore the experiences of nurse mentors with students who struggle to learn in the practice environment; the most important aspect relating to nurse students who have a learning difficulty such as dyslexia – be that diagnosed or non-diagnosed, disclosed in practice, or undisclosed.

In Chapter 1, rationale for the study was presented along with background information relating to areas of importance. The aim and objectives for the study were introduced and discussed. The literature review required for the doctoral research proposal was presented in Chapter 2 and Chapter 3 provided information relating to the research design, including; choice of the constructivist grounded theory approach, the research methods and the data collection and analysis process used within the study. Chapter 4 presented the findings relating to the three main categories identified within the study; 'Practice Environment', 'The Mentor/Student Relationship' and 'Dyslexia and Learning Difficulties' which provided contextual background for the theory 'To mentors, dyslexia is just spelling' which is presented and discussed in Chapter 5.

EVALUATION OF THE THEORY

Through analysis of data collected from nurse mentors' about their experiences with students in practice, the categories identified in Chapter 4 and the theory described in Chapter 5, have been shown to encompass issues relating to mentors' knowledge, understanding, beliefs, attitudes and values relating to the struggling student and towards dyslexia and

learning difficulties in the practice environment, thus achieving the aim and objectives of this study. In an effort to ensure that the theory presented meets the criteria for constructivist grounded theory, consideration of credibility, originality, resonance and usefulness of this study will now be presented.

CREDIBILITY

A grounded theory does not intend to provide verifiable results but instead offers a set of theoretical propositions that account for the main issues identified within the study (Breckenridge 2010, p 238). The theoretical propositions put forward for this study were that:

a) Mentors do not consider dyslexia or learning difficulties as an issue in practice.
b) The practice environment, the relationship mentors have with their students and mentors' knowledge an understanding of dyslexia and learning difficulties are the three main factors contributing to this perspective.

These propositions support findings of previous research in some areas but, most importantly, offer new insights into the experiences of mentors when supporting students who struggle to learn in the practice environment. They have been shown to account for the main issues arising from the data, making the study credible because it represents the perspective of the group involved. The process of using a grounded theory approach and methods ensures that familiarity with the topics raised in the research is achieved through in depth engagement with the data.

The sample for the research was relatively small but was obtained from three NHS sites; two acute hospital settings and one mental health setting. This gave the sample a diverse mix of experience from a range of settings, providing the opportunity to make systematic comparisons between participants from each setting which gave the findings added depth.

The constant comparison method of data analysis helped to ensure that codes, concepts, categories and theory all have strong and defendable links

with the data from which they emerged. Procedural credibility is enhanced through the rigorous and systematic application of the grounded theory procedures. Details of how the codes and categories were developed along with extracts from participant interviews provides insight into how the theory was developed and allows for independent assessment from those outside of the study.

The reflexive process, using diaries and memos is another way in which the outsider can review the thinking of the researcher and provides a window for them to access and understand in more detail, how the researcher has interacted with their own study. The reflexive approach taken by the researcher in this study has been rigorous and prevalent throughout the research study, providing insights into the researcher's perspective throughout the process and allowing access to the researcher's journey for those outside the study.

ORIGINALITY

The category of 'The Practice Environment' largely affirms prior research on this subject. The fact that the findings from this study supports outside research serves to validate the findings of this study relating to the practice environment. The practice environment exerts a considerable influence on the mentor/student relationship and issues around time, staffing levels, morale and supernumerary status of students have all emerged in previous research. However, the idea of how learning in practice is different from learning in theory and how this relates to the 'theory-practice gap' adds a new dimension to understanding how mentors appreciate students who struggle to learn in practice.

The category of 'The Mentor/Student Relationship' again identifies elements that are supported by previous research. The relevance of attachment theory, the difficulties with failing students, the importance of the mentor as a role model are all examples of areas where the findings from this research have some resonance with previous research. Areas where new insights have emerged are around the ways in which mentors

see themselves working with students. The idea of 'conversations' as the main way in which mentors work and impart their knowledge and experience to students has not been identified in previous research. Exploration of the dimensions of these conversations would perhaps throw more light on the work of the mentor and the personal nature of the mentor/student relationship itself.

The category of 'Dyslexia and Learning Difficulties' relating to the work that nurse mentors do with their students in practice, is largely un-researched in literature outside of this study and offers new and unique insights into issues affecting the mentor/student relationship. Once again there are issues within this category that have resonance in previous research. The issues around disclosure of learning difficulties in practice have already been highlighted in research based on the student's experiences in practice. The new dimension to this knowledge is that the mentors in this study demonstrated appreciation for students who chose to disclose their learning difficulties and welcomed the idea of more information that might help them support the student more effectively.

New insights in this category also centred on the mentor's conceptualisation of learning difficulties. They lacked detailed knowledge and understanding of these difficulties and for them, issues around learning needs and dyslexia rarely surfaced in the practice environment due to the myriad of other factors they had to deal with on a daily basis. Most mentors were unconfident in what knowledge they had about dyslexia and learning difficulties and many felt they had never encountered anyone with dyslexia in practice. When personal experience was identified, mentors had more knowledge and understanding than they originally recognised.

The theory advocated in this research is new. Explaining how mentors prioritise dyslexia and learning difficulties within the scope of their work with students in practice, and what their knowledge and fears are around this subject area has not been covered before. Dyslexia and learning

difficulties do not figure highly due to a large number of other considerations that include the needs of patients and the challenges of the practice environment. Mentors also perceive dyslexia to be an educational issue rather than a practice issues and only refer to it in relation to documentation and medication, i.e. issues which involve the need to read and write safely and effectively. The mentors appeared generally unaware of other practice skills that might be affected by dyslexia and learning difficulties. The exception to this was when they had a more rounded appreciation of the full scope of learning difficulties which was often due to having personal experience with someone who has dyslexia.

Using grounded theory is a new approach to understanding the experiences of nurse mentors in relation to supporting students who struggle in practice. There is limited research that explores this phenomenon and none that uses a grounded theory approach to offer a conceptual rendering of the subject area. The theory itself offers insight into how mentors perceive dyslexia and learning difficulties and how this impacts on their work with students. By addressing the issues identified in the study in relation to the needs of mentors and achieving a greater awareness of the needs of dyslexic students, it may help to reduce the burden felt by mentors who feel unprepared to support students who have a learning difficulty in practice.

There are social and theoretical implications for this study in that this is the first theory put forward to explain the mentor experience of supporting students with learning difficulties. Social and professional implications can also be seen in the need to consider the practice environment in terms of supporting a non-judgmental culture where greater understanding of the needs of students with learning difficulties is promoted and student nurses feel more secure and confident disclosing their learning difficulties if they wish to do so. Societal and organisational implications relate to the need for NHS organisations and establishments of higher education to work more closely together to support both mentors and students and other

members of staff by encouraging dyslexia friendly environments and training that promotes understanding as well as just providing facts. The work of mentors with their students goes largely unrecognised by organisations that employ nurses and there is no specific remuneration or recognition for this important role.

RESONANCE

Resonance for this study can be demonstrated through the categories of 'Practice Environment', 'The Mentor/Student Relationship' and 'Dyslexia and Learning Difficulties', all of which are recognisable entities from nurse mentor, nurse student and learning difficulties perspectives. They might also be recognisable in other clinical settings where experienced professionals support learners and others who have less experience than themselves. This could include other healthcare professions such as midwifery, radiotherapy, physiotherapy, occupational therapy and medicine. However there might also be some significance outside of the healthcare setting in places of business and other service professions.

Resonance within this study comes from staying true to the data collected from mentors and producing findings that they can understand and appreciate as relevant to their work in their clinical setting. This was achieved by systematic and rigorous attention to the constant comparison method. The findings will be familiar to nurse mentors because the concepts developed are named about, and relate specifically to, the experiences they have in the clinical setting and they help to explain what these people are experiencing in practice and why.

Concepts were derived with as little recourse to the literature as possible before data collection commenced, whilst still providing adequate information for a doctoral research proposal. This enabled me as the researcher to stay more open to the issues that were important to the nurse mentors who participated in the study.

Resonance will be enhanced by using a reflexive approach to the research. Through the use of reflexive diaries and memo-writing I have tried to identify individual experience and personal assumptions that might have relevance for the research I carried out. Awareness of these issues helped to make sure that categories identified, along with the theory are reflective of the data. Integration of extant literature in the discussion of issues arising in the findings has provided additional data to support the development of theory within the study.

USEFULNESS

The theory produced, offers interpretations that can be used by nurses, mentors, nurse students and both NHS and Higher Educational establishments. It is useful in terms of practical application to the clinical environment as it can be used to create awareness of issues relating to dyslexia and learning difficulties. Providing an explanation of mentors' experiences can promote better understanding of the problems experienced by mentors in relation to supporting students in the practice environment. It may also help to promote the status of the mentor in relation to the importance of the work they do with students.

It is useful in terms of the student nurse who is provided with insight into the mentors' perspective of supporting them in practice. Research already exists highlighting the student with dyslexia's perspective, but this is the first time that the mentor's perspective has been explored. Providing an insight into the mentor's view can help students to understand something that has hitherto been accessible only on a very individual personal basis. This knowledge can therefore help to inform the student's decision to disclose about their learning difficulties in practice.

It is useful in terms of the NHS and University establishments as it offers new insight into ways of improving the training and updating of mentors in relation to how they cover aspects of disability within their courses. Prioritising the promotion of better understanding of the needs of students with learning difficulties and other disabilities, alongside the factual

aspects of policies and procedures about disability, could contribute to the promotion of more inclusive attitudes towards disability. The idea of encouraging insight and understanding into the needs of the student with a learning difficulty promotes a different emphasis for mentorship training, asking it to move towards a more experiential format. A better understanding of what it means to have a learning difficulty would improve the placement experiences of students who have these learning difficulties as it would lead to improved ways of supporting students in practice, for example in the identification and implementation of appropriate and timely reasonable adjustments.

The culture of practice placements where negative attitudes and discrimination exist could gradually be challenged and improved if mentors completing training and updates are supported to understand their own personal prejudices and attitudes. The new insights created could lead to improved consideration of the needs these students have in relation to learning in the practice environment. In addition, if as Pollak (2005) suggests, all students benefit from practices designed to help students with dyslexia, then this approach to training could be of benefit to an even wider student population.

The study also contributes to the existing knowledge bases of nurse education and dyslexia and learning difficulties and can be used to support insight into issues relating to the complexities of the mentor/student relationship that takes place in a dynamic and challenging environment. Recommendations will be made later in this chapter in relation to improving the experiences of both nurse mentors and nurse students in the practice environment.

STUDY CONCLUSIONS

IMPLICATIONS FOR NURSING PRACTICE

Nurse mentors are directly involved with the education and support of students in the practice environment and they need to become more

aware of the issues faced by students with dyslexia and learning difficulties and how this may impact on their ability to learn in the clinical setting. They need to embrace a broader spectrum of possibilities when considering a student who is showing signs of struggling in the practice environment and develop strategies (reasonable adjustments) that can be individualised to suit a range of individual circumstances and can be implemented without compromising patient care. Opportunities to share good practice and discuss issues arising around supporting students in practice should be created and encouraged. This study can help to remind mentors to move towards this more 'student centred' approach to mentoring.

More needs to be done to create awareness and promote appropriate non-judgmental responses amongst nurses, nurse mentors and all other healthcare workers in relation to learning difficulties and other disabilities so that myths and ignorance can be addressed. Open and honest discussion between professionals needs to be encouraged so that personal prejudices can be identified and addressed. Changes in these attitudes are at the heart of making the practice environment more welcoming and supportive of students who have learning difficulties. In this way, the stigma of learning difficulties can be reduced and the diversity of learners can become, not just accepted, but valued.

There are implications also for academic nurse practice. It has been shown how mentors believe that dyslexia and learning difficulties are the responsibility of nurse education and that knowledge of how to support students with dyslexia and learning difficulties can be found with the nurse academics. Nurse academics therefore have responsibility to develop training that addresses the needs of mentors to 'understand' more about the student with dyslexia and other disabilities and make this training feel relevant and useful to them. There should also be better liaison between clinical nurses and academic nurses so that knowledge and understanding

can be shared. This is one way that the 'theory – practice gap' might be closed.

STUDY LIMITATIONS

The theory developed using grounded theory within this study is specific to the study sample from which it developed and is therefore limited in scope and depth. More research is needed and more development in other contexts and settings to improve the resonance and usefulness of the theory and make it fully substantive.

A lack of theoretical sensitivity on the part of the researcher, particularly at the beginning of the research process has meant that theory development was slow. The theory in this thesis is presented for further development in other contexts that may allow for transferability and further enhancement.

The researcher is an inevitable presence within the study. This has been embraced as part of the interpretivist, constructivist approach to the study, however to minimise this as a limitation, the researcher has taken time and effort to maintain a reflexive presence within the process at all times; using reflective diaries and theoretical memos to document idea formulation, analytical thinking and personal bias.

RECOMMENDATIONS FOR PRACTICE

More needs to be done to raise awareness in the practice environment of the issues faced by students who have a learning difficulty. This has implications for ward, hospital and university policy regarding the disclosure of information relating to the student with learning difficulties, and the measures of support that could be made available in the form of reasonable adjustments.

Better liaison between the practice and academic institutions on matters of dyslexia and learning difficulties would promote a joined up approach that would benefit both agencies helping them to provide a better experience for nurses, nurse students and nurse mentors. If academia is seen by the nurse mentors as being the knowledgeable partner in terms of dyslexia and

learning difficulties, academia has a responsibility to share this expertise with their practice partners more routinely. Student confidentiality must be maintained but discussions between academics and practice partners about supporting students with learning difficulties should be encouraged. Discussion around ways of supporting disclosure by students so that the information is received in a positive fashion would benefit both student and mentor. One way of doing this might be to identify an interested academic and an interested mentor in practice who could liaise about important issues and take the lead on supporting mentors as well as students with learning difficulties who are going out into practice.

Mentors are given educational input around disabilities and learning difficulties but the findings of this study indicate that they do not manage to contextualise this information in terms of how to identify and support students who have these extra learning needs. This is complicated by the fact that learning difficulties are often not disclosed, are generally associated with education and therefore the responsibility of the academic institution rather than practice. The training of mentors for their role, including mentor updates, would be improved if more emphasis was given to the promotion of experiential learning within training and updates, to help the mentor understand the needs of the dyslexic student. Challenging the beliefs and values of mentors in relation to how they perceive dyslexia and learning difficulties should be the main aim of education and training as, although much harder to achieve, it is more likely to carry over into a change of behaviour and attitude in practice. This need not be confined to mentors but could be adopted in academic institutions as well as practice settings so that cultures of inclusion and acceptance are encouraged in all environments experienced by students with learning difficulties.

Work needs to be done to create a more supportive environment in practice for students with dyslexia and learning difficulties so that they feel safer and more confident to disclose their learning difficulties to mentors. This would allow mentors to work more closely and openly with these

students and encourage the innovative use of time and other reasonable adjustments to better support their learning in practice.

FINAL THOUGHTS

The whole experience of planning, doing and writing up this research study has been a learning process in itself. Everything I thought I knew about research, I know in more depth and with more clarity now. From this point of view, it is just a shame that I am at the end and not the beginning. However the end of this project can be seen as the beginning of something new.

In order to develop the theory from this research study further, giving more depth and breadth to its substantive properties, I would like to carry out a further grounded theory study, with a larger sample of mentors; but importantly, this time, staying more attuned to theory production from the outset. It may then be necessary to broaden the scope of the enquiry by including other health care practitioners, nurse lecturers and students as part of the sample population. I would also hope to be more aware of the nuances inherent in data relating to the sensitivity of the subject matter in further research projects as I feel this is central to a workable theory in practice. Formal theory production would be possible if the emphasis was more on workforce attitudes to disability and other professions and work environments were considered.

As a separate strand, I am also interested in developing research around an experiential training programme on dyslexia and learning difficulties that could be used to evaluate the efficacy of the experiential approach to educational training in such matters.

