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AN EXPLORATION INTO STUDENT NURSES' PERCEPTION OF PATIENT SAFETY AND EXPERIENCE OF RAISING CONCERNS

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EdD

2017

AN EXPLORATION INTO STUDENT NURSES' PERCEPTION OF PATIENT SAFETY AND EXPERIENCE OF RAISING CONCERNS

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A thesis submitted in partial fulfilment of the requirements of the University of Northumbria at Newcastle Upon Tyne for the Degree of Professional Doctorate

Research undertaken in the Faculty of Health and Life Sciences

November 2017

Abstract

Background

Patient safety is of paramount importance in healthcare delivery. Following the inquiry into the Mid Staffordshire Health Trust (Francis 2013, 2015), there has been an increasing demand for nurses and other healthcare professionals to be open and candid in a transparent culture where harm and error are minimised. Despite this drive for openness, there is evidence that health care professionals remain reluctant to raise concerns and this includes student nurses as well as registrants. There is however paucity in research focusing upon the underlying factors which prevent student nurses from raising concerns about suboptimal practice. In an attempt to contribute to the discussion, this study will focus upon student nurses.

Aim

The overall aim of this research is to understand student nurses' perception of what they believe is a patient safety incident in their practice placements and understand the reasons that influence their willingness or reluctance to raise concerns about patient safety.

Findings

Four main themes emerged from analysing the data: the context of patient safety; team culture; hierarchy and fear of retribution.

Analysis and discussion of the data revealed that students were driven to raise concerns as they possessed strong moral and ethical beliefs to uphold patient safety. However, they had an overwhelming desire to fit in with their clinical colleagues and feared retribution and failure if they voiced concerns regarding care. This demonstrated that student nurses were subject to a fluctuating moral compass which was determined by psychological and sociological determinants.

Conclusion

This research study has provided information which contributes to our understanding of student nurses' beliefs about patient safety. It also helps us to recognise the factors that influence student nurses' willingness or reluctance to speak up. This is important because with an increased understanding of their experiences and beliefs, we are better informed to broaden our teaching on this topic and develop effective policies to protect student nurses who raise concerns.

Acknowledgements

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee / University Ethics Committee.

I declare the word count for this thesis Is 59,247

Name: Melanie Fisher

Signature

Date

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Chapter 1: Introduction and Background to Study

This chapter will introduce the reader to the background and context underpinning this research study. The study is influenced by socio –political and professional drivers in an ever changing health service where quality and safety are high on the agenda. In addition, standards in nurse education are evolving, placing emphasis on the nursing workforce of tomorrow. It is therefore poignant and timely to focus on student nurses as they are the coaches of future generations of registered nurses.

The issue of patient safety has been recognised globally for many years. Error and mishap are commonplace in patient care, perhaps inevitably as healthcare provision becomes more complex and challenging. Errors or mishaps are defined as mistakes which are made by humans: (human error) or technical (caused by device malfunction). Ultimately errors and mishaps may compromise patient safety and lead to significant morbidity and mortality (National Patient Safety Agency 2004, Vincent 2010, Fisher and Scott 2013). Whilst many errors occur as a result of system failure, there is still evidence that individuals are failing to report errors which points towards a need for a shift in culture within healthcare (Reason 1995, Vincent 2010, Francis 2013). As early as 2000, the Department of Health offered a number of recommendations in their report: 'An Organisation with a Memory' (Department of Health 2000). They concluded that the NHS requires a culture that responds to and learns from failures, but despite raising awareness about preventable mortality and adverse safety incidents there continues to be a number of preventable deaths and incidents reported

(Department of Health 2000). More recently, patient safety has been elevated to the top of the agenda in UK healthcare provision following the investigation into the Mid Staffordshire Hospital enquiry and subsequent findings and recommendations in the Francis report (Francis 2013). Mid Staffordshire is not an isolated case where substandard care has been exposed, but it is a significant catalyst in the call for a change in reporting culture within the National Health Service and beyond. Francis comments that extent of failure of the system present in Mid Staffordshire suggests that a fundamental culture change is required. He postulates that for a common culture to be shared, three characteristics are required: openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered; transparency: allowing true information to be shared, and candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered. Following this publication, Francis published a subsequent report: Freedom to Speak Up' (Francis 2015) in recognition that there is a need for a culture in which concerns raised by staff are taken seriously, investigated and addressed by measures that are appropriate and corrective. He makes the point that everyone should raise concerns if they feel this is required, regardless of role, rank or seniority. This includes student nurses who are at the forefront of care delivery.

As well as meeting with registrants to inform his review, Francis (2015) recognised that student nurses bring a new perspective when they enter clinical environments as they have a 'fresh pair of eyes', are keen to learn and can challenge constructively and objectively as they bring in new learning that is evidence based.

This has implications for Higher Education and student nurse education. Universities are now required to ensure that patient safety is embedded in their healthcare programmes and provide clear guidance on how to raise concerns about substandard practice. In addition, they are required to have clear and coherent systems to support students through this process (NMC 2010). This is currently under discussion in the draft of policy guidance for standards in nurse education (NMC 2017). In addition, at the time of undertaking this research study, NHS England has introduced a standard whistleblowing policy to be cascaded in all NHS Trusts in England (NHS Improvement 2016). Essentially this policy is designed to encourage health care workers to air concerns about sub-optimal care and was published in response to Francis Freedom to Speak Up (2015). This includes 'students'. However, there is little data available currently to glean an insight into whether student nurses are actively using this policy to report concerns.

The issue of 'raising concerns' and whistleblowing in the health service has long been discussed but the majority of dialogue seems to be anecdotal and is reported in media focused journals and papers as opposed to robust, peer reviewed academic journals.

Whilst the terms' 'raising concerns' and 'whistleblowing' are often used interchangeably, there are differences. Whilst raising concerns or 'speaking up' is associated with approaching or questioning clinical practice, whistleblowing is viewed more as an action required when a patient's safety or rights are in danger (Mansbach et al 2013). At the time of completing this thesis, the Nursing and Midwifery Council has offered further clarification on these interchangeable terms. Raising a concern to the NMC is considered to be the antecedent of whistleblowing, and for a concern to qualify as whistleblowing, they offer

guidance on specific criteria which must be met. The criteria is underpinned by legal jurisdiction and employment status of the individual (NMC 2017b). At the outset of this research design, it was my intention to examine the issue of raising concerns in a 'local' context associated with a questioning approach to practice. Therefore throughout the data collection process, the term 'raising concerns' is used.

There have been earlier attempts to investigate the underpinning discourse associated with raising concerns (Department of Health 2000, Rennie and Crosby 2002, Jackson et al 2010) because when episodes of care have been compromised or patient safety issues have emerged it is often nurses who raise concerns. Nurses are required to raise concerns as they must practice in accordance with the Code of Professional Conduct and Ethics (NMC 2015). However, raising concerns can be defined as 'whistleblowing' which can be a stigmatised and hidden activity in spite of policy and guidance and may still carry considerable ramifications. Furthermore, there is often disparity in the dissemination of such policies leading to potential misunderstanding and confusion. Following the Francis enquiry into the failings of Mid Staffordshire NHS Trust (Francis 2013, 2015), educational institutions that provide nurse education programmes are required to embed patient safety in the curriculum and develop strategies to raise concerns in their programmes of study. The University where this research study is focused does have a policy on raising concerns and there is a strong link with placement providers who have explicit localised policies on raising concerns. On occasion these policies are implemented when students raise concerns about patient safety. However, dealing with what are sometimes very complex 'whistleblowing' issues can be challenging for students.

Students who witness substandard practice, often do so in variety of contexts and much of this is underpinned by the students own social and moral compass which can often be at odds with the organisational culture, beliefs and values. These complicated factors can often lead to the student deciding against raising a concern. In addition, these tensions can lead to disharmony with partner providers leaving students who have raised concerns feeling anxious, guilty, with some students experiencing what they regard as punitive treatment by staff. Furthermore, their perception is that their progress on the programme is potentially compromised.

For academics in a supervisory role this poses a dilemma in terms of how students are taught to recognise safety and respond appropriately to adverse incidents, as well as ensuring appropriate and effective support strategies are in place. How policies and guidelines are best achieved to facilitate this remains indistinct. If we are to understand the underpinning factors that influence students' willingness or reluctance to raise concerns, it is necessary to explore the relationship between the culture and values that are held by the organisations in which they work and study, as well as the students' own identity and values. This interface may provide us with potential solutions to enable us to guide our teaching and inform policy.

Patient Safety in the UK and beyond

In order to contextualise this study, it is necessary to explore the trajectory of the patient safety concept in the current climate of healthcare. As far back as the nineteenth century, Florence Nightingale commented:

'It may seem a strange principle to enunciate as the very first requirement in a hospital is that it should do the sick no harm' (Florence Nightingale 1860 / 1969 p4)

This statement from Florence Nightingales notes on nursing reminds us that patient safety is not a new concept, yet over one hundred years on, patients are still being harmed as a result of poor or negligent care.

Errors and mishaps are not something new to the healthcare arena and have occurred since the inception of the NHS and also some time before. However, the concept of patient safety is now at the forefront of medical care in the United Kingdom and also in the wider global community. Patient safety is not a standalone discipline but rather one that is integrated into all aspects of healthcare (NMC 2015, GMC 2015, HCPC 2015) and furthermore it is the responsibility of all who come into contact with patients. It is a topic that is firmly grounded in Nursing and Healthcare curricula (NMC 2010) as it is imperative that anyone entering a career in healthcare understands the importance of maintaining safety and preventing error or harm.

It is perhaps poignant to make some distinction between what is seen as avoidable harm and harm caused by those with malevolent intent. Those with dishonest intent, are managed through the criminal justice system as their intentions are deliberate and their aim is to ultimately cause harm. The majority of patient safety incidents reported in the UK are those which are caused in error and not through dishonest intent. The National Patient Safety Agency (2004) defined a patient safety incident as:

'any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS- funded healthcare'

(National Patient Safety Agency 2004)

Patient safety is discussed in a more candid and transparent way than it was some years ago. As recently as two to three decades previously, incidents affecting patients were often left unreported or at best dealt with 'in house' (Vincent 2010). The image of medicine would be tarnished and public trust would dwindle therefore it was considered not to be in the public interest to disclose. However, it is important to recognise that medicine and healthcare treatment and interventions have inherently carried risks and indeed medical iatrogenesis is an unavoidable accompaniment to many treatments and cures. The concept of keeping patients safe during a trajectory of care is indeed the essence of care to medical and nursing staff. For medical staff it is grounded in the Hippocratic Oath to 'do no harm' and for nurses it is established in the code of conduct as set out by the Professional Regulatory Body (Nursing and Midwifery Council 2008, 2015).

However, not all harm is avoidable. In his writing, the philosopher Ivan Illich (2002) believed in the concept of medical nemesis and his controversial views implied that by medicalising illness and health, doctors in particular have moved beyond proper boundaries and by doing so have potentially caused harm. It is recognised that for some, treatment can indeed be worse than the disease itself but the individual has to decide whether the outcome is worth it. Whilst acknowledging Illich's view point it is important to consider balancing this against the great benefits and advances brought over the past few decades. (Fisher and

Scott 2013). It is therefore difficult sometimes for the less experienced eye to distinguish between harm that is avoidable and harm which is an inevitable consequence of modern health care treatment. This is particularly relevant to the inexperienced student nurse.

Errors of course do occur in the delivery of care and of those that do incur harm, they are often categorised as human error or system - technical errors. There has been a marked improvement in the way incident information is reported, recorded and disseminated in more recent years which in turn facilitates a greater understanding of the nature and trends underpinning safety events. Safety in healthcare is explicitly linked to the quality agenda and local data is now escalated to national data to enable learning from error to take place (NHS England 2016).

Patient safety is a concept that is acknowledged globally with the United States taking a firm interest mainly influenced by litigation and other financial mistakes. The United Kingdom has been quick to follow and this has been in part influenced by the media who are instrumental in dissemination of information and generate public opinion. Mistakes made in the delivery of healthcare arguably make for interesting reading and boost viewing statistics. In addition, the general public have greater access to information about healthcare, informed by social media, the internet and other forms of communication. This in turn generates high expectations of healthcare delivery. The influential catalyst to the development of patient safety was the publication of the United States Institute of Medicine's report in 2000: 'To Err is Human' (Khon et al 2000) which raised political and public awareness. The Institute called for national effort to address safety in healthcare. In addition, it recommended that a centre for patient safety should be established within the Agency for Healthcare Research. The report and

its subsequent response instigated global interest which in turn spurred other Governments to take action. In 2000, the Chief Medical officer for the Department of Health: Sir Liam Donaldson, led a similar investigation to determine the frequency of errors and subsequent processing in the United Kingdom. This resulted in the publication of 'Organisation with a Memory (OWAM) (Department of Health, 2000). There had been some notable incidents that were starting to put patient safety in the spotlight, not least the Bristol 'Heart scandal' where a doctor observed that babies were dying at high rates following cardiac surgery. An investigation followed in 1998 chaired by Professor Ian Kennedy QC and a report published in 2000 (Kennedy 2000). The incident was regarded as high profile and a catalyst in the way that incidents were reported. It is pertinent to note that this is an incident that was raised as a concern by a medical officer who in effect was reported as 'blowing the whistle', a practice quite controversial during this era. Essentially following OWAM, a number of recommendations were made. One such recommendation was the creation of the National Patient Safety Agency (NPSA), the purpose of which was to inform, support and influence organisations and people working in the health sector with the essential aim of learning from error. (NPSA 2006). The reporting of incidents to national central systems helps protect patients from avoidable harm by increasing opportunities to learn from mistakes. Consequently, the NPSA established the building blocks for learning from mistakes in the first National Framework for Reporting and Learning from Serious Incidents Requiring Investigation published in 2010. NHS England continues to develop a serious incidence framework recognising changes in the NHS systems and the increasing importance of taking a whole – system approach to quality. Incidents are now subsequently categorised according to severity. Serious incidents are rare but there is general acknowledgement that

systems and processes have weaknesses which will inevitably lead to error and mishap. However, good organisations will recognise harm and potential harm and will undertake swift, thoughtful and practical action in response, without inappropriately blaming individuals (NHS England 2015).

In spite of these developments and systems which are currently well established in the NHS, there are still a significant number of errors reported. Over 300,000 incidents in healthcare within the UK were reported to the National Reporting and Learning Service, the reporting arm of the NPSA between October and June 2011. More recently in the six months from October 2013 to March 2014, 778,460 incidents were reported to the system – 12.8% more than in the same period for the previous year 2012 -2014. (NHS England 2014). This of course needs to be examined in context as the increase in incidents may be influenced by a more candid and open approach to reporting as opposed to an increase in unsafe practice. NHS England assert that clinicians review all incidents resulting in severe harm and death, and have observed that the accuracy in coding of these incidents is improving, further demonstrating increased engagement with the importance of reporting and learning from patient safety incidents.

The public inquiry into the failings of Mid Staffordshire Hospital (Francis 2013) has influenced a change in the way we report, process and manage the quality of care in the NHS. The report identified the suffering of many patients which it claims was primarily caused by a serious failure on the part of a provider Trust Board. It criticised the Trust for its inability to listen sufficiently to its patients and staff to ensure the correction of deficiencies brought to the Trust's attention. It failed to tackle an insidious negative culture, failing leadership instead allowing a focus upon achieving financial balance and achieving national access targets. Following the investigation, Francis (2013) made over 290 recommendations that

would lead to an improvement in care. One such recommendation significant to this research project was:

'to ensure openness, transparency and candour throughout the system about matters of concern' (Francis 2013 p10)

To achieve success in this, the report suggests that a fundamental culture change is needed in the NHS. There had been warning signs evident that there were shortcomings in the standard of care at Mid Staffordshire and this had been raised by the Primary Care Group (PCG) leading to an external review. There were found to be deficiencies in aspects of care delivery and leadership and to note:

'while the Trust aspired to have an open and learning culture, it was not strong enough to reassure staff that everyone reporting an incident would be treated the same way' (Francis 2013 p 52)

The Inquiry examined a series of 'whistleblowing' policies adopted by the Trust during the period of review and they demonstrated that they all had the clear objective of supporting employees who raised concerns. However, after interviewing employees including registrants who had raised concerns, this was clearly not always the case and the treatment of some employees undoubtedly deterred others from raising concerns. One particular staff nurse who raised concerns relating to two ward sisters discussed how there was little consideration for preserving anonymity, little evidence that her concerns had been taken

seriously and consequently she suffered harassment from colleagues and eventually left her role for other employment.

The Francis report is not without its critics. The Care Quality Commission (2013) and National Health Executive (2014) have commented that even if all 290 recommendations were implemented now, the fundamental shift in culture can only be achieved if patient care is put to the top of agenda for trust boards. This will take time and commitment over many years. There is however general acceptance that the NHS needs to develop a culture of transparency.

Patient safety: the expectations and responsibilities of student nurses

There have been a number of additional reviews into the quality of care and patient safety in the UK including the 'Review of the quality of care and treatment provided by 14 hospital trusts in England (Keogh 2013). The review of care in the 14 hospitals was conducted by a variety of staff including nursing students and perhaps this demonstrates that students have an important place in reporting concerns about poor practice and can be a catalyst for change.

The standards for pre-registration nursing education NMC (2010) already stipulate that providers of programmes must make sure that students understand their responsibilities and know how to raise concerns when they believe the safety of patients is at risk.

The Government in response to Francis supported the professional regulators to impose a duty of candour on healthcare professionals when something goes wrong requiring disclosure of information. Subsequently, the NMC produced an updated code of practice (NMC 2015) after a period of consultation with a number of stakeholders. Within the code they explicitly call for nurses and

midwives to raise concerns when a patient is at risk. They also updated their guidance on raising concerns (NMC 2015).

As a consequence of both Francis reports (2013, 2015) there has been a profound effect on healthcare delivery and policy. Most NHS providers do now have policies in place to enable employees to raise concerns, as in the Mid Staffordshire investigation, central to the matter is the protection and support afforded to individuals who do raise concerns. Higher Education providers offering programmes for undergraduate health care professionals are in addition required to have in place policies which are developed to support students who witness incidents concerning patient and public safety. Francis (2015) has recommended particular measures for vulnerable groups and student nurses are categorised under this heading.

Nonetheless there exists some contention about the support and protection available to those who do speak up. There remains remarkably limited literature on 'nurse' experience of whistleblowing and even less on whistleblowing by student nurses. Of the few studies that have been carried out, the majority are from international institutions and provide some insight into the experience of student nurses values, beliefs and experiences but provide little in terms of recommendations for enhancing how we can best support students. Student nurses appear to intrinsically understand the moral and ethical duty to raise concerns but this is hampered by extrinsic factors embedded in the core values, culture and beliefs of the organisation. Many fear the negative consequences bestowed on them or the 'wrong doer' as a result of speaking up. This raises questions about the effectiveness of policies and procedures in place to raise,

concerns. It is therefore imperative that we have a better understanding of the social factors which affect student nurse behaviours to enable us to support them more effectively and develop more meaningful policies.

Questions and aims of research study

The overall aim of this research is to understand student nurses' perception of what they believe is a patient safety incident in their practice placements and understand the reasons that influence their willingness or reluctance to raise concerns about patient safety.

The intended outcome is to:

> ➢ Understand student nurses' perception of what constitutes a patient safety issue in their clinical practice placements

> ➢ Appreciate the cognitive processes related to why students may not raise concerns and understand what factors influence their decision making process.

