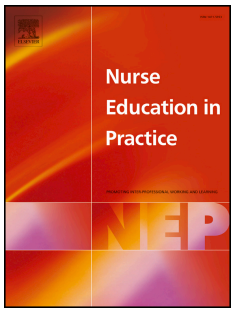
Accepted Manuscript



Revisiting task orientated care: Oral histories of former student nurses in Ireland (1960–2001)

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PII: S1471-5953(17)30791-6

DOI: 10.1016/j.nepr.2017.11.003

Reference: YNEPR 2328

To appear in: *Nurse Education in Practice*

Received Date: 26 September 2016

Revised Date: 28 September 2017

Accepted Date: 7 November 2017

Please cite this article as: Fallon, A., Chiardha, Toni.Uí., Meaney, T., van der Putten, D., Brennan, M., Chionna, Jackie.Uí., Bradley, S., McNicholas, M., Smyth, S., Revisiting task orientated care: Oral histories of former student nurses in Ireland (1960–2001), *Nurse Education in Practice* (2017), doi: 10.1016/j.nepr.2017.11.003.

REVISITING TASK ORIENTATED CARE: ORAL HISTORIES OF FORMER STUDENT NURSES IN IRELAND (1960-2001)

Acknowledgements

The authors wish to acknowledge funding received from the School of Nursing and Midwifery, National University of Ireland Galway.

Word Count

4996 words without references.

5765 words with references.

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REVISITING TASK ORIENTATED CARE: ORAL HISTORIES OF FORMER STUDENT NURSES IN IRELAND (1960-2001)

Highlights

- Tasks consisted of household tasks and tasks involving patient care.
- Student nurses learned the task by observing and imitating others.
- Student nurses were aware the task had to be completed quickly and correctly.
- Student nurses had coping strategies to deal with stresses surrounding the task.
- The task-person influenced student nurses' experiences more than the task itself.

INTRODUCTION

Task orientated care is a model of delegating nurses to patient care with a focus on the task rather than the patient. Task orientated care is arguably not commonly used today, but it is timely to revisit task orientated care, in light of the debate regarding student nurses' supernumerary status. Task allocation and supernumerary status influence the status of the student. Models of allocating nurses to patient care more commonly used today are, total patient care, team nursing and primary nursing care (Duffield et al 2010).

Nurse training and education in Ireland went through enormous changes during the twentieth century. The first training schools were established in the nineteenth century by religious orders (Scanlon 1991). Demands for regulation of nurses resulted in the Nurses Act 1919, and the establishment of the General Nursing Council to regulate registration and training of nurses. The provision of nurse training was influenced by two significant events in the early half of the twentieth century. They were national independence in 1922 and the establishment of the Hospital's Commission in 1933 (Scanlon 1991). The health service was established in 1947 (Barrington 1987) and following the Nurse Act 1950, An Bord Altranais

was established to take over the functions of the General Nursing Council in 1951 (Robbins 2000).

Membership of the European Economic Community (EEC) in 1973, was the most significant factor that influenced nurse education in the second half of the twentieth century in Ireland (Scanlon 1991), although the need for change had been highlighted earlier (Tracey 2005, O'Dwyer 2007). European directives led to increased theoretical input and a greater range of clinical experience to allow for mutual recognition of nursing qualifications between member countries (Robbins 2000). These events eventually led to a move away from the hospital based apprenticeship model of training to higher education in third level institutions in Ireland and the move to supernumerary placement for the student.

Since the 1990s in Ireland, the move to third level education changed the status of the student from hospital employee to supernumerary status. Supernumerary status requires that student nurses are surplus to ward staffing requirements while on clinical placement. The function of clinical placement is thus to learn through clinical practice, not just to work (Allan & Smith 2009). Supernumerary status has its limitations, resulting in on-going debate on its merits. There is an argument that supernumerary status aids learning (Shepherd & Uren 201), although there is an expectation that student nurses will contribute to the ward workload while learning (Allan et al 2011). It has also been reported that students can find it difficult to gain clinical practice experience with supernumerary status, especially if they are seen as observers (Allan & Smith 2009). Despite these apparent limitations, it has been argued that supernumerary status enhances the student and mentor experience (Shepherd & Uren 2014).