CONCLUSIONS

This grounded theory study has presented the development of the emerging theory that 'To mentors dyslexia is just spelling'. This theory provides evidence that can benefit nurse mentors, students with learning difficulties such as dyslexia, schools of nursing and NHS Hospital and

Mental Health Trusts. If mentors can be better supported and trained to meet the needs of students with dyslexia and other learning difficulties they would have more confidence to support any student who struggles to learn in practice.

It is hoped that institutions responsible for nurse training and NHS Trusts will become more aware of the needs of the dyslexic student and more appreciative of the work that mentors do with their students; that these organisations will work more closely together to promote awareness and acceptance of learning difficulties in practice as well as academia; and that they will consider the training of mentors in terms of creating understanding of the problems faced by dyslexic students. Creation of mentor training that is more experiential and appreciative of student stories is likely to be more powerful as it would concentrate on the realities of practice. By contextualising the learning it would also help to bridge the theory practice gap that still appears to exist between academic and practice environments. In due course, improvements in the work that mentors do with their students are likely to improve patient care in the future, and that is perhaps the ultimate reason for being a nurse.

GLOSSARY

CATEGORY: a higher level concept that represents a group of codes.

CLINICAL PRACTICE FACILITATOR: a qualified nurse who is an experienced mentor and has responsibility for student nurses and nurse mentors in practice.

CODE: a form of shorthand that researchers repeatedly use to identify conceptual recurrences and similarities in the patterns of participants' experiences

CONSTANT COMPARISON METHOD: an analytical process in which incoming data is compared with existing data in the process of code and category development.

CONSTRUCTIONISM: a theoretical perspective that assumes people create social reality through individual and collective actions. Rather than assuming realities in an external world, constructionists study what people at a particular place and time consider as real.

CONSTRUCTIVISM: a research paradigm that recognises that reality is constructed by those who experience it and thus research is a process of re-constructing that reality.

CORE CATEGORY: a concept that encapsulates a phenomenon apparent in the categories and sub-categories constructed and the relationship between these.

DYSLEXIA: an unseen disability that affects the way information is stored, processed and retrieved, with problems affecting memory, speed of processing, time perception, organising and sequencing. Weaknesses in literacy are often the most visible sign.

GROUNDED THEORY: an approach to research that aims to produce a theory, grounded in the data, through the application of specific methods.

IN VIVO CODES: participant's words used to encapsulate a broader concept in the data.

EXTANT LITERATURE: existing literature outside of the current investigation.

NURSE MENTOR: a qualified nurse who has undertaken training to become a mentor and has responsibility for supporting nurse students in practice.

NURSING AND MIDWIFERY COUNCIL: professional body that has responsibility for upholding professional standards and maintaining the live register of nurses and midwives in the U.K.

MEMOING: a fundamental analytical process in grounded theory research that involves the recording of processes, thoughts, feelings, analytical insights, decisions and ideas in relation to a research project.

MENTOR UPDATE: yearly update training required for maintaining continuing mentorship status.

MENTOR REGISTER: A list of qualified nurses who have passed mentorship training and are up-to-date with NMC requirements to practice as a mentor.

REFLEXIVITY: an active, systematic process used by the researcher in order to gain insight into their work that will guide future actions and interpretations.

ROYAL COLLEGE OF NURSING: a union and membership organisation that represents nurses and nursing, promoting good practice and shaping health policies.

SPECIFIC LEARNING DIFFICULTY: an umbrella term used to cover a range of frequently co-occurring difficulties such as dyslexia.

SUBSTANTIVE THEORY: theory that aims to address a studied phenomenon in a specific situation.

SYMBOLIC INTERACTIONISM: a theoretical perspective derived from pragmatism which assumes that people construct selves, society and reality through interaction. Meanings arise out of actions and, in turn influence actions.

THE CHICAGO SCHOOL: a tradition in sociology that arose at the University of Chicago during the early decades of the 20th century. Chicago school sociology assumes dynamic, reciprocal relationships between interpretation and action. Social life is interactive, emergent and in determinant.

THEORETICAL SAMPLING: the process of identifying and pursuing clues that arise during analysis in a grounded theory study.

THEORETICAL SENSITIVITY: the ability to recognise and extract from the data, elements that have relevance for the emerging theory.

TRIENNIAL REVIEW: a three yearly review at which point mentors are re-assessed for inclusion on the live mentor register.

REFERENCE LIST AND BIBLIOGRAPHY

Acocella, I. (2012) The 'focus groups' in social research: advantages and disadvantages. *Qual Quant.* 46, pp 1125-1136.

Age, L. (2011) Grounded Theory Methodology: Positivism, Hermeneutics and Pragmatism. *The Qualitative Report*, 16 (6), pp 1599-1615.

Aitkins, S. And Williams, A. (1995) Registered nurses' experiences of mentoring undergraduate nursing students. *Journal of Advanced Nursing*. 21, pp 1006-1015.

Ali, P. And Panther, W. (2008) Professional Development and the Role of Mentorship. *Nursing Standard,* 22 (42), pp 35-39.

Allan, H., Smith, P. and O'Driscoll, M. (2011). Experiences of supernumerary status and the hidden curriculum in nursing: a new twist in the theory-practice gap? *Journal of Clinical Nursing,* 20, pp 847-855.

Anderson, L. (2011) A learning resource for developing effective mentorship in practice. *Nursing Standard*, 25 (51), pp 48-56.

Andrews, M. And Wallis, M. (1999) Mentorship in Nursing: a literature review. *Journal of Advanced Nursing* 29 (1), pp 201-207.

Annells, M. (1997) Grounded Theory Method, Part 1: within the five moments of qualitative research. *Nursing Inquiry*, 4 (x), pp 120-129.

Arksey and Knight (1999) *Interviewing for Social Scientists.* London: Sage Publications.

Attwood, A. (1979) The mentor in clinical practice. *Nursing Outlook*, 27, pp 714-717.

Ausubel, D. (1968) *Educational Psychology: A Cognitive View*. New York: Rhinehart and Winston.

Bandura, A. (1986) *Social Foundations of Thought and Action: A Social Cognitive Theory*. New Jersey: Prentice Hall.

Bartholomew, K. (2006) *Ending nurse-to-nurse hostility: Why nurses eat their young and each-other*. Marblehead MA: HCPro Inc.

Becker, P. (1998) Pearls, pith and provocations: Common pitfalls in grounded theory research. *Qualitative Health Research*, 3 (2), pp 254-260.

Benner, P. (1984) *From Novice to Expert.* Massachusetts: Addison Wesley Press.

Beskine, D. (2009) Mentoring students: establishing effective working relationships. *Nursing Standard*, 23 (30), pp 35-40.

Birks, M., Chapman, Y. and Francis, K. (2006a) Moving Grounded Theory into the 21st Century: Part 1 – An Evolutionary Tale. *Singapore Nursing Journal,* 33 (4), pp 4-10.

Birks, M., Chapman, Y. and Francis, K. (2006b) Moving Grounded Theory into the 21st Century: Part 2 – Mapping the Footprints. *Singapore Nursing Journal*, 33 (4), pp 12 –17.

Birks, M. and Mills, J. (2015) *Grounded Theory: A Practical Guide (2nd Edition).* London: Sage Publications.

Bjork, I., Bernsten, K., Brynildsen, G. and Hestetun, M. (2014) Nursing students' perceptions of their clinical learning environment in placements outside traditional hospital settings. *Journal of Clinical Nursing*, 23 (19-20), pp 2958-2967.

Bloom, B. (ed.) (1956) *Taxonomy of Educational Objectives, the classification of educational goals – Handbook I: Cognitive Domain* New York: McKay.

Bloor, M., Frankland, J., Thomas, M. and Robson, K. (2001) *Focus Groups in social Research*. London: Sage Publications.

Bondy, K. (1983) Criterion-referenced definitions for rating scales in clinical evaluation. *Journal of Nurse Education,* 22 (9), pp 376-382.

Bowlby, J. (1973) *Attachment and loss: Vol. 2. Separation.* New York: Basic Books.

Bowlby, J. (1982) *Attachment and loss: Vol. 1. Attachment (2nd Edition).* New York: Basic Books

Breckenridge, J. (2010) Being Person Driven In A Service Driven Organisation: A Grounded Theory of Revisioning Service Ideals and Client Realities. PhD Thesis, Available at: http://etheses.qmu.ac.uk/492/1/Jenna_Breckenridge's_final_thesis.pdf (last accessed on 14/01/2016).

Breen, R. (2006). A Practical Guide to Focus Group Research. *Journal of Geography in Higher Education,* 30, (3), pp 463-475.

Brown, L., Douglas, V., Garrity J. and Shepherd, C. (2012) What influences Mentors to pass or fail students? *Nursing Management,* 19 (5), pp 16-21.

Burtson, P. and Stichler, J. (2010) Nursing work environment and nurse caring: relationship among motivational factors. *Journal of Advanced Nursing*, 66 (8), pp 1819-1831.

Cameron-Jones, M. and O'Hara, P. (1996) Three Decisions about Nurse Mentoring. *Journal of Nurse Management*, 4, pp 225-230.

Campbell, D. (2013) 7,000 key NHS clinical staff made redundant amid enforced cuts. *The Guardian*, 31 Dec. Available at: www.theguardian.com/society/2013/dec/31/nhs-staff-laid-off-amid-savings-drive . (Accessed Nov 2015).

Carr, J., Heggarty, H., Carr, M., Fulwood, D., Goodwin, C., Walker, W. and Whittingham, K. (2010) Reflect for success:

recommendations for mentors managing failing students. *British Journal of Community Nursing*, 15 (12), pp 594-596.

Carvel, J. (2004) 'Nursing chief criticises few 'too posh to wash'. *The Guardian*. Available at: www.theguardian.com/uk/2004/may/11/politics.society . (Accessed Nov 2015).

Casey, D. and Clark, L. (2011) Roles and responsibilities of the student nurse mentor: an update. *British Journal of Nursing,* 20 (15), pp 933-937.

Charmaz, K. (2000) Grounded theory: Objectivist and constructivist methods IN Denzin, N. and Lincoln, Y., (Eds), *The Sage Handbook of Qualitative Research (2nd edition),* Thousand Oaks: Sage Publications.

Charmaz, K. (2005) Grounded Theory in the 21st Century: Applications for Advancing Social Justice Studies IN Denzin, N. and Lincoln, Y. (Eds.) *The Sage Handbook of Qualitative Research* (3rdedition). London: Sage Publications.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London: Sage Publications.

Charon, J. (2007) *Symbolic Interactionism: An Introduction, An Interpretation, An Integration.* New Jersey: Pearson Prentice Hall.

Chen, H. And Boore, J. (2009) Using a synthesised technique for grounded theory in nursing research. *Journal of Clinical Nursing,* 18, pp 2251-2260.

Chuan, O. and Barnett, T. (2012) Student, tutor and staff nurse perceptions of the clinical learning environment. *Nurse Education in Practice*, 12, pp 192-197.

Clarke, E. (2005) *Situational Analysis: Grounded Theory after the Postmodern Turn.* Philadelphia: Sage Publications.

Clutterbuck, D. (1998) *Learning Alliances: Tapping into Talent.* Wiltshire: The Cromwell Press

Colyar, J. (2009) Becoming Writing, Becoming Writers. *Qualitative Inquiry,* 15 (2), pp 421-436.

Cooney, A. (2010). Choosing between Glaser and Strauss: an example. *Nurse Researcher,* 17 (4), pp 18-28.

Cooney, A. (2011). Rigour and Grounded Theory. *Nurse Researcher*, 18 (4), pp 17 – 22.

Cooper, J. (2009) Your learning needs come first. *Nursing Standard,* 24 (4), p 70.

Corbin, J. and Strauss, A. (2008) *Basics of Qualitative Research; techniques and procedures for developing grounded theory (3rd Edition).* London: Sage Publications.

Cowen, M. (2010) *Dyslexia, Dyspraxia and Dyscalculia: a toolkit for nursing staff.* London: Royal College of Nursing.

Cutcliffe, J. (2008) Grounded Theory IN Watson, R. and Cowan, S. (Eds.) *Nursing Research: Designs and Methods*. Philadelphia: Churchill Livingstone, pp 221-230.

Cutcliffe, J. (2000) Methodological Issues in Grounded Theory. *Journal of Advanced Nursing*, 31 (6), pp 1476-1484.

Cutcliffe, J. (2003) Reconsidering reflexivity: Introducing the case for intellectual entrepreneurship. *Qualitative Health Research*, 13 (1), pp 136-148.

Darling, L. (1984) What do nurses want in a mentor? *Journal of Nursing Administration,* 14, pp 42-44.

Darling L. (1985) What to Do About Toxic Mentors. *Journal of Nursing Administration*, 15, pp 43-44.

D.D.A. (2005) Available at: www.opsi.gov.uk/acts/acts2005/ukpga_20050013_en_1 (last accessed 8th April 2010).

Decker, J. and Shellenbarger, T. (2012) Strategies for nursing faculty to promote a health work environment for nursing students. *Teaching and Learning in Nursing*, 7, pp 56-61.

Denzin, N. and Lincoln, Y. (2000) *Handbook of Qualitative Research* (2nd Edition). Thousand Oaks C.A.: Sage.

D.F.E.S. (2004) *Delivering Skills for Life: A Framework for Dyslexia.* The Department for Education and Skills, Leicester: NIACE available at http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=AFDD2& (last accessed 8th April 2010).

DoH (2011) Government arrangements for research ethics committees: A harmonised edition. England: Department of Health Research and Development Directorate. Available at: https://www.gov.uk/government/uploads/system/uploads/attachmentdata/file/213753/dh133993.pdf (last accessed – 20/02/2016)

Downie, C. and Basford, P. (2003) *Mentoring in Practice: A Reader.* London: University of Greenwich.

Duffield, C., Diers, D., Aisbett, K. and Roche, M. (2009) Churn: Patient turnover and casemix. *Nursing Economics*, 27 (3), pp 185-191.

Duffield, C., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M. and Aisbett, K. (2011) Glueing it together: Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research,* 24, pp 344-355.

Duffy, K. (2003) Failing Students: a qualitative study of factors that influence the decisions regarding the assessment of students' competence in practice. London: NMC.

Duffy, K. (2004) Mentors need more support to fail incompetent students. *British Journal of Nursing,* 13 (10), p 582.

Earnshaw, G. (1995) Mentorship: the students' views. *Nurse Education Today,* 10, (4), pp 274-279.

Edmonds, M. and Gelling, L. (2010) The complexities of grounded theory: a commentary. *Nurse Researcher,* 17 (4), pp 4-7.

Elcock, K. and Sharples, K. (2011) *A Nurse's Survival Guide to Mentoring.* China, Elsevier Ltd.

Elcock, K. (2014) Supporting students with disabilities: good progress but must try harder. *British Journal of Nursing,* 23 (13), p 758.

Eleigil, A. and Yildirim, H. (2006) Students' Opinions About, and Expectations of Effective Nurse Clinical Mentors. *Journal of Nurse Education,* 47 (3), pp 118-123.

Equality Act 2010, Part 6, c. 1-4. Available at: http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf (Last accessed 07/03/2016).

Evans, W. (2014) 'I am not a dyslexic person I'm a person with dyslexia': identity constructions of dyslexia among students in nurse education. *Journal of Advanced Nursing,* 70 (2), pp 360-372.

Evans, W. (2015) Disclosing a dyslexic identity. *British Journal of Nursing,* 24 (7), pp 383-385.

Fawcett, A. and Nicolson, R. (2007) Dyslexia, learning and pedagogical neuroscience. *Developmental Medicine and Child Neurology*, 49 (4), pp 306 – 311.

Foster, H., Ooms, A. and Marks-Maran, D. (2015) Nursing students' expectations and experiences of mentorship. *Nurse Education Today*, 35, pp 18-24.

Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery office.

Frankham, J., Stronach, I., Bibi-Nawaz, S., Cahill, G., Cui, V., Dymoke, K., Dung, M., Lungka, P., Mat-So, H. and Mohd Khir, M. (2014) De-skilling data analysis: the virtues of dancing in the dark. *International Journal of research and Method in Education*, 37 (1), pp 87-100.

