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Non-nursing tasks as experienced by nursing students: Findings from a phenomenological interpretative study

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ABSTRACT

Background: During their clinical learning experience, students are exposed to the nursing profession as a powerful structural reality, experiencing the so-called professional socialisation, a process recognised as the basis of professional identity. Inside this process, students progressively acknowledge their professional identity as being composed of several competencies and, among these, also non-nursing tasks.
Objectives: To explore non-nursing tasks in the context of nursing students' clinical learning experiences.
Design: An interpretative phenomenological study design was performed and carried out in 2016. The COnsolidated criteria for REporting Qualitative (COREQ) research principles were used in reporting study methods and findings.
Setting: Two Italian Bachelor of Nursing degree programmes located in Northern Italy.
Participants: Students attending their nursing programmes who a) had successfully passed one or more theoretical examinations; b) had one or more clinical learning experiences in varied contexts (e.g. hospital, community); c) were attending the 1st, 2nd or 3rd year, and d) were willing to participate, were interviewed with an open-ended, face-to-face, audio-recorded interview.
Methods: A thematic analysis was performed.
Results: Participating students (n = 18) were between 20 and 25 years old and were attending the 1st to the 3rd (and final) academic year. Non-nursing tasks were experienced by them according to three main themes: a) "Being out of the scope of the learning experience," b) "Being forced by external and internal forces," and c) "Dealing with mixed outcomes by looking for a compromise." All students have reported learning to perform non-nursing tasks by shadowing clinical nurses and also practising these tasks by themselves. Internal and external forces prompted students to perform non-nursing tasks, which were recognised as having positive, negative, and neutral effects on themselves and on their learning outcomes.
Conclusions: Non-nursing tasks are acquired since the beginning of the clinical experience, thus shaping the nursing students' professional identity. At the undergraduate nursing level, strategies should be implemented to prevent the phenomena that a) threaten the acquisition of more complex nursing competences expected by patients and society, and b) shape future generations to be flexible and to perform different tasks, included those below their role.

1. Introduction

An increased concern has recently emerged internationally regarding the amount of non-nursing tasks expected of nurses (Bruyneel et al., 2013; Veličković et al., 2014), which have been reported as occupying from 35% (Fitzgerald et al., 2003) to 62% of the entire nursing-shift duration (Bruyneel et al., 2013). Non-nursing tasks have been defined as the condition where clinical nurses perform tasks below their scope of practice (Veličković et al., 2014), including housekeeping duties, delivering or retrieving food trays, transporting non-critical patients, doing administrative work, filling in charts and forms, answering phone calls, calling health-care workers or family caregivers, or

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waiting for something/someone (Bruyneel et al., 2013; Kearney et al., 2016; Veličković et al., 2014).

Factors at the health-care institutional and at the professional levels have been recognised as antecedents of the increased burden of non-nursing tasks (Bruyneel et al., 2013; Veličković et al., 2014). Moreover, in light of professional socialisation and identity development processes, factors at the educational levels have also been recently recognised (Bruyneel et al., 2013).

The purpose of nursing education is to create a professional identity as well as competences expected of nurses at the entry level, through different learning processes, where professional socialisation has been considered crucial (Scully, 2011). At entry level, nurses are required to function as: a) an independent practitioner, thus being able to perform the responsibilities expected only of nurses; b) a dependent practitioner, thus capable of e.g., administering medical orders and treatments; and c) an interdependent practitioner, thus possessing responsibilities that nurses share with other members of the health-care team, e.g. ensuring patient safety (Kearney et al., 2016).

Through professional socialisation, which is highly contingent and contextual, students are provided with an ordered view of professional life, they are shaped in their intra- and extra- professional relationships in the work environment; moreover, they are also provided ground rules for everyday conduct of nursing practice (Van Maanen and Schein, 1979, p. 4). Furthermore, according to Clouder (2003), professional socialisation is based mainly on two processes: a) "*learning to play the game*", where nursing students learn by witnessing the role played by nurses in daily practice, and b) "*self-presenting*" where students develop an identification process that will result in a better fit within the professional role's spaces and boundaries. In this context, shadowing nurses doing non-nursing tasks, or performing nursing tasks as part of the learning process can critically influence early professional socialisation for nursing students.