> ➢ Develop an insight into the factors associated with the students' willingness to raise concerns

> ➢ Develop the way in which we as nurse educators coach and support students who raise concerns

> ➢ Inform the development of a safety culture through the education and support of student nurses whilst undertaking undergraduate education which will be embedded in their practice as registrants

> ➢ Inform policy development in order to facilitate raising concerns and supporting those who do

Approach to the Research Study

The methodological approach to this study will be explained in detail in chapter 3 but in order to guide the reader through the research study it is necessary to provide a brief overview of the methodology used here.

On reviewing the literature, it became apparent that mixed methodologies were used in some studies, incorporating both qualitative and quantitative research approaches. In order to achieve the aim and intended outcomes of this research study, it was necessary to understand the 'lived experiences' of individuals therefore individually sensitive data is required. To identify themes or links shared by individuals, an interpretive, qualitative approach to human enquiry would be required. The epistemological and ontological position is congruent with this approach and a quantitative methodological paradigm would not have enabled the researcher to explore truth and meaning as experienced by individuals.

There is considerable debate and even conflict amongst researchers about the best way to deal with social phenomena (Corbin and Strauss 2008, Savin- Baden and Howell-Major 2013, Creswell 2013). Whilst some researchers would indeed approach this study from a positivist or post-positivist approach, it was my intention to attempt to glean information from participants' personal and unique experiences to address the aims and outcomes of the research study. This requirement lends itself to a qualitative approach.

There are a number of qualitative enquiry traditions discussed in the literature and in contemplation of this research study, I acknowledged the value of such varied approaches which include: grounded theory, narrative, naturalistic enquiry, ethnography, case study and phenomenology. Following academic discourse with colleagues and supervisors as well as reflecting on personal and

philosophical beliefs, the decision was made to adopt an interpretative

phenomenological approach to this study. Cresswell (2013) and Smith et al

(2013) describe a phenomenological study as one that gives us insight into the

essence of experiences. Phenomenologists focus on describing what all

participants have in common when discussing a phenomenon whereas a

narrative study focuses on the stories of single individuals (Cresswell 2013). It is

intended that the personal experiences of student nurses in relation to patient

safety and their experiences of raising concerns will be examined. To expand

further, themes and common experiences will be identified to discover a universal

essence or what Van Manen (2014) describes as the very nature of the thing.

Though the literature uses a number of terms to categorise different types of

phenomenology, the two main categories are: descriptive phenomenology

founded by the German philosopher Husserl and later refined by Heidegger as

interpretive phenomenology (Smith et al 2013). Interpretative phenomenology is

described by Smith et al (2013) as an approach committed to exploring how

individuals make sense of life experiences. Interpretative Phenomenology is an

interpretative endeavour informed by hermeneutics, the theory of interpretation. It

believes that humans are sense making creatures and therefore the accounts

which participants provide will reflect their attempts to make sense of their

experience (Smith et al 2013, p 3). The personal experiences, beliefs and values

of individuals (student nurses) in this study sits well with this research aim. For

the purpose of data collection, a purposive sample of student nurses all enrolled

on the Adult pre-registration nursing programme were selected. The sample

included students in their first, second and third year of the programme all of

whom were on placements in a variety of different trusts in the region. Data

collection was performed using semi-structured interviews captured on a digital

voice recorder. To answer the research question, the interview questions were designed to be semi-structured which sits within the interpretive approach. The data was then analysed using 'Framework', an applied policy strategy developed by social researchers (Richie et al 2015). This provided a platform on which to present and discuss the findings and consider recommendations.

Summary

This chapter has provided an overview of the rationale for conducting this study. It has illustrated that patient safety is a priority in healthcare delivery and healthcare staff are required to speak up if they witness practice that falls below the expected standard, this includes student nurses. However, how students are supported in this process remains indistinct and requires further investigation if we are to understand the underpinning factors that may inhibit students' willingness to speak up.

The following chapter will provide an insight into the underpinning literature and emerging conceptual framework.

Chapter 2: Literature review and development of the conceptual framework

This chapter will be presented in two parts: part one will provide an overview of the literature search and part two will discuss the development of the conceptual framework.

Part 1: The Literature

The purpose of this qualitative research study was to explore the lived experience of student nurses and their perceptions of patient safety and willingness to raise concerns. Specifically, the research aimed to examine the context in which student nurses understood patient safety as well as factors influencing their willingness or reluctance to raise concerns. In order to glean an insight into existing research on this topic, the literature search commenced at the start of the research study in 2013 and concluded on completion of this doctoral thesis.

Huberman and Miles (2002) assert that an essential feature of theory building is comparison of the emerging concepts, theories or hypotheses with the extant literature. With this in mind, researchers must be mindful of the requirement to retrieve quality literature from a variety of reliable sources. Silverman (2014) argues that a literature review should combine argument with critical thought, it should be exciting to read and he recommends writing the literature review after data analysis is complete. Acknowledging Silverman's words, a model developed by Bloomberg and Volpe entitled 'Road map for conducting the literature review was used to guide the process (Bloomberg and Volpe 2012). The literature review consists of four stages illustrated below (figure1).

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1  • Identify and retrieve literature

2  • Review and analyse literature

3  • Synthesis: write and review

4  • Develop the conceptual framework
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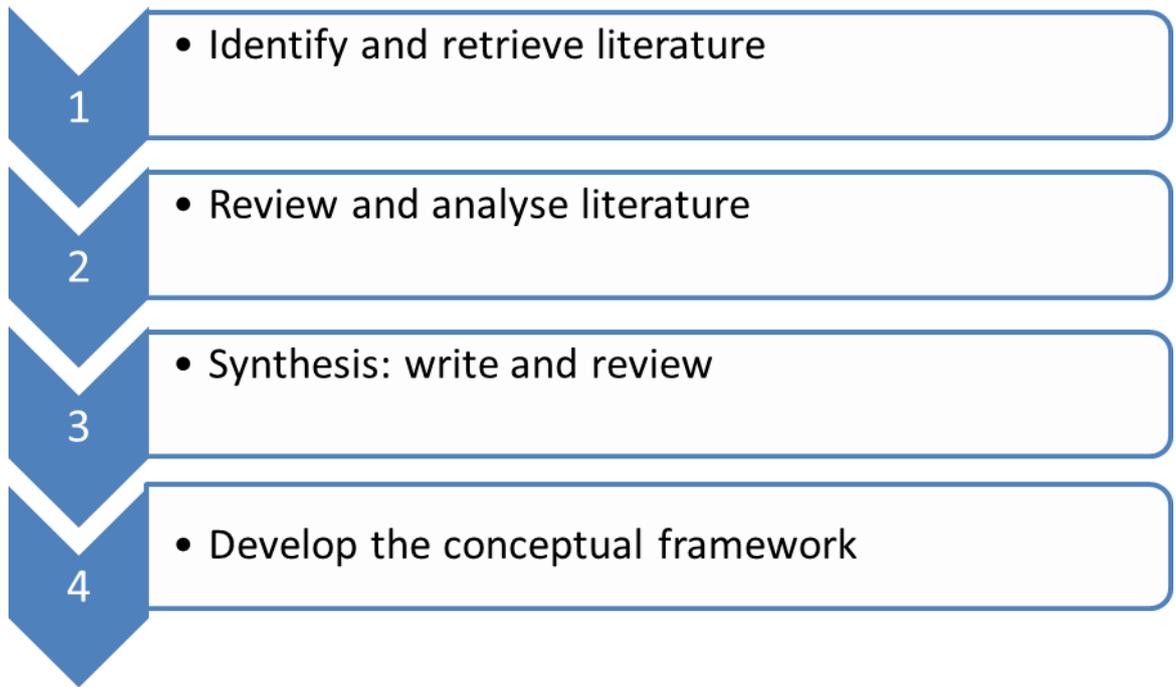
Figure 1 Literature review strategy

To identify and retrieve the literature, a variety of information sources were used and accessed via search engines and catalogues. Familiarisation with the online data bases relevant to the topic was essential and much of the literature was accessed using, though not exclusively: Web of Science, CINAHL, Medline and Google Scholar. There was no specific timeframe during which the literature was reviewed as this was an ongoing process throughout the research study (Polit and Beck 2010, Bloomberg and Volpe 2012, Cresswell 2013, Silverman 2013). A variety of literature was accessed including: books, peer reviewed journal articles, professional regulatory body sites, published reports and included primary as well as secondary sources. Although primary sources of literature are preferred, secondary sources are a useful way of obtaining an overview of a field or topic. However, it is recommended that researchers maintain caution as not all secondary sources can be considered completely reliable and may be open to interpretation (Bloomberg and Volpe 2012).

Polit and Beck (2010) advocate the strategy known as the 'ancestry approach' or 'footnote chasing (Cooper 1998). Essentially this entails using citations from relevant studies to track down earlier research. This was a useful strategy during the literature review process because it became apparent in the early stages that there was a gap in the literature in relation to the focus on student nurses raising concerns. It became necessary to consider the literature already unearthed to ensure that all possible yield was covered. It was decided initially that a limited range of publication dates should be selected and therefore the parameter was publications within the last ten years. Most of the literature on research design recommends literature published within the last 5-10 is appropriate for a contemporary research study (Polit and Beck 2010, Blaikie 2012, Bloomberg and Volpe 2012, Silverman 2013, Cresswell 2013,). However, it became apparent early in the literature retrieval process that there was a paucity of publications on this particular topic. The publication date restriction was subsequently removed seeking instead to review earlier work in order to identify themes, patterns and emerging concepts and also to compare and contrast with more recent studies. An attempt was made to obtain theoretical and empirical literature and key words were used to refine the search and identify themes in the literature.

The key words used initially were: student nurse, patient safety, whistleblowing, raising concerns. (see figure 2). Acknowledging the broadness of these initial keywords, it did provide a number of relevant journal articles and reports to inform the initial stages of the literature review.
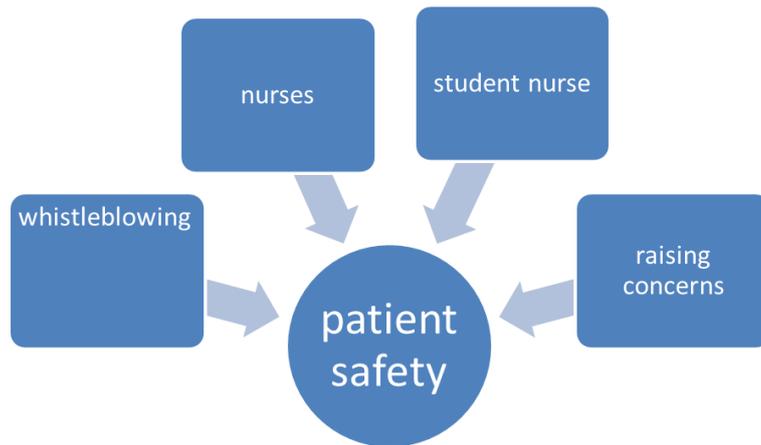
Figure 2 Search strategy

As the literature search progressed and themes started to emerge from the interview data, it was necessary to expand the key words used in the search (see figure 3). This provided a much broader based literature retrieval but in addition, it also facilitated the 'narrowing down' of themes. It also allowed the exploration of a wider trench of journal material from other disciplines such as psychology, sociology and occupational –based journals.
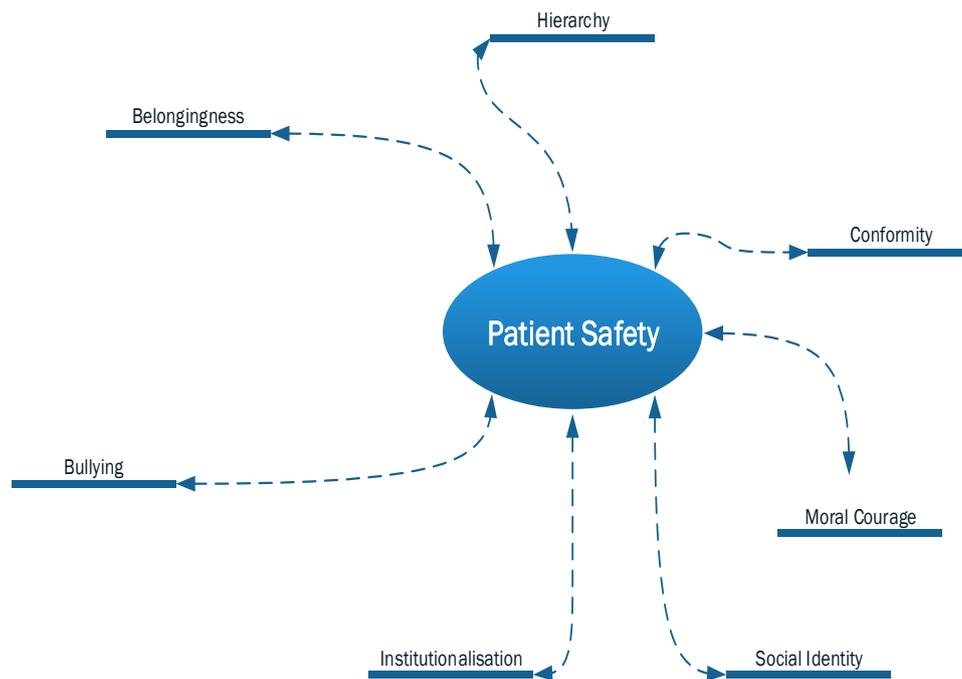
Figure 3 Refined search strategy

This was done with caution, as it is recognised that there is a potential danger that the information gleaned may become unwieldy and irrelevant. Subsequently, as a plethora of related literature was retrieved, to allow for the maintenance of a narrow focus it was necessary to develop a system for recording, storing and managing the material. This was achieved by grouping and indexing the literature and filing accordingly. The electronic system 'Endnote' was also utilised. This was beneficial as a resource for storing, retrieving and identifying material. It was particularly important throughout to revisit databases to check for any new literature, legislation, policy that may have emerged.

During the review and analysis stage of the literature search, an analytical approach was adopted and applied consistently. Each piece of literature was categorised according to type and a short precis was written.

Once this was organised, patterns, trends and similarities were identified as well as contradictions and opposing views. Literature discussing similar findings is significant as it connects phenomenon that may not always be associated with each other (Huberman and Miles 2002). This often adds validity and stronger generalisability to subsequent discussion. In addition, it became necessary to classify sources of literature that appeared to be more peripherally related to the topic as opposed to directly relevant.

This ongoing process adopted, together with the emerging data generated from the interviews, facilitated the development of the conceptual framework. This is a repository for the findings as well as a tool to aid analysis (Bloomberg and Volpe 2012).

Inclusion Criteria:

> ➢ Literature that was written in English

> ➢ Published within the last twenty years

> ➢ Research carried out internationally as well as UK

> ➢ Peer reviewed as well as grey literature

> ➢ Websites

> ➢ Peer reviewed literature from other disciplines such as industry and aviation

> ➢ Reports, guidelines and legislation

Themes in the literature

The literature that was retrieved through a systematic search was synthesised and categorised into the following key themes:

- ➢ Students and speaking up

- ➢ Whistleblowing in context

- ➢ Legislation and guidance

- ➢ Student nurses, socialisation, identity and the organisation

Students and speaking up

Although literature was extensively searched, it became apparent that there was a gap in the literature surrounding nurses and raising concerns and in particular with regard to student nurses raising concerns. Studies which preceded Francis (2013) tended to be largely empirical studies that concentrated on registered nurses with limited comparisons to pre-registration students. Many of the published studies were restricted to surveys and the generalisability of some of the research is problematic.

Notably, significant qualitative research on raising concerns amongst nurses was conducted by Attree (2007) and later by Jackson et al (2010). Their work features in many subsequent publications on this topic. The findings revealed that potential negative consequences prevented many registrants from reporting concerns and many of these concerns were justified. These studies provide a useful insight into some of the prevailing factors that influence nurses' willingness or not to speak up and not surprisingly, it is obvious that students inevitably will share these concerns. However, the focus of these research studies was the

experience of registrants and not student nurses, therefore the transferability of findings related to students needs to be met with caution. Registrants are duty bound by a code of conduct whereas student nurses are working towards demonstrating they can uphold the code and there are subtle though significant differences (NMC 2015). Nonetheless, similarities in the findings were found later in more recently published work.

Many of the previously published studies regarding student nurses and raising concerns appeared to be found largely in journals and papers that are anecdotal in type, often generated from surveys conducted by news type non peer reviewed journals. This can perhaps be explained in terms of a response by the profession to the Mid -Staffordshire Inquiry and the subsequent generation of interest (Francis 2013). However, there is a slow but steady growth of more journal articles exploring the concept of raising concerns amongst nurses, perhaps underpinned by the clear legislative and professional requirement and expectations for students to report safety incidents and poor practice (NMC 2015, Francis 2015).

The overriding findings from the literature review suggest that student nurses have a high level of awareness regarding their responsibilities and expectations surrounding the issue of patient safety and raising concerns. Many have a clear ethical and moral position which guides their actions but this is often compromised for fear of reprisal, causing trouble and potentially compromising their successful placement experience (Duffy 2002, Ahern and MacDonald 2002, Levett-Jones and Lathlean 2007, 2009, Lachman 2008, Jackson et al (2010), Mansbach and Bachner, 2010, Elcock 2013, Ions et al 2015). Recognising what constitutes a patient safety issue amongst student nurses is not so clear in the literature. Attree et al (2007) attempted to address this by examining how patient

safety was addressed in the curriculum. This study was carried out pre- Francis

and therefore patient safety though important was not always explicit in health

curricula in the way it is now following Francis (2013). A focus group approach

was used to elicit the views of students and lecturers on each group's perception

of patient safety and concluded that perspectives of what is regarded as patient

safety and what constituted threats to safety varied. The curriculum focused more

on risk and safe practice rather than specific patient safety issues. However,

students were aware of the prevalence of risks to patient safety with many of

them experiencing 'near misses' in clinical practice such as: falls, medication

error and communication failures. Interestingly, students perceived that staff and

systems were the greatest threat to patient safety. Similarly, a Canadian study

(Duhn et al 2012) examined the correlation between learning patient safety in the

classroom and in practice. Their findings supported the importance of engaging

students in safety principles early on but did not specifically reveal what students

perceived as patient safety concerns though some mentioned the importance of

hand hygiene, medication safety and effective communication.

A later Canadian study by Killam et al (2013) sought to elicit the views of first

year undergraduate student nurses about unsafe clinical learning situations. The

study did not reveal the specific clinical safety incidents students perceived but

rather focused on their subjective understanding of when it was most unsafe in

the clinical setting. It did establish that stress is an inherent component of clinical

learning for first year students and conceptualised compromised clinical safety as

a complex phenomenon involving interplay of multiple variables across personal,

professional and programmatic dimensions. In contrast to these findings,

Montgommery et al (2014) examined the viewpoints of third year student nurses

of the circumstances which threaten safety in the clinical setting. They elicited

that third year advanced students in comparison to entry level students described three unique circumstances which have the potential to threaten safety in the clinical setting. Safety broadly defined as patient or student freedom from physical and psychosocial risk or harm was compromised by misguided practice, lack of readiness and negation of professional boundaries. The central focus of these two Canadian studies was the students' awareness of their own safe practice as opposed to raising concerns but nonetheless highlighted the perception of novice to expert practice and the tensions students' experience.