BACKGROUND

Several studies have examined the apprenticeship system of nurse education, which 'meant that nurses were initiated into a tradition and an organic community, of which ward sisters were the guardians, and which involved crucially the formation of character as its essence' (Bradshaw 2001, p. 29). During the apprenticeship model of nurse education, the student learnt quickly that there were unwritten rules, which suggested that students should 'pull their weight', work quickly and 'look busy' even if there was little or nothing to do (Melia 1987 p. 26). In addition, written and unwritten rules were enforced by the ward sister. Staff nurses and other students also enforced unwritten rules by more subtle social controls.

The apprenticeship system was based on the notion that students would automatically learn the skills of nursing as they worked in clinical areas and that trained nurses would teach and supervise learners as they worked (Marson, 1982). During the apprenticeship model of nurse training, tasks were allocated to students according to their stage of training. Simple tasks were allocated to the most junior. Task orientated care ensured the job got done as there was clear accountability for completing tasks.

Many studies from England and Ireland highlighted the inefficiencies and inequalities of nurse training where the student was both learner and worker (Bendall 1975, Fretwell 1982, Gott 1984, Melia 1987, Treacy 1987, Burnard and Chapman 1990) as was the case during the apprenticeship model of nurse education. Much of nursing care which was carried out in hospitals in England during the apprenticeship model was organised to service a prescribed routine (Menzies 1970, Bendell 1975, Orton 1981, Walsh and Ford 1989). This routine care consisted of various tasks to be performed by nurses at various times throughout the day. A study conducted in Ireland found that care delivered in this manner was fragmented, not person-centred, and there was less opportunity for continuity of care (Chavasse 1981). A

further study by Fealy (2006) on the history of nurse training in Ireland outlines that the student nurse was key to maintaining a task orientated approach to the work undertaken on the ward. However, no historical study has been undertaken that explores student nurses' experiences of clinical learning during the apprenticeship model of nurse education in Ireland.

Aim

To explore student nurses' learning experiences as students during the apprenticeship model of nurse training, and transition to third level education in a hospital in Ireland, through oral history.

The purpose of this article is to report on their remembered experiences of task allocation.

RESEARCH DESIGN

Oral history was used in this study as it provided access to a hidden world and gave a voice to those who otherwise would not have been heard (Kirby 2009, Hallett 2005). These aspects of oral history were particularly relevant as student nurses' voices, from the last decades of the twentieth century in Ireland have not been heard in academic and professional literature. Several studies have been undertaken on the history of nurse education in Ireland (for example: Scanlon 1991, Fealy 2006) however, none of these studies have drawn on oral histories as a primary source. Oral history can therefore fill in missing gaps in information, and provide further clarification on documentary sources used in other studies. Furthermore, a strength of oral history is that it can draw attention to the unique history of nurse education in Ireland, but also to the unique experiences of student nurses in an individual hospital in Ireland.

A major criticism levelled at oral history is that of faulty memory due to the passage of time. Oral narrators make up for this time lapse by virtue of the fact they will have had personal involvement with the event. It is also likely that stories will have been told over and over informally, thus enhancing the narrator's memory (Portelli 2016). In addition, there are issues of power in any relationship between interviewer and interviewee (Kirby 2009). All members of the research team who undertook oral histories were nurses and all had personal experience of the apprenticeship model of nurse training. This experience can be argued to have facilitated researchers' understanding and sensitivity towards participants' accounts.

Ethical approval was granted from the local research ethics committee. Twelve past student nurses who trained from the 1960s to 1990s were recruited to the study, through posters and fliers at the hospital where the study took place (Table 1). Nurses interested in participating were asked to contact a member of the research team. They were then sent an information letter and consent form. Participants were advised that they could withdraw from the study at any time.

Analysis of oral histories was undertaken using a practical approach to interpretation as outlined by Miller-Rosser et al (2009). This analysis process consisted of four levels. Level one involved collecting oral testimonies, where historical accounts of nurses' memories of training were accessed. Interviews took place at participants' venue of choice and were audio recorded with consent. Interviews took place between 2010 and 2011. To ensure anonymity and confidentiality, participants' names were assigned codes which were used on tapes and transcripts of oral histories. Interviews were carried out by a team of researchers. A semi-structured interview guide was used to explore nurses' memories of

their learning experiences as student nurses. At level two, participants' biographies were scribed and their learning environment was reconstructed through their oral testimonies. An insight into the social, traditional and cultural aspects of their clinical learning environment was achieved. At level three, themes that emerged from multiple participants' accounts were identified. Common themes or 'telling extracts' from participants' biographies were extrapolated (Miller-Rosser et al 2009, p. 479). Agreement on themes identified during this cross analysis was reached by three researchers. Finally at level four, a collective meaning or historiography was reconstructed around student nurses experience of task allocation.