In dealing with the reality of the nursing profession, nursing students have been recognised to have little power, functioning mainly as passive recipients who are progressively shaped into what the profession considers as "*good*" nurses. Thus, students can experience the theory–practice gap, the distance between the role expected and its presentation in the real world (Scully, 2011); they can also experience role confusion, ambiguity, and lack of clarity (Takase et al., 2006; Tunc and Ozen Kutanis, 2009) which can threaten their identity development as a nurse and increase their propensity to drop out of university (Dante et al., 2016). Furthermore, when nursing students prove themselves unable to match their role expectations with the reality, they can experience the so-called *reality shock*, a concept firstly introduced by Kramer (1974).

Despite its relevance, to the best of our knowledge no study to date has attempted to describe non-nursing tasks as experienced by nursing students during their clinical rotations and, more generally, to identify and discuss them as a component of the early professional socialisation process in nursing (Price, 2009). Therefore, the aim of this study was to explore non-nursing tasks as experienced by nursing students during their early professional socialisation in clinical learning environments.

2. Methods

2.1. Study design

This is a nested study devoted to nursing students within a large study called "ExpeRience, Antecedents and consequences of non-nursIng task Project" (APRI project, Grosso et al., 2019) developed by the Nursing Board of Belluno (Italy) and aimed at identifying non-nursing tasks' occurrence, antecedents and consequence among registered nurses.

Specifically, an interpretative phenomenological study design (De Chesnay, 2015) was performed with the aim of: a) providing a detailed account of students' real-life experiences in their own terms rather than according to pre-existing theoretical frameworks; b) trying to make sense of what is experienced by each student with regards to non-nursing tasks; and c) emphasising the idiographic nature of their non-nursing tasks learning experiences (Pringle et al., 2011).

The study was performed in 2016 and reported here according to the COnsolidated criteria for REporting Qualitative research (COREQ) principles (Tong et al., 2007).

Table 1
Setting features.

Two Italian Bachelor of Nursing Science (BNS) programmes located in the North of Italy were approached, with 180 and 430 students, respectively. By the law, they were three years in length.
In both programmes, the clinical experience was offered at the end of the first theoretical semester of the 1st year, devoted to the acquisition of the fundamental concepts of nursing care. Then, clinical rotations were offered in the 2nd and in the 3rd year, with an increased number of hours, reaching 1800 in total before graduation.
Clinical competency aims were defined according to the professional profile expected at the entry levels by Italian law and shared with the clinical instructors at the unit levels.
Students were expected to attend 34 h/week on average; they were considered as supernumerary in the clinical settings and their supervision was held by a clinical instructor, as an expert nurse, trained in pedagogical methods.
At the faculty levels, expert tutors encountered the students on a periodic basis, conducting in-depth debriefings of their clinical experiences and promoting the critical appraisal of their learning processes.

2.2. Participants and setting

A purposeful sample of nursing students was approached (Graneheim et al., 2017) in two Bachelor of Nursing Science Degrees (BNS Degree named 'A' and 'B') located in two distinct universities of North Italy and homogeneous in their curriculum as assessed on a preliminary fashion (Table 1). To ensure the highest variability of experiences (Vaismoradi et al., 2013) students who: a) had successfully passed one or more theoretical examinations, b) had one or more clinical learning rotation in diverse contexts (e.g., hospital, mental health), c) were attending the 1st, 2nd or 3rd year, and d) were willing to participate, were considered eligible. An initial list of 22 students belonging to both campuses was identified and progressively included; as the approach emphasises variation in content and multiplicity of experiences aimed at covering significant variations (Graneheim et al., 2017), participant recruitment ended when saturation of data was achieved (Vaismoradi et al., 2013) and this occurred when 18 students were included, as judged independently and then agreed upon by three researchers. All students invited agreed to participate and gave their written, informed consent; those who agreed to participate and who were not interviewed according to the saturation achieved were immediately informed.

2.3. Research team

The research team was composed of: a) faculty members ($n = 3$, with advanced education in nursing and in organisational disciplines, 2 of them were female), b) a female clinical nurse educated at the university level; and c) of nurses working at the managerial levels ($n = 3$, all with advanced education in nursing, 2 of them male); moreover, one student in her 3rd and final year of nursing education was also included as a part of the research team. The nurses with advanced education were trained at the university levels on research methodologies; the clinical nurse was not trained on research methods before this study, while the student had just passed her evidence-based course which included briefly contents on qualitative approaches.