Not all of the articles reviewed focused on research studies explicitly. Duffy et al (2012) wrote from a nurse educators' perspective raising the question of whether too much was expected of student nurses in relation to raising concerns. She discusses the inexperience of students and lack of understanding which is a potential barrier to identifying evidence based or recommended practice. Duffy also acknowledges the importance of the socialisation of students. Students' possess a desire to be accepted and to 'fit in' as well as ultimately pass the assessment which is echoed in many of the previously mentioned studies. This was taken further by Elcock (2013) who observes that student nurses worry that they will fail the placement or be labelled as a trouble maker. She goes on to suggest that universities and placement providers need to enable students to find ways to feel safe in sharing their concerns. She postulates that students have three options: say nothing, write about their concerns or raise a concern with the local trust or university. Elcocks article is an editorial based on her opinion and experience as an educator. She does however raise similar issues that were uncovered in much of the existing literature.

Central to this debate is the concept of 'patient safety' and the students' perception. Steven et al (2014) conducted a multi-method study exploring how

students learn about patient safety in the curricula from four university programmes. Their analysis pointed to differing views between academics and organisations on patient safety. This could go some way in explaining why students' perceptions of patient safety vary between students. In clinical practice, patient safety was viewed as a complicated problem which is addressed by systems and strategies. In organisations, patient safety appears to be driven by fear of litigation and the potential consequences of professional misconduct. In the curriculum, patient safety tended to focus on 'the correct way to do something' but the connection and correlation between practice and classroom could sometimes be lost. Students learned by observing staff but no formal mechanisms appeared to exist for students to learn about organisational systems. Furthermore, students can adopt a degree of cognitive dissonance in an attempt to rationalise care and avoid challenge.

What much of the literature uncovers is that student nurses are increasingly aware of the importance of safe practice. A study by Bellefontaine (2009) explored what influences student nurses' ability to report potentially unsafe practice. The study adopted an interpretive phenomenological approach using semi-structured interviews. Analysis revealed that factors influencing the students' ability to report potentially unsafe practice included: relationship with their mentor, support from university or practice, the students' level of confidence and fear of failing. The research study uses a small sample and the report provides scant detail on the methods but nonetheless makes an important link with the role of the mentor in supporting students to raise concerns. A similar study using narrative enquiry was carried out in Hong Kong on new graduate nurses (Yee-Shui Law and Chan 2015). Although this study was performed on graduate nurses in a Chinese university, and therefore there are potential

organisational and cultural differences, the importance of the mentor was highlighted.

There is little if at all any distinction in the literature between students' experiences raising concerns in the hospital or community setting. This was noted by Rees et al (2014) who conducted an online survey to fifteen nursing schools in the UK. Their focus was to elicit memorable professional dilemmas. Most occurred in the hospital placement setting but this is still arguably where the majority of placements occur. A theme identified in this study was that students discussed the possible sanctions they would face if they raised a concern. Other themes elicited in the study included: abuse of students, care dilemmas and patient dilemmas instigated by students.

Most of these studies were carried out with the aim of improving student support when raising concerns and some instigated further research. For example, the work of Rees et al (2014) preceded a larger scale study involving a combination of health care students including medical students, nurses and allied health students (Monrouxe et al 2015) conducted a larger scale study (2,397 medical students and 1,399 healthcare students) using a questionnaire, the aim of which was to understand the experiences of students witnessing professional dilemmas. Apart from 10%, all students reported experiencing some form of professional dilemma over the past year including, breaches of safety, dignity, work place abuse. Interestingly the authors wished to synthesise gender differences in this area which is lacking greatly in this topic. However, it did not report any significant gender experiences or differences but did conclude that females were more likely to claim distress as an impact on self.

Steven et al (2014) also revealed in their study, that challenging practice was problematic for students since they needed to 'fit in' and they were concerned about whether they passed or failed their placements. Similar findings were echoed in a later study by Ion et al (2015). This small scale qualitative study was carried out in the UK. The focus was exploring factors which student nurses take into account when considering how to respond to poor care. The findings suggest that students have varying levels of awareness regarding their responsibilities in relation to escalating and raising concerns. Whilst some students who decided to report were driven by a clear moral or ethical position, others preferred to keep a low profile on their journey to registration, fearing potential impacts on grades, interpersonal conflict and uncertainty about the seriousness of the concern. Although a small-scale localised study, the findings appeared to be consistent with previous studies.

Searching outside the nursing literature revealed a small number of studies relating to whistleblowing in other occupations: i.e. police, aviation and social work. The majority of these studies were reported in occupational and human resource journals. Though not specifically significant during the early part of the research study, they did provide an insight into the wider psycho- social discussion on analysis of the findings, particularly in relation to the concept of 'Human Factors' a recognised contributory concept in relation to error, initially in the in high- reliability industries but increasingly recognised in health care provision.

During the process of critiquing the literature, it became apparent that the findings in more recent literature did seem to correlate with that unravelled in earlier studies. For example, in the last decade, Begley (2002) carried out a research study with student midwives using a mixed methods approach. The

findings revealed that the very pronounced hierarchical nature of the profession prevented the students from raising concerns with senior colleagues. Similarly, in the same year Rennie and Crosby (2002) conducted a study of medical students in Scotland. Their findings concluded that some of the factors influencing their decision not to raise concerns included camaraderie and retaliation by peers. Though two different professional groups, both learn in the healthcare setting and experience similar organisational cultural issues so it is not surprising that there are similarities between these professional groups and student nurses.

Bradbury – Jones et al (2007) explored the concept of empowerment amongst student nurses and the impact on speaking up. The findings from their study indicated that those who felt empowered spoke up whereas others who had experienced bullying and disempowerment felt unable to challenge what they perceived as poor practice. Much of the literature revealed that fear of bullying, reprisal or sanctions influenced students' decisions on whether or not to speak up. This was often reported as horizontal violence or 'mobbing'.

It would seem that when comparing and contrasting studies on students raising concerns, earlier studies compared with more recent studies post-Francis reveal little that is new.

What is evident in the literature is the lack of clarity, distinction and comparability of using interchangeable terms such as 'raising concerns' and 'whistleblowing'. The researcher contends that the terminology is important and this view appears to be supported in the literature. During this stage in the literature review it became apparent that students' willingness to report or not to report poor practice was inextricably linked to their desire to 'fit in', not 'rock the boat' and avoid

negative consequences. This prompted an expansion of the literature search to yield more information.

Whistleblowing

The term 'whistleblowing' is often used interchangeably with raising concerns in the literature but arguably the term 'whistleblowing' has negative connotations as it is often associated with 'trouble shooting' (Milligan et al 2016). At the time of conducting this research study, the Council of Deans in 2016 commissioned a systematic literature review focusing on supporting nursing, midwifery and allied health professional students to raise concerns with the quality of care following the Francis recommendations (Francis 2015). They concluded that there exists a lack of guidance for students on how to escalate concerns and universities have a clear role in aiding students through some of the challenges to raising concerns. They also recommend that further studies into the lived experience of healthcare students be considered therefore this current doctoral research study is both timely and appropriate.

The term whistleblower is defined in the literature as:

'Someone who identifies an incompetent, unethical or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong' (McDonald and Ahern 2000 p314)

Francis (2015) defines the term whistle-blower as:

"a person who raises concerns in the public interest. For the purpose of concerns relating to the NHS, and in particular patient safety concerns.' (Francis 2015 p 221)

Perhaps one of the most prolific and well known cases of whistleblowing involving a nurse is that of Graham Pink. Undoubtedly many nurses are familiar with his name and his experience of blowing the whistle in the 1990's. Graham Pink published his diary in 2013 detailing his experience of whistleblowing including narratives and excerpts from correspondence in relation to his subsequent dismissal. Whilst the book is anecdotal and does not provide the reader with a balanced view, it does highlight the negative and punitive action that was taken against him as a result of speaking out about shortcomings in care. Although the events occurred in the 1990's, the details are significant as the impact of this case influenced legislation. A further high profile contentious case of whistleblowing was that of Margaret Haywood who was struck off the Nursing and Midwifery Council register for breaching patient confidentiality by filming the care of patients which she considered to be substandard. This was broadcast on a BBC Panorama documentary (Gallagher 2010). Ms Haywood was later reinstated on appeal. Controversially, this case does suggest that there exists a dichotomy between the professional regulator encouraging its members to raise concerns and then subsequently acting punitively.

Of the few reported cases involving student nurses and whistleblowing, The North Lakeland Garland Hospital was at the centre of a report accusing the Trust of poor practice in the 1990's. Five student nurses voiced their disquiet to a nurse tutor and wrote to the Trust management team detailing what they perceived to be illegal practices. (Faugier and Woolnough 2002). The Trust concluded that there had been deviation from accepted practice but with 'good intent' and no disciplinary action was taken. However, some- time later the Trust was forced to take action after two temporary nurses reported poor practice. The Commission for Health Improvement, the commissioning governing body at that time

concluded that had the student nurses' complaints been taken more seriously, further abuse may have been avoided. A more recent case involving a student nurse is reported in the nursing news media (Nursing Standard 2011). Student Nurse Tonkin in Cambridge witnessed an intravenous medication error on her first placement. The registrant told the patient not to say anything. The patient was allergic to this particular medication though did not suffer a reaction. The registrant did not report the matter but the student nurse did to the ward manager. The student had to give evidence to the Nursing and Midwifery Council and the registrant was removed from the register. However, the student took an interrupt from the programme as a result of the experience and cross examination by a solicitor asking how she as a 'failed student' could question a registrant. These cases are known within the nursing profession and perhaps to a lesser extent the general public. Most of these contentious cases are reported in non-peer reviewed journals and are anecdotal in style but they are significant.

There have been a number of surveys conducted to elicit the experiences of student nurse' willingness to speak up, particularly following Francis (Nursing Times 2013). They go some way in providing an insight into the views of students with regard to this matter but they lack validity and reliability and further empirical research is required.

Whilst much of the literature reviewed concentrated on the experiences and beliefs amongst individuals about whistleblowing, there have been attempts to understand the ethical and deontological context of whistle-blowing in some of the international literature. Hooper (2011) discusses the act of whistleblowing from a deontological and consequentialist perspective focusing upon Australian nurses. An earlier US study by Lachman (2008) also examined the notion of whistleblowing nurses as troublemakers or virtuous. The authors uncover issues

with whistleblowing which are similar to that of the UK. Drawing upon the case of Ms Haywood in the UK and comparable cases in Australia, Hooper (2011) examined the paradoxical dilemmas associated with feeling ethically and morally obliged to report poor practice combined with personal and professional consequences of doing so. She also explored the utilitarianism of whistle-blowing suggesting that different situations require different actions depending on the justification of the potential consequences. She argues that the action by Ms Haywood from a consequentialist perspective was justified because although she realised she was breaching patient confidentiality it was necessary for the 'greater good' in terms of systematic change. She compares this with the deontological view of whistleblowing which is based on the concept of duty as the basic moral premise that guides ethical behaviour. In other words, individuals report poor practice for its own moral worth rather than the results is seeks to attain. Lachman (2008) also concludes that the 'end justifies the means' in relation to whistleblowing if the outcome results in increased patient safety, changes in misconduct and supports professional nursing. Ahern and McDonald (2002) put forward a different perspective. They conducted research in Australia utilising a descriptive survey design to examine the beliefs of nurses who reported misconduct and those who did not. Their findings focused on those reporting poor practice supported patient advocacy while those who did not report retained a belief in the traditional role of the nurse. A limitation of this study is the low response rate reported by the authors, however they note that a higher proportion of whistleblowers responded as opposed to non- whistleblowers which suggest that the survey may have provided them with an added incentive to participate in the study. Research conducted in the US (Waytz et al 2013), focused upon large scale quantitative studies involving employees from

organisations. Though the focus was not on nurses, the authors wished to explore the psychological dilemmas faced by individuals who blew the whistle. The findings revealed that participants who blew the whistle often faced different moral and ethical dilemmas associated with disloyalty to colleagues or the organisation.

Of interest, Mansbach and Bachner (2010) reported findings from an Israeli study that nurses were more likely to whistleblow internally as opposed to externally. Furthermore, the nurses were more likely to withdraw or redact statements as the investigation progressed. It should be acknowledged that experiences researched on a global perspective will undoubtedly have variables such as culture and gender that may not necessarily be transferable to UK nurses.

It appears from reviewing the literature that policy makers, professional regulators and organisations favour the term 'raising concerns' whereas contemporary journal articles and news type journals talk of 'whistle blowing'.

Legislation and guidance

It seems therefore that there appears to be a clear dichotomy between the requirement for student nurses to speak up against substandard practice and the strategies that are in place to support them to do so. Francis (2015) purports that because healthcare students move around to different placements, they are in an ideal position to raise concerns when they witness poor practice in the interest of patients. He does go on further to acknowledge that students are vulnerable if they do so as a result of the inherent power dynamics exist on placements.

During the last decade, as well as an emphasis on patient safety, the UK has also seen a rise in issues surrounding safeguarding and recognition of the shortcomings in systems equipped to deal with incompetent and substandard practice. The Department of Health have stipulated that all those involved in the delivery of care have a duty to safeguard patients and those who are vulnerable. A breach of duty may lead to sanctions by regulatory bodies and potentially prosecution (Department of Health 2011).

Perhaps one of the most significant items of legislation in relation to whistleblowing is that of the Public Interest and Disclosures Act 1998. Within the NHS, employees who hold a reasonable belief that by disclosing confidential information it is in the interest of the public, then they are protected by law. The Act does require that individuals raise concerns internally in the first instance as opposed to directly raising them with an external agency. Vicarious liability rests with the employer in the event of individuals who do raise concerns being the victim of bullying and harassment. In April 2015, the Act was amended to offer protection to student nurses and midwives from retaliation or victimisation if they raised concerns. Prior to this date, students were exempt from protection under this act. These changes in legislation suggest recognition and acknowledgement that student nurses are pivotal in developing good practice. When on placement they are in a good position to notice things that may be wrong as they bring to practice a fresh pair of eyes and their knowledge is underpinned by contemporary theory (Francis 2015). Francis also makes the point that students' caring and compassionate natures are not yet tarnished by the scars of previous experiences.

There is discussion in the report regarding the subsequent treatment of students who raise concerns stating that some claimed they had failed their placement

after raising concerns, some suffered detriment from co-workers and some lost their place at university. Whilst the experiences of students varied greatly from different educational establishments, the claims cannot be ignored and must be taken into consideration when policy planning.

Conversely, despite developments in legislation and professional guidance, it remains unclear who students should raise a concern with. In section 16 of the code (NMC 2015), advice is given regarding raising concerns with emphasis on the immediacy particularly if asked to practice beyond their competency. This is particularly pertinent to nursing and midwifery students. Of note, the code also reminds registrants not to obstruct or hinder a member of staff who wishes to raise a concern. The Royal College of Nursing does in addition offer an on-line and telephone service available to members who may be registrants or students offering advice on raising concerns. The NMC does however appear to be directing students towards internal reporting via their mentor or university lecturers. It could be argued that a dichotomy exists as students are in addition reminded of the requirement to maintain confidentiality so it is perhaps unsurprising that students find this myriad of advice daunting and confusing.

One of the principle endeavours contained within the report (Francis 2015) is the importance of an open and honest reporting culture. The review aimed to address the need for measures to be instigated in order to promote good practice when protecting vulnerable groups who raise concerns. This called for a cultural shift requiring organisations to reconceptualise whistleblowing and raising concerns so that it was embedded and habitual in organisations and viewed as a learning opportunity as opposed to a source of criticism. The Government responded by supporting the proposal to place a duty of candour on service providers and its employees. The NHS Constitution for England (Department of

Health 2015) made a number of pledges to set out the rights and values of patients and staff: 'to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff or the organisation itself, at the earliest opportunity' (NHS Constitution 2015, p 15).

In response, all NHS care providers are required to implement a policy on whistleblowing (NHS Improvement 2016).

Despite the recommendations made by Francis and the health and social care initiatives which followed, the impact of these initiatives remains as yet unknown.

Part 2: Development of the emerging conceptual framework

It is acknowledged that some researchers have difficulty identifying and utilising a theoretical framework to explain their research (Vincent et al 2015). Reason and Rigor (2012) define conceptual frameworks or theoretical frameworks as a way of linking all of the elements of the research process and rationalise why the topic one wishes to research matters. The conceptual framework determines how to frame the problem and enables the researcher to make reasoned defensible choices and align analytical tools with research questions. It is argued that the conceptual framework is central to the entire research process as without it, the study may remain weakly conceptualised, under-theorised and lacking in quality (Bloomberg and Volpe 2012). At the start of this study, there was some uncertainty about which theoretical framework would inform this research topic, particularly as the methodology chosen was to discover the lived experience of the research participants. Surprisingly, it became quite evident during the literature review that there was a pattern emerging in the literature embedded in sociological and psychological theories. The literature alluded to conformity, discipline, conditioning, group polarisation, identity and organisational behaviour. It became apparent therefore that a conceptual map of the theories central to the topic was required in order to examine the inter-relationship and bridge the paradigms that explain the research issue within the phenomenon

Student nurses' socialisation and the organisation

The social and psychological literature asserts that identity is a fundamental human need which is influenced by groups, environment and organisations (Tajfel 1982, Ashforth and Mael 1989, Baumeister and Leary 1995, Hogg and Abrahams 1999, Jenkins 2008). Like all professional organisations, students must be socialised and assimilated into the nursing and healthcare profession

and specific hospital or health setting where they are undertaking their practice placement. Socialisation is an important process and allows students to develop their unique professional identity (Brennan and Timmins 2012). The subject of socialisation amongst nurses, though sparse, has been studied over a period of time with the earlier work of Melia (1987) on occupational socialisation of nurses influencing later authors (Levett-Jones and Lathlean 2006, 2008, 2009). Nursing students develop social connectedness and learn socialisation skills required for engaging in relationships with patients and colleagues. The process of socialisation begins on entry to pre-registration nursing, where student nurses experience practice placements in a variety of clinical settings during their programme of learning. However, the approach to nurse education in the UK has changed and continues to change considerably. The last two decades saw nurse education migrate from hospital based training to the Higher Education setting. Currently, there are now apprenticeship style opportunities for nurses to train in NHS trusts. These developments will inevitably impact on the socialisation of student nurses.

To explore and understand the concepts of student nurse socialisation, this study will use Social and Organisational Identity Theory as a conceptual framework to examine the current tensions and difficulties that student nurses are experiencing in their practice placements, and the impact this may have upon their willingness to 'speak up'.

The psycho-social field of social identity is well documented in the literature and it is generally accepted that identity matters and shapes our personal beliefs,

philosophies and behaviours. Jenkins (2008) puts forward his view that identity matters because:

'it is the basic cognitive mechanism that humans use to sort out themselves and their fellows individually and collectively' (Jenkins 2008, p 13)

Fundamentally, people categorise others continually as a matter of course as categorisation makes a powerful contribution to the everyday reality of groups. Through the discipline of social constructionism, groups are socially constructed and therefore a reality. There exists a plethora of material in the literature defining social identity and intergroup relations. The literature suggests that a longstanding conventional understanding of the notion of selfhood and personhood is that individuals distinguish between the private, internal self from the public, external person (Jenkins 2008). The terms personal identity and social identity are used interchangeably in the literature. Ashforth (2001) Puts forward the view that:

'social identification is the perception of oneness with or belongingness to the social category or role' (Ashforth 2001, p 25)

Ashforth draws upon the work of Tajfel (1982) who goes further and adds that in order to achieve the stage of identification, a cognitive sense of membership is necessary and also an evaluative one which is related to value connotations.