Galaburda, A. (1989) Ordinary and extraordinary brain development: anatomical variation in developmental dyslexia. *Annals of Dyslexia* 39: 67-80.

Gardiner, C. (1998) Mentoring Towards a Professional Friendship IN Downie, C. and Basford, P. (2003) *Mentoring in Practice: A Reader.* London, University of Greenwich.

Gerrish, K. and Lacey, A. (2006) *The Research Process in Nursing (5th Edition).* Oxford: Blackwell Publishing Ltd.

Ghezeljeh, T. and Emani, A. (2009) Grounded Theory: methodology and philosophical perspective. *Nurse Researcher,* 17 (1), pp 15-23.

Gidman, J., McIntosh, A., Melling, K. and Smith, D. (2011) Student Perceptions of support in practice. *Nurse Education in Practice*, 11, pp 351-355.

Glaser, B. (1992). *Basics of Grounded Theory Analysis: Emergence versus Forcing.* Chicago CA: Sociology Press Ltd.

Glaser, B. (1978). *Theoretical sensitivity: advances in the methodology of grounded theory.* Mill Valley, California: Sociology Press.

Glaser, B. and Strauss, A. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.

Gopee, N. (2011) *Mentoring and Supervision in Healthcare*. (2nd Edition) London: Sage.

Gray, M. And Smith, L. (2000) The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study. *Journal of Advanced Nursing,* 32 (6), pp 1542-1549.

Green, J. and Thorogood, N. (2014) *Qualitative Methods for Health Research (3rd Edition)*. London: Sage Publications.

Grossoehme, D. (2014) Overview of Qualitative Research. *Journal of Health Care Chaplaincy,* 20 (3), pp 109-122.

Gwernan-Jones, R. and Burden, R. (2009) *Are They Just Lazy?* Student Teachers' Attitudes about Dyslexia. *Dyslexia,* 16, pp 66-86.

Haigh, C. (2008) Editorial: Embracing the theory/practice gap. *Journal of Clinical Nursing,* 18, pp 1-2.

Hall, H., Griffiths, D. and McKenna, I. (2013). From Darwin to Constructivism: the evolution of grounded theory. *Nurse Researcher,* 20 (3), pp 17-21.

Hegenbarth, M., Rawe, S., Murray, L., Arnaert, A. and Chambers-Evans, J. (2015) Establishing and maintaining the clinical Learning environment for nursing students: A qualitative study. *Nurse Education Today*, 35, pp 304-309.

Hesse-Biber, S. and Leavy, P. (2006) *The Practice of Qualitative Research.* Thousand Oaks CA: Sage Publications.

Holloway, I. and Biley, B. (2011) Being a Qualitative Researcher. *Qualitative Health Research,* 21 (7), pp 968-975.

Holloway, I. and Todres, L. (2006) Grounded Theory IN Gerrish, K. and Lacey, A. (2006) *The Research Process in Nursing (5th Edition).* Oxford: Blackwell Publishing Ltd

Hornsby, B. (1997) *Overcoming Dyslexia: A Straightforward Guide for Families and Teachers.* London: Vermillion.

Houle, C. (1961) The Enquiring Mind. Madison USA, University of Wisconsin Press.

Howlin, F., Halligan, P. and O'Toole, S. (2014) Evaluation of a clinical needs assessment and exploration of the associated supports for students with a disability in clinical practice: Part 2. *Nurse Education in Practice,* 14, pp 565-572.

Hunter, A., Murphy, K., Grealish, A., Casey, D. Keady, J. (2011) Navigating the grounded theory terrain. Part 1. *Nurse Researcher*, 18, (4), pp 6-10.

Hunter-Carsch, M. and Herrington, M. (2001) *Dyslexia and Effective Learning in Secondary and Tertiary Education.* London: Whurr.

Hurley, C. and Snowden, S. (2008) Mentoring in times of change. *Nursing in Critical Care*, 13 (5), pp 269-275.

Huybrecht, S., Loecxz, W., Quaeyhaegens, Y., De Tobel, D. and Mistiaen, W. (2011). Mentoring in nurse education: Perceived characteristics of mentors and the consequences of mentorship. *Nurse Education Today,* 31, pp 274-278.

Illingworth, K. (2005) The effects of dyslexia on the work of nurses and healthcare assistants. *Nursing Standard* 19 (38): 41-48.

Jervis, A. and Tilki, M. (2011) Why are nurse mentors failing to fail student nurses who do not meet clinical performance standards? *British Journal of Nursing*, 20 (9), pp 582-587.

Josselson, R. (2013) *Interviewing for Qualitative Inquiry: A Relational Approach.* New York: The Guilford Press

Kantek, F., Yildrim, N. and Kavla, I. (2015) Nurses' perceptions of motivational factors: a case study in a Turkish university hospital. *Journal of Nursing Management*, 23, pp 674-681.

Kirby,J., Silvestri, R., Allington, B., Parrila, R. and La Fave, C. (2008) Learning Strategies and Study Approaches of Postsecondary Students with Dyslexia. *Journal of Learning Disabilities,* 41 (1), pp 85-96.

Kleinsasser, A. (2000) Researchers, Reflexivity, and good data: Writing to unlearn. *Theory into Practice*, 39 (3), p 155.

Knowles, M. (1970) *The Modern Practice of Adult Education: From Pedagogy to Androgogy* (2nd Edition). Chicago: Follett Publishers.

Knowles, M. (1984) *Androgogy in Action: applying modern principles of adult learning.* San Francisco: Jossey-Bass Inc. Publishers.

Knowles, M. (1990) *The Adult Learner: A Neglected Species*. Houston, Gulf Publishers.

Kolb, D. (1984) *Experiential Learning: Experience as the Source of Learning and Development*. New Jersey: Prentice Hall.

Kramer-Kile, M. (2012). Situating Methodology within Qualitative Research. *Canadian Journal of Cardiovascular Research,* 22 (4), pp 27-31.

Krueger, R. and Casey, M. (2009). *Focus Groups: A practical guide for applied research* (4th Edition). Thousand Oaks CA: Sage Publications.

Lambert, S. and Loiselle, C. (2008) Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing,* 62 (2), pp 228-237.

Lee, J. (2003) *Making the Curriculum Work for Learners with Dyslexia*. London: Basics Skills Agency.

Levinson, D. (1978) *The Seasons of a Man's Life*. New York: Knopf.

Levett-Jones, T. and Bourgeois, S. (2007) The clinical placement: an essential guide for nursing students. Sydney: Elsevier Publishing.

Licqurish, S. and Seibold, C. (2011) Applying a contemporary grounded theory methodology. *Nurse Researcher,* 18 (4), pp 11-16.

Lindeman, E. (1926) *The Meaning of Adult Education*. New York: New Republic Press.

Longo, J. (2007) Horizontal violence among nursing students. *Archives of Psychiatric Nursing,* 21 (3), pp 177-178.

Maben, J., Latter, S. and Macleod Clark, J. (2006) The theory-practice gap: impact of professional bureaucratic work conflict on newly-qualified nurses. *Journal of Advanced Nursing*, 55 (4), pp 465-477.

Maclure, M. (2013) The Wonder of Data. *Cultural Studies – Critical Methodologies,* 13 (4), pp 228-232.

Maijala, H., Paavilainen, E., Astedt-Kurki, P. (2003) The use of grounded theory to study interaction. *Researcher*, 11 (2), pp 40-57.

Malloy, T and Penprase, B. (2010) Nursing leadership style and psychosocial work environment. *Journal of Nursing Management*, 18, pp 715-725.

Mauthner,N. and Doucet, A. (2003) Reflexive Accounts and Accounts of Reflexivity in Qualitative Data Analysis. *Sociology*, 37 (3), pp 413-431.

McCann, T. and Clark, E. (2003a) Grounded theory in nursing research: Part 2 – Methodology. *Researcher*, 11 (2), pp 7 – 88.

McCann, T. and Clark, E. (2003b) Grounded theory in nursing research: Part 2 – Critique. *Researcher,* 11 (2), pp 19-28.

McIntosh, A., Gidman, J. and Smith, D. (2014) Mentors' perceptions and experiences of supporting student nurses in practice. *International Journal of Nursing Practice,* 20, pp 360-365.

McNamee, M., Attonito, K. and Woolforde, L. (2013) Fostering Healthy Work Environments Through Nursing Education Initiatives. *The Journal of Continuing Education in Nursing,* 44 (5), pp 199-200.

McPheat, C. (2014) Experience of nursing students with dyslexia on clinical placement. *Nursing Standard,* 28 (41), pp 44-49.

Megginson, D. and Clutterbuck, D. (1999) *Mentoring in Action: A Practical Guide for Managers.* London: Kogan Page.

Monaghan, T. (2015) A critical analysis of the literature and theoretical perspectives on theory-practice gap amongst newly qualified nurses within the United Kingdom. *Nurse Education Today,* 35, pp e1-e7.

Moore, J. (2009). An exploration of the origin of classic grounded theory. *Nurse Researcher,* 17 (1), pp 8-14.

Morris, D. and Turnbull, P. (2007) The disclosure of dyslexia in clinical practice: Experiences student nurses in the United Kingdom. *Nurse Education Today,* 27, pp 35-42

Morris,D. and Turnbull, P. (2006) Exploring the clinical experiences of pre-registration student nurses with dyslexia. *Journal of Advanced Nursing*, 54 (2), pp 238-247.

Morton-Cooper, A. and Palmer, A. (2000) (2nd Edition) *Mentoring, Preceptorship and Clinical Supervision: A guide to Professional Support in Clinical Practice.* Oxford: Blackwell Publishing.

Murray, C., Rosen, L. and Staniland, K. (2010) *The Nurse Mentor and Reviewer Update Book.* England: Open University Press.

Neary, M. (2000) *Teaching, Assessing and Evaluation for Clinical Competence*. Cheltenham: Nelson Thornes Ltd.

Nelson, J. and Frontczak, N. (1988) How Acquaintanceship and Analyst Can Influence Focus Group Results. *Journal of Advertising, 17 (1), pp 41-48.*

Ness, V., Duffy, D., McCallum, J. and Price, L. (2010) Supporting and mentoring nursing students in practice. *Nursing Standard,* 25 (1), pp 41-46.

Newbury, J. (2011) Reflexivity in a study of family carers in home palliative care: a personal account. *Nurse Researcher,* 19 (1), pp 30-36.

NICE (2014) *Safe staffing for nursing in adult inpatient wards in acute hospitals: Safe staffing guideline.* London: Nursing and Midwifery Council.

Nicholls, D. (2009a) Qualitative Research: Part one – Philosophies. *International Journal of Therapy and Rehabilitation,* 16 (10), pp 526-533.

Nicholls, D. (2009b) Qualitative Research: Part two – Methodologies. *International Journal of Therapy and Rehabilitation,* 16 (11), pp 586-592.

Nicholls, D. (2009c) Qualitative Research: Part three – Methods. *International Journal of Therapy and Rehabilitation,* 16 (12), pp 638-647.

NMC (2015) *The Code: Professional standards of practice and behaviour for nurses and midwives*. London: RCN.

NMC (2010) *Standards for Pre-Registration Nursing Education.* London: NMC.

NMC (2006) *Standards to Support Learning and Assessment in Practice: NMC Standards for Mentors, Practice Teachers and Teachers*. London: NMC.

NMC (2008) *Standards to Support Learning and Assessment in Practice: NMC Standards for Mentors, Practice Teachers and Teachers*. (2nd Edition) London: NMC.

Norman, I. (2013) The nursing practice environment. *International Journal of Nursing Studies*, 50, pp 1577-1579.

Oliver, P. (2010) *The Student's Guide to Research Ethics, (2nd Edition).* Maidenhead: Open University Press.

O'Mara, L., McDonald, J., Gillespie, M., Brown, H. and Miles, L. (2013) Challenging clinical learning environments: Experiences of undergraduate nursing students. *Nurse Education in Practice*, 14, pp 208-213.

Osterman, K. and Kottkamp, P. (1993) Reflective Practice for Educators. *Newbury Park CA:* Corwin Publishers.

Papathanasiou, I., Tsaras, K. and Sarafis, P. (2013). Views and perceptions of nursing students on their clinical learning environment: Teaching and learning. *Nurse Education Today,* 34, pp 57-60.

Papert, S. (1980). *Mindstorms.* New York: Basic Books.

Parahoo, K. (2009). Grounded Theory: what's the point? *Nurse Researcher,* 17 (1), pp 4-7.

P.A.T.O.S.S (2010) http://www.patoss-dyslexia.org/ (last accessed April 8th 2010).

Pellatt, G. (2006) The role of mentors in supporting pre-registration nursing students. *British Journal of Nursing*, 15 (6), pp 336-340.

Pollak, D. (2005) *Dyslexia, The Self and Higher Education*. England: Trentham Books Ltd.

Powell, R. and Single, M. (1996) Focus Groups. *International Journal for Quality in Health Care,* 8 (5), pp 499-504.

Price, G. and Skinner, J. (2007) *Support for Learning Differences in Higher Education: the essential practitioner's manual*. England: Trentham Books Ltd.

RCN (2007) *Guidance for mentors of nursing students and midwives: An RCN toolkit (2nd Edition).* London: RCN

RCN (2009) *Research Ethics: Guidance for nurses (3rd Edition).* London: RCN.

RCN (2010a) *Guidance on safe nurse staffing levels in the U.K.* London: RCN.

RCN (2010b) *Dyslexia, dyspraxia and dyscalculia: a toolkit for nursing staff.* London: RCN.

RCN (2010c) *Dyslexia, dyspraxia and dyscalculia: a guide for managers and practitioners.* London: RCN.

RCN (2011) *Informed consent in health and social care research: RCN guidance for nurses (2nd Edition).* London: RCN.

RCN (2012) *Safe staffing for older people's wards: An RCN toolkit.* London: RCN.

RCN (2013) *Safe staffing levels – a national imperative*. London: RCN.

Robinson-Pant, A. (2002) "What can PRA offer to educational researchers?" Keynote conference paper presented at NETREED (Network for Research and Evaluation on Education and Development), in Norway (available at: www.netreed.uio.no/conferences)

Rogers, A. (1996) *Teaching Adults*. (2nd Edition) London, Open University Press.

Rogers, C. (1969). *Freedom to Learn: A View of What Education Might Become* (1st Edition). Columbus, Ohio: Charles Merill.

Rogers, C. (1980). *A Way of Being*. Boston: Houghton Mifflin.

Roller, M. and Lavrakas, P. (2015) *Applied Qualitative Research Design: A Total Quality Framework Approach.* New York: The Guilford Press

Riddick, B. (2000) An Examination of the Relationship Between Labelling and Stigmatisation with Special Reference to Dyslexia. *Disability and Society,* 15 (4), pp 653-667.

Ridley, C. (2011) The experiences of nursing students with dyslexia. *Nursing Standard,* 25 (24), pp 35-42.

Roth, W., Mavin, T. and Dekker, S. (2014). The theory-practice gap: epistemology, identity and education. *Education and Training,* 56 (6), pp 521-536.

Salzman, P. (2002) On Reflexivity. *American Anthropologist,* 104 (3), pp 805-813.

Sandalowski (2008) Justifying Qualitative Research. *Research in Nursing and Health,* 31, pp 193-195.

Sanderson-Mann, J. and McCandless, B. (2006) Understanding dyslexia and nurse education in the clinical setting. *Nurse Education in Practice,* 6, pp 127-133.

Sanderson-Mann, J. and McCandless, B. (2005) Guidelines to the United Kingdom Disability Discrimination Act (DDA) 1995 and the Special Educational Needs and Disability Act (SENDA) 2001 with regards to nurse education and dyslexia. *Nurse Education Today*, 25, pp 542-549.

Schon, D. (1983) *The Reflective Practitioner: How professionals think in action*. London: Temple Smith

Schon (1987) *Educating the Reflective Practitioner.* California: Jossey-Bass Inc.