All members – student included - developed the study design and the interview guide; three members (student included) performed the interviews and the data analysis. All members discussed and agreed

Table 2
Interview guide.

Demographic	Age Gender
Nursing student career	Year of Nursing Education (1st, 2nd, 3rd) Academic success, yes or no (=failing to pass one or more examinations, thus requiring the repetition of one year) Last clinical training experience attended (in which unit) and considered as a reference for the interview
Non-nursing tasks	Regarding the concept of non-nursing tasks as *the condition where clinical nurses perform tasks below their scope of practice* (Veličković et al., 2014), *including housekeeping duties, delivering or retrieving food trays, transporting non-critical patients, doing clerical work, replenishing charts and forms, answering phone calls, searching for health-care workers or family caregivers, or waiting for something/someone* (Bruyneel et al., 2013; Kearney et al., 2016; Veličković et al., 2014): - What is your experience regarding non-nursing tasks? - Can you remember in-depth one or more episodes in which you were involved as a nursing student in doing a non-nursing task, by describing in-depth, ▪ what you did, ▪ who requested that duty, ▪ why this request was formulated from your point of view, by analysing antecedents (e.g. the workloads), ▪ what are the consequences of non-nursing tasks, according to your experience. According to the episode(s) just recalled, can you summarize the meaning of the experience regarding non-nursing task(s) for you as a nursing student? How often have non-nursing tasks been required to be performed in daily practice according to your experience?

upon the findings emerged. Aiming at not influencing participants during the research process, no contact between them and the interviewers was established before the beginning of the study.

2.4. Data collection process

A semi-structured interview was used to collect the data (Table 2): this was developed by a focus group comprising 11 members of the Nursing Board with advanced education and a range of role responsibilities, from clinical to managerial; they performed five consecutive meetings, all lasting 1 h and a half. In these meetings, members conducted a review by checking published (e.g., Kearney et al., 2016; Bruyneel et al., 2013) and unpublished papers and contents of professional social networks; they also analysed 64 letters from nurses received by the President of the Nursing Board requesting help with regards to non-nursing tasks. They agreed to use the term 'non-nursing task' rather than other terms (e.g., organisational work) as usually used in the current context of nurses working in the community. Then, the interview guide was agreed upon by the focus group members (Grosso et al., 2019) and adapted to nursing students.

Initially, two pilot interviews were performed in the nursing programme 'A', aimed at ensuring the questions' feasibility and understandability. No changes were suggested by interviewed students; their interviews were not included in the final analysis. Then, the nursing programme 'B' not involved in the pilot phase was approached and potential participants ($n = 11$) were identified by the faculty coordinator according to the inclusion criteria; at the same time students from the nursing programme 'A' ($n = 11$) were also approached by the faculty coordinator of the nursing programme. All potential participants were invited via email to take part in the study, by describing the aims of the study, the confidentiality of the data collected and also by describing the focus of the research (=non-nursing task) by providing a full definition (Bruyneel et al., 2013; Kearney et al., 2016; Veličković et al., 2014). They were also initially informed of the questions included in the interview, allowing them to reflect on the topic in advance. All students agreed to participate after the first email of invitation.

Interviews were then started and conducted by an externally trained researcher (SG in the Bachelor 'A', and AP and GD in the Bachelor 'B') at a time and place convenient to participants, thus ensuring that students were free to share their experiences; participants were encouraged to share as many experiences as possible. During each interview, only the participant and the interviewer were present, aiming at ensuring confidentiality. The interviews lasted between 20 and 50 min and they were all audio-recorded. Records were immediately transcribed verbatim aiming at continuing evaluating the saturation, by sharing the data collected among researchers. When the data saturation was achieved as judged independently by three researchers, the data collection process ended.

During the interviews, notes were collected by the interviewers, allowing continuing self-critical reflection and awareness of prior knowledge or idea about the phenomenon of interest (Vaismoradi et al., 2013).

2.5. Data analysis

At the beginning, data analysis principles were shared among researchers: in line with the study design, researchers were interested in learning 'non-nursing tasks' according to the students' world by analysing their responses as manifested forms of beliefs and constructs (Smith and Eatough, 2006).