Jenkins (2008) discusses the notion of selfhood as arising from Germanic roots and influenced by the work and beliefs of sociologists Durkheim and Marx. Jenkins suggests selfhood has four basic meanings, the first being an indication of uniformity as in the 'same self' and secondly to the individuality and essence of a person evoking consistency or internal similarity over time and difference from

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others who are external. The third meaning is linked to introspection, as in 'self-doubt' or 'self- confidence' and the fourth as a sense of independence and autonomy. According to social identity theory, the self is reflexive as it can take itself as an object and can subsequently name or categorise itself in relation to other social categories and classifications (Stets and Burke 2000). Jenkins (2008) purports however that some distinction between the internal and external is unavoidable as he warns that not everything that is happening inside of our mind and body is obvious to others and there is not always harmony between how we see ourselves and how others see us. Jenkins does assert that selfhood and personhood are completely and utterly implicated in each other. He explains how intellectual traditions recognise two polar models of humanity: the autonomous self and the 'plastic' self, the former evoking independence and reflexivity and the latter focusing on structural functionalism and structuralism. People classify not only themselves but indeed others into various social categories. These may be defined as: gender, marital status, religious affiliation, age and organisational membership (Ashforth and Mael 1989, Tajfel 2010). Categories are defined by prototypical characteristics interpreted by members and through this process of self-categorisation, an identity is formed.

Conversely May (2013) believes that the self requires much more than simply identity and proposes that understanding people's sense of self through the concept of belonging does something very different from identity per se. She purports that individuals belong to different categories such as gender, class, ethnicity and therefore this intersectional theory of identity may have a cumulative effect. So in other words, a woman may be discriminated against because she is a woman, a lone mother and also because she is black.

The terms social identification and group identification appear in the literature interchangeably. The early seminal work by Ashforth and Mael (1989) suggests that group identification is based on a number of principles. They claim that identification is viewed as a perceptual cognitive construct that is not necessarily associated with any specific behaviours or affective states. However, May (2013) argues that the self is inherently relational and dependent on interconnections between the self and the social. She believes that such an approach is necessary in order to appreciate the impact that social change has on us as individuals.

Much has been written about groups in the social identity literature (Ashforth and Mael 1989, Hogg and Abrahams1999, Jenkins 2008,). To identify with the group an individual need only believe that they are psychologically attuned to the group and it is not necessary for them to expend effort towards the groups' goals. Group identification is in addition seen as personally experiencing the success and failures of the group. Ashforth and Mael (1989) go on to suggest that social identification is distinguishable from internalisation with conflicting beliefs prevailing in terms of values, attitudes and beliefs. Although certain attitudes and behaviours are associated with members of a social group, accepting this as a definition of self does not equate with acceptance of those values and attitudes. A further principle of group identification is termed classical identification in which an individual identifies with a person and their position or role. This could be: doctor – patient, husband – wife, father – son and so on. The relevance of this is that an individual partly defines themselves in relation to a social referent and may be perceived as a desire to emulate, or vicariously acquire the qualities and characteristics of the other.

Social identity theory is not without its critics. Brown (2000) suggests that Tajfel, one of the most prolific authors of social identity theory drew much of his

inspiration from his own personal experience based on societal problems and rights. Brown goes on to comment that the main focus of social identity theory and its application lie in domains where there is group conflict whether this be religious or racial. Thus social identity theory is utilised as a theoretical explanation. He claims that the reasons behind the acceptance of social identity theory was as a result of an 'historical accident' in the 1970's Brown argues that such societal conflicts should be diminished by the restructuring of ideologies and that the functional and psychological appeal becomes devalued as a legitimate device. Nonetheless there is no question that social identity concepts are widely used as explanatory ideologies in disciplines.

The discipline of social psychology has explored the concept of group behaviour as the expression of cohesive or solidary social relationships between individuals. Groups have been defined as two or more persons who are in some way socially or psychologically interdependent (Tajfel 2010). Similarly, Hogg and Abrahams (1999) define a social group as a set of individuals who hold a common social identification or view of themselves as members of the same social category. Some hold the view that social identity theory is contradictory to conventional views of group relations because according to its theory, it is believed that favouritism occurs even in the absence of strong leadership or member cohesion (Ashforth and Mael 1989). There have been studies conducted which have demonstrated that simply assigning an individual to a group is enough to affect in- group favouritism (Tajfel 1982). From a social comparison process, those individuals who demonstrated the same or similar categorisations as existing members were seen as part of the 'in-group', whereas those individuals who differed were seen as the 'outgroup'. It is believed amongst scholars that personal identity gives way to social identity because in many

situations we react to others as unique individuals with particular personal characteristics. These individual characteristics can however be silenced if we enter a group situation and may be particularly pertinent if we disagree with an attitude, opinion or action. This suggests that we can immerse ourselves in a new identity as a member of a social group and as someone with the characteristics of that group. This is made possible because social identification enables an individual to locate themselves in the new environment where the 'self' is comprised of personal identity but instead adopts the characteristics symbolic of the social group. The social categories in which individuals place themselves are part of a structured society. An example of this is illustrated in the seminal work by Hogg and Abrahams (1999). They illustrate this concept using the example of black people versus white people and discuss the contrasting categories that exist including: power, prestige, status. They also make the observation that these individuals are born into an already structured society. They do however in the course of their life derive their subsequent identities from the social categories to which they belong. Earlier work by Ashforth and Mael (1989) provided ideas that social identification and group identification are similar and they use the terms interchangeably in their work. An important point they make is that although certain attitudes and values are typically associated with members of a given social category, acceptance of the category as a definition of the self does not necessarily mean acceptance of those values and attitudes. They go on to suggest that individuals may define themselves in terms of the organisation in which they belong or work, they may still disagree with the prevailing values, systems, authority and philosophy of the organisation. Indeed, it is recognised that people may have multiple social identities determined by their societal roles and occupational and organisational roles.

It seems rational therefore that if social identity prevails in society, it also prevails in the context of organisations. Organisational identification is a critical construct that has long been acknowledged in literature that focuses upon organisational behaviour. Ashforth and Mael (1989) postulate that organisational identification is a specific form of social identification comprising a number of existential motives which include: searching for meaning, connectedness, empowerment and even immortality. Its members therefore are seen to be prototypical of its values and beliefs. Some individuals may fit this category and their perceptions and even self-esteem can be affected by positive and negative intergroup experiences. Individuals often feel compelled to be obedient to authority and comply to the rules and demands of the organisation even though to do so may conflict with their own values and beliefs. It has been suggested however that one of the biggest contributions that social identity theory has made to organisational behaviour is the recognition that a psychological group is far more than an extension of interpersonal relationships. Organisational identification is often thought of as a cognitive link between the self and the psychological attachment one adopts with the organisation. For example, individuals may adopt the behaviours and defining characteristics of that organisation Dutton et al (1994). This can however have a negative as well as positive effect on the sense of self as organisational identification does not always connote pride in affiliation with the organisation.

Ashforth (2001) draws upon the work of Turner (1982) who claims that social identity is the cognitive mechanism which makes group behaviour possible. Interestingly and of great significance, an even greater component of social identity and group behaviour is one of conformity. It can be argued that there is a

strong correlation with these theoretical explanations and the way in which student nurses behave.

Social Identity in Groups and Organisations

The phenomena of social conformity in organisations and social influence is acknowledged in the literature (; Tajfel 1982; Ashforth and Mael 1989, Hogg and Abrahams 1999). Conformity as a psychological concept can be linked to Maslows work in the 1950's (Maslow 2000). Maslow sought to understand the components of human need and he discussed the significance of belongingness within groups. The general conclusion is that social influence is central to the concept of social behaviour and conformity is qualitatively separate from individuality. It is an intragroup phenomenon which manifests as normative behaviour. Baumeister and Tice (1990) suggest that people comply and obey in order to avoid exclusion from groups. This however has a negative impact on behaviour including an increase in affiliative behaviours and acquiescence. The existence of authority, hierarchy and pressure often influences people to obey. Social psychology has been discussed as the study of social influence and a large sub-section of this relates to conformity and conditioning. Well documented evidence in the discipline of psychology by Milgram in the 1960's revealed how individuals can become obedient to authority and felt compelled to comply under pressure (Wetherell 1997). This work is well acknowledged by scholars even though Milgram's experiments were seen as controversial. Many of the subjects in Milgram's experiments acted in such a way that was at odds with their social identity and personal philosophical and ethical beliefs. Hogg and Abrahams (1999) draw upon the work of sociology scholars Durkheim and Goffman and examine the notion of social 'norms' to achieve societies' goals. Norms can be imposed through legislation and laws and rules of society which by their very

nature become invisible and taken for granted. They are the context within which we exist. These types of norms are imposed on individuals through socialisation within educational organisations and by agents of social control. Their existence in society results from a homogenous consensus view. Social structures are constructed by people. So in other words if enough people behave in similar ways for long enough, this becomes identified as 'accepted'. Social rules are created through talk and interaction. Social norms on the other hand emerge from the set of expectations in groups and organisations in relation to behaviours, perceptions, stereotypes. Kiesler and Keisler (1969) cited in Hogg and Abrams 1999) adopted the definition of conformity as:

'a change in behaviour or belief towards a group as a result of real or imagined peer pressure' (Keisler and keisler cited in Hogg and Abrams 1999, p 160)

Perhaps the study of how shared cultural repertoires are used in every day interaction can be attributed to the work of Erving Goffman (1961) Goffman viewed the social aspect of life and interaction as a performance in his publication 'The Presentation of Self in Everyday Life.' He described the performance of life drawing on theatrical metaphors such as: roles, script, props, stages. He believed that individuals attempt to control the impression they give to others in order to appear of sound character in social situations.

Linked with this concept and taking it even further than organisations, Hart (2012) in his seminal work aimed to offer greater understanding of law, coercion, conformity and morality. He discusses law as the union of primary and secondary rules arguing that a simple model of law as the sovereign's coercive orders fails to produce salient features of a legal system. Instead, law and coercion are underpinned by social norms and rules as well as formal legislation.

Much of what is discussed correlates with the way in which nurses and student nurses behave, therefore these theories are pivotal to this research study. If we view the hospital as an organisation, on entering the organisation (hospital), the students are exposed to the values, beliefs and culture of that organisation that exist on a macro level. However, in addition, individual wards and departments within the organisation have their own individual values, beliefs and team culture created by the team. The theory of team and group behaviour is well documented in the literature and is attributed to the work of Tuckman (1965). Although it will not be explored in any detail here, it is acknowledged therefore that micro organisations exist within organisations possessing their own culture, values and beliefs, thus some ward or other clinical environments will be perceived as functional and positive whereas others will be perceived as bad.

It can be argued that on entering the healthcare organisation a degree of depersonalisation takes place amongst patients and also staff. The NHS and healthcare professions have campaigned for the treatment of patients to encompass a holistic culture where patients are not depersonalised but treated as individuals and not labelled as an illness or damaged body part. Conversely it can be argued that a similar depersonalisation occurs when hospital workers are identified by their hierarchical uniforms and dress code indicating seniority and experience. Nursing uniforms post -Nightingale were designed in military style with hierarchical starch and quasi-military markings. The nurse's cap portrayed her grade and often her training hospital as if to promote a sense of belongingness to an elite club or order. The novice nurse was expected to carry out orders from her seniors and discouraged from challenging practice and decision making. As a student nurse, I recall carrying out actions as ordered to by a senior nurse or doctor. Some of these actions did not sit with my, own beliefs

and philosophies but I took solace from the fact I was obeying orders from those who 'know better'. This can be explained in terms of the concept of group conformity, conditioning and its links with belongingness. In order to avoid exclusion by others in a group, individuals conform, obey orders and strive to present themselves in a positive light. This can however lead to acquiescence and engagement in negative behaviours. Whilst it is expected that health care has moved on from this hierarchical era of paternalism, studies have indicated that this is not the case. As far back as the 1960's, Menzies Lyth (1988) uncovered the nature of student nurses' relationship with senior nurses and the anxieties induced by work patterns, team dynamics. Similarly, Levett -Jones and Lathlean (2008) carried out more recent research which was to examine the socialisation of student nurses focusing upon their respect for authority and obedience. They studied the concept of students' desire to 'fit in' and their reluctance to 'not rock the boat'. This seems to suggest that social identity is significant amongst this group. Depersonalisation can be made even worse by regimented practice and behaviour born of Nightingale's military direction based on obedience. Hospital routines were often followed slavishly to the point where actions and practices were irrational and lacked evidence but rather were based on custom and practice. Traditionally nursing students were socialised to obey, conform and respect authority. Students were expected to do and say what was expected of them and they were discouraged from challenging or questioning practices and behaviours. Anecdotes from colleagues tell of getting into trouble with senior nurses because the patient's bed did not look neat and the sheet corner had not been folded in a pristine way. Whether the patient was comfortable held little relevance, yet as students they were more in fear of being disciplined for an untidy sheet so prioritised this over patient comfort. These

behaviours can therefore be potentially explained drawing upon social identity and organisational identity theory. To reiterate Jenkins (2008) view, he postulates that identity is important because it is the basic cognitive mechanism that humans use to sort out themselves and the collective. He also argues that identity does not determine behaviour and that people work with various hierarchies of identification which are often fluid (Jenkins 2008).

A study of hospital nurses by Melia (1987) examined the socialisation of hospital trained nurses in the UK. Her qualitative study identified that in order to survive, student nurses fitted in with dominant strategies of 'getting the work done' as they were 'just passing through'. This experience of students does not seem to have changed significantly to date.

There are already acknowledgements of the causative relationship between hierarchy, obedience and compliance, with errors occurring in the high reliability industries such as aviation, military and nuclear industries. Often failure to 'speak up' has contributed to catastrophic incidents (Reason 2008, Vincent 2010). Much has been invested in these industries so that we can learn from failure. This human factors approach advocates that individuals must speak out when they know something is wrong (Dekker 2011). The last two decades have seen this approach gradually being adopted by healthcare organisations but there is still little evidence of its impact. This brings us back to the original research aim:

'to understand student nurses' perception of what they believe is a patient safety incident in their practice placements and understand the reasons that influence their willingness or reluctance to raise concerns about patient safety'

Menzies - Lyth first published her very significant psychodynamic study of organisational life in 1959. Her study illuminated the way in which anxieties

generated by the organisation (a hospital), led to collective defences that became institutionalised as social systems and work practices. In her seminal work, she provides an example which illustrates how hospital routines were followed slavishly to the point that common sense is compromised. An example she provides, focuses upon a nurse who wakes a patient up to give him a sleeping tablet to help him sleep.

It is interesting that the term 'institution' is used throughout the literature concerned with organisations. The term itself is defined as a pattern of behaviour in any particular setting that has become established over time as 'the way things are done' (Jenkins 2008). Menzies- Lyth (1988) concluded that to a degree all institutions have these features of structures and dynamics. She argues that psychotic anxiety is seen as much in democratic groups and institutions as it is in more rigid groups.

An institution is recognised by individuals as the normative specification and intersubjective relevance of how things are done. Hospitals and health care settings have developed to what they are today from the institutions of yesterday. Faucault (1973), a catalytic theorist wrote prolifically on the culture of power that existed in psychiatric institutions and the relationship between power and knowledge. He was concerned with the way in which people willingly subjugate themselves to subtle forms of power. He postulates that it is the taken for granted activities humans engage in that demonstrate this, for example we go to school, go to the doctors, shop etc. We willingly medicalise our bodies in the Western hemisphere and obey when we are told to attend for screening, eat less fat, drink less alcohol. It seems logical then that students entering the nursing profession and health service subjugate themselves to the culture, values and beliefs of such a well- established and powerful organisation. Furthermore, the

psychological assertion previously discussed that humans recognise themselves with social groups is particularly relevant to nursing. May (2013) discusses 'knowing the rules of the game'. Drawing on the work of Bourdieu (1977) she suggests that we feel at ease in places where our habitus or learned habitual ways of thinking and doing corresponds with the social fields we find ourselves in because we have a 'feel for the game'. When we do not have this feel for the game we are likely to experience unease due to a destabilizing effect on the sense of self.

There have been attempts to study this phenomenon in nursing. Levett-Jones and Lathlean (2007, 2008, 2009) identified a number of factors that impact and are consequences of 'belongingness' amongst student nurses. Adopting a mixed – method case study they studied eighteen student nurses from two universities in Australia and one in the United Kingdom. They explored the contextual factors and interpersonal dynamics that were seen to have significant bearing on some of the student experiences. Of these experiences they revealed that a sense of belonging to the nursing team is crucial to a positive and productive learning experience. On the other hand, alienation resulted from unreceptive and unwelcoming clinical environments. Often dissonance was created when students felt disconnected and where their own personal and professional values did not articulate with those values and behaviours evident in the practice environment. The concept of belongingness is derived from a fundamental human need to be accepted and the converse of acceptance can be devastating (Baumeister and Tice 1990). However, although seemingly the focus of a number of research studies May (2013) argues that few authors discuss in detail what is meant by the concept of belongingness. Maslow (2000) in his quest to explain human need believed that belongingness was crucial to a persons' fulfilment

along with what he described as 'basic needs'. These included: physiological, safety and security, self-esteem, acceptance. These were essential factors in the achievement of self-actualisation. Though Maslow himself acknowledged that this theory was based on clinical observations alone, the theory is generally accepted within the discipline of psychology. Miller (2003) offers a comprehensive definition of belongingness suggesting that::

'belonging is a 'feeling that affords sense of accord with who we are in – ourselves and a sense of accord with the various physical and social contexts in which our lives are lived out' (Miller 2003, p 220)

May (2013) further suggests that belonging is an inherent capacity in people who have developed a sense of self, because this sense of self is partly based on who we feel similar to, in other words who we belong with. So belonging is what we have in common with other people and also what differentiates us from others. Identity can therefore be produced through the drawing of boundaries and categorisation between individuals.

 Baumeister and Leary (1995) discuss the concept of belongingness as the need to be and perception of being involved with others at differing interpersonal levels. This is relevant if we examine the fluidity of hierarchies. Many prevailing cultures in the hospital and healthcare settings reveal further subcultures existing of informal relationships of hierarchy and power between permanent team members. Students quickly learn the pre-requisites to the process of 'fitting in' and discover what supports and inhibits the process during their practice placement which is essential to survival. Though seniority of staff may dictate the hierarchy of power, this is not always the case, with dominant unqualified healthcare assistants wielding power over the team. This was discovered in the research conducted by Levett – Jones and Lathlean (2009) which suggested that

group conformity amongst student nurses may be viewed in the context of enhancing one's chances of inclusion into a group. Students often acquiesce and adopt the values and terms of the institution in order to survive their placement and achieve a sense of belonging, however this may not sit comfortably within their moral compass.

Brennan and Timmins (2012) offer an exploratory paper examining the influence of changing nursing student identity in the UK, USA and Ireland. They emphasise the tensions between compliance and critical thinking amongst students. Nurses were traditionally educated in the hospital training school and therefore formed an association with that particular hospital. The student's identity was shaped by institutional ritual and routine and also by the adornment of medals worn on their uniforms which were unique to that organisation (Brennan and Timmins 2012). Arguably their learning needs were secondary to the needs of the organisation. This social milieu provided them with a sense of institutional pride and identity. However, linked with this concept is one of conformity which often leads to ritualistic practice and absorption of the individual into the existing culture. The authors emphasise that institutional compliance can create a barrier to transparent accountability and whistle-blowing against substandard practice. Nurse education has moved on from the traditional training schools to university based higher education awarding a degree as well as registered nurse qualification. Yet although this move affords students more freedom and focused teaching and learning, what is not clear is the impact the transition has on their professional identity once qualified. The authors draw upon the earlier work of Levett-Jones and Lathlean (2007, 2009) to explore the concept of identity and belongingness. They draw the conclusion that students are now at the nexus

between competing stakeholders: the university developing and nurturing their critical thinking and the healthcare institutions novice to expert approach.