Table 1 Oral History Participants

FINDINGS AND INTEGRATED DISCUSSION

Ten female and two male nurses were included in this study. To ensure anonymity analysis based on gender was not undertaken. Year of nurse training and education ranged from 1960-2001. Participants' names have been coded to ensure confidentiality. Codes represent year of commencement of nurse training. SA represents 1960s (S represents Sixties). Remaining S codes represent the 1970s. Similarly, codes commencing with E represent 1980s, and N represent the 1990s (Table 1). All nurses undertook their nurse training and education in the one hospital. The three areas that impacted on the student nurse's learning experience and which will be discussed here are, household tasks, tasks involving patient care and the task-person.

Household tasks

Abel Smith in his seminal work on the history of nursing wrote in 1960, 'If three years of training were needed in 1890, the period of training must now be too short. If three years are adequate now, three years must have been too long sixty years ago' (Abel Smith 1960, p. 243). The solution to this riddle was articulated at the inaugural meeting of the Nurse Tutors section of the Irish Nurses Organisation in 1961 by Miss E O'Sullivan, President. She stated 'The teaching of the student nurse must dovetail with the day-to-day running of the hospital as a service to the community. The student is not only a student, she is also a part time employee and her practical experience must not only meet her needs as a student but also the needs of the hospital' (Anon 1961, p.7). Being 'not only a student' required that the student nurse had tasks and responsibilities as a learner but also as an employee or worker. Nurses' testimonies reveal that student nurses had responsibility for a variety of tasks as hospital employees, chief among them being household tasks.

Household work included cleaning, dusting, and giving meals to patients. There was an emphasis on ritualistic cleaning practices, and *'the better you were at the cleaning, the more the sisters liked you*' (SE). There was a ward 'book' where students were allocated their tasks for the day. One participant explained, '*Your name was in the book and you'd see what you were doing that day, and the worst day was the sluice day because you never saw a patient all day long, bedpans and cleaning'* (EA). During the apprenticeship model of nurse training, nurses were seen as 'handmaidens, subservient, dependent and unthinking' (McKenna et al. 2006, p. 135). During the 1950s and 1960s, being kind, neat and amenable to discipline were valued as student nurse characteristics (Jinks et al. 2014). These characteristics suited an environment that was 'authoritarian, routinized and restrictive', as

the apprenticeship model was considered to be (Bradshaw 2001, p. 234). One nurse who trained in the 1960s commented:

> *Cleaning radiators; dusting radiators first. I suppose making beds in the morning, but I just have memories of being embarrassed. Wet dusting and dry dusting the radiators, putting the cloth through (SA).*

First year student nurses were allocated to the sluice room, this was graphically remembered by SA in the 1960s:

> *Washing all the bedpans, all the urinals. There was a bedpan washer but it never seemed to work properly, effectively shall we say. So, they had to be done properly. The urinals were soaked in disinfectant. Oh, not forgetting the sputum mugs, of course. Those horrible things, down the sluice.*

Similar experiences were recounted from the 1970s and 1980s where student nurses were under pressure while undertaking these tasks:

> *It was done, every day. Toilets cleaned. We did the toilets as student nurses, first year student nurses cleaned the toilets and hand basins. They were immaculate because the ward sister would walk around afterwards. Just when she'd be just on her look around she'd check and they were all clean. And all of that was done first thing in the morning* (SB).

> *It was all about work. You were paid so you work* (EA).

Meal time was equally ritualistic. Although student nurses ensured patients received adequate nutrition, they also had responsibility for serving meals to patients. The ward sister oversaw the work. A participant recounting an experience from the 1960s explained:

> *Ritual in the morning was you'd go like the clappers making the... feed the patients, serve breakfast, then feed those who needed to be fed and take the trays out. Trays... no, there weren't trays. It was a trolley. So, you put the cups on the top and plates on the lower and it clack, clack, clacked up the ward, and made sure that patients had enough, you know. You'd ask them if they needed more bread or whatever* (SA).