Thus, in a preliminary fashion, the research team considered all notes collected during the interviews; then openly shared their preconceptions (Vaismoradi et al., 2013) regarding the concept of non-nursing tasks and its meaning for students, aiming at preventing biases in data analysis.

The transcribed interviews were then numbered consecutively (interviewed Nursing Student n. 5, NS 5). According to Vaismoradi et al. (2013), the transcripts were read and re-read to obtain a global view and to familiarise the reader with the data. Then, in the first stage of analysis, initial codes were generated by coding interesting features of the phenomena under study (Graneheim et al., 2017) underlined in the text and then reported in the left-hand margin as interesting or significant segments. In the second stage of analysis, the emerged codes were collapsed into potential themes and each was defined by generating a clear definition and a name. In the third stage, the themes were also connected to each other by generating a map. In producing the report, selected extracts from the interviews were included.

To guarantee rigour and trustworthiness, three researchers (AP, SG, GD) performed the entire process in an independent fashion; in each step, as they shared the findings agreed on, the codes emerged. The confirmability and consistency of the analysis were established by holding meetings to discuss preliminary findings, where emerging codes and themes were discussed with the entire research team, including the student, until a consensus was reached (Graneheim et al., 2017). Dependability was also ensured by describing the data analysis in detail and providing direct quotes appropriately numbered (e.g., NS 1). Specifically, in the cases where homogeneity in the contents emerged, an emblematic quote was cited by reporting the words of one student (e.g., NS 3), and students who reported substantially the same contents but with different words, were reported in brackets [e.g., NS 4 and NS 6, 7 and 5].

Table 3
Participants.

N. student	Gender	Age (years)	Year of study	Academic success	Clinical learning experiences[a]	Clinical learning setting attended[b]	Duration (days)[c]
1	F	22	1st	Yes	1	Medical department	15
2	M	21	2nd	Yes	5	Week surgery	15
3	F	20	1st	Yes	1	Week surgery	15
4	F	20	2nd	Yes	5	Geriatric unit	15
5	M	22	3rd	No	7	Medical unit	7
6	F	24	1st	Yes	1	Thoracic unit	15
7	F	21	2nd	Yes	4	Pneumology unit	15
8	F	22	3rd	Yes	11	Surgical department	21
9	M	23	3rd	Yes	11	Hospice	2
10	F	21	3rd	Yes	11	Rehabilitation unit	21
11	M	22	1st	Yes	1	Acute medical unit	15
12	F	22	3rd	Yes	11	Hospice	21
13	F	22	2nd	No	5	Surgical unit	21
14	F	22	3rd	Yes	11	Mental health department	21
15	F	23	3rd	Yes	10	Intensive care unit	10
16	F	20	1st	Yes	1	Nursing home	15
17	M	22	2nd	Yes	6	Cardiology unit	6
18	F	25	2nd	Yes	7	Neurology unit	11

Legend: M = male; F = female.
[a] On average, two clinical experience were expected in the 1st year, four in the 2nd; from five to seven in the 3rd year of nursing education.
[b] As a reference for the interview.
[c] Since the last clinical rotation has started.

2.6. Ethical issues

The APRI research project was approved by the Nursing Board Steering Committee as well as by the General Assembly of all RNs of the Belluno Nursing Board (Italy) in their annual meeting; moreover, the authorization to approach students was obtained by the Deans of the nursing programmes involved, after having ensured that the research project would be conducted in full accordance with the international ethical principles and with those established at the national level.

Potential participants were fully informed on the aim of the study and their written informed consent was obtained before their taking part in the study; anonymity was ensured during the interview and the examples reported were anonymised in their contextual features during the process of verbatim transcription. Moreover, they were free to withdraw from the interview at any time, and those who participated received no rewards.

3. Findings

In Table 3 the main characteristics of participating students (n = 18) are reported. Their experience regarding non-nursing tasks is based upon three main themes: a) "Being out of the scope of the learning experience," b) "Being forced by external and internal forces", and c) "Accepting non-nursing tasks and searching for a compromise."

3.1. "Being out of the scope of the learning experience"

The experience of nursing students regarding non-nursing tasks was categorised in a main theme as "*Being out of the scope of the learning experience*." All students reported to have experienced situations where the tasks performed during the clinical experience were not in line with their learning aims as expected by the faculty and by themselves. Specifically, students reported two polarities reflecting two interconnected conditions as summarised in Fig. 1. Students reported their experience of being exposed to clinical nurses performing non-nursing tasks,

"*… they did auxiliary tasks*"

(NS 11)

thus, functioning as a role model, implicitly requesting nursing students to do the same.