Of interest, Levett-Jones and Lathlean (2006, 2007, 2009) discuss belongingness as a concept of 'being part of, feel accepted, fitting in'. Its antithesis is therefore alienation which reflects exclusion from social and cultural participation (Hajda 1961). This relates back to the seminal work of Maslow who discussed the significance of belongingness within groups. He proclaimed that humans were driven by a motivational hierarchy of basic needs: physiological needs, safety and security, belongingness and acceptance, self-esteem and then finally self-actualisation. Maslow posited that unless each stage of the hierarchy was met, humans would be unable to focus on the next level in that hierarchy (Maslow 2000).

The general conclusion is that social influence is central to the concept of social behaviour and conformity is qualitatively separate from individuality. It is an intragroup phenomenon which manifests as normative behaviour. Baumeister and Tice (1990) suggests that people comply and obey in order to avoid exclusion from groups.

Referring back to the studies by Levett Jones and Lathlean (2006, 2007, 2009), a mixed methods approach using purposive sampling was adopted. The purpose of the mixed methodology was to apply a quantitative approach across a mixed set of cultures and systems as well as eliciting the narrative accounts of students' belongingness experience. Their findings revealed that in order to have a positive and productive learning experience, student nurses require a sense of belonging. Students seek connectedness and friendly working relationships with nursing colleagues. Their findings echoed similar results in Melia's earlier work

suggesting that 'getting the work done', fitting in' and 'learning the rules' were the dominant strategies used by students to survive their placement (Melia 1987). Some students reported knowingly and willingly engaging in poor practice as directed by the registrant in order to feel secure and 'fit in'. They did not wish to 'rock the boat'. However, once the students felt that acceptance, they were less likely to conform to the directives of registrants. This adds to the observations of later authors that despite the progress made in the theoretical component of nurse education, little appears to have changed with regard to clinical learning and culture (Duffy 2012, Brennan and Timmins 2012, Steven et al 2014, Ion et al 2015).

On reviewing the literature, it became apparent that the student nurse was being observed through a social lens. Student nurses enter the profession with their own social identity, behaviours and experiences. They are then indoctrinated into the organisational culture of Higher Education and practice placements. Fundamental to their survival is their desire to belong.
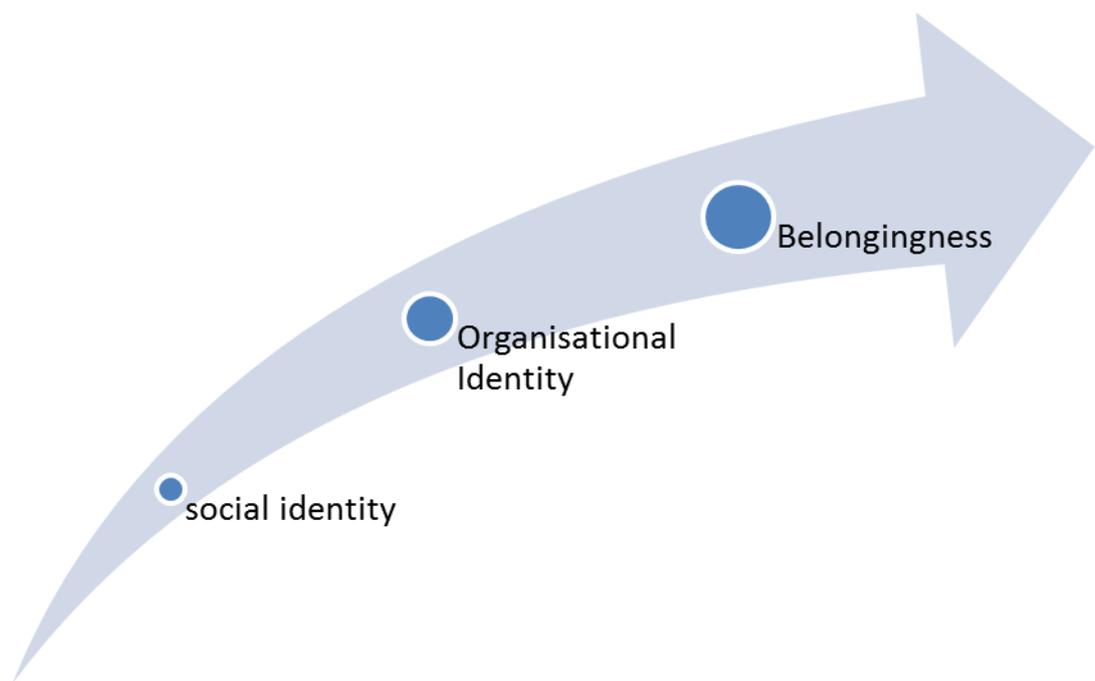
Figure 4 Conceptual lens

Summary

To summarise, this chapter has examined the literature relating to raising

concerns and in particular the factors that influence people to speak up or remain

silent. Although there was a dearth in literature specifically focusing upon student

nurses, the literature search did reveal relevant material embedded in social and

psychological theory. The personal beliefs, values and philosophies of nurses often appears to be at odds with organisational values and beliefs. Whistleblowers appear to be driven by a strong sense of moral obligation but this is often tinged with fear of reprisal. A strong theme of social and organisational factors was prevalent throughout the literature and this has helped guide the development of the conceptual framework. There are however gaps in the literature suggesting that this topic is worthy of further research, and in particular in relation to student nurses. It is anticipated that this research study will offer an insight into how nurse educators can support students to recognise and acknowledge the tensions between their own social identity and that of the organisation.

The following chapter will present the research methodology selected to address the aims and outcomes of this research study.

Chapter 3: Research Methodology and Research Methods

This chapter will provide an explanation of the methodology selected to address the aims and outcomes of this research study. A detailed discussion on the research methods used will follow with consideration given to the ontological and epistemological assumptions underpinning the research study.

Experienced researchers remind us that we all bring certain beliefs and philosophical assumptions to our research whether we are aware of this or not (Cresswell 2013). Often these philosophical assumptions at a less abstract extent may guide our research and inform our choice of theories. When planning a research study, it is necessary to reflect on one's own personal philosophies and beliefs about knowledge in order to select the appropriate methodology for this study. The starting point was to consider the aims and intended outcomes of the project. Researchers need to consider the following questions:

How do we know what we know and what is 'my' position on reality and truth? Does the design of the study needed to incorporate an approach that would answer the research questions and sit with the researchers own philosophical position?

Crotty (2013) advocates that there are four elements which must be considered when contemplating a research proposal: epistemology, theoretical perspective, methodology and methods. Epistemology is concerned with the theory of knowledge (Crotty 2013). Blaikie (2012) suggests that an epistemology is:

'a theory of how human beings come to have knowledge of the world around them (however this is regarded), of how we know what we know' (Blaikie, 2012, p 18)

So put simply, how do we know what we know?

Ontology on the other hand is concerned with the nature of what exists (Blaikie 2012). It is concerned with the nature of reality and human beings. Research methodology is the general study of method in particular fields of enquiry (Blackburn 2008). Many researchers would suggest that ontological issues should feature within these elements and Crotty (2013) argues that ontological and epistemological issues tend to merge together. It is important therefore to reflect on research paradigms and situate their philosophical stance in relation to this proposed research study.

Guba and Lincoln suggest that:

'a paradigm may be viewed as a set of basic beliefs (or metaphysics) that deals with ultimate or first principles' (Guba and Lincoln, 1994 p 106)

In other words, a paradigm represents a worldview that defines for its holder, the nature of the world, the individuals place in it and its relationship to those parts.

Historically and particularly in the nineteenth century, many areas of research used quantitative empirical methods characterised by the popularity of positivism. Researchers focused mainly on areas and questions that could be visualised, observed and measured. Mathematical and statistical procedures were used to explore, predict and explain phenomena (Laverty 2003). However, the last century saw a paradigm shift with qualitative research methodologies growing particularly in the social sciences. Increasing questions emerged about the focus of enquiry concentrating on methodologies that emphasised discovery, description and meaning rather than prediction, control and measurement (Laverty 2003, Blaikie 2012, Cresswell 2013). Qualitative research rejects the positivist approach of utilising traditional scientific methods to gain knowledge, but rather seeks to study social observations and therefore qualitative research

sits within an interpretive paradigm. There are ontological and epistemological differences between positivist and interpretive research. Epistemology deals with the nature of knowledge and it provides a philosophical grounding for deciding what kinds of knowledge are possible and how we ensure they are adequate and legitimate (Crotty 2013). An interpretive approach to research seeks to understand phenomena from the participants' perspective, how they 'see the world'. Individuals construct reality based on influences such as: gender, culture, education, attitudes and social behaviour. Subjective evidence is based on individual views therefore the researcher tries to get as close as possible to the participants being studied. In contrast, positivists contend that the researcher should be independent from the study. The ontological issues raised in qualitative research focus upon the researcher embracing the idea of multiple constructed realities as opposed to the positivist view that reality can be measured validly and reliably.

As the researcher in this study, I subscribe to the ontological and epistemological position that knowledge is constructed and that individuals whilst sharing some views of reality, may in fact interpret phenomena differently. In order to answer the questions posed in this research, there is a need to understand the feelings and experiences of individuals and attempt to unravel and make sense of them. As a researcher, we are an integral part of the research experience. It seemed fitting therefore to design a qualitative study that would seek to explore the lived experience of participants and understand their interpretation of phenomena. However, qualitative research as a set of interpretive activities reveals a milieu of theoretical paradigms from constructivism, feminism through to ethnic models of study. It does not have a distinct set of methods or practices that are entirely its own. Qualitative researchers utilise narrative, content, discourse and archival

analysis (Denzin and Lincoln 2000 and 2013). Qualitative research draws upon and uses the approaches of ethnomethodology, grounded theory, narrative, phenomenology, interviews, psychoanalyses and other methods, disciplines with no one method being privileged over another. Furthermore, to a novice researcher many of the methods appear similar or to overlap. Richards and Morse (2013) in their attempt to make understanding methodology more accessible discuss two distinctive methods: description and interpretation. They argue that more descriptive methods are those whose primary goal is to describe a situation of phenomenon vividly in detail and give a clear picture of what is going on. The results may clarify problems and are often used to determine or detect change. Interpretive methods on the other hand seek to see both 'what is going on, what it means and how can it be explained'.

To the inexperienced researcher, refining choice can be a daunting task but after much deliberation and academic discourse with peers, it became apparent that the phenomenological approach would appear to sit with the research aims and questions in this study. In addition, this methodological approach is congruent with my own philosophical and epistemological position. Other research methodologies were considered but essentially my aim was to understand the 'lived experience' of student nurses. Other methodologies would not have afforded me the same opportunity, but rather would have offered exploration from a different perspective.

Phenomenology has become increasingly popular particularly within the social sciences (Laverty 2003, Cresswell 2013, Smith et al 2013) yet confusion still exists about the various unique aspects of different approaches in phenomenology. The founding principle of phenomenology inquiry is that experience should be examined in the way that it occurs, and in its own terms.

Van Manen (2014) offers a detailed explanation on the meaning of phenomenology but concludes that it is essentially the study of lived experience or the life world.

Phenomenology

Phenomenology is both a philosophy and a research methodology. The movement arose in Germany before the first world war, challenging the dominant epistemology of the time. Considered the figurehead in the phenomenology literature, Edmund Husserl (1859-1938) is recognised for his influence on the paradigm which has seen transformation over the last century. His initial work focused on mathematics and the calculus of variations which sits with the positivist approach to research. However, his interest in philosophy influenced his decision to concentrate on his formal education in this field. Husserl believed that psychology was flawed because it attempted to apply methods of the natural sciences to human issues. Husserl's views challenged dominant views on the origins and nature of truth of the time. With the belief that humans are not only responding automatically to external stimuli but rather responding to their own perception of what the stimuli mean, he pursued his studies in the belief that it promised a new science of 'being'. (Moran and Mooney 2002, Laverty 2003, Smith et al 2013). Husserl was inspired by Franz Brentano (1838- 1917). Brentano coined the phrase 'descriptive phenomenology' and this provided Husserl's motivation to develop the concept of phenomenology. Husserl adopted Brentano's belief that every mental act is related to some object and implies that all perceptions have meaning (Moran 2000). Brentano termed this concept 'intentionality' and refers to the internal experience of being conscious of something. For Husserl, he believed that phenomenology is the rigorous and unbiased study of things as they appear in order to arrive at an essential

comprehension of human experience. A key epistemological feature of phenomenology is the concept of phenomenological reduction and this was revised by later philosophers.

With the increasing acknowledgement of phenomenology as a philosophy and research method, what followed was a development of the concept of phenomenology by a number of scholars who had seen a shift from the traditional ideas of Husserl move to newer approaches. The different approaches all have commonalities, but they also possess distinctive features. Whilst newer approaches may widen opportunities for exploration of phenomenon, they can also blur and confuse the boundaries (Dowling 2004).

Husserl was motivated intellectually by Brentano's notion of 'descriptive psychology'. He adopted Brentano's account of intentionality as the fundamental concept of understanding and classifying conscious acts. A key epistemological strategy of phenomenology is the concept of 'reduction' – the life world stands as people experience it without resorting to interpretations. Husserl asserted that main focus of understanding how individuals experienced phenomena was that it appeared through consciousness. The researcher therefore needs to see the individuals account with fresh eyes and refrain from judgement. The researcher therefore must 'bracket' their preconceptions and presuppositions and render them as clear as possible. Husserl used bracketing which he termed 'epoch' as a method to arrive at the essence of a phenomenon.

Bracketing has been defined as the suspension of all biases and beliefs regarding the phenomenon being researched prior to collecting data about it. This is in an effort to remain objective without forming pre-conceived ideas, (Laverty 2003, Dowling 2004, Denzin and Lincoln 2015). The concept of

bracketing however was debated further by later scholars suggesting that presuppositions are not to be eliminated or suspended.

Later developments in the approach to phenomenology are attributed to the work of Martin Heidiegger (1889 – 1976), Hans – George Gadamer (1900 -2001), Maurice Merleau –Ponty 1908 - 1961).

Heidegger began his philosophical career as a student of Husserl. Whilst he agreed with much of Husserl's views, he differed in his view on the importance of description as opposed to understanding. Heidegger's approach to phenomenology is often taken to mark the move away from transcendental phenomenology and to set out the beginnings of hermeneutic phenomenology. He proposed that consciousness is not separate from the world of human existence and he argues for an existential adjustment to Husserl's writings that interprets structures such as basic categories of human experiences rather than just as pure, cerebral consciousness (Dowling 2004, Smith et al 2013) Heidegger (1962) in his seminal writings in 'Time and Being' described phenomenology as a way to engage with the world and interpret experience. Heidegger was concerned with ontological findings, an understanding of 'being' which he termed 'Dasein', the essence of Heideggerian phenomenology. Crotty (2013) purports that Heidegger's phenomenology of Dasein brings him 'to his starting point on the journey towards being that is the shadowy pre-understanding of being that we all possess and what he calls the fore-structure of being (Crotty 2013). Merlo Ponty (1908 -1961) shares Husserl and Heidegger's commitments to understanding our being in the world but also believed that there was a need for a more contextualised phenomenology. He asserted that meaning is created in dialect and is described as the interaction in human relationships. Sartre shared the view of Heidegger that individuals are caught up with living in the world and while we

have self – consciousness and seek after meaning, this is action orientated, self-conscious and engages with the world in which we inhabit. The primary difference between the approaches of Husserl and Heidegger is that Heidegger was critical of the Husserl's emphasis on description rather than understanding and that presuppositions should not be eliminated therefore bracketing is unnecessary. This approach by Heidegger adopted a more interpretive paradigm known simply as 'hermeneutics'.

Heidegger and his personal friend Gadamer are credited with placing interpretive hermeneutic phenomenology firmly at the centre of contemporary philosophical debate (Dowling 2004). Gadamer (1990/1960) in his primary work 'Truth and Method' is concerned with emphasising the importance of history and the effect of tradition on the interpretive process. Gadamer subscribes to Heidegger's hermeneutics and the relationship between the fore-structure and the new object (Smith et al 2013).

Hermeneutics

Hermeneutics is known as the 'art of interpretation' and is considered to be one of the most extensively debated topics in contemporary philosophy (Dowling 2004). The term hermeneutics translated literally is science of biblical interpretations (Crotty 2013) and was used extensively in the seventeenth century. But since then the word has migrated and is recognised in scholarly circles as a disciplined approach to interpretation. Gadamer suggests that hermeneutics is not a method but a fluid set of guiding principles aiding the human search for truth in the concealed forgetfulness of language (Regan 2012). Sometimes the terms phenomenology and hermeneutics are used interchangeably but there are differences and it was necessary to decipher many

meanings and understandings in order to make sense of them. Essentially, in the context of research, Dowling (2004) in her quest to understand the differences offers us the interpretation that interpretive phenomenology as opposed to descriptive phenomenology is simply known as hermeneutics. However, it is important to clarify that this definition does not seek to simplify hermeneutics because there are no universal principles applied and in fact there are a number of schools of thought. Blaikie (2012) argues that of all research paradigms, hermeneutics is the most complex and diverse and the least well understood by social scientists. The earlier origins of the development of hermeneutics can be traced back to Schleirmacher (1768 – 1834) who provided the foundation for hermeneutics. He saw hermeneutics as the science for understanding language and moved on from the analysis of texts to the understanding of conditions of dialogue between historical periods (Blaikie 2012). Schleirmacher believed that understanding has two dimensions: grammatical interpretation and psychological interpretation. The latter is an important concept in modern day phenomenological research because it involves trying to place oneself within the mind of the author or social actor (interview subject) in order to elicit what was known by the person as they wrote the text or prepared for a social interaction. He believed that it was important to construct the life context in which the activity has taken place. This is known as the 'hermeneutic circle' of endeavouring to grasp the unknown whole in order to understand the known parts. Similarly, Dilthey (1833- 1911) cited in Blaikie (2012) shared Scheirmachers views on hermeneutics as being seen as a core discipline that provided a foundation for understanding expressions of human life. He considered the most fundamental form of human experience to be lived first-hand, primordial unreflective

experience. The lived experience can only be understood through its expressions, gestures, informal rules of behaviour.

More contemporary reviews of hermeneutics are discussed widely in the literature. There is acknowledgement of the classical development of hermeneutics by Schleirmacher and Dilthey then the later work of Heidegger and Gadamer (Smith et al 2013).

Gadamer places a strong emphasis on language and texts and affirms the position of the researcher in the 'hermeneutic circle' which has been described as the most resonant idea in hermeneutic theory (Smith et al 2013). The concept of the circle is that it aims to look at the 'whole' and the 'part'. Put simply, the meaning of a word can only become clear when viewed in the context of the sentence. Equally the meaning of the sentence depends on the cumulative meaning of individual words. Gadamer believed that the hermeneutic circle enables us to understand the meaning of something held by another by not attaching blindly to our own fore-meaning. He asserts that we remain open to and embrace the meaning held by another person or text. Essentially it helps us to be aware of our own biases in order for the text to portray its uniqueness against our own fore meanings (Smith et al 2013). The debate on the role of researcher bias is contended extensively amongst phenomenologists. Ajjawi and Higgs (2007) suggest that:

'the hermeneutic circle is a metaphor for understanding and interpretation, which is viewed as a movement between parts (data) and whole (evolving) understanding of the phenomenon, each giving meaning to the other such that understanding is circular and iterative. Therefore the researcher remains open to questions that emerge from studying the phenomenon and allows the text to speak: the answer is then found in the text' (Ajjawi and Higgs 2007 p 623)

The action of 'bracketing' was discussed earlier and the belief by Husserlian phenomenologists that suspension of all biases and beliefs regarding the phenomenon before researching it is essential if objectivity is to be maintained. Conversely, the hermeneutic approach suggests that presuppositions are not eliminated or not suspended and the hermeneutic circle goes some way in addressing this.