Lunch and dinner were particularly stressful for students as they were required to line up in front of the ward sister and know all patients' dietary requirements in detail. The ward sister dished up food from a large trolley in the ward kitchen. The student nurse then served the meal to the patient and returned to the kitchen to wait in line for the next meal.

> *When we'd be giving out dinners and you'd line up. You had to know what every patient had because, you're next. Who's this patient, what's wrong with this patient? Do you know anything about that condition, she'd ask, didn't matter if you were 1st or 3rd year. So you made sure you didn't line up unless you knew the next patient and what was wrong with them and you'd be checking and asking, what's wrong with her, what's wrong with her? What did she have done today?* (SB).

It is evident from oral testimonies that student nurses were under enormous pressure to meet the requirements of being 'not only a student', but also a hospital employee. Melia (1987) also found that one of the first tasks student nurses learned on clinical placement

was the ward routine where various tasks had to be performed at various times throughout the day.

Tasks involving patient care

The approach to patient care was a generalized one rather than an individualized one. Much of the nursing care was organised to cover a prescribed routine (Orton 1981, Walsh and Ford 1989). Student nurses learned tasks by observing and imitating what they saw. Oral testimonies revealed that student nurses were eager to learn and diligently observed nurses as they worked. SC remembers one of her first days on the wards in the 1970s, where she was inspired by a nurse giving a bedpan to a patient:

> *I remember this patient asked me for a bedpan and I remember I asked…I didn't know in the name of God where to turn, left, right centre and I remember the wards were impeccable clean and tidy then because of course we did the cleaning and tidying and I remember this nurse, I asked this nurse and she said, oh I'll get it! And she walked down to the sluice room. She got a bedpan and she put a green cover on it and she walked so smartly down the long ward, I thought if I am ever able to do that, I have it made. Just to be able to get a bedpan like that and walk down the long ward and serve it to a patient, I have it made, because she looked so, in that simple act she just looked so well doing it, and that's my abiding memory* (SC).

Tasks that involved direct patient care, included but were not limited to: feeding, bathing, bowel rounds, observation rounds, fluid chart rounds, drug rounds and dressing rounds. Student nurses really enjoyed tasks that involved direct patient care. EA from the 1980s described the joy when she was allocated to bath day:

> *But the day that you got the bath day, now that might sound boring but it was a great day, because you'd give all these patients a bath. You got a chance to go into the bathroom, talk to them for half an hour, take your time, close the door, big chats, bit of fun, they were great days* (EA).

If student nurses were having a difficult day with a staff nurse or ward sister, the patient usually came to their rescue. This was fondly remembered by SE in the 1970s. '*They [patients] knew you'd get into trouble and they would kind of tip you off if the sister was coming, or they thought there was something done wrong*'. In the 1980s EC recalled: '*They [patients] could see the way staff nurses would speak to you, very badly at times and you'd pull the curtains around the bed and sometimes they'd say to you, never mind her girleen. Have a sweet there girleen'.*

Despite a focus on tasks, nurses also remembered an ethos of care and wanting to do the best for the patient, '*It wasn't particularly patient centred, but you could be patient centred*' (EA). EC also recalled in the 1980s, on the last day in preliminary training school (PTS) introductory block where an ethos of care was evident in the classroom. Before going on the wards for the first time, one of her class mates started crying, and the tutor asked: '*what's wrong*'? Her class mate replied: '*I can't remember the 12 functions of the stomach*'! To which the tutor replied, '*No patient is going to ask you that, if you can't be caring, it's time*

to leave the room now. Are you able to do that'? And everybody looked, and she said. '*Nursing is about being kind. Can everyone in the room do that'*? Furthermore, EB recalled from 1980s that even though care was ritualistic, she remembered that nurses tried different methods to treat pressure sores, she recalled: '*They were actually looking for ways to heal things, unknown to them-selves, you know that sort of way. I know that now but then I didn't'* (EB).