"*… if my clinical supervisor does photocopies, it is implied that I must do it as well*".

(NS 10)

They also performed non-nursing tasks on their own,

"*… delivering lunch trays …*",

(NS 1 [NS 4, 8, 10, 13 and 16])

"*… performing administrative tasks …*".

(NS 9 [NS 10, 13 and 18])

These tasks were recognised as sharing some features: a) they did not require knowledge acquired in the nursing programme, and b) they were outside the purpose of nursing practice as ideally conceptualised by nursing students and learned since the 1st year of their nursing education.

Students reported spending from 10% (NS 2, 4, 11, 14) to 30% (NS 13), or from 50% (NS 1, 7, 8) to 80% (NS 9) of their time in the clinical setting. Most reported spending approximately 1 h a day performing activities that added no value to their learning, and the time spent in these activities was greater during night shifts:

"*… there can be a lot of work to do, lack of staff, and I did a bit of everything …*".

(NS 1 [NS 16])

However, during mornings, because of intense workloads, the likelihood of being involved in non-nursing tasks was greater,

"*…because there were always so many activities to be performed …*".

(NS 8 [NS 5, 7, 9 and 13])

3.2. "Being forced by external and internal forces"

Different forces, some external to students and others internal, were implicated in learning and performing non-nursing task as students.

As internal forces, students reported perceiving different degrees of freedom in deciding to perform or not, non-nursing tasks: in some units, students were expected to be flexible, thus gently forcing them to accept the performance of these duties:

"*… I was encouraged to adapt to the needs of the unit …*",

(NS 12 [NS 16])

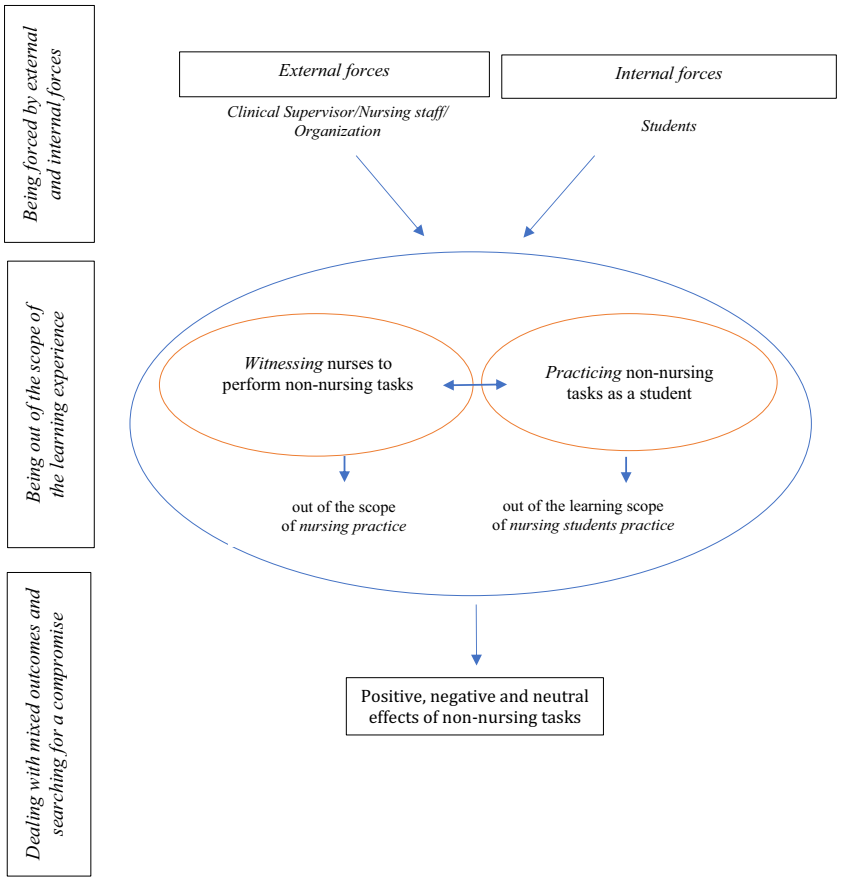

Fig. 1. Non-nursing tasks according to the experience of nursing students.