Scully, N. (2011). The theory-practice gap and skill acquisition: An issue for nursing education. *Collegian*, 18 (2), pp 93-98.

S.E.N.D.A. (2001) www.opsi.gov.uk/acts/acts2001/ukpge_20010010_en_1 (last accessed 12th April 2010).

Silverman, D. (2014) *Interpreting Qualitative Data (5th Edition).* London: Sage Publications.

Skinner, B. (1971) *Beyond Freedom and Dignity*. New York, Knopf Publishers.

Snowling, M. (2000) *Dyslexia: A Cognitive Developmental Perspective.* Oxford: Blackwell Publishing Ltd.

Smedley, A. and Morey, P. (2009) Improving learning in the clinical nursing environment: perceptions of senior Australian bachelor of nursing students. *Journal of Research in Nursing,* 15 (1), pp 75-88.

Smith, J., Bekker, H. and Cheater, F. (2011) Theoretical versus pragmatic design in qualitative research. *Nurse Researcher*, 18 (2), pp 39-51.

Stein, J. (2001)The magnocellular theory of developmental dyslexia. *Dyslexia: An International Journal of Research and Practice,* 7, pp 12-36.

St. Pierre, E. and Jackson, A. (2014) Qualitative Data Analysis After Coding. *Qualitative Enquiry,* 20 (6), pp 715-719.

Swain, J., Pufhal, E. and Williamson, G. (2003) Do they practice what we teach? A survey of manual handling practice amongst student nurses. *Journal of Clinical Nursing*, 12 (2), pp 297-306.

Taylor, L., Hume, R. and Welsh (2010) Labelling and self-esteem: the impact of using specific vs. generic labels. *Educational Psychology,* 30 (2), pp 191-202.

Tee, S. and Cowen, M. (2012) Supporting students with disabilities – Promoting understanding amongst mentors in practice. *Nurse Education in Practice,* 12, pp 6-10.

Unruh, L. and Zhang, N. (2013) The role of work environment in keeping newly licensed RNs in nursing: A questionnaire survey. *International Journal of Nursing Studies,* 50, pp 1678-1688.

Van Bogaert, P., Kowalski, C., Mace Weeks, S., Van heusden, D. and Clarke, S. (2013). The relationship between nurse practice environment, nurse work characteristics, burnout and job outcome and equality of nursing care: A cross-sectional survey. *International Journal of Nursing Studies*, 50, pp 1667-1677.

Van Manen, M. (1997) *Researching Lived Experience* (second edition). Canada: The Althouse Press.

Veeramah, V. (2012) Effectiveness of the new NMC mentor preparation course. *British Journal of Nursing*, 21 (7), pp 413-418.

Vygotsky, L. (1986) *Thought and Language.* Massachusetts, M1T Press.

Wadlington, E., Elliot, C. and Kirylo, J. (2008) The Dyslexia Simulation: Impact and Implications *Literacy Research and Instruction*, 47 (4), pp 264-272.

Walls, P., Parahoo, K. and Fleming, P. (2010) The role and place of knowledge and literature in grounded theory. *Nurse Researcher,* 17 (4), pp 8-17.

Walsh, D. (2010) *The Nurse Mentor's Handbook: Supporting Students in Clinical Practice.* Maidenhead: Open University Press.

Wang, S., Noe, R., Wang, Z. and Greenberger, D. (2009) What affects the willingness to mentor in the future? An investigation of attachment styles and mentoring experiences. *Journal of Vocational Behaviour*, 74, pp 245-256.

Williams, E. and Palmer, C. (2013) Benefits and challenges of critical care as a learning environment. *Nursing in Critical Care,* 19 (6) pp 310-315.

West, S., Clark, T. and Jasper, M. (2007) *Enabling Learning in Nursing and Midwifery Practice: A Guide for Mentors.* Chichester: John Wiley and Sons Ltd.

White, J. (2007) Supporting nursing students with dyslexia in practice. *Nursing Standard,* 21 (19) pp 35-42.

Willis, P. (2012) Quality with compassion: the future of nursing education. Report of the Willis Commission on Nursing Education. London: Royal College of Nursing. Available at: http://www.williscommission.org.uk/data/assets/pdffile/0007/495115/WilliscommissionreportJan2013.pdf. (Accessed Nov 2015)

Wilson, A. (1989) A new role for staff nurses: the effects of super-numerary students. *Professional Nurse*, 5, (2), pp 105-106.

Winterman, E., Sharp, E., McNamara, G., Hughes, T. and Brown, J. (2015) Support for mentors in clinical education. *Nursing Times,* 110 (51), pp 21-23.

Wright, D. (2000) Educational support for nursing and midwifery students with dyslexia. *Nursing Standard*, 14 (41), pp 35-41.

Yin, R. (2016) *Qualitative Research from Start to Finish (2nd Edition).* New York: The Guilford Press.

Zarif, T. (2012). Grounded Theory Method: An Overview. *Interdisciplinary Journal of Contemporary Research,* 4 (5), pp 969-979.

APPENDIX 1

Participant Information Sheet

Research Project: Dyslexia and Learning Difficulties: Nurse Mentors' Experiences With Students Who Struggle to Learn in the Practice Environment.

Name of Researcher: Linda Johnson

E-Mail - l.johnson@ucs.ac.uk

Tel. – 01473 338 502

Name of Research Supervisor: Dr. Jacqueline Watson

E-Mail – Jacqueline.Watson@uea.ac.uk

Tel. - 01603 592 924

Introduction

I would like to invite you to take part in the above research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Please feel free to contact myself or my research supervisor to talk over this invitation or for further information about anything that is unclear. Please take time to decide whether or not you wish to take part.

Purpose of Study

I am a nurse lecturer at University Campus Suffolk and I have an interest in the way that we as nurse educators feel able to support students who have learning difficulties such as Dyslexia. My interest started a few years ago when I had a highly intelligent and articulate personal student who had learning difficulties (Dyslexia and Dyspraxia). My experiences with this student proved to me that I did in fact know very little about how dyslexia affects the individual and what this means for them in terms of their ability and success in studying in higher education and in particular in learning in nursing environments out in practice. Research has already been done by

others into the nursing student's perspective of learning in the practice environment but I want to find out more about the mentors' perspective. What are your experiences and perceptions of working with and supporting dyslexic students in practice?

The Aim of This Research

- The aim of this research is to explore nurse mentors experiences with students who have (or may have) dyslexia/dyspraxia in the practice environment, with a view to analysing how your knowledge, understanding, training, attitudes, beliefs and values might impact on the support you are able to give to these students**.**

Why Have You Been Chosen?

You have been invited because you are a registered nurse mentor for adult branch student nurses. Other adult branch nurse mentors from a variety of backgrounds and nursing environments have also been invited to take part in this research project. It does not matter if you have not had direct experience of mentoring a student with learning difficulties (Dyslexia).

The initial invitation is to attend a focus group meeting with other participants (venue and time to be decided – travelling time can be claimed for but I'm afraid there is no budget to pay for your time). At the focus group meeting you will be asked to fill in a short, anonymous demographic questionnaire and then join in with a group activity aimed at helping with the exploration of issues relating to the support of students who struggle in practice. General discussion about the issues arising from the group work will follow, along with discussion around the potential impact of learning difficulties (Dyslexia) on the nurse mentor / student relationship. The session will last for one hour in total.

Some of the participants attending the focus group will be contacted following the focus group session and invited to attend an individual interview with a trained health professional where you will be asked to talk further about your personal experiences and views on the subject. The interview will last approximately 30 – 45 minutes and will take place at

your convenience in a suitable venue that provides some quiet and privacy. The health professional who conducts the interview will have your best interests in mind at all times.

What Will Taking Part in This Research Mean for You?

Your right to refuse this invitation, or to pull out of the research at any time, will be fully respected. You will be supported in your decision and you will not be required to give a reason why. Refusing or pulling out of the research at any time will not affect you adversely in any way.

In the interests of privacy and confidentiality your name and identity will not be recorded alongside any of the interview data – either from the focus group or from an individual interview. Codes will be used to identify all participant contributions. You will have the right to withdraw consent for the use of the data that you provide up until the point of analysis. Analysis of data from the focus group will begin two weeks after the date the focus group is held and analysis of data from individual interviews will begin two weeks following the date of the interview. Benefits to you would include some insight into the research process but also in the long run it is hoped that the research will provide insight into the needs of mentors in practice when supporting students who may have learning difficulties (dyslexia) which could result in improved training and support for mentors to manage these situations with more confidence and competence.

Having your best interests in mind throughout the research process will mean that any risks to you will be minimised. Thoughtful and professional treatment of any individual who finds an issue distressful to discuss will be paramount at all times and time and support will be offered to you to reconsider your contributions to the research at this or any other point. Any disclosure which is thought to constitute a serious breach of yours or another's professional code of conduct may mean that the interviewing process will need to be terminated and further action may need to be taken.

The discussion within the focus group and the conversations at the individual interview stage will be digitally recorded. Some written notes may be taken by the researcher along the way. All of these notes and recordings will be anonymised and kept under lock and key at all times when not in use. They will be destroyed at the conclusion of the research study.

There will be opportunities for you to review the findings of the research along the way and the overall results will be shared with you at a later date if you so wish. The researcher will occasionally need to check with you that the correct interpretation of your contributions has been made.

Any complaints about the research or how it is conducted should be directed to the;

Head of School: Education and Life Long Learning (Name to be included)

The University of East Anglia, (Full postal address with telephone numbers to be included)

APPENDIX 2

Informed Consent Form:

Research Project: Dyslexia and Learning Difficulties: Nurse Mentors' Experiences With Students Who Struggle to Learn in the Practice Environment.

Name of Researcher: Linda Johnson **Name of Research Supervisor:** Dr. Jacqueline Watson

E-Mail - l.johnson@ucs.ac.uk E-Mail – Jacqueline.Watson@uea.ac.uk

Tel. – 01473 338 502 Tel. - 01603 592 924

		Please Initial Each Box Below
1	I have read the Participant Information Sheet for this project and have understood the purpose of the study	
2	I have had the opportunity to ask questions and have received satisfactory answers.	
3	I am aware that my participation is voluntary. I am free to withdraw from the research project at any time without giving a reason and will be supported in this decision.	
4	I am aware that I have two weeks following the date of the focus group to withdraw consent for the data I produce in the focus group to be used.	
5	I am aware that I have two weeks following an individual interview to withdraw consent for the data produced in the interview to be used.	
6	I am aware of who will have access to the data, how the data will be stored and what will happen to the data at the end of the	

	study and that confidentiality will be maintained in accordance with the Data Protection Act 1998.	
7	I agree for the focus group to be audio recorded	
8.	I agree for the individual interview to be audio recorded.	
9	I agree for the work produced during the focus group to be photographed. **(Please note this *<u>does not</u>* include photographing of individual participants.)**	
10	I agree to anonymous quotations being utilised in publications.	
11	I agree to participate in the above research project by taking part in the proposed focus group.	
12	I agree to participate in an individual, one-to-one interview, as a follow up to the focus group, at a later date, if requested.	

Name of Participant ..... Signature .....

Date ..... (Version 3: 15/03/2013)

APPENDIX 3

Demographic Questionnaire

Participant No. 1

Research Project: Dyslexia and Learning Difficulties: Nurse Mentors' Experiences with Students Who Struggle to learn in the Practice Environment.

Name of Researcher: Linda Johnson

Name of Research Supervisor: Dr. Jacqueline Watson

E-Mail - l.johnson@ucs.ac.uk E-Mail Jacqueline.Watson@uea.ac.uk

Tel. - 01473 338 502 Tel. - 01603 592 924

		Please tick appropriate box below; Or fill in appropriate information
1 AGE:	20 – 30	
	30 - 40	
	40 - 50	
	50 - 65	

2 Gender	Male	
	Female	
3 Field of Nursing	Adult	
	Mental Health	
4 C.V. History	Date Qualified as a registered nurse	Month Year
	Date Qualified as a Nurse Mentor	Month Year

5	Length of time working as a trained Mentor		
		Acute Sector	Years Months
		Community	Years Months
		Other (please specify here) ----------	Years Months

6	How many students have you mentored in the last year?		No. of students mentored in last year.....

6	How would you rate your confidence in supporting a student who struggles to learn in the practice environment?		
		Very Good	
		Good	
		Generally Confident	
		Not Very Confident	
7	Have you had any personal experience with someone who has a learning difficulty?		

		Yes	No
7	How would you rate your confidence in supporting a student who has learning difficulties?		
		Very Good	
		Good	
		Generally Confident	
		Not Very Confident	

Appendix 4

Table 1: Demographic Details of Research Participants

Participant No.	M/F	Age Range	Years a nurse	Years a Mentor	Speciality	Confidence with Struggling Students	Confidence with Dyslexic Student
1 (FG1)	F	40-50	22	18	Adult - general	No response	No response
2 (FG1)	M	40-50	13	8	Adult - general	good	Good
3 (FG1)	F	50-65	34	10	Adult – acute	Generally confident	Not very good
4 (FG1)	F	30-40	10	3	Adult – acute	Good	Generally confident
5 (FG1)	F	40-50	20	15	Adult – acute	Very good	Good
6 (FG1)	F	40-50	17	12	Adult - acute	Good	Generally Confident
7 (FG1)	F	40-50	5	3	Adult - acute	Generally confident	Not confident
8 (FG1)	F	30-40	10	8	Adult - general	Not confident	Not confident
9 (FG1)	F	30-40	13	4	Adult - acute	Generally confident	Generally confident
10 (FG1)	F	50-65	30	12	Adult - oncology	Very good	Very good
11 (FG5)	F	50-65	33	8	Adult - acute	Generally confident	Generally confident
12 (FG6)	F	50-65	32	27	Adult - acute	Good	Good
13 (FG6)	F	50-65	38	17	Adult - acute	Very good	Good
14 (FG6)	M	50-65	28	27	Adult - general	Very good	Very good
15 (FG2)	F	30-40	11	5	Adult – acute	Not confident	Not confident
16 (FG2)	F	30-40	4	2	Adult – acute	Generally confident	Generally confident
17 (FG2)	F	40-50	21	8	Adult - acute	Not confident	Not confident
18 (FG2)	M	30-40	9	3	Adult - acute	Good	Generally confident
19 (FG3)	F	50-65	8	5	Mental Health - acute	Very good	Good
20 (FG3)	F	20-30	7	4	Mental Health - acute	Generally confident	Generally confident
21 (FG4)	F	40-50	12	9	Mental Health – secure inpatients	Generally confident	Not confident
22 (FG4)	F	20-30	3	2	Mental Health – acute	Good	Not confident
23 (FG4)	M	50-65	24	18	Mental Health - community	Good	Generally confident
24 (FG4)	M	20-30	4	3	Mental Health - acute	Generally confident	Generally confident

Key: (FG = Focus Group)

Table 2: Statistics Relating to Mentor Demographics

Aspect	FG 1		FG 2		FG 3		FG 4		FG 5		FG 6		Total	
AGE:														
20's	0		0		1		2		0		0		3	
30's	3		3		0		0		0		0		6	
40's	5		1		0		1		0		0		7	
50+	1		0		1		1		1		3		7	
Ratio: Male / Female	1:9		1:3		0:2		2:2		0:1		1:2		5:8	
Years a Nurse:														
Spread	5-34		4-21		7-8		3-24		8		28-38		3-38	
Mean	17.4		11.25		7.5		10.75		8		32.6		17	
Years a Mentor:														
Spread	2-15		1- 4.5		2-4		1-27		7		10-25		1-27	
Mean	9.3		2.6		3		8.8		7		20		9.75	
Confidence	ST st	D st	ST st	D st	ST st	D st	ST st	D st	ST st	D st	St st	D st	ST st	D st
Very Good	2	1	0	0	0	0	2	1	1	0	0	0	4	1
Good	3	2	1	0	0	0	1	2	0	1	2	0	7	5
Generally Confident	3	3	1	2	1	1	0	0	1	1	3	2	8	9
Not Confident	2	3	2	2	0	0	0	0	0	0	0	2	4	7