Student nurses were not encouraged to talk to patients up until the 1990s as this was not seen as work, '*you were doing nothing*' (SB), '*so sitting talking to patients was always seen as, you always felt very conscious that it wasn't seen as work'* (ED). Students were reprimanded for talking to patients. *'You could be annihilated in front of a patient'* (SD). Students had to appear busy when talking with patients. They used different strategies to overcome this, for example talking to patients '*between lunches when ward sister was gone'* (SB) or pretending to be busy for instance to be '*fixing a bed*' (SB). Students experienced this up to the early 1990s. '*There was no such thing as pulling up a chair and talking to them. No way and if you were caught sitting on a bed, forget it. You were doomed*' (NA). In contrast two nurses from the 1990s identified practices that differed from previous decades in the way that they as students could talk with patients. This change coincided with a change in the structure and content of the programme, and an increase in theoretical input. NB recalled, '*You might sit down and chat to them [patients], and you know Sister certainly didn't like to see you standing around doing nothing, and you know if you were kind of not really sure what to do, you'd sit down and talk to the patients'*. This was validated by a second nurse from the 1990s, as not only were student nurses permitted to talk with patients, they were also becoming more aware and discerning when they spoke with

patients, *'On the wards we learnt a little more diplomacy, when to speak and when not to speak'* (NC).

Task allocation was evident up to the 1990s, NB recounted. '*There was no patient allocation, you just went from one bed to the other, but it worked. I mean it worked. It was organised chaos, but it worked*'. However, a move away from task allocation was also becoming evident in the 1990s, with the advent of clinical placement co-ordinators in the ward setting.

> *The other thing they [CPC] used to always push on us that it's not just task-orientated. They always taught that to us. It was difficult sometimes to implement that because it wasn't the system that was going on…It was quite a good thing she was trying to instil in us and I hope we all took that with us, but at the same time it didn't match with what was happening. Which I suppose is no harm because certainly there was a gap identified there. We realised, you know that there was a difference between theory and practice* (NB).

Student nurses learned tasks quickly by observing others. However, if the student was having a difficult day, the patient usually came to their rescue. Despite a focus on tasks, students observed an ethos of care, where they could be patient-centred in a task-centred world. They enjoyed caring for and speaking with patients. In the earlier years talking was not considered work and students were reprimanded for doing so. This began to change in the nineties, as it is evident that students were becoming more aware of the intricacies involved when interacting with patients. A questioning approach was not encouraged. Students became very skilled at completing the task to the requirements of the ward sister or staff nurse, but were not encouraged to question the method they were taught.

The task-person

The 'task-person' came in many forms, and delegated the task to the student nurse. Student nurses were positioned at the lower end of the hierarchical structure (Fealy 2006). The ward sister and senior staff nurse were the main task-people. They determined the allocation of tasks according to the student nurses' year of training. The 'guardian' of the apprenticeship system was considered to be the ward sister (Bradshaw 2001, p. vii). Student nurses were often placed under severe strain to undertake the task correctly, as remembered in the 1980s, '*You were terrified then… and you were afraid of doing something wrong'* (SE).

This hierarchical approach became all pervasive, and was quickly learned and replicated by student nurses as recounted from an experience in 1960s,

> *She looked like she was a figure in authority…she was probably just a little drier behind the ears than we were wet, and she was up at the end of the ward and I'm coming in along the ward and she said, "receiver nurse, receiver"! And I was thinking, Oh, telephone receiver was the first thing that struck me. But it was the authoritative way she asked for it, but I discovered she was about a class and a half ahead of me* (SA).

However, senior student nurses were also role models, as remembered by EB in the 1980s, '*they were our saving grace, the third years'* and ED in the late eighties/early nineties remembered, *A huge part of the role models for me and for a lot of my colleagues fellow students were more senior students*. Student nurses learned to cope by keeping busy, or appearing to be busy. According to EA, '*A good nurse was the busy nurse who got the most done'.* Appearing busy and staying below the radar was a skill in itself. Although student

nurses were a significant part of the workforce, their presence and contributions were not acknowledged. Treacy (2005, p. 42), in her historical work on nursing in Ireland, suggests that much of nursing work went unnoticed, which she describes as 'invisible nursing'. It is clear from nurses' accounts in this study, that student nurses were well practiced in the art of being invisible. EB from the 1980s explained, '*You just had to learn to weave through the ward, or how to hide as we say, hide effectively'.* This was also supported by EA's memories from the 1980s, '*I was very good at ducking and diving'* (EA), and when it came to contributing to ward rounds or being included in discussion about patient care, she recalled, '*Never, we were invisible'* (EA). These memories of not being included or acknowledged, continued well into the nineties, NA remarked: '*There was no leeway. There was no compromise. There was no discussion. There was no questioning. Questions didn't really happen'* (EC). This is not surprising, as the notion of the 'good' nurse who did not question was very much a child of the apprenticeship system (Kelly and Watson 2013, p. 1).