"… *demonstrating flexibility* …".

(NS 13 [NS 17])

In other units, where students perceived themselves free to critically evaluate the appropriateness of the tasks to perform according to their learning aims, they decided to perform the tasks based on their wish to belong to the team and to help overworked nurses,

"…*they were all busy* …".

(NS 3 [NS 5 and 9])

Moreover, nursing students decided to perform these tasks to manage the time when they were not engaged in other learning activities:

"… *I was free* …".

(NS 3 [NS 9, 11, 12, 16])

In these low-engaged moments, they felt uncomfortable about the imbalance between the nurses' high workloads due to the number of patients and the amount of non-nursing tasks that needed to be performed and their limited workload as students.

Nursing students also reported performing non-nursing tasks because they feared the evaluation of competences expected at the end of the clinical experience, which was in the hands of the clinical nurses,

"… *if I refuse to do these tasks … I do not show modesty …. and this can have an effect on my evaluation* …".

(NS 6 [NS 9])

According to their perceptions, student evaluation is not based solely on their proven competences but also on the *halo* effect:

"… *as the ability to adapt … to be proactive*".

(NS 8 [NS 11, 12, 14 and 17])

As external forces, the clinical supervisor as the nurse responsible of the patients care and also of the clinical learning of students was perceived as prompting students to perform non-nursing activities in four ways:

(a) by performing the tasks thus demonstrating that nurses have to be flexible;
(b) by explicitly asking the students to perform the tasks:

"…*when they were in need for help* …"
(NS 1 [NS, 4, 11 and 14])

(c) by asking the student to look for some auxiliaries to perform a task; in this case, because

"… *they were already fully engaged in other activities* …",

(NS 4 [NS 8 and 15])

or

"… *I was afraid to give an order to the auxiliaries* …",

(NS 11 [NS 12])

nursing students decided to perform the task themselves.

(d) by asking students to do simple activities as a strategy to collect data on their reliability: after this initial assessment, clinical supervisor gave students more complex activities to perform.

Considering also external forces at the unit level, according to the participants' experience, the inherent culture prompted students to be flexible and become involved in different activities; students also reported that it was embedded in the culture of the units that learning a wide variety of activities, even outside their learning goals, was valuable because

"… *nursing students should be coached early to deal with the real work environment*".

(NS 6 [NS 8 and 10])

3.3. "Dealing with mixed outcomes by searching for a compromise"

According to the experience of participants, the consequences of non-nursing tasks were classified as positive, negative, and neutral. Performing a non-nursing task can be valuable in understanding the process of patient care, thus representing a meaningful occasion to learn its complexity and deriving insight regarding the implications of nursing care:

"… *accompanied patients from one unit to another …*",

(NS 1 [NS 2, 9, 13 and 14])

"… *it was important because I understood the complexity of transitions …*".

(NS 9 [NS 14])

Students reported feeling satisfaction when they had the opportunity to help nurses, to develop a sense of involvement in the nursing journey, and to develop a sense of

"… *usefulness as a student …*".

(NS 2 [NS 3 and 16])

Moreover, third-year students performing non-nursing tasks reported having learned to negotiate tasks, by asking their clinical tutor to be more focused on their learning aims. These students also offered more support to 1st and 2nd year students in developing negotiation skills.

However, positive effects occurred only when the task was repeated a limited number of times, and the student was advised to focus his/her attention on the patient and nursing-care implications of the task. Moreover, when the clinical supervisor authorised the students to stop their non-nursing task to take part in an activity in the unit that was important for their learning processes, the students' perception was positive.

Negative effects, however, were also reported when the task was repeated several times. Repeating the same non-nursing task without gaining further understanding of the patient or of the nursing care process was considered to have no impact on the learning experience. Students perceived that the situation led them to

"… *Miss several learning opportunities …*".

(NS 2 [NS 5 and 15])

Negative effects were reported especially among the 1st and 2nd year students, because they felt their ideal conception of the nursing profession was being threatened:

"… *Doing these things … it was far apart from what I intended to learn as a nurse …*",

(NS 10 [NS 12 and 13)

as well as their professional identity, which happened when they spent long hours supporting nursing aides in their tasks:

"… *I was not in a strict relationship with the nurses … because I was entrusted to the nurses' aides …*".