Key: (FG = Focus Group)

(ST st = struggling student)

(D st = dyslexic student)

APPENDIX 5

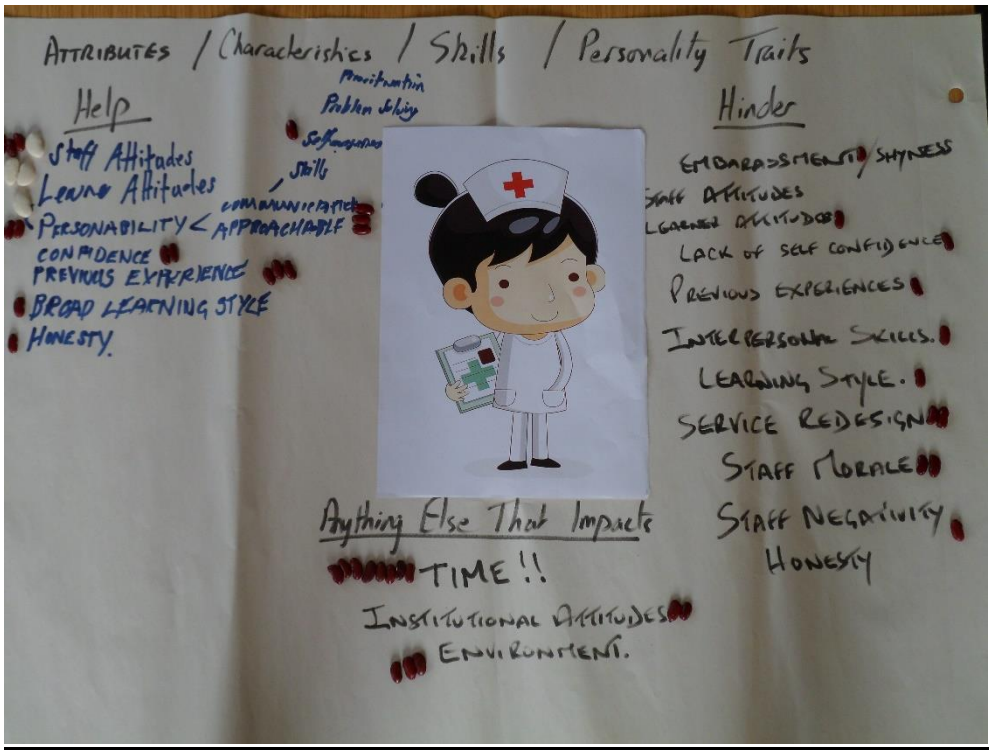
INTERVIEW SHCHEDULE – WAVE 1: FOCUS GROUPS

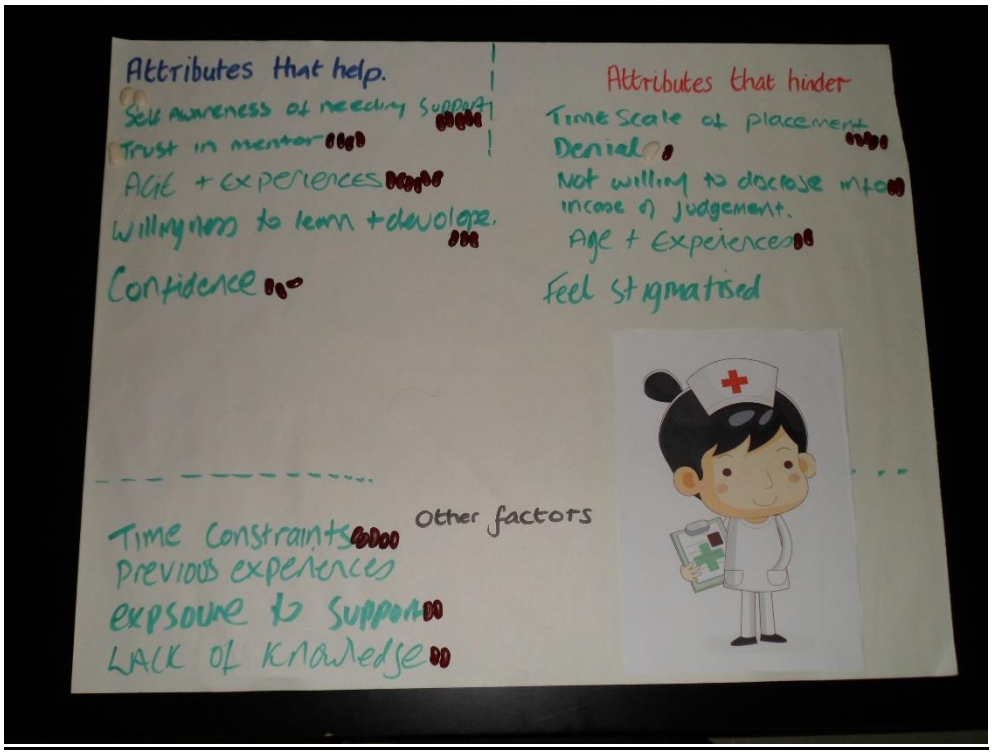
1. Welcome
2. Introduction from me: to include
    a. Introduction to study and topic area
    b. No right or wrong contributions – I am interested in a range of experiences and it is your opinions and experiences not mine that count. If you disagree with a voiced opinion then please let your disagreement be known.
3. Consent form and Participant information / right to withdraw
4. Demographic questionnaire and contact details / confidentiality / anonymity
5. Turn Tapes On
6. Participants to introduce themselves briefly
    a. Who are they?
    b. Where do they work (general area – not necessarily specific ward)?
    c. Where did they train?
    d. How long have they been a mentor?
    e. How do they feel about mentoring student?
7. Introduce Activity – explain requirements and get started
8. Discussion around activity
    a. Talk me through what you have put down.
    b. What have you got out of doing it?
    c. What are your conclusions about students who struggle to learn in the practice environment?
    d. What might be done to help?
    e. Is there anything anyone would like to add?
9. Discussion around learning difficulties
    a. What do you understand by learning difficulties
    b. What do you understand about reasonable adjustments?

10. Discussion around the role of the mentor
    a. How do you feel about mentoring a student who has a learning difficulty?
    b. What might help you feel prepared to support students with learning difficulties?
11. Does anyone have any other experiences or stories they would like to share?

APPENDIX 6

EXAMPLES OF GROUP WORK ACTIVITY





APPENDIX 7

INTERVIEW SCHEDULE - WAVE 2: INDIVIDUAL INTERVIEWS – EXPERIENCED MENTORS

1. Welcome
2. Re-iterate issues from consent form and gain verbal consent for interview. Re-iterate their right to withdraw at any time without prejudice.
3. Introduce and explain activity
    a. Discuss mentor's prioritisation of cards.
4. How do participants perceive their role as mentor?
    a. What is the role of the mentor?
    b. What does it mean to you to be a mentor?
    c. What is the hardest thing about being a mentor?
5. How do mentors go about working with students who struggle to learn in practice?
    a. What do students struggle with?
    b. How do you identify students who are struggling?
    c. How do you go about supporting these students?
6. What do mentors understand by dyslexia, learning difficulties and reasonable adjustments?
    a. What do you understand by dyslexia and learning difficulties?
    b. What do you understand by reasonable adjustments?
    c. What reasonable adjustments might you make in practice for students who have dyslexia or another learning difficulty?
7. Only one out of six of the focus groups held actually put dyslexia down on the group work activity. Are you surprised about this?
    a. Why do you feel this way?

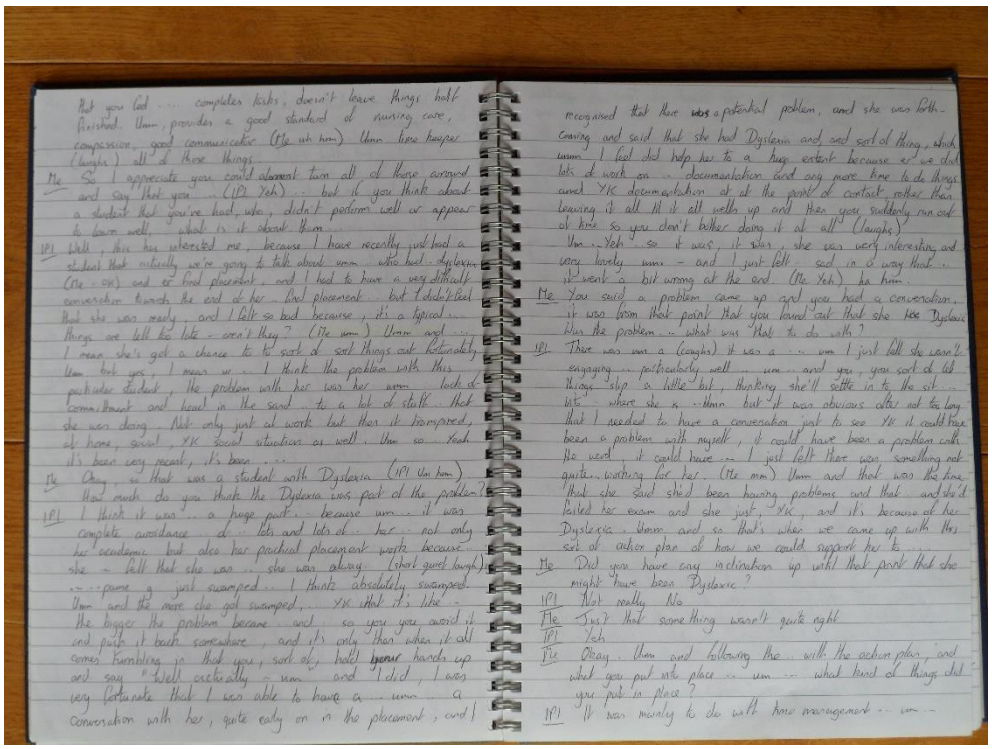
APPENDIX 8

INDIVIDUAL INTERVIEWS – WAVE 3: MENTORS WITH A LEARNING DIFFICULTY

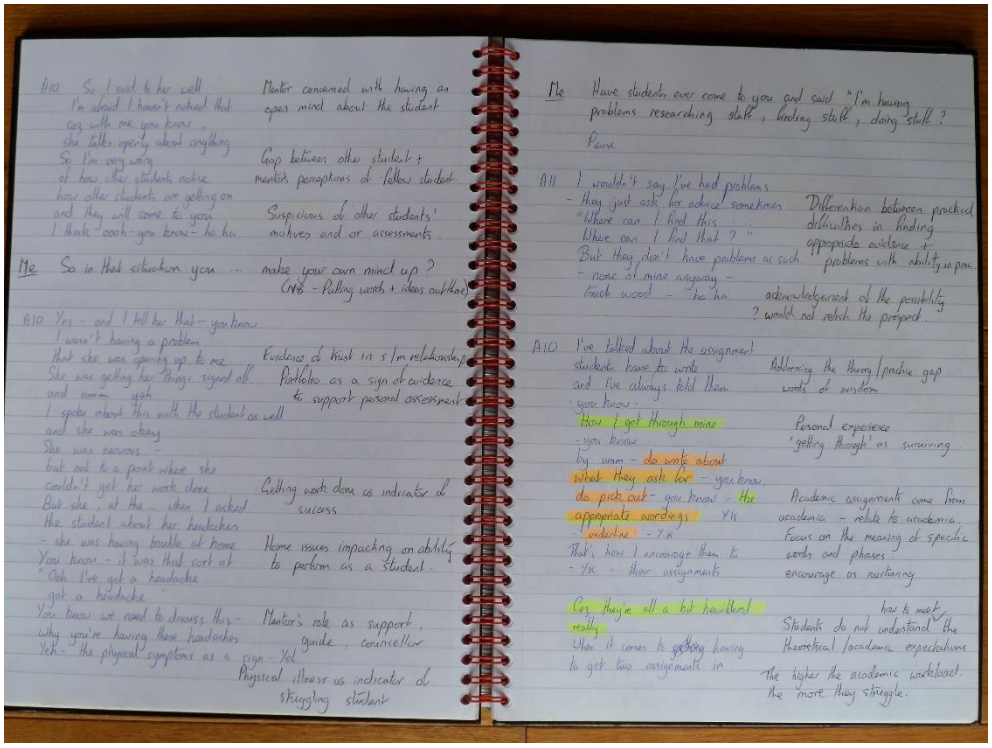
1. Welcome
2. Re-visit consent and right to withdraw at any time without prejudice.
3. Introduce Sort Card Activity
    a. Discuss mentor's prioritisation of cards
4. How do participants perceive their role as mentor?
    a. What is the role of the mentor?
    b. What does it mean to you to be a mentor?
    c. What is the hardest thing about being a mentor?
5. How has having dyspraxia / dyslexia affected your role as a mentor?
    a. What have been your main experiences?
    b. How have your experiences impacted on how you work with students?
6. What could be done to better support students who have a learning difficulty in practice?
7. Only one out of six of the focus groups held actually put dyslexia down on the group work activity. Are you surprised about this?
    a. Why do you feel this way?

Appendix 9

Photographic Example: Transcription by Hand



Photographic Example: Passage by Passage Coding



APPENDIX 10

Table to Show: Codes and Categories for Focus Groups and Focus Group Activity

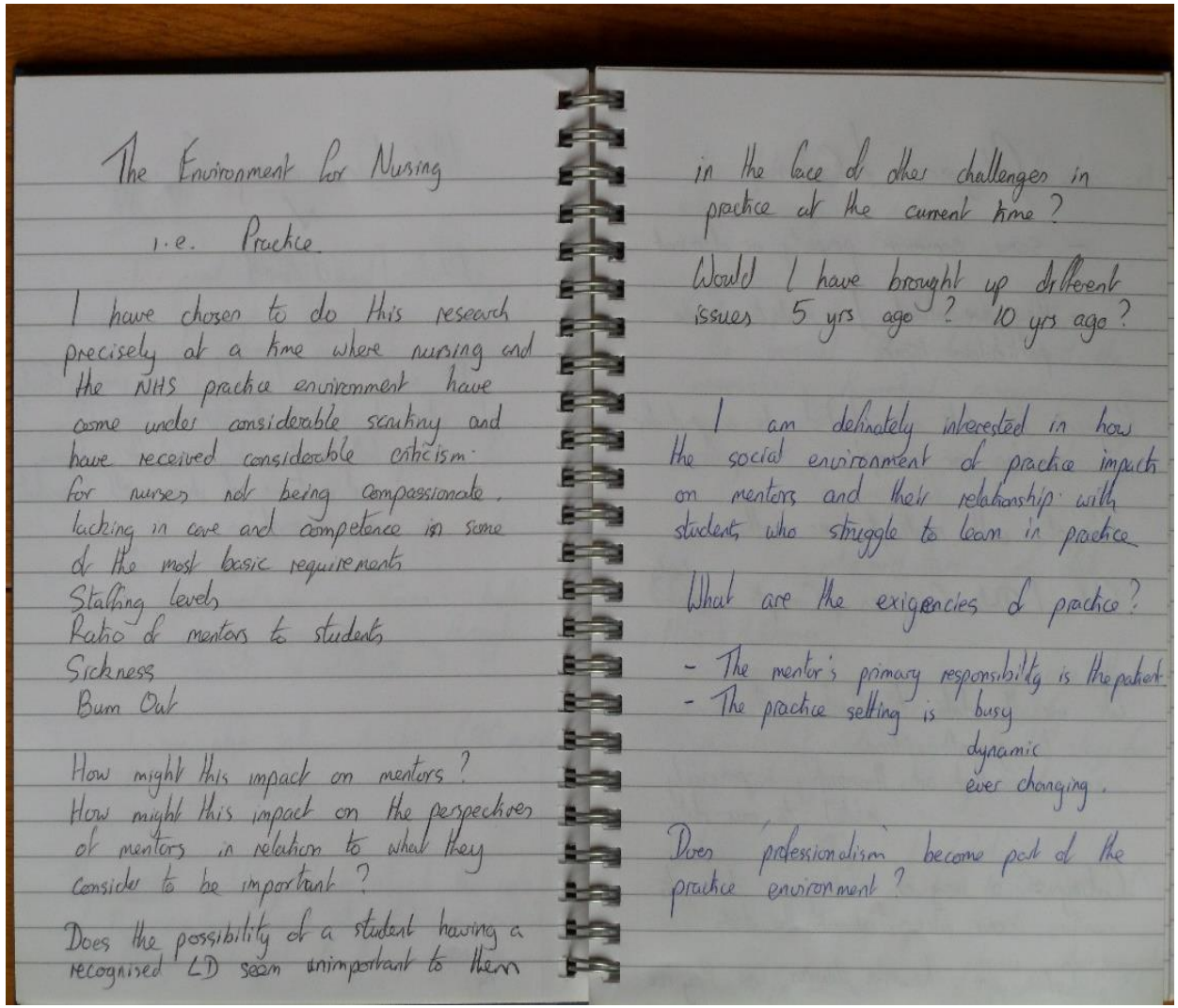
Codes and Categories	FG 1	FG 2	FG 3	FG 4	FG 5	FG 6
Mentor / Student Relationship	x	x	x	x	x	X
Time	x	x	x	x	x	X
Clashes		x	x		x	X
Role Model				X		
Trust		x				X
Rapport				x	x	
Honesty					x	X
Welcome			x		x	X
Inclusion			X			
Conversations		x			x	x
Mentor Experiences	x	x		x		X
Mentor Beliefs and Values				x	x	
Student Attributes	x	x	x	x	x	X
Enthusiasm	x	x	x	x	x	X
Confidence	x	x	x	x		X
Personable			x	X		
Empathy				x		X
Reflective					X	
Trustworthy					X	
Age and Experience		x	X			
Self-Awareness /		X				