Though a complex paradigm, Crotty (2013) attempts to offer a distinction of the key characteristics of hermeneutic phenomenology which differ from other theories. He suggests that the essence of hermeneutics is a sharing of meaning between communities and to elicit a deep understanding and interpretation of texts and dialogue. Skilled hermeneutic enquiry has the potential to uncover meanings and intentions that are, in this sense hidden in the text. Interpreters may end up with an explicit awareness of meanings' and especially assumptions that the authors themselves would have been unable to articulate.

With regard to this research study, it has been necessary to reflect upon personal prior knowledge and experience both as a nurse and an educationalist in relation to the phenomena under investigation. To attempt to bracket and put this aside is arguably a task that is unachievable as acknowledgement of views and opinions which are embedded in thinking and actions, shaped experience and socialisation are inevitable. Nonetheless, being aware of the notion and purpose of bracketing is a reminder of potential bias and as such an understanding of this issue will go some way in facilitating objectivity in the analysis and discussion of findings.

Using a hermeneutic phenomenological approach requires due consideration given to the selection of a data analysis tool. Essentially, this research study

seeks to understand the lived experience of student nurses and the interpretation of their experience in such a way that policy guidance can be drawn from the conclusions. With this in mind, after revisiting the various approaches to qualitative data analysis the model of analysis selected was 'Framework'. Framework for applied social policy analysis sits comfortably with the epistemological position of this research study and the intended outcome of informing policy. Developed in the 1980's by social policy researchers Richie and Lewis at the National Centre for Social Research, Framework is a recognised method of qualitative analysis and is particularly useful in the analysis of semi-structured interview transcripts (Gale et al 2013). It is a tool which is capable of dealing with large amounts of data and provides a transparent audit trail throughout the process. Generating themes from data is a widely used analytical method in qualitative research and is essentially an interpretive process. Categories arising from the data can be either inductive or deductive. It is acknowledged in this study that existing information and knowledge does exist, though it is minimal, therefore a deductive approach is appropriate. Patterns in the data are systematically searched enabling the researcher to provide meaningful descriptions of the phenomena. The principle of the Framework approach is that qualitative data analysis can be undertaken systematically (Huberman and Miles 2002). It sits within a broad family of thematic analysis methods and is not aligned with any particular epistemological, philosophical or theoretical approach to content analysis. Maggs- Rappor (2001) suggests that debates about epistemological and ontological perspectives underpinning qualitative methods can overshadow the robustness of studies arguing that published qualitative studies often lack transparency in relation to the analytical

processes employed. Framework is a flexible analytical tool that supports key steps in the data management process (Kiernan et al 2015).

Trustworthiness

To ensure quality in research, it is a requirement that the researcher remains cognisant throughout the research process of issues surrounding trustworthiness and validity which are key issues contemplated by the audience to which research summons. The literature offers a plethora of discussion about reliability and validity, however there exists a debate between scholars on the appropriateness of the terms used in relation to qualitative research (Polit and Beck 2010, Richie et al 2012, 2014, Cresswell 2013, Silverman 2013,).

In all research, issues of credibility and integrity are scrutinised but exactly how and what methods are utilised becomes murky. In quantitative research, the benchmark standards for credibility are validity and reliability. Bloomberg and Volpe (2012) advise researchers that if research is valid, it then clearly reflects the world being described. If research is reliable then two researchers studying the same phenomenon will arrive at compatible assumptions. However, there are arguable differences between quantitative and qualitative methods of trustworthiness. Richie et al (2014) take this further and postulate that validity and reliability are central concepts in generalisation and whether or not the wider inference can be sustained. The concept of reliability and validity were developed in the quantitative paradigm of research and given the epistemological differences that exist between quantitative and qualitative research, application of these concepts could potentially lead to confusion. Polit and Beck (2010) suggest that the terms: validity and reliability are avoided by some because of their association with quantitative research. For example, statistical tests would

arguably be inappropriate in qualitative research. There are others however who oppose those disagreeing with the terms validity and reliability arguing that the terms are appropriate in all research paradigms (Polit and Beck 2010). The debate about credibility in qualitative research appears to be grounded in the argument about empirical science versus soft science. This can be illustrated in the comments of Robson (2011) who asserts that the problem does not lie with the actual terms of 'reliability' and 'validity' but rather with their somewhat overly rigid application in ways that do not always appear appropriate to qualitative work. Richie et al (2014) concur with this view point sustaining that whilst reliability and validity are imperfect terms and open to misinterpretation, when considered in their wider terms as referring to the stability of findings then they are relevant to qualitative research. Bloomberg and Volpe (2012) advise that qualitative research is characterised by ongoing discourse and terminology has been developed in the literature to inspire contemporary thinking on alternative terminology. Thus a dialect on 'credibility, trustworthiness, dependability is seen throughout the literature as a contrast to older more traditional terminology associated with quantitative empirical discourse (Lincoln and Guba 1995, Guba and Lincoln 1998).

This research study acknowledges the principles of reliability and validity to inform the understanding of how to make the research credible. However, the term 'trustworthy' would appear to sit more comfortably with the chosen methodology, methods and epistemology (Lincoln and Guba 1985).

There exists in the literature a number of frameworks to guide the researcher in consideration of trustworthiness. Lincoln and Guba (1985) advocate the following four criteria for developing the trustworthiness of a qualitative enquiry:

- ➢ Credibility

- ➢ Dependability

- ➢ Confirmability

- ➢ Transferability

Credibility is associated with true interpretations of the findings in data and equates with validity in quantitative data. The essential question asked is whether this research study accurately represented the feelings and experiences of participants. As the researcher, I acknowledged early in the study my own beliefs and experiences regarding the subject under study based on previous roles as both a registered nurse in practice and as an educationalist. Some of these underpinning experiences and beliefs could be perceived as influencing the researcher subsequently leading to researcher bias. Throughout the doctoral research study, I kept a reflective diary on my experiences, thoughts and beliefs and discussed these with supervisors. Reflexive journals and notes are an important contribution to the trustworthiness of research studies (Polit and Beck 2010) but it is argued that alone, they offer little to address issues of trustworthiness, nonetheless, keeping a reflexive journal helped me to explore my own feelings and attitude towards the subject matter and remain aware of my own presuppositions and experience.

Of significant importance in this study, one further step in the process of analysis using the Framework approach is that of summary and display. This provides a visual matrix of thematising the data by participant and quotes. This provides a level of transparency that some data analysis tools do not. Readers of the research can visualise the data displayed and observe how themes are mapped

against subjects. This offers an additional method to measure validation of the study.

The second criterion that Guba and Lincoln (1985) describe is that of dependability. This equates with reliability and is associated with whether or not the findings would be replicated if the study was repeated. This is difficult to measure in qualitative studies but by asking the supervisors of the researcher to examine the data and identify themes, this provides a form of interrater reliability (Huberman and Miles 2002).

This was observed in this research study and the approach also goes some way to address the notion of confirmability which is concerned with objectivity and the potential for congruence about the data's accuracy when looked at by others. Transferability refers to the extent to which the findings can be transferred or be applicable to other similar groups. Lincoln and Guba (1985) note that in qualitative research, the researcher cannot specify the validity of an enquiry, but rather they must provide enough descriptive data to allow consumers to evaluate the applicability of the data to other contexts. The participants under study are representative of other groups of students undertaking a three-year programme in Adult Nursing therefore arguably, the findings are representative of this homogenous group.

In conducting this research, steps have been taken to acknowledge issues of trustworthiness with regard to this research study acknowledging the complexities of demonstrating how this can be achieved in qualitative research. In addition, the application of Framework as a data analysis tool offers additional evidence of transparency by way of data summary and display, providing the

reader with an opportunity to follow the analytical journey throughout the

research (see figure 5)

Paradigm
- Interpretive paradigm
- Inductive

Methodology
- Hermeneutic Phenomenology
- Ethical approval
- Ethical consideration: consent and participant information
- Sampling method

Method
- Semi-structured interviews using digital voice recordings
- Note taking during interviews

Analysis
- Applied Policy Framework
- NVivo
- Five stages of analysis: familiarisation, thematic framework, indexing and sorting, reviewing data extracts, data summary and display (Ritchie 2014)

Findings
- Synthesis and critique
- Examining theoretical framework

Trustworthiness
- Reflexivity
- Member checking
- Data summary and display

Figure 5 Research project plan

Methods

The research setting and sample

There are a number of sampling strategies used in qualitative research and for the purpose of this study the method of purposive sampling was adopted. In this method, samples are criterion based. The study focused on students undertaking the adult nursing programme and would include a cross section of first, second and third year students, female and male. The rationale for this approach stemmed from a wish to elicit the experience of a range of students at different stages of training, age and gender to ensure a maximum variance sample. This approach sits with the underpinning interpretive methodology.

Recruiting a sample of students from all fields of nursing, including: adult, child, learning disability and mental health was considered. However, the decision to focus upon adult nursing students was informed by the aims of the research. In my own experience of teaching students about patient safety, I have become aware that students in fields of nursing other than adult can sometimes be confused by the terms: 'patient safety' and 'safeguarding'. Whilst the two terms are closely linked, there are differences. It is a requirement in nurse education that learning outcomes must reflect all four fields of nursing (NMC 2017). However, adult nursing is focused upon the physical as well as psychological care of patients and essentially is procedure –based. Students from the mental health and learning disability fields are educated to focus upon building effective relationships with service users and carers and there is an emphasis on the safeguarding of vulnerable children and adults. They are directed to the identification of someone who may be at risk of harming themselves or someone else. Becoming a children's nurse focuses upon the very specific health needs of

children and their development towards healthy adulthood in order to minimise the impact of illness. I was cognisant that during data collection, they may share these experiences rather than patient safety experiences which could potentially distort or misalign the information required. Therefore I made the decision to focus upon Adult students for the purpose of this research study.

Ritchie et al (2014) describe purposive sampling to be exactly what the name suggests. Members of the sample are chosen with a purpose – to represent a type in relation to a key criterion. The principle aims of this approach are to ensure that all key constituencies of relevance to the subject matter are covered and also to ensure that enough diversity is included so that the impact of the characteristic concerned can be explored (Ritchie et al 2014). There are a range of approaches to purposive sampling and the approach used in this study adopted the principles of stratified purposive sampling (Cresswell 2013), an approach in which the aim is to select groups that display variation on a particular phenomenon, however each of which is fairly homogeneous so that subgroups can be compared. Cresswell (2013) advocates that in a phenomenological study, participants must be individuals who have all experienced the phenomena being explored and that they can articulate their experiences. There are over six hundred adult student nurses studying on the adult nursing programme at the university, including students in their first, second and third year. Their practice placements include a variety of healthcare settings in six health trusts. Student ages vary between eighteen and fifty. Though predominantly female, there are a growing number of male students enrolling on the programme. Students were informed of the research by myself as the researcher and invited to participate after permission was sought from the organisation.

Recruitment

Students were informed of the research study during lectures and seminars. A number of willing participants presented as interested parties. Those who indicated they would be interested were provided with more detailed information regarding the study and informed of the underpinning ethical principles which guided the research.

Twelve students were eventually selected and data collected until data saturation was achieved. This was probably achieved at ten interviews, however, an additional two more interviews were undertaken to test data saturation and ensure no new themes arose (see appendix 4).

In order to reach data saturation there are a number of factors which need to be considered when considering sample size. Qualitative samples have a tendency to be comparatively small to those in quantitative studies. Richie et al (2014) put forward the view that if the data is properly analysed, there will come a point where very little new evidence is obtained from individuals and therefore increasing the sample size no longer contributes to new evidence.

Data collection

There exists a number of methods of data collection for the purpose of qualitative inductive research including: focus groups, in-depth interviews observations, diaries, videos (Corbin and Strauss 2008). As this study aimed to elicit the 'lived experience' and views of individual students, the method of data collection

adopted was by individual semi-structured interviews. Qualitative research can provide compelling descriptions of the human world (Brinkmann and Kvale 2015). This view is shared by Yeo et al cited in Richie et al (2014) who postulate that the interview data includes the participants' explicit interpretations and understanding of events unlike some data, such as documents or observations which can be subjective. The literature does not offer distinctive features of how a phenomenological interview should be designed and King and Horrocks (2014) acknowledge the lack of explicit guidance. However, they offer a discussion focusing on the key features of phenomenological interviews as a data collection method. They describe semi-structured interviews as the 'exemplary' method for interpretive phenomenological enquiry because the emphasis is on exploring how people interpret their experience. They suggest that interpretive phenomenology researchers favour generic semi-structured interviews with a strong emphasis on gathering detailed descriptions of the phenomena under investigation. It is suggested that it is data analysis rather than collection that links the philosophical ideas however King and Horrocks (2014) argue that more thought needs to be given to how interviews can be used in a truly phenomenological manner grounded in the philosophy. Though no standard procedures exist for conducting a research interview, Kvale (2013) reminds the researcher to be mindful of the methodological options available, ethical implications and anticipated consequences of the choices for the interview project.

King and Horrocks (2014) suggest that flexibility is a key requirement of designing an interview study. They postulate that the interviewer should anticipate that issues may arise during the interviewing process and should be able to respond appropriately. This was particularly poignant when designing this

study as alluded to earlier in the chapter. The topic area is of a sensitive nature and potential participant reaction unknown.

In qualitative research, an interview guide is used which outlines the main topic area but is flexible regarding the phrasing of questions and order in which they are asked (See appendix 5). King and Horrocks (2014) argue that this approach allows the participant to lead the interaction in unanticipated directions and this was found to be the case in this present study.

Kvale (2014) reminds us that the researcher is critical for the quality of scientific knowledge and for the soundness of ethical decisions in interview enquiry. Moral research behaviour and sensitivity encompasses the moral integrity of the researcher.

Ethical considerations

Throughout all research studies, good ethical practice is paramount. When conducting research within the university organisation, strict guidelines on ethical practice must be adhered to. The University abides by a strict ethical code and no research is permissible until formal ethical approval has been granted. The safety of research participants is paramount and their protection became intense in the twentieth century fuelled by scandals around harmful and exploitative studies carried out on humans (Polit and Beck 2010, Punch 2014, Ritchie et al 2014). The principles of ethical research are underpinned by: beneficence, non-maleficence, justice and autonomy (Beauchamp and Childress 2009). In addition, formal regulations exist which govern research ethics such as the 1947 Neuremberg code, the 1964 Helsinki Declaration by the World Medical Association and the 1974 Belmont report USA. Professional regulations and ethical codes provide detailed rules which are more specific than the

philosophical and deontological codes underpinning them (Punch 2014). Their

standards include: informed consent and confidentiality. In addition to the

university regulations and ethical code, as a Nursing and Midwifery Council

registrant, the researcher is bound by a code of ethics and practice (NMC 2015).

This study achieved ethical approval from the Universities Department of Ethics

before data collection commenced.

All participants were provided with information about the study (appendix 1 and

2). In addition, they were asked to sign a consent form (appendix 3). They were

assured of confidentiality and anonymity and reminded that they had the right to

withdraw from the study at any point. All participants were allocated a letter and

not referred to by name. Participant information was kept in a locked cupboard in

a locked room. Any information regarding participants stored on computer was

done so on a secure drive that is password protected and accessible only to the

researcher. Following completion of the research, the data will be destroyed once

the study is completed. Digital voice recordings were made using a digital voice

recorder, property of the university. Recordings on the device were deleted

immediately after the interviews were transcribed.

In consideration of the topic under investigation, it was envisaged that some of

the discussion could lead to participants becoming upset during the interview.

The interviews were all carried out in the university premises and therefore the

university student support and wellbeing service as well as Occupational Health

Department were available should they be required. Participants were reminded

that as pointed out in the written information they were provided with, if during the

interview the candidate disclosed information regarding patient safety which the

researcher felt required further action, then the interview would be aborted and

the researcher would be duty bound to report the information to the Director of Programmes .It was also important that if students revealed experiences which appeared to be unresolved and required further action in terms of student support, then this would also be considered.

As a Senior Lecturer, it was necessary to remain cognisant that this relationship with the students could potentially make them feel that they were coerced into participating in the study and that their answers to questions posed at the interview may be mooted. Every effort was made to ensure students felt relaxed and under no pressure to participate by using good communication skills. This sits with the principles of hermeneutic philosophy. Not to explore the philosophical underpinnings in relation to data collection and analysis would potentially weaken the research approach.

The location of the interview environment should be predetermined. Brinkmann and Kvale (2015) suggest that the setting of the interview stage is crucial as the interviewees will want to have a grasp of the interviewer before allowing themselves to talk freely and expose some of their experiences. I was acutely aware as an insider researcher, students participating in the research would recognise me as a senior lecturer and programme lead. This could have led to them feeling uncomfortable whilst engaging in discussion and disclosing sensitive information. Consequently, I made a considered effort to emphasise that for the purpose of the study, the roles were that of researcher and participant. An interview room was identified in the university and a 'do not disturb' notice was placed outside of the room. The participants were made as comfortable as possible. The participants were put at ease and this was facilitated by a pre-interview briefing. This went some way in building a good rapport with all participants. The interview questions were designed to encourage the

participants to engage in dialogue and a digital voice recorder was used to capture the interview.

It became increasingly easier as each interview occurred to move away from the script and engage the participant in conversation while still adhering to the same set of questions. I remained mindful however of the juxtaposition that remained apparent in my role as an insider researcher. As a senior lecturer known to the students, this could have provided a power imbalance. This prompted me further to continue my journey of reflexivity.

Brinkmann and Kvale (2015) suggest that the live interview situation provides a richness to the data collection that the digital voice recording alone cannot capture. The participants' voice, non- verbal and facial expressions accompanying the statements provide access to subjects' meanings that is remain otherwise uncaptured in transcribed texts. The researcher may wish to make notes during the interview to assist with analysis and this was duly done.

After the interview, it is reported by Brinkmann and Kvale (2015) as good practice for the interviewer to provide a de-brief, summarising the main points discussed and giving the participant an opportunity to comment on any other points not covered in the interview. I found this worked well.

Data was collected over a two and half year period. During the initial data collection phase, emerging themes became apparent. The recurring themes were evident in subsequent interviews and this raised the question of how many subjects were required. The literature suggests that researchers should interview as many subjects as necessary to find out what they need to know (King and Horrocks 2014, Kvale 2014, Brinkmann and Kvale 2015,).

The audio taped voice recordings and notes taken at interview were carefully transcribed and the audio recordings saved to a secure password protected drive on the university computer. Verbatim transcription of the recordings is a critical step. Researchers who transcribe their own data not only are afforded the opportunity to immerse themselves deeper in the data but it also allows them to learn about their own interviewing style (Kvale 2014). One of the biggest barriers to the researcher transcribing their own data is the constraint of time. This research study experience was no exception to this but I was able to transcribe six interviews with the intention of connecting meaningfully with the data. Subsequently due to workload demands it was not possible to transcribe further interviews as it was not practical to do so and therefore the support of a transcriber, a university employee with ethical clearance was employed. This provided a pragmatic and useful support in the data collection process. There are no standard rules for transcribing interview data, however, Kvale (2014) advises that specific agreement and instructions should be made with regard to verbatim transcription word by word including expressions such as 'hmmm' or 'erm'. It is important that this is consistent in transcripts otherwise there is a danger that the emotional cues and expressions if not included in the transcription may distort the true meaning and interpretation of the dialogue. It was agreed that the interview would be transcribed verbatim but in addition, the researcher had access to the audio taped voice recordings to further scrutinise and indecipherable emotive dialogue.