(NS 8)

Negative consequences were also reported by students who felt themselves considered:

"… *as a workforce …*",

(NS 8 [NS 10])

because the practice of these non-nursing activities did not increase their learning outcomes.

Finally, the impact of non-nursing tasks was considered neutral when students perceived a good compromise between negative and positive effects, as mentioned above.

4. Discussion

The participants' demographic profiles were in line with those documented in previous Italian studies with regards to age, gender distribution, and the number of clinical experiences performed at each stage of nursing programme (Palese et al., 2017).

According to the findings, students are exposed from the beginning to non-nursing tasks by witnessing nurses doing non-nursing tasks and by practising these tasks themselves. Because the tasks do not increase nursing knowledge, students are from the beginning given approval to function in a zone below their competence, wasting their time, approximately 1 h a day, which would otherwise be used in learning more complex competences. Moreover, according to De Meis et al. (2007) who documented that non-nursing tasks include, in addition to simple tasks, everything that keeps the nurse away from the patients' bedsides, nursing students can lose the opportunity to stay with patients. Therefore, in addition to causes such as the lack of staff (Veličković et al., 2014), non-nursing tasks begin at the educational level, where professional socialisation and conformity processes shape the future workforce, by replicating the same role patterns displayed by current nurses.

Clinical nurses' function as role models, leading students to learn the same tasks that nurses perform on a daily basis, which then appear to be professionally accepted. On the other hand, the process of professional identification (Clouder, 2003) prompts students to include non-nursing tasks in their presentation of self as a nurse, thus confirming that these duties are acceptable. However, these tasks are not in line with students' expectations, who are then required to cope with role ambiguity (Takase et al., 2006; Tunc and Ozen Kutanis, 2009). Moreover, these tasks are beyond the expectations of the faculty as expressed at the classroom level, so confirming that the gap between theory and practice, as well as that between health-care and health-education institutions, still exists (Scully, 2011).

Although university students are expected to function as self-directed learners, capable of negotiating learning outcomes and activities (Cadorin et al., 2016), our participants reported performing non-nursing tasks pressured by external and internal forces. External forces were attributed mainly to the organisational culture of the nursing staff and clinical tutors, while internal forces were attributed mainly to the student.

On the student's side, three main mechanisms seem to be involved in the internal forces: a) the need to be accepted and belong to the nursing team, by demonstrating humility, adaptability, and flexibility, which are core values of the professional community of nurses; b) the student nurses' moral obligation to offer to help the nurses, who are perceived as being overwhelmed by intense workloads; and c) the attempt to prevent stress resulting from nurses aides' task delegation.

Becoming a professional with a precise identity is based on being part of the team (Levett-Jones and Lathlean, 2008) and on the professional's socialisation where full participation in social and cultural practices accepted by the community is expected (Lave and Wenger, 1991). In this process, students adjust their expectations and behaviour by doing non-nursing duties to achieve congruence between their role expectations and the reality (Takase et al., 2006). This adjustment is also driven by the evaluation of the competences achieved by students at the end of the clinical placement, which is performed by the nursing staff, based on criteria other than competences alone (Wu et al., 2015), forcing students to adapt to the context. Moreover, in a very busy environment, with high turnover of patients and nurses, clinical nurses base their decisions, e.g. to engage students in performing more complex tasks, by first assessing their competence in non-nursing tasks.

The second mechanism underlying non-nursing tasks as perceived

by students is a manifestation of the moral obligation, which represents the core value of nurses towards patients (Schaefer et al., 2016). Nursing students feel the same moral obligation towards overwhelmed clinical nurses by doing things to prevent or reduce their workloads or by allowing them to have a rest. The last mechanism reflects the difficulties of students to delegate tasks to, generally, older, more experienced nurses' aides who may not easily take orders from younger nursing students. Nurses' aides have been documented as receiving an inadequate sense of value and respect from nurses in general; teamwork and communication between nurses and their aides have also been documented as critical (Bellury et al., 2016). Therefore, students may perceive themselves as not being in the best position to delegate tasks, and performing the task themselves may help them avoid stress.

Some external forces reflect the culture of the organisation that expects great flexibility and adaptation from nurses by performing a wide range of activities (Bruyneel et al., 2013): although nursing students were considered supernumeraries, and so not part of the organisation, they were expected to be useful and to function as extensions of the regular staff.