Denial						
Other			x	x	x	X
Struggling Student	x		x	x	x	X
Sickness / Attendance	x		x	x	x	X
Avoidance	x		x		x	X
Slow		X				
Excuses	x			x		X
Lacking Skills		x	x		x	x
Working With Students	x		x	x	x	X
Teaching / Learning Style	x		x	x		X
Working Alongside	x				x	X
Failing Students				x	x	X
Small Steps / Small Successes					x	X
Challenging						
Individual Approach	x			x	x	X
Tradition			x	x		X
Environment Issues	x	x	x	x	x	X
Time	x	x		x	x	X
Busy	x	x			x	
Scary	X					
Importance for Learning					x	X
Mentor / Student Ratio			x	x	x	
Other					X	x
Academia not			x	x		x

Prized						
Outside Factors Important		x	x	x	x	x

APPENDIX 11

EXAMPLE 1: REFLEXIVE DIARY



The Environment for Nursing

i.e. Practice.

I have chosen to do this research precisely at a time where nursing and the NHS practice environment have come under considerable scrutiny and have received considerable criticism for nurses not being compassionate, lacking in care and competence in some of the most basic requirements
Staffing levels
Ratio of mentors to students
Sickness
Burn Out

How might this impact on mentors?
How might this impact on the perspectives of mentors in relation to what they consider to be important?

Does the possibility of a student having a recognised LD seem unimportant to them in the face of other challenges in practice at the current time?

Would I have brought up different issues 5 yrs ago? 10 yrs ago?

I am definately interested in how the social environment of practice impacts on mentors and their relationship with students who struggle to learn in practice

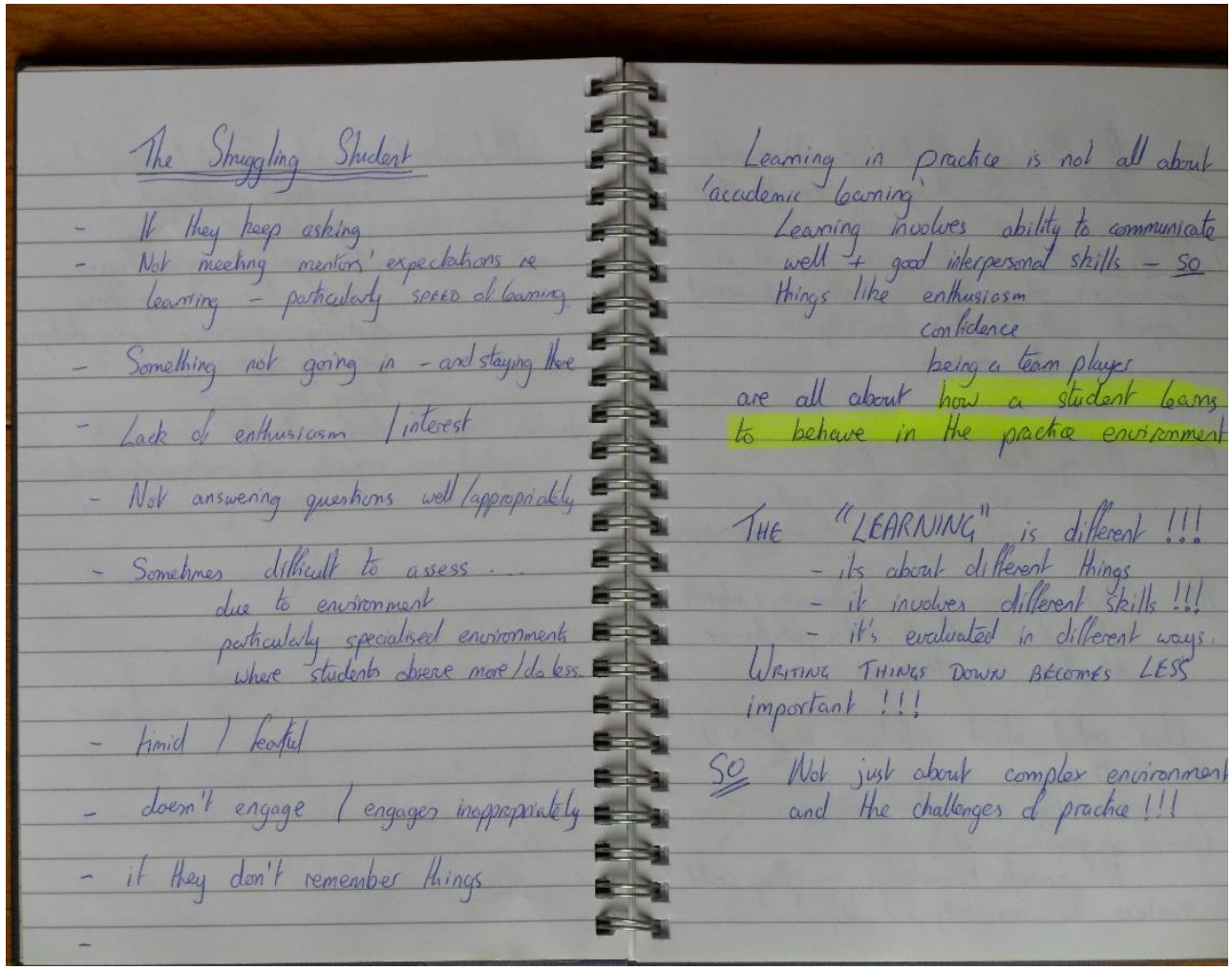
What are the exigencies of practice?

- The mentor's primary responsibility is the patient
- The practice setting is busy
  dynamic
  ever changing.

Does professionalism become part of the practice environment?

APPENDIX 11

EXAMPLE 2A: MEMO-BOOK



The Struggling Student

- If they keep asking
- Not meeting mentors' expectations re learning - particularly SPEED of learning
- Something not going in - and staying there
- Lack of enthusiasm / interest
- Not answering questions well / appropriately
- Sometimes difficult to assess ... due to environment particularly specialised environments where students observe more / do less
- timid / fearful
- doesn't engage / engages inappropriately
- if they don't remember things
-

Learning in practice is not all about 'academic' learning

Learning involves ability to communicate well + good interpersonal skills - so things like enthusiasm confidence being a team player are all about how a student learns to behave in the practice environment

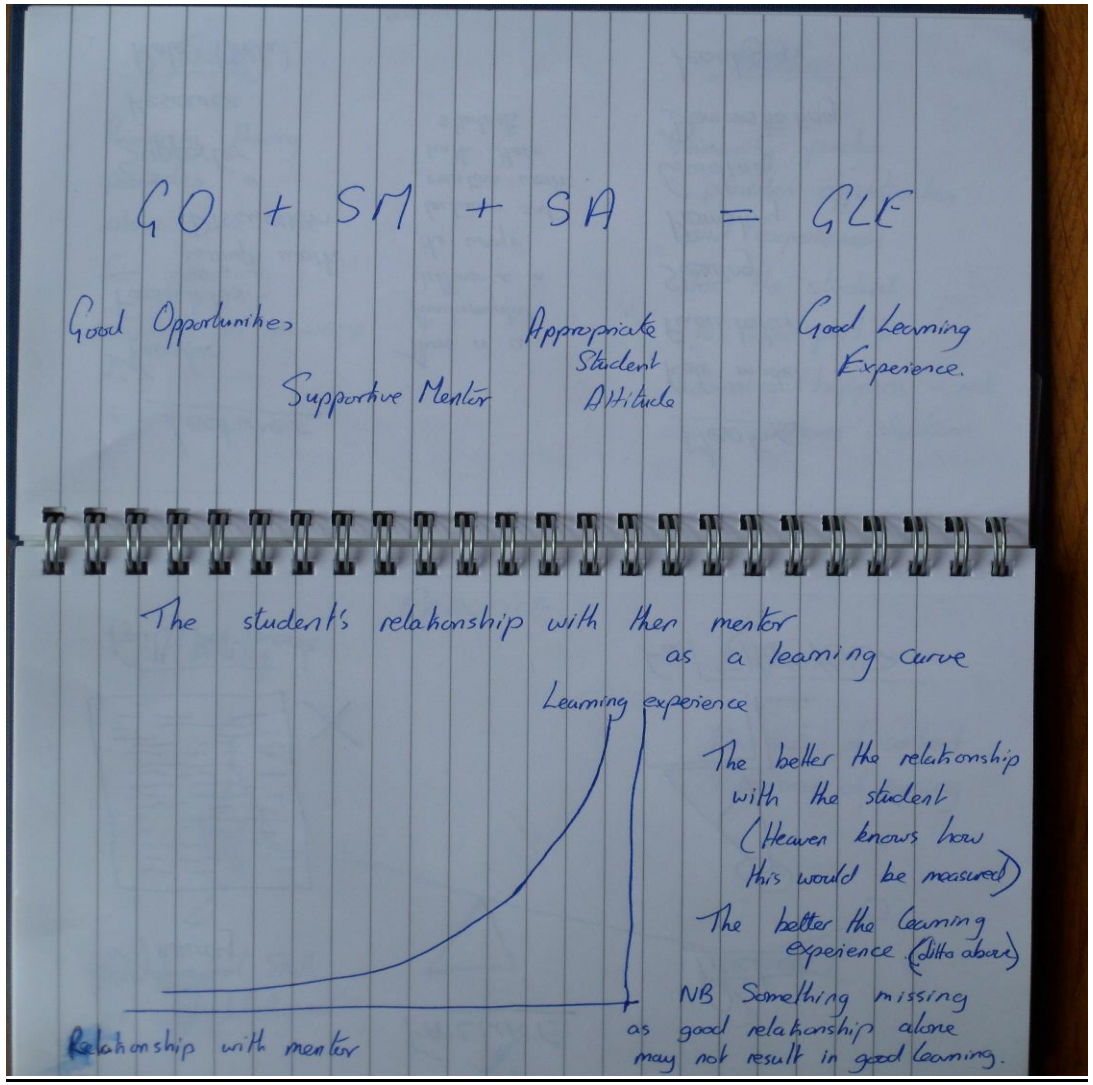
THE "LEARNING" is different !!!
- its about different things
- it involves different skills !!!
- it's evaluated in different ways.

WRITING THINGS DOWN BECOMES LESS important !!!

SO Not just about complex environments and the challenges of practice !!!

APPENDIX 11

EXAMPLE 2b: MEMO-BOOK



APPENDIX 12:

CODES FOR - FOCUS GROUP AND INDIVIDUAL INTERVIEWS (EXPERIENCED MENTORS)

Table to Show: Amalgamation of FG and GI Codes and Categories

Codes and Categories	GI 1	GI 2	GI 3	GI 4		FG 1	FG 2	FG 3	FG 4	FG 5	FG 6
Mentor / Student Relationship	x	x	x	x		x	x	X	x	x	x
Role of Mentor	x	x	x	x				x	x	x	X
• **Role Model**	x								X		
• **Teacher / Educator**	x	x	x	x							
• **Supporter / Listener**	x	x	x								X
• **Pastoral**	x		x					x			X
• **Welcoming / Inclusion**	x	x	x					x		x	X
Mentor Beliefs and Values	x	x	x	x		x		x	X	x	
• **Tomorrow's Nurses**	x	x		x							X
• **Tradition**	x	x				x		x	x	x	X
• **Personal Satisfaction**	x	x	o	x							
Student Attributes	x	x	x	x		x	x	x	x	x	X
• **Enthusiasm**		x				x	x	x	x	x	X
• **Confidence**	x	x	x	x		x	x	x	x		X
• **Self- Awareness**		x				x	x		x		
• **Expectations**			x			X					
Working With Students (To Build Success)	x	x	x	x						x	X
• **Conversations**	x	x	x	x		x	x	x	x	x	X
• **Enablement**	x	x				x			x		X

• **Working Alongside**	x	x	x	x						x	X
• **Failing Students = V Difficult**	x	x	x	x			x		x	x	X
• **Trust**	x						x				X
View of Academia											
• **Positive**	x			x		x		x			X
• **Negative**									x		x
Environment											
Time	x	x	x	x		x	x		x	x	X
• **Protected time**	x			x							
• **Time Out**			x	x			x			X	
• **Crucial Commodity**	x	x	x	x			x		x	x	X
• **Time for Mentor / Student Relationship**	x	x		x			x		x	x	X
• **Time for Reasonable Adjustments**									X		
• **Making Time for Dyslexia**		x		x					x	X	
Too Many Students	x	x	x					x	x	x	X
Difficult Place for Students	x	x	x			x	x	x	x	X	
• **Scary**	x					x		x			
• **Busy**		x	x			x	x			X	
• **Staffing**	x	x	x	o		x			X		
• **Morale**	x								X		
Outside Factors											
• **Positive Attitude Towards**		x	x			x	x			x	X
• **Negative Attitude Towards**				x						X	
Dyslexia and Learning Difficulties											
Knowledge and Understanding											
• **Just Spelling**	x					x		x	x	x	X
○ **Spelling**	x		x	x				x	x	x	X
○ **Writing**	x		x	x					x	x	X

○ **Reading**	x	x	x	x				x			
○ **Anything with Paper**	x	x	x						x		X
• **Memory**		o	x			X					
• **Seeing Things Differently**	x		x	x					X		
• **Dyspraxia**		x						x			X
• **Dyscalculia**	x			x						X	
• **Not a Problem in Practice / Academic Problem**		x		x		x	x	x	x	x	X
• **Not About People Skills**	x			x				x	x		X
• **Organised / Confident Student with Dyslexia**				x		X					
• **Worries**											
○ **Documentation**	x	x	x				x				X
○ **Medication**	x					x		x	x	X	
Disclosure	x	x	x	x		x	x		x	x	X
• **It would be Good to Know**	x					x	x		x	x	
• **Don't Ask**		x		x			x			X	
• **Confidentiality**		x	x	x			x				X
The Struggling Student	x	x	x	x		x	x	x	x	x	X
• **Avoidance**	x	x				x		x	x	x	X
• **Lack of Confidence**	x	x	x	x		x	x	x	x	x	X
• **Sickness**	x					x	x	x	x	x	X
• **Anxiety**			x					X			
• **Age and Experience**		x					x		x	x	
Political Correctness (Concerned)	x		x	x		x	x	x		X	
• **Non-Judgemental**	x	o	x	x		o		o		X	
• **Labels**							X				
• **LD v IQ**	+	-	+	+		+ & -	+				
• **Don't Ask (NB: from above)**		x		x			x			X	
Time is an Important Issue with Dyslexia	x	x	x	x	x	x	x	x	x	X	
Coping Strategies											