Richards and Morse (2013) assert that any study regardless of philosophical paradigm, is only as good as the researcher and in qualitative research the researcher is the 'instrument'. The skills of the researcher should demonstrate the quality and scope of data as well as the interpretation of the results. The

researcher therefore should prepare for qualitative scrutiny before commencing any study. I remained mindful of this requirement throughout the process.

Analysis

A total of twelve participants were interviewed and their transcripts transcribed. Unlike quantitative analysis there are no clearly agreed procedures or rules which exist to facilitate data analysis. Polit and Beck (2010) remind us that the purpose of data analysis, regardless of the type of data or underlying research paradigm, is to organise, provide structure to and elicit meaning from the data. Data analysis is an active and interactive process requiring careful scrutiny in order to achieve deeper meaning and understanding. It became apparent many of the traditional approaches shared similar features, however approaches varied in terms of their epistemological assumptions about the nature of qualitative enquiry. Ritchie et al (2014) suggest that when determining the type of qualitative analysis to be conducted researchers need to consider the status of their data, whether it be substantive or structural. Substantive approaches are concerned with capturing interpretations and meanings in the data, focusing on 'what the text says'. Structural orientation on the other hand focuses on language and the structure of talk, in other words 'what the text does' (Richie et al p 272). Similarly, Cresswell (2013) asserts that across the literature on qualitative research, although there are variations in approaches, qualitative analysis consists essentially of organising data then reducing data themes through a process of coding then condensing the codes and presenting the final data in tables or discussion. The term 'coding' is used throughout the literature (Huberman and Miles 2002, Corbin and Strauss 2008, Saldana 2009, Cresswell 2013, Richards 2015). Ritchie et al (2014) argue that term coding is used in a broad way because it encapsulates aspects of the way data is continually labelled and

sorted throughout the analytical process. However, they go on to suggest that coding also involves making things a part of a classification system so that data that is similar is grouped together. They warn that coding may potentially fix meaning too early in the analytical process and prefer the process of indexing and sorting.

The Framework Approach

Following on from revisiting the various approaches to qualitative data analysis the model of analysis selected was 'Framework'. As discussed earlier, Framework for applied policy analysis sits comfortably with the epistemological position of this research study and the intended outcome of informing policy. Using Framework provided an audit trail throughout the process of analysis. The tool allows researchers to generate themes from data by systematically searching for patterns and analysing content. This subsequently allows researchers to provide meaningful cognitive descriptions of the phenomena.

There are essentially five key steps in the Framework process:

Familiarisation: the first step in the process by which the researchers immerse themselves in the data obtaining an overview of the emerging topics raised. The purpose of this is to produce an initial thematic framework and index. Familiarisation is achieved by the researcher reading the transcripts so they become absorbed in the raw data. Richie et al (2014) advise at this stage to revisit the research questions and sampling strategy to identify any potential gaps. When reviewing the material, it is important to identify issues that are interesting and appear across the data set, they may be substantive or more focused on methodology. This step ensures that any themes that are developed are grounded in and specifically supported by the data (Kiernan et al 2015).

Handling such raw data can become complex and unwieldy, as the researcher became aware at this stage in the process and further discussion of this will be considered in chapter 4.

The next stage involves constructing an initial thematic framework: organising a set of headings under which people's views can be sorted. The views are sorted into themes and subthemes that comprise the initial thematic framework. Underpinning ideas are grouped and sorted using a hierarchical arrangement of themes and sub-themes.

Once step two has been addressed, the process of indexing and sorting takes place: establishing which parts of the data are the same thing. Labels are applied to chunks of data judged by the researcher to be the same thing.

Reviewing data extracts: identifying other ways in which data may be organised as initial thematic frameworks can often be crude and require refining. This stage allows the researcher to be further immersed in the data. It is important to be cognisant that at this stage researcher bias may emerge and therefore the researcher must be aware of this in their judgement and decision making. Using Framework however means that a systematic approach is used to analyse data and this is made transparent for the reader. It is this stage that adds to the trustworthiness of the research.

Many tools developed for qualitative analysis share some of the above steps in the process of analysis but as well as including indexing and sorting data, Framework adds a further step: 'data summary and display'. This essentially consists of thematic matrices displaying all participants and themes plus subthemes. This allows the researcher to move back and forth between different

levels of abstraction without losing sight of the raw data and furthermore it provides transparency (Richie et al 2014, Kiernan et al 2015).

There are a number of computer –assisted qualitative analysis (CAQDAS) software packages available for use in universities and social research agencies to assist in the generation of data management. The overall aim of such packages is to assist the researcher in the analytical process. I was introduced to NVivo as a standard tool licensed to the university and this provided an opportunity to enhance my capabilities of data management, interpretation and storage of data. In addition, NVivo facilitate the data summary and display step. These actions are permissible using a straight-forward manual approach using computer based 'office software and even handwritten colour coded diagrammatical organisation of data. However, in addition CAQDAS helps the researcher to return to verbatim data that may be removed from original context with the click of a mouse button. They can assist in developing typologies by allowing the researcher to demonstrate their thinking at various stages of the analysis process and also draw diagrams and maps to support the visualisation of themes and emerging categories. One of the main advantages of CAQDAS is the speed in which it can organise data. This is an obvious benefit in large qualitative studies and can also facilitate working with teams of researchers.

As a novice to the software, I seized the opportunity to develop my own understanding of computer based technology in facilitating the research process. This proved beneficial in terms of speed which is consistent with the views of research experts (Flick 2009, Lewins 2008 and Seale 2010). In spite of the benefits to CQDAS, I became aware of the additional value of manual methods of data analysis. Whilst NVivo was invaluable in assisting with sorting data and storage, for the purpose of absorbing and digesting the data, I discovered myself

continually reading, re-reading and attempting to decipher the transcriptions alongside listening to the digital voice recordings until a clear recognition of dialogue, meaning and experiences were captured. It is acknowledged that CAQDAS cannot determine themes and therefore the epistemological assumptions and benefits constitute shortcomings of NVivo. This was apparent when the repeated use in dialect of 'think' 'erm' and 'and' appeared as common user words in scripts. Undoubtedly these words were recognised in terms of the frequency in which they were used but in reality bear little significance in the meaningfulness of data being examined. Weitzmann, cited in Richie et al (2014 p 289) points out that the very ease and speed of software has the potential to encourage researchers to take shortcuts. The researcher in this study was mindful of this throughout and made a deliberate attempt to utilise a number of ways to extract rich data from the transcripts in order to come to a valid conclusion.

Summary

In summary, this chapter has provided a detailed discussion on the methodology and research approach adopted in this study. The interpretive phenomenology approach to this study is justified as it sits appropriately with the underlying ontological and epistemological assumptions. An outline has been provided of the interpretive approach selected and its congruence with the research aims. The importance of adhering to a robust ethical code of practice has been highlighted. The data collection strategy and method of analysis has been discussed. Justification of the use of the framework approach to analysis has been offered, together with consideration of issues relating to trustworthiness and reliability of this research. The following chapter will present the findings from this research study.

Chapter 4: Presentation of Findings

This chapter presents the findings from the twelve semi-structured interviews conducted with the student nurses. The first part of the chapter will introduce the participants to allow the reader to understand the context of the research study. The process of analysis using the Framework approach will be discussed taking the reader through a step by step process. The resultant findings from this research study will then be presented.

The participants

The participants in this research study consisted of a purposive sample of twelve student nurses currently studying on the BSc Adult Nursing Programme in one university in the North East of England. Eleven students were female and one student was male. Their ages ranged from 18 years to 45 years of age with the mean age being 21 years. There was a mix of students in their first, second and third year of study. They were assigned to six partnership trusts in the North East of England. Each student participated in a semi-structured interview.

The interviews were transcribed as discussed previously. Transcription by the researcher allows researchers to become familiar with and immerse themselves in the content and this was the case in this research study.

Familiarisation

The first stage of analysis termed 'familiarisation' was systematically applied to the interview notes to ensure full immersion during the data collection process and upon completion. During the data collection process, it became apparent that themes were emerging and it was necessary at this point to place the data into

early groupings. It is at this point that the original research questions were

revisited in order to highlight any potential gaps or limitations of coverage. Figure

6 illustrates the themes that appeared to be emerging from the raw data.

Figure 6: Familiarisation
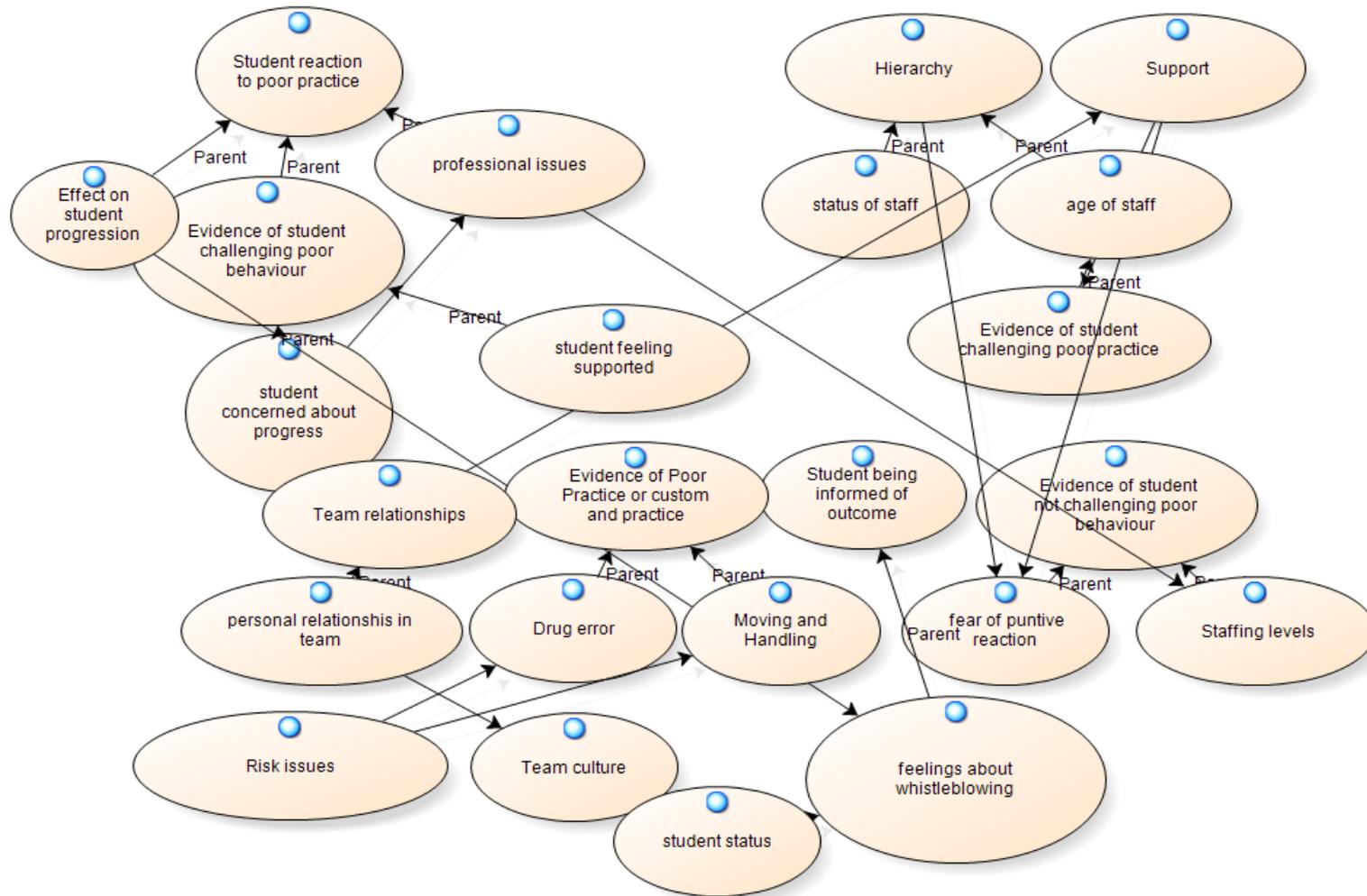
The data was sorted into composite sets which would form the basis for emerging themes and subsequently the initial underlying foundation for the thematic framework. All of the participant transcripts were used in this stage of the process but it was necessary to identify topics of interest that were recurrent across the data set and relevant to the research question. At this stage in the process of familiarisation, it became apparent that the themes emerging from the data could be described as broad and unwieldy. Some of the themes merged with others and on further examination there was potential duplication, for example: student reaction to poor practice and evidence of student challenging poor behaviour. However, it is the context in which these issues were discussed by participants that justified the identification of these as separate themes whilst acknowledging their correlation with each other. A further example is illustrated where some participants discussed their feelings about patient safety in the broader context, referring to professional behaviour and practice. Other participants however, discussed more tangible and specific issues such as medication error and patient handling. This is important because the research question was designed to elicit what student nurses believed was in fact a patient safety issue. As many participants suggested medication administration error and poor patient handling as something they had witnessed in practice, it seemed fitting therefore to group this data. However, further analysis revealed that participants would refer to medicine administration and patient handling when discussing their reaction to poor practice so there were different concepts emerging which were worthy of being thematised.

During the familiarisation process, I remained mindful that I held my own pre-suppositions and perceptions of students and their understanding of patient safety issues. I was conscious throughout the process of the underpinning

methodological philosophy and I strived to remained objective when sorting the data focusing on the entire content rather than allowing myself to be selective and choose data that seemed to fit with my own beliefs.

On reflection, this stage in the process proved challenging. The diagram on first viewing appears untidy and unwieldy. However, I engaged in academic discourse with my supervisors who confirmed that this was in fact usual during the first stage of analysis. I repeatedly read and re-read the transcripts as well as listened to the audio recordings in an attempt to clarify if what had been discussed was interpreted appropriately. Subsequently, throughout the research process and towards the end of the study, it became apparent that the diagram represents exactly my though processes at the time of initial data familiarisation and subsequently informed the organisation and development of the initial thematic framework.

It was becoming evident during this stage of the analytical process, that what appeared to be emerging was a combination of intrinsic and extrinsic factors. External factors existed which were out of the students' control, embedded in the organisational culture and behaviours which existed in their practice placements. At the other end of the continuum, students themselves held beliefs and values which sat deep within their own personal philosophies and determined their actions and behaviours. There was a sense of student role, status and identity emerging as a significant factor in behaviour. This appeared to be reinforced by the need to fit in and learn the rules.

Essentially, it was becoming apparent that there was a degree of overlap within the content of the data. Some dialogue was similar to others and in some way

interconnected, whereas others seemed distinct. The next stage of the process involved constructing the initial thematic framework.

Constructing the initial thematic framework

After reading through the data numerous times, it was becoming apparent that many of the students talked about their understanding and interpretation of what constituted a patient safety issue, with patient handling and medication administration commonly discussed. Many of the students suggested that staff shortages were a key contributor to compromised safety and further analysis of data exposed more personal accounts of students witnessing poor practice. Some students discussed their own experience of raising concerns whereas others shared their personal beliefs and values with regard to raising concerns and challenging suboptimal practice. It became evident on reviewing the data that students had a clear understanding of the importance of the concept of safe practice. In addition, they held a strong sense of moral obligation to 'do the right thing'. However, this was challenged by a combination of their fears of reprisal, effect on progression and interpersonal relationships.

The process of the familiarisation stage generated the concepts discussed above. It then became necessary to sort out the nodes into a hierarchy of themes and subthemes to initially construct a framework that could be used across the data set. Each superordinate theme and subtheme was assigned a numerical code (see figure 7).

Figure 6 Initial thematic framework
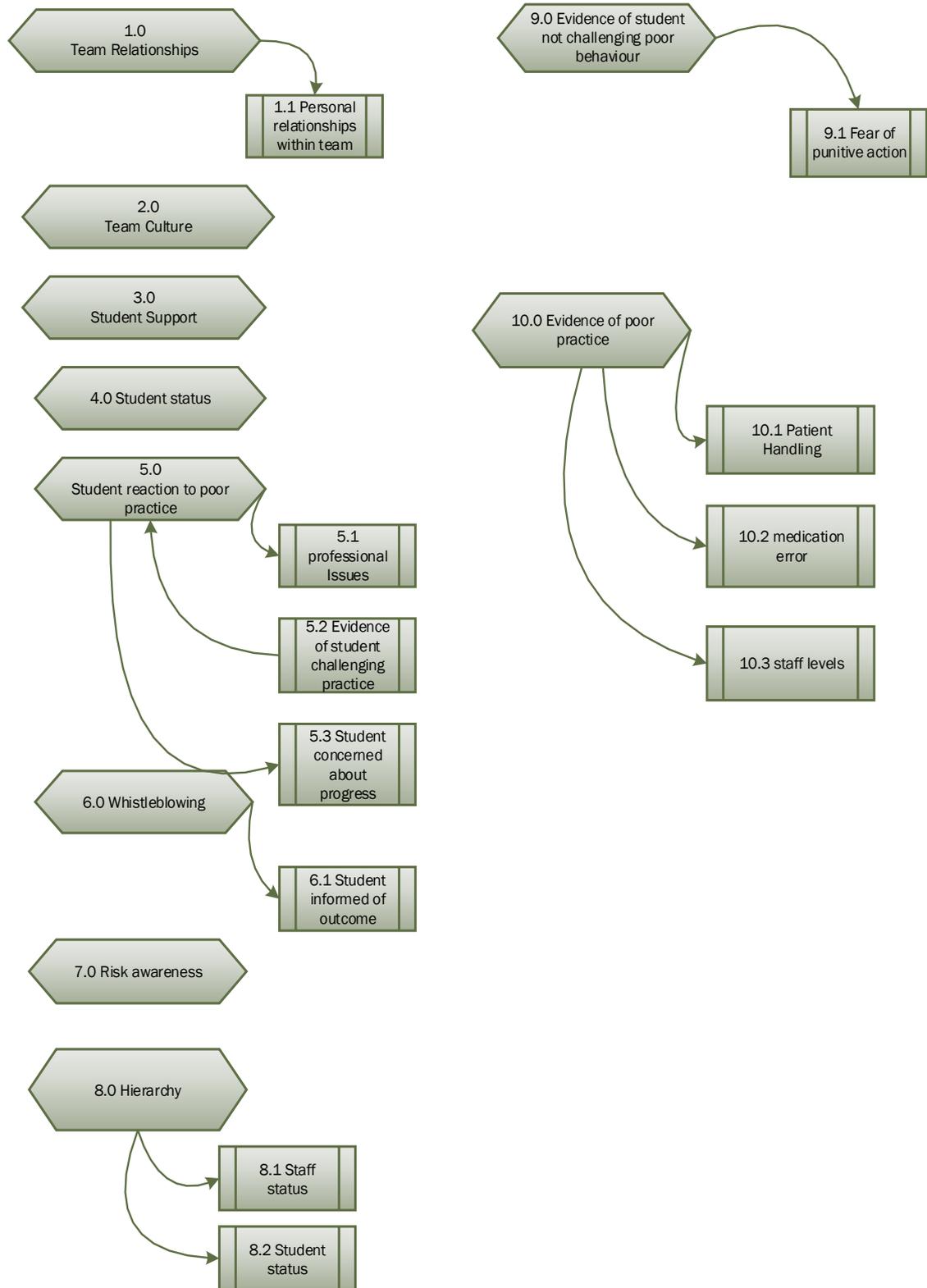
This part in the data collection process proved to be taxing because although many of the emerging themes seemed to be interlinked, it was important not to separate them out too broadly as this may have decontextualized important relationships. Instead, broad headings were used then further subheadings attached in order to organise the data further. It is acknowledged that during this stage in the construction of the thematic framework, areas of enquiry and familiarisation should be drawn upon, but in addition, it is necessary to reflect upon a priori knowledge to provide assurance that the research aims are being addressed.