In evaluating the impact of non-nursing tasks, our students also reported positive effects, contrary to previous studies, which suggested that individuals in the early stages of their careers, when called to perform "inferior" assignments, tend to experience the greatest discrepancy between their expectations and organisational reality (Tims et al., 2016; Wang et al., 2016).

Students seem to emphasise the learning value of these tasks, indicating that they accepted these duties as part of their education. In their attempt to reach a compromise, they find that these tasks are more accepted when the learning outcomes expected by the student nurse are protected, when tasks entrusted are occasional, and when the clinical supervisor helps students finding a learning point in the task, as well as their ability to stop the task at any moment when other valuable experiences are available in the unit.

Overall, findings reveal that performing non-nursing tasks is closely intertwined with the process of professional socialisation, because it implies the acceptance of values and attitudes that are at the core of the nursing profession and, as in any professional community, are subject to social control. It also reflects in-group/out-group perceptions in other professional communities (e.g., nurses' aides). The findings also suggest a certain degree of tension and misalignment in the students' process of professional socialisation, which requires the development of a congruence between personal expectations and the general requirements of the professional role, and the need of organisational socialisation (Ellis et al., 2017).

5. Limitations

We included only students continuing their nursing education, therefore in the position to adjust themselves to the clinical environments; exploring the experience among those who left the nursing programme. e.g., due to academic failure or dissatisfaction, could be valuable (Takase et al., 2006). Only nursing students were involved: therefore, aimed at understanding the phenomena inside other professional health-care professional education, more varied student profiles are suggested in future research. Students were interview during their clinical learning experience, so reporting their reflections in action (Schon, 1984); an in-depth reflection can also emerge at the end of the clinical experience or nursing programme, suggesting further student involvement at the end of the nursing programme, before and after graduation. Furthermore, according to the study aims and the study design used, no analysis with regards to the potential differences among experiences of students who have had a single placement and those who have more (up to 11) rotations has been performed: further studies are encouraged to discover differences, if any, in the non-nursing task experiences of students according to the amount of clinical rotations attended.

Lastly, findings were not checked for their consistency with the participants as suggested by Morse (2015) as well as they were not compared across years, according to the academic year attended by participants thus suggesting lines of future research in the field. Furthermore, the validity of the findings also reflects the context in which the students were immersed (e.g. hospital, Nursing Home); further studies should involve students attending a wide variability of settings.

6. Conclusions

Nursing students learn early in their nursing education that performing non-nursing tasks is part of the nursing profession, by witnessing nurses doing simple tasks and by practising these tasks themselves. In practising these tasks, students perceive themselves as "*Being out of the scope of their learning clinical experience*" as expected personally and by the faculty, suggesting that the gap between the academic and practice levels still exists. Therefore, non-nursing tasks, which represent a large part of a nurse's time, as documented internationally, are acquired during the clinical experience, suggesting that at these levels strategies aimed at preventing the phenomenon should also be designed and implemented.

The time devoted to non-nursing tasks is variable and can reach 1 h/day, thus wasting students' time that would otherwise be spent learning competences that are more complex. Nursing students perceive internal and external interconnected forces as antecedents to learning and performing non-nursing tasks. Although university students are expected to be independent self-learners, they appear to be frail and in need of support in focusing their learning experience on nursing care, as well as in negotiating tasks and delegating to nurse's aides basic duties. Moreover, they should also be supported in dealing with the moral obligation to help nurses face high workloads, which is valuable but, in the long term, can distract them from acquiring core nursing competences.

Units hosting nursing students should be supported in reflecting on their culture, specifically if it requires a high degree of student adjustment to non-nursing tasks. Clinical tutors should also be prepared to perform the evaluation of the competence achieved by students focused on the nursing scope of practice, so ensuring that they are evaluated for their learning aims and not for their ability to adjust to the context; moreover, clinical tutors should also support students in understanding when non-nursing tasks can be of value for their learning processes or when performing these tasks is a waste of learning time.

Furthermore, clinical supervisors should evaluate the occurrence (occasional or not) of non-nursing tasks, and determine if there is a greater risk of perpetuating a nursing identity where these tasks are accepted but also have been recognised as a great source of missed nursing care.

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Appendix A. Supplementary data

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