• **Let Them Guide You**	x									X	
• **Organised**	x		x				x	X			
• **Notebook**			x								
• **Questions**			x			x				O	
• **Reasonable Adjustments in Place**	Y	N		N			x	x		x	X
• **Confidence as a Coping Strategy**	x		x			x		x	x	x	X
Knows Someone with Dyslexia	x	x	x	x		x	x			x	X
• **Colleague**	2		1	1		x	1			1	1
• **Family Member**	1	1	0			x	1				1
Number of Students Mentored With Dyslexia	Few	Rare	1	1		Few		Few	Few		
• **Known**											
• **Possible**	x	x	x	x				0	1		
Findings From Focus Group Activity											
• **Surprised**				X							
• **Not Surprised**	x	x	x								

APPENDIX 13:

TABLES OF FULL DATA SET – CODES AND CORE CATEGORIES – WITH DATA LOCATIONS

Table to Show: Data Location for FG, GI and LD Codes and Categories: Mentor/Student Relationship

Codes and Category		**Wave 2** General Individual Interviews:				**Wave 1** Focus Groups:						**Wave 3** Learning Difficulties Individual Interviews:	
CATEGORY Mentor / Student Relationship													
2nd Level CODES	1st Level CODES	GI 1	GI 2	GI 3	GI 4	FG 1	FG 2	FG 3	FG 4	FG 5	FG 6	LD 1	LD 2
		Data Collection References: (page number, line number)											
Mentor Style													
	○ **Role Model**	(1, 9-10) (2, 13-14) (17, 27-28)		(2, 1)	(2, 5-14)								
	• **Teacher / Educator**	(1, 24-26)	(5, 14-15)		(3, 3-4)								
	• **Supporter / Listener / pastoral**												
	• **Challenger**	(5, 17-25) (5, 29-32)	(7, 1-10)	(3, 9-14)	(7, 1-5) (7, 15-19)						(5, 10-13)		
	• **Welcoming / Inclusion**	(5, 7-15) (6, 18-24) (6, 31-35)	(9, 1-4)	(1, 8-9) (2, 33-35) (3, 1-4) (3, 28-29) (6, 31-32) (9, 26-29)		(3, 27-29)				(3. 18-19)	(3, 25-31) (7, 33)		
	• **Motherly /**			(2, 2-3)	(4, 6-9)			(18, 10-11)					(13, 9-15)

Parenting Style												
Mentor Beliefs and Values												
• **Student Nurses are the Future**	(7, 15-18)	(5, 24-25)										
• **Personal Satisfaction**	(1, 30) (2, 7-8) (3, 21) (3, 9-12)	(5, 22-23)		(1, 12-13) (1, 19-20) (4, 18)						(10, 24-26)	(3, 6-10)	(14, 2-5)
• **Mentorship is an Important Role**		(2, 26-27)		(1, 13-15) (2, 33-34) (11, 19-21)	(1, 28-30) (4, 15-21)					(12, 18-19) (14, 17)	(1, 8-9) (4, 16-17)	
• **Letting students down**	(4, 7-8)		(1, 22-25)				(22, 30-33) (23, 1-6)	(11, 3-5)				
Student Attributes												
• **Enthusiasm**		(1, 4-8)		(5, 16-17)	(3, 3-5) (3, 7-9) (7, 4-8) (10, 17-19)	(1, 7-8) (6, 12-14)		(1, 3-4) (13, 6-12)	(1, 3-8) (3, 2-3)	(7, 9-14) (7, 21) (11, 6-8) (11, 26-27) (11, 32-34)	(1, 24-25) (2, 1-2) (5, 29-31)	
• **Confidence**	(7, 27-28)	(1, 17-23)	(6, 5-11) (9, 19-21)		(4, 7-15) (7, 1-2) (10, 22-31)	(11, 18) (14, 12-16)	(7, 13-15) (8, 4-6) (8, 28-30) (10, 8-9) (10, 26-29) (15, 1-4)	(6, 19-25) (12, 16-18) (12, 19-21) (15, 12-15) (27, 4-9)	(1, 12-13) (4, 30-32)		(2, 19-20)	(2, 1-5) (7, 29-30) (11, 21-23)
Working With Students												
• **Individual Approach**			(8, 13-18)			(8, 34-35) (9, 1-3)			(4, 5-6)	(4, 27-30) (7, 31-32)	(2, 2-4) (12, 3-10)	
• **Conversations**	(6, 6-10) (15, 35)	(8, 10-11) (11, 3-8)		(6, 5-6)				(5, 25-28)	(5, 34-35) (6, 1-3)			(1, 23-26) (2, 7-10)

	(23, 9-11)	(3, 21-24)							(6,18) (11, 28)			
• **Enablement**	(1, 12-14) (1, 29-30) (2, 27-30) (7, 15-16) (10, 1-2) (10, 11) (15, 33)		(1, 4-5) (6, 31-35)	(3, 19-20)								(2, 23-26) (7, 3-7) (12. 20-21)
• **Working Alongside**	(10, 23-27) (16, 14-19) (17, 4-12)	(10, 3-19)	(5, 5-11)	(3, 27-31) (4, 3-5) (7, 12-17)	(3, 12-14) (5, 8-10)		(20, 8-10)			(6, 17-21) (6, 28-33) (14, 6-9)	(13, 14-20)	
• **Failing Students is very Difficult**		(13, 10-27) (13, 29-30)		(5, 31-35) (6, 1-2)				(16, 13-14) (16, 36-37) (18, 10-5)		(15, 30-35) (16, 1-7)		(3, 9-21) (4, 4-6)
• **Trust**	(6, 14-17)		(4, 20-24)	(6, 34-35) (7, 1)		(1, 19-21) (7, 17-21) (7, 23) (8, 1-7) (9, 33-34)			(4, 28-29)		(1, 10-14)	
• **Intuition**		(6, 27-28) (7, 16-20)			(10, 1-6) (10, 13)		(12, 2-3)		(4, 3-4) (4, 14)	(13, 29-31)		
• **Use of Action Plans**	(3, 25-26)					(12, 19-20)			(6, 24-25) (8, 33-34)			

Table to Show: Data Location for FG, GI and LD Codes and Categories: Environment

	General Individual Interviews: Wave 2				Focus Groups: Wave 1						Learning Difficulties Individual Interviews: Wave 3	
Codes and Category	GI 1	GI 2	GI 3	GI 4	FG 1	FG 2	FG 3	FG 4	FG 5	FG 6	LD 1	LD 2
CATEGORY Environment 2nd Level CODES / 1st Level CODES												
Time												
• **Protecting time and Time Out**			(2, 14-20) (2, 23-26)	(9, 22-29)		(8, 18-19)	(18, 10-15) (23, 9-10)					(6, 8-13)
• **Time is an Important Commodity**	(3, 29-30) (4, 2-9) (4, 23	(2, 1-10) (6, 17-20)	(1, 16-17) (2, 10-12) (2, 22-26)	(1, 9-11) (5, 17-19)	(4, 1-5)	(2, 27-30) (3, 32-34) (4, 1-5) (8, 14-17)	(22, 29-30) (23, 9-10)	(2, 33-36) (3, 1-5) (5, 23-25) (10, 34-35)	(1, 4-5)	(2, 23-25) (7, 30)	(3, 30-35) (12, 19-25)	(1, 17-19)
• **Making time for students important**		(2, 9-10) (12, 2-3)							(1, 14-15)		(4, 1-4) (4, 22-23)	(1, 17-19)
• **Senior Staff have less time**			(1, 14-15) (1, 26-30)						(2, 16-21)		(3, 32-35	
Mentor / Student Ratio												
• **Too Many**	(4, 3-9) (7, 9-11)	(2, 14-25)					(11, 1-3) (23, 14-	(2, 33-35) (3, 1-5)	(9, 19-24)		(3, 30-34)	(13, 19-26) (13, 29-33)

Students / Not enough mentors							15)	(7, 24-26) (20, 9-11) (25, 27-29)				
• **Supernumerary Status of Students**										(2, 26-33) (3, 1-4) (5, 3-5) (7, 30)		(1, 7-11)
Difficult Place for Students												
• **Scary**	(2, 34-35)				(3, 23-27)		(3, 3-11) (5, 9-23) (6, 1-3) (6, 13-19) (7, 32-35)	(3, 3-5)	(6, 3)			(2, 3-5)
• **Busy / daunting / ever changing**	(2, 15-17) (23, 9-14)	(11, 16-18) (12, 12-18)	(1, 16-25) (2, 6-8)		(4, 14-20)			(5, 11-15) (11, 1-3) (7, 16-23) (8, 20-21) (9, 25-29) (11, 25-30)	(3, 3-5) (9, 12-17)		(5, 16-26) (5, 30-31)	(2, 2-5)
• **Staffing Problems and morale**	(2, 11-12) (21, 8-9)	(2, 15-25) (5, 6-7) (5, 11-12)					(23, 17-18)	(7, 1-3) (7, 5-6) (7, 8-15)			(3, 4-6)	
• **Effect of Ward Culture**	(2, 8-11) (2, 23-25) (20, 24-33)			(2, 8-11) (2, 21-22)			(17, 5-7)	(1,15-22) (1, 26-30) (5, 29-33) (3, 12-16) (6, 4-6) (10, 14-23) (11, 19-27)	(1, 17-18) (1, 25-29)	(4, 3-11)	(2, 29-30) (5, 3-7) (10, 16-35) (11, 5-10) (11, 20-21)	
• **Patients come first**	(6, 24-28) (7, 20-23)			(2, 22-24) (7, 29-32)	(3, 19-22)							
Outside Factors have an impact on student learning	(8, 2-6)		(4, 15-17)			(11, 24-28) (14, 17-25)	(8, 11-15) (8, 17-19) (11, 30-32)	(11, 35-36) (18, 1-9)	(1, 13) (1, 19) (11, 29-24)	(8, 33-35) (9, 9-11) (12, 31-36) (13, 13-16)	(3, 23-26)	

							(12, 6-13) (12, 30-34)			(13, 20-28) (14, 35) (15, 1-2) (15, 4-8) (19, 26-28)		
Practice Placements too short	(6, 15-17)	(8, 16-35) (9, 5-7)		(8, 8-14)		(1, 25-31) (8, 20-31)	(11, 16-17)	(14, 1-3) (14, 19-23) (26, 20-26)				(14, 2-14) (14, 18-22)
Theory/Practice Gap												
• **Academic Learning Different from Practice Learning**	(7, 6-8)	(10, 20-24)	(6, 14-26)	(3, 34-35)		(10, 22-25) (10, 27-28) (10, 29-34)		(3, 32-36) (4, 7-8)				(11, 28-31)
• **Practice more important than academic**				(10, 15-18)			(7, 27-30)	(16, 10) (23, 17-23)				
• **Liaison with academic staff**	(9, 13-16) (9, 24-27)	(3, 33-35)		(6, 4-5) (9, 12-13)	(14, 15-17)		(14, 4-5) (14, 9-10)	(12, 22)	(9, 27-30) (12, 21-23)			(12, 17-18)
• **More training on LD**					(15, 20-24)			(27, 13-22)				

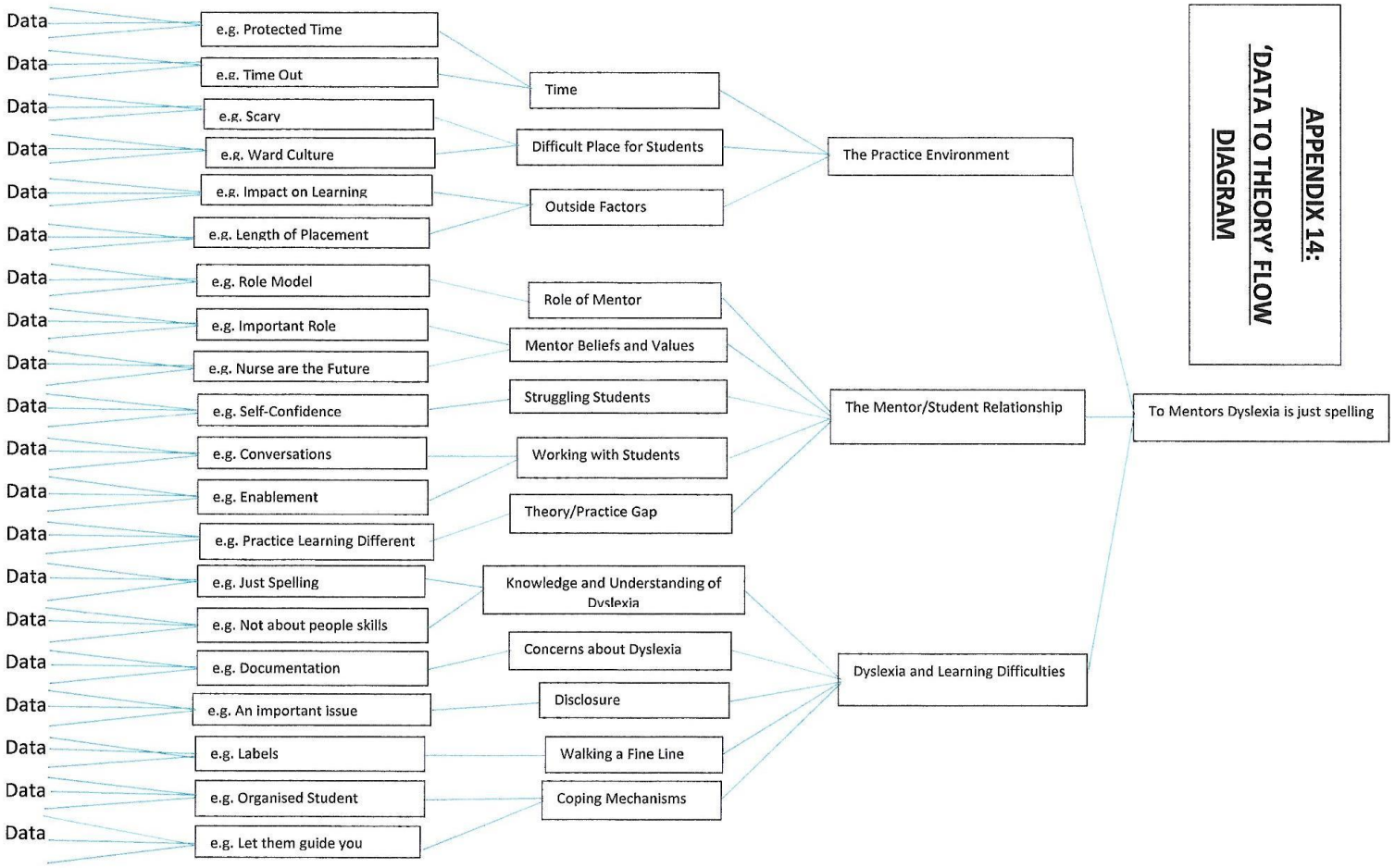
Table to Show: Data Location for FG, GI and LD Codes and Categories: Dyslexia and Learning Difficulties