In addition to dealing with the hospital hierarchy, the student nurse was required to accompany the priest as he gave Holy Communion to patients. The student nurse had to ensure that both the ward and patients were prepared. There was a sense of urgency that everything had to be ready for the arrival of the priest. This was a major source of stress for student nurses as this task was their responsibility. One nurse remembered the adulation that existed for, '*The priest and the professor of medicine. Everyone stood back*' (SC). In preparation for the arrival of the priest,

> *You had to have the covers on the bed. We had blue and pink ones, so you had to have alternate beds, blue and pink down the long ward and you had to make sure that the proper corners were on the beds and that there was absolutely nothing on*

> *the floor and that the poor patient in the bed was sitting up straight and looking at the priest when he came. It wouldn't do for them to be lying down at all. Oh. It was major* (SB).

The practice of escorting the priest as he gave Holy Communion to patients, continued into the 1980s,

> *He'd arrive on the ward he'd ring the bell and there would be a mad flurry. Who's on obs? You know, it didn't matter what patient you were with. You dropped all. You dropped all…You went around in front of Father with the bell ringing. The priest is here. The priest is here. All went quiet. All went completely quiet* (EC).

Catholic Priests were also directly involved in teaching student nurses by providing lectures on ethics. Ethics became an issue in nurse training in the 1950s, from the controversy that existed over the proposed mother and child scheme. A syllabus on ethics was approved by the Archbishop, and taught by priests. Following the Nurses Bill in 1984, An Bord Altranais was given power to provide guidance on ethical conduct and behaviour of nurses (Robbins 2000).

Student nurses' learning experiences of tasks appear to be influenced more by the task-people than the task itself. The task-person, especially the ward sister was a particular worry for the student nurse. However, the student nurse coped with this by using strategies to avoid the ward sister and appear busy. This was easily done as the student nurse believed that she was already invisible to those in authority. In addition to the ward sister and senior staff nurse, the student also had the priest as a task-master, and during a busy morning would have to stop everything to attend to the priest.

CONCLUSION

This study explored nurses' experiences of task allocation during their student years, using oral history testimonies. The three main areas that impacted on students were household tasks, tasks involving patient care and the task-person. Household tasks were particularly onerous on the student nurse. Household tasks consisted of cleaning, dusting and serving meals to patients. Tasks were regimented and routine. Being 'not just a student', but also a hospital employee resulted in the student having a clear role as worker, not just learner. Therefore, working rather than learning was the priority during practice placements.

Tasks around patient care were also regimented and routine. Tasks were organised around the ward schedule, rather than the needs of patients. However, in comparison to household tasks, students particularly enjoyed these tasks with patients. Often, patients came to the rescue of student nurses if they were having a bad day. Even in a task orientated environment nurses remembered an ethos of care. Talking with the patient was not considered work in the early decades, but by the nineties this was changing and communication with patients rather than talking was given greater recognition. As a hospital employee, students undertook tasks involving patient care based on their year of training. The student could not question, and the purpose of learning a skill was not only to meet students' learning needs, but to meet the hospital's needs.

Finally, nurses' memories suggest that the task-person had more influence on the task than the task itself. The ward sister was the principal figure of authority for the student nurse. The student nurse was at the lower end of the hierarchy and therefore was not in a position to refuse a request to undertake a task, from anyone. The student nurse used many strategies to avoid those in authority, by appearing busy and being invisible. As a result,

students' learning was not prioritised. The findings from this study suggest that the clinical learning environment significantly influences students learning. Therefore, an environment that is inclusive, supportive and understanding of students' learning is recommended, regardless of the model of nurse training or education that might be in place. This study will contribute to the limited evidence that exists on student nurses' learning experiences generally, but task allocation specifically, during the apprenticeship system of nurse training in Ireland in the twentieth century.

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CONFLICT OF INTEREST

Six authors had previous employment in the hospital where the study took place.

Table 1 Oral History Participants

Participant	Training years
SA	1960s
SB	1970s
SC	1970s
SD	1970s
SE	1970s
EA	1980s
EB	1980s
EC	1980s
ED	1980s
NA	1990s
NB	1990s
NC	1990s