	General Individual Interviews: Wave 2				Focus Groups: Wave 1						Learning Difficulties Individual Interviews: Wave 3	
Codes and Category	GI 1	GI 2	GI 3	GI 4	FG 1	FG 2	FG 3	FG 4	FG 5	FG 6	LD 1	LD 2
CATEGORY Dyslexia and Learning Difficulties												
2nd Level CODES / 1st Level CODES												
Not a Problem in Practice / Academic Problem	(8, 19-21) (12, 7-9) (15, 9-12) (19, 13-24)			(9, 1) (10, 23-29) (12, 16-17)		(6, 17-21) (10, 15-17) (10, 22-24) (14, 30-35)	(18, 1)	(20, 21-25)		(19, 15-23) (20, 28-31) (21, 5-10)		(2, 26-28) (5, 15-17) (11, 29-31)
Organised, confident students with dyslexia who disclose do alright	(19, 18-24)					(6, 17-21) (10, 15-17) (14, 30-35)		(21, 21-24)				(2, 26-28) (5, 15-17) (11, 29-31)
Knowledge and Understanding of Learning Difficulties												
• **Good**	(12, 1-35) (13, 4-13) (13, 33) (14, 5-9)				(12, 28-29) (15, 17-18)	(3, 30-31)	(17, 3-4) (19, 5-8)	(23, 1-12)	(10, 23-30)			
• **Not so Good**					(15, 3-7)	(9, 24-28) (16, 21-22)	(22, 11-24) (22, 23-24)				(17, 22-24)	
• **Spelling / Writing /**	(11, 32-35) (12, 1-3) (12, 4-6)	(4, 19-21) (12, 28-35)	(8, 29-31)	(8, 31-35)		(8, 24-25) (13, 23)	(17, 28-31) (18, 2-3)					

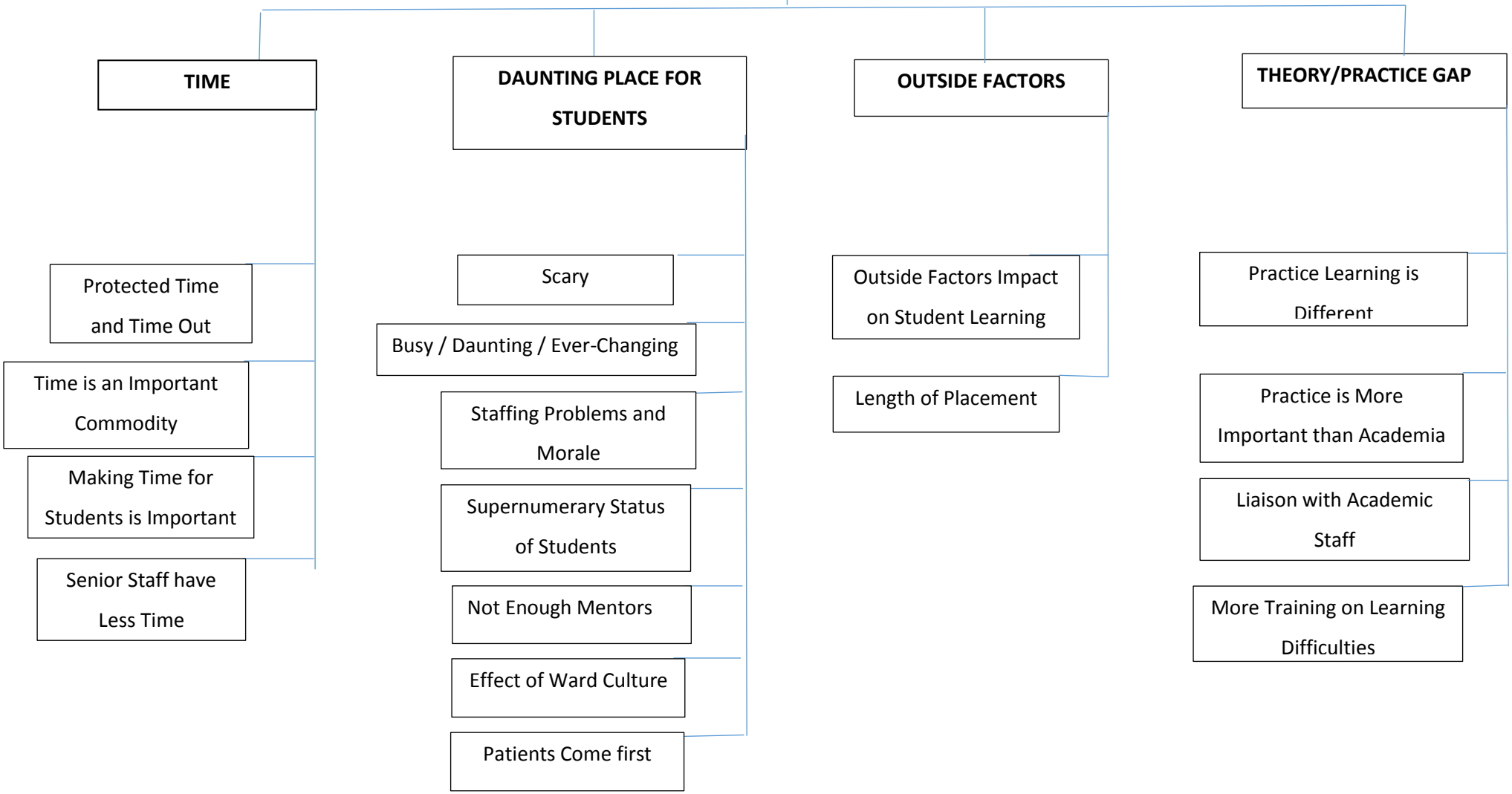
Reading / anything with paper	(13, 33)						(18, 25-27)					
• **Processing information / memory**	(10, 31-32)		(4, 2-3)	(6, 11-19) (8, 18-21) (11, 25-35)	(5, 23-29)	(13, 16-22)		(21, 14-15)				
• **Dyspraxia**		(4, 31-32)						(21, 21-24) (22, 1-10)				
• **Dyscalculia**												
Concerns About Dyslexia												
• **Documentation**	(9, 2-8) (16, 28-35) (20, 17-19)		(5, 27-35)	(9, 2-4)		(10, 16-19) (11, 4-8)		(23, 17-19)	(6, 3-7)	(11, 18-19) (20, 19-27)	(16, 29)	(11, 2-11)
• **Medication**	(11, 24-28) (15, 5-7) (20, 18-20)			(8, 27-30)	(5, 35) (6, 2-7)		(19, 23-25) (22, 30-34) (23, 1-6)	(20, 29-34) (21, 1-4) (21, 14-18)		(14, 1-3)	(16, 30-31) (17, 6-9)	(3, 2-3) (6, 27-30) (7, 20-23) (11, 14-15)
Disclosure is an important issue	(18, 19-30) (19, 2-5)	(12, 25-27)			(14, 6-10)	(2, 15-19) (6, 29-33) (9, 32-34) (12, 33) (13, 1-3)	(12, 2-4) (18, 15-17)			(19, 5) (19, 20)	(14, 8-9) (14, 19-27)	(2, 15-20) (3, 34-35) (4, 1) (6, 17-25) (12, 3-6) (12, 16-18)
• **It would be Good to Know**	(18, 21-22)		(9, 2-4)		(14, 1-12)	(11, 9-14) (12, 1-2) (12, 7-11) (16, 3-10)			(8, 19-21) (13, 1-8)			(11, 34-35) (12, 1) (12, 7-13)
• **Wouldn't Ask Student**		(3, 25-27) (12, 11-12)							(10, 7)			
The Struggling Student												
• **Avoidance / Sickness**	(8, 2-4)		(4, 14-18)			(11, 24-28) (14, 17-25)	(11, 30-32) (12, 6-13) (12, 30-34)	(11, 35-36)		(12, 31-36) (9, 13-16) (13, 24-28) (14-15, 34-35 & 1-2) (15, 4-8) (15, 17-19)		
• **Lack of Confidence**	(7, 27-28)		(6, 5-11) (9, 19-21)		(7, 1-2)		(8, 4-6) (10, 8-9) (10, 26-	(12, 19-21) (15, 12-	(1, 12-13)			(2, 2-5)

							29)	15) (27, 4-9)				
• **Age and Experience**		(8, 15-16)				(10, 2-7)	(7, 25-27)	(2, 16-20) (2, 23-28) (5, 33-35) (8, 33)	(1, 11-12) (1, 17-18) (1, 25-28) (1, 30)			
Political Correctness												
• **Non-Judgemental**	(9, 11) (11, 8-12)		(8, 8-11)			(3, 14-16) (12, 30-31)	(20, 17-24) (20, 17-24)				(15, 8-9)	
• **Labels / intolerance and bullying**	(14, 25-34)		(9, 5-8)	(10, 32-35) (11, 1-3) (12, 32-35)	(14, 13-14)	(2, 17-19) (3, 17-21)	(4, 10-14)				(12, 24-35) (13, 1-5) (14, 33-35) (15, 1-5) (15, 8-9) (17, 25-26) (18, 11-16)	(8, 34-35) (9, 1-6) (9, 28-31) (10, 1-3) (10, 8-12)
• **Learning Difficulty v IQ**	(10, 5-9) (13, 30-31) (13, 27-30)	(3, 8-16) (4, 16-19) (4, 31-35)	(5, 19-23)	(12, 32-35)							(9, 15-21) (12, 1-3) (15, 8-10) (15, 27-30)	(10, 1-6)
• **Wouldn't ask student**		(3, 25-27) (12, 11-12)							(10, 5)			
Time is an Important Issue with Dyslexia – extra time needed for dyslexic students	(12, 29-33) (13, 21-26)	(12, 2)		(9, 16)	(15, 8-13)		(22, 28-33) (23, 1-6)	(20, 21-26) (26, 27-35)	(7, 17-18) (12, 24-25)		(8, 6-10) (11, 31)	(4, 24-26) (5, 7-12) (8, 10-11) (11, 29-31)
Reasonable Adjustments												
• **In Practice**	(8, 30-33) (10, 13-17) (10, 19-23) (12, 20-24) (14, 26-34) (15, 23-28)	(4, 21-24)	(7, 8-11)		(14, 11-13) (15, 8-18)	(12, 17-18)		(25, 6-27)	(7, 23-29)	(15, 9-14) 20, 14-18)	(16, 29-32) (17, 10-11)	(4, 24-26) (5, 19-24) (5, 27-35) (6, 1-4) (10, 19-25) (10-28-29) (11, 2-11) (12, 25-35)
• **Practice**	(20, 20-21)	(3, 16-17)		(11, 6)			(23, 17-			(9, 20)		(10, 29)

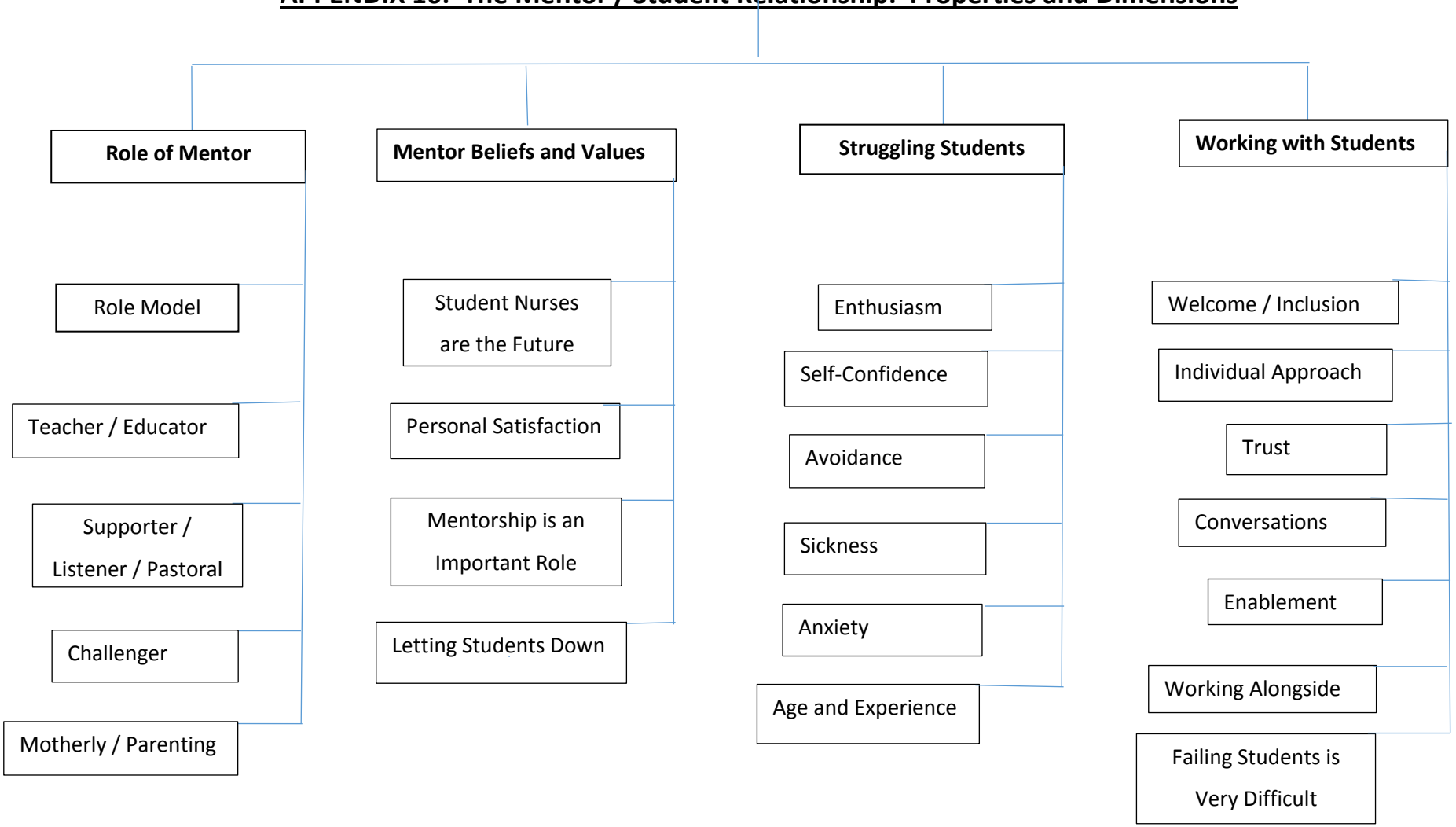
won't / can't change		(12, 2-3)					18)					
Knows Someone with Dyslexia												
• **Colleague**	(8, 17-20)		(8, 23-27)	(8-9, 35, 1)	(11, 21-32)	(4, 31-33) (5, 1-3)	(17, 15-25)	(22, 12-13)	(13, 31-34)	(18, 24)	(14, 28-34)	
• **Family Member**	(11, 13-14)				(13, 7-8)			(21, 25-34) (22, 2-7)		(17, 29-30)	(6, 5)	
Mentors who have supported a Dyslexic student												
• **Definite**		(4, 4-5)	(4, 30-36)	(9, 9-13)		(6, 17-21) (14, 29-32)	(17, 26-31)	(20, 19-21) (22, 30-34) (24, 4-18)	(5, 10-11)	(19, 1)	(13, 7-9)	(2, 23)
• **Never**					(12, 12)	(12, 23-25)		(23, 24-25)				
Findings From Focus Group Activity												
• **Surprised**				(12, 25-30)								
• **Not Surprised**	(21, 26-28) (22, 9-12)	(12, 7)	(8, 6-8)								(19, 6-7)	


APPENDIX 14:
'DATA TO THEORY' FLOW DIAGRAM
To Mentors Dyslexia is just spelling
The Practice Environment
The Mentor/Student Relationship
Dyslexia and Learning Difficulties
Time
Difficult Place for Students
Outside Factors
Role of Mentor
Mentor Beliefs and Values
Struggling Students
Working with Students
Theory/Practice Gap
Knowledge and Understanding of Dyslexia
Concerns about Dyslexia
Disclosure
Walking a Fine Line
Coping Mechanisms
e.g. Protected Time
e.g. Time Out
e.g. Scary
e.g. Ward Culture
e.g. Impact on Learning
e.g. Length of Placement
e.g. Role Model
e.g. Important Role
e.g. Nurse are the Future
e.g. Self-Confidence
e.g. Conversations
e.g. Enablement
e.g. Practice Learning Different
e.g. Just Spelling
e.g. Not about people skills
e.g. Documentation
e.g. An important issue
e.g. Labels
e.g. Organised Student
e.g. Let them guide you
Data

APPENDIX 15: Environment: Properties and Dimensions



APPENDIX 16: The Mentor / Student Relationship: Properties and Dimensions



APPENDIX 17: Dyslexia and Learning Difficulties: Properties and Dimensions