Data from the remaining participants was analysed and sorted into the emerging thematic framework. It is important to note that the framework did not remain static but evolved and developed with more themes being added as new data emerged. The resultant framework became simpler to work with. By this stage, I was familiar with the data extracts and felt more confident that the themes and subthemes truly reflected the issues that were becoming transparent.

A clear picture was emerging of the student nurses understanding of what constituted a patient safety issue, with all of them acknowledging the concept as an important issue in their curriculum and in practice placements. Many of the participants volunteered information about their personal experiences of witnessing poor practice and some discussed their experiences of being coerced into performing practices they knew were incorrect. Reactions varied as some of the participants felt able and had actually challenged poor practice whereas others had reluctantly kept quiet. There were a number of variables which influenced their decisions. The team and inter-relationships appeared to be a significant influence in student behaviour. Fear of retribution was a major factor in determining whether a student felt confident to speak up when poor practice was

witnessed. Consequentially, the data was appearing to suggest that students know when something is wrong and feel they ought to raise concerns. However, many remained reluctant in anticipation of punitive action.

It was imperative that the construction of the thematic framework would provide a sound model in which to work and one that clearly illustrated the correlation between concepts. An example of this can be seen at figure 7 where the parent theme which clearly merged from the data was perception of hierarchy. Two further subthemes (see figure 7) of 8.1 staff status and 8.2 age of staff were evident and this enabled data to be sorted more concisely and clearly. Once satisfied with the initial framework, it was then necessary to move to the next stage of the analytical process which required sorting the data and cross matching it to the index.

Indexing and Sorting

Data extracts from all the interview participants was used and sorted into appropriate subthemes. Initially this was assisted by the NVivo software, but as this stage in the process gradually became more complex, it proved more appropriate and beneficial to carry out this stage manually. Subjects weaved in and out of each other and appeared to fit in more than one subtheme. However, this highlighted the linkage and potential interconnectivity that could be noted for later analysis.

Once all of the data extracts had been selected and referenced to the index, the data could then be viewed as a whole and distinctions unpacked. After conducting the first seven interviews, it was becoming apparent that much of the data appeared to be similar in content. Participants were discussing common issues and shared similar views. It was after conducting a total of twelve

interviews and applying the analytical process described above that it became

apparent that there was no new information being generated and therefore data

saturation had been achieved for the purpose of addressing the research

question.

To capture this for subsequent analysis and discussion, on completion of data

collection, it was important at this stage to sort the data into final key themes and

subthemes which I felt would be meaningful and manageable. As a result, four

key themes were identified:

> Hierarchy

> Team Relationships

> Context of exposure

> Fear of retribution

These key themes captured the essence of what was being discussed in the

data. It then became possible to link each indexed theme to one of the above.

This enabled the data to be managed and organised in a meaningful way (see

figure 8).

Hierarchy

8.0 perceptions of hierarchy

8.1 staff status

8.2 age of staff

4.0 student status

Team Relationships

2.0 team culture

1.0 relationships in team

1.1 personal relationships in the team

Context of Exposure

5.1 professional issues

10.0 evidence of poor practice

7.0 risk awareness

10.1 patient handling

10.2 medication error

10.3 staffing levels

5.o student reaction to poor practice

5.2 evidence of student challenging practice

6.0 whistleblowing

6.1 student informed of outcome

3.0 student support

Fear of retribution

9.0 evidence of student not challenging poor behaviour

9.1 fear of punitive action

5.3 student concerned about progress

Figure 7: Indexing and sorting
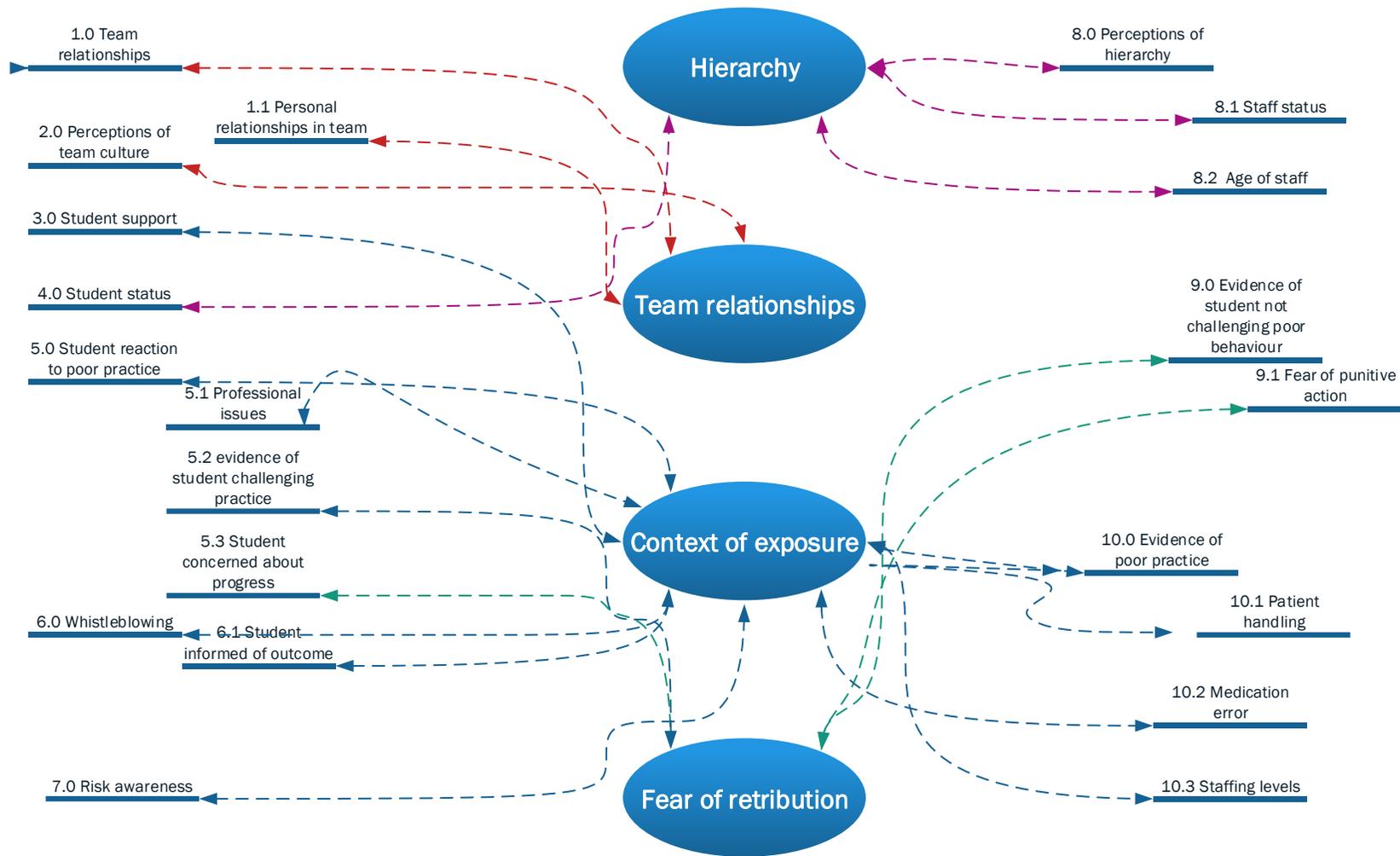
The data was beginning to illustrate student perceptions of the context of patient safety. The influence of relationships with team members including those involved in assessing them was strong. Students appeared to be cognisant of their student identity and recognised how their status interconnected with other team members. There was an explicit sense of wanting to 'fit in' and avoid 'trouble' in order to progress successfully but this often posed a conflict within their ethical and moral beliefs. Recognition of the existence of hierarchy and paternalism clearly emerged as an inhibitory influence in determining student behaviour. It was also becoming clear at this stage, that the stage of training had a significant influence on student behaviour, with third year students more likely to challenge practice than first years.

Data summary and display

During the data summary stage, the data was organised into the four Key themes and each participants' comments in relation to the subordinate themes was indexed. An example of a data summary and display chart is provided in figure 9 and a further chart is presented in the appendices.

The researcher's annotations appear in blue ink and provides an insight into how I was interpreting what had been said in context. .It was clear that the data was beginning to offer a comprehensive collection of beliefs and values held by the participants, congruent to the research aims and objectives.

Table 1: Data summary and display; Theme hierarchy

Participant	8.2 age	8.1 staff status	8.0 hierarchy	4.0 student status
A Female Age 21-25 2nd year		*if you are a student nurse and you are complaining about a doctor and sometimes it is a lot to do with the hierarchy whether you are listened to or not*	*it is a lot to do with the hierarchy whether you are listened to or not*	*So I did feel as a student nurse especially ….on your first year…you think erm should I really be saying anything* Participant discusses role as a student and compares the experience of being a first year with a second year. The discussion focuses more upon fear of retribution than in relation to hierarchy in terms of experience, role and age.
B Female Age 21-25 2nd year	*If they are older than you then it is difficult to say er do you mind or can you just you know, discuss that practice with you or whatever it might be then you can feel quite intimidated…*	It appears that age and experience influence the response made by participants		*'As a student you are in a position to say well I am just a student so do you mind if we do it like this the way I have been taught to…'*
C Female Aged 21-25 2nd year	*Raising concerns is an age thing. I have actually had this conversation with my mentor. When I am qualified, I am young and just out of university so I am young and they will see me as younger and even though I have knowledge they might not see me as having much experience…* This participants account of the influence of age is also related to student status	*I probably would raise it in not quite a demanding manner because I don't think I've quite developed the clinical knowledge to challenge a qualified but I would question them rather than tell them*		*Researcher: Do you think as a second year you may have more confidence then because you mentioned that incident happened in your first year. Do you think being a second year gives you more confidence?* *C* *Yes because we have more theoretical knowledge that we have learned in uni and also being I would say now my confidence isn't that high to report it and just starting second year 'Im still not experienced but if I look back I have really learned A LOT.*

D Female Age 35 - 40 1st Year	*'I wouldn't be intimidated age wise. My mentor was around the same age as me. We both had children so we had that in common……Well luckily I am old anyway haha I'm 40….*	*she was my mentor and she was the expert and she had been on the ward for 5 years and I didn't and I didn't even think twice about it until she said oh wear your gloves for this one and it was only afterwards I thought…..hmmm….and you know…it is hard and just went along… I trusted her 100% so I did just go along because in my thoughts I thought she knows best.*		
E Female Age 21 – 25 1st year	*'I would feel quite uncomfortable challenging them especially if they were a lot older than me just because of their age and how much experience they have had on the ward compared to me who has been there for two weeks…'*			
F Female Age25 30 1st year		*'There was one particular healthcare who had been there years….you have heard people talking about this particular person. I wouldn't go up to her and directly say to her…'* This seems to suggest that that the influence of role and status of staff is not restricted to seniority		
G Female Age 21 -25 3rdyear				*I think it would be different. I don't know whether it would be any easier. I'd like to think it would be 'cos I've already done it, but then if you're on like a different ward with different staff, if you're still a new member of staff, it would still be really difficult, but I think I would go about it a different way as a qualified*

H Male Age 21 -25 3rd year				
I Female Age 21 -25 3rd year		*'I think maybe sisters and higher, I think I would be a bit cautious and maybe go to speak to another nurse…I maybe wouldn't go directly to a doctor…'*		*'They might think why is she raising a concern? She's come out on the ward, she's just started. She's a third year, she's not qualified and she's raising concerns about how we care for people, I've been here a long time and I know how to do my job so don't tell me otherwise sort of thing…'*
J Female Age21 -25 3rd year			*'I think they are very much interlinked. I mean obviously as age increases, it's likely that someone 's going to be higher up the hierarchy…'* (participant J) *'I think the NHS kind of entrenches the hierarchy…even visually, they have outside every ward in my local trust a poster which has who's who and it purports to just identify who's who but it's a pyramid and at the top you have matrons and it goes down… at the bottom row you have students, domestics, even that kind of visual reinforces that some people are more important than others…'*	*'Well I'm not sure what they are doing is correct practice but they have been on this ward for x amount of years and they've always done it like this and they would just say to me oh well you're a student you've been doing this for three years don't tell me how to do my job…'*

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K Female Age 21 -25 3rd Year	*'When you're a bit younger, you might feel like you're not taken as seriously if it'd against an older person, like if the person you were raising a concern about was older and the had a you know…long career…'*	*'Like if it was a healthcare assistant…I know it sounds silly but they're quite forceful if they are all together…'*	*I've seen.. if they are a lower band and they want to complain about someone higher up, it always seemed a bit. .they don't want to do it coz they are scared because they are a higher band than them…'* *You go to some wards, there will be the paternalism thing and it is : consultant, doctor, nurse, healthcare assistant, student. That's how it'll go…*	
L Female Age 25 -30 3rdyear	*'I think they would look at me as going what do you know anyway, you're just young…'* (participant L) *'I think I'm a little bit different because I'm a little bit older than the other students on this course, me being 27 and I've been in a management role before…'*			

Research Findings

This section will now present the findings identified after the systematic process of data analysis. In order to present the findings in an organised and methodical way, each key theme will be used as a subheading.

Theme: Context of exposure

As it was necessary to elicit what the students perceived to be a patient safety issue based on their placement experiences, the familiarisation data identified the general context of exposure which was organised as a key theme. The data revealed what students felt were patient safety issues and provided an insight into their experience of raising concerns. It was possible to acquire a perception, of what had they been exposed to; their reactions, and extract a glimpse of whether they were aware of the required action expected of them. It was also possible to glean some idea of their perceptions of the support mechanisms available to them and how they could be accessed. This key theme was broad, but necessarily so to provide a platform to view the context in which students understood the concept of patient safety. In addition, it would allow for a number of subordinate themes to be teased out, drawing on specific concepts that could be examined further. It was an important theme in relation to addressing the research question.

What is clear is that the data distinctly revealed that all of the participants indicated an awareness of the concept and importance of patient safety. However, their perceptions of what actually constituted a safety issue varied, and to some extent was surprisingly limited.

What became abundantly evident was that participants' were aware of good practice underpinned by evidence, the tenet of safe nursing and healthcare

delivery. This is emphasised throughout the nursing curriculum. However, many of them admitted to frequently observing substandard practice that appeared to be ritualistic, often embedded in the culture of their particular placement.

Medication errors and patient handling

A proportion of the participants discussed their experience of witnessing medication errors, including first, second and third year students.. As one first year participant stated:

'Er medicine management. I've seen quite a few common errors' (Participant A 1st year female student)

This suggests that medication administration error appears to be commonplace in practice placements though the participant did not quantify exactly what she meant by 'quite a few'.

Another participant discussed her experience of a mistake being made due to poor communication during the medicine administration procedure:

*'I was aware of this patient and he was given double the medication… because of lack of communication' (*participant C 2nd year female student)

It became evident that students were well attuned to proper practice when discussing medicine management but what was less distinct was their confidence to challenge practice that deviated from the accepted. Another participant, a third year student shared more detail on a medication incident they had witnessed whilst on placement:

'Erm it was the first day of management placement and my mentor, we were doing the medication round and this elderly woman was prescribed erm 15mg of codeine and we didn't have it on the ward; we only had 30mg, so my mentor decided she would give the 30mg and I said to her could she not check why she was only prescribed 15 because 15 is a bit of an unusual dose really: you don't

normally see that. And she just said ; no it won't kill her', it'll be fine and she gave it and I didn't really know what to do' (participant G 3rd year female student)

This is a significant finding as it demonstrates how students are coerced to participate in practice that is not in line with legislation and professional behaviour. Yet this third year student is suspended in a situation whereby they are faced with conforming to the expectations of their clinical mentors and role models and at the same time they are required to adhere to professional practice.

Similar observations were reported in relation to patient handling:

'I think the main one I have seen is moving and handling. There is a big difference between what we have learned in uni and what I have seen. You know when you move someone up the bed and you use slide sheets? Well I've never really seen that on placement' (participant E 1st year female student)

'Like sometimes maybe the physio has said something like 'it takes two people' but then it's 'oh can you just take so and so to the toilet' (participant F 1st year female student)

This dialogue reveals further, the dichotomy between adhering to safe principles of practice taught within the university setting and conforming to the accepted custom and practice that appears to exist within some teams.

Some of the students discussed other areas of substandard practice and potential human error which appeared obvious at the time and prompted the student to speak up to avoid harm or the delay of treatment:

'Yes a patient was nil by mouth but they were going to give them breakfast and I said er are they not nil by mouth and they said oh I'll check that and it was oh yes they are so they didn't give her breakfast' (participant C 2nd year female student)

The fact that this participant was a second year student may be significant in that they had developed more confidence than that of a first year but this was not clear. On the other hand, it could be argued that this was a typical reaction that anyone would make when the potential mistake was obvious.

There was a perception amongst students that they instinctively knew when something was wrong if it was transparent and conspicuous. Other areas of practice that rely perhaps more upon clinical decision making and professional judgement by the registrant can possibly lead to the student being reluctant to challenge what after all may be perfectly legitimate practice tailored to that individual patient. Although key principles of best practice are taught within the university setting, there are variations in procedures practiced in different trusts and by individual staff members.

'I'm doubting myself in what I know, but I am still a very junior member of staff compared to other people, so I might get something completely wrong and wouldn't want to look like a fool in front of my peers' (participant L 3rd year female student)

The perceived dichotomy of whether junior students were experienced enough to identify what it is exactly that constitutes definitive poor practice was captured in the above comment and reinforces the trepidation and uncertainty felt by students on judging the appropriateness of some practices even by senior students in their third year of the programme. It is also an important finding because it suggests that there is a lack of openness and transparency in some clinical environments. Students fear ridicule and this can inhibit their ability to question.

Professional issues

The data provided information which gave an insight into the type of practices that prompted them to speak out or remain silent. Whilst many of the patient safety issues identified by the students were of a tangible and physical nature such as patient handling and medication administration discussed above, others did allude to professional issues and in particular the attitude of some staff. There was a strong sense of acknowledgement and willingness to uphold professional behaviour and practice and this was evident in all of the interview data. Some of the students interviewed had in fact reported poor practice whilst on placement, whereas others had witnessed substandard practice but remained quiet. This is a significant finding as it suggests that students do know what they are supposed to do when they witness poor practice but often do not take action. This in itself is a professional issue which rests with the students as well as qualified staff.

Some of the participants had raised concerns in practice in relation to the attitude of staff. In their view, they felt the behaviour demonstrated fell below the expected standards required of professionals:

'When I raised my concern it was more about the professionalism of the staff. Erm and how the culture of the ward…the atmosphere didn't feel friendly…everybody was task orientated and there was no communication' (participant H 3rd year male student nurse)

The student went on to discuss this incident in greater depth during the interview and revealed more detail about the circumstances, actions and feelings surrounding this experience which is captured further on in this chapter.

Similarly, another third year participant shared her experience of raising a concern based on staff attitude and behaviour:

'Erm in my previous placement in a local trust I reported an incident where it wasn't so much patients' physical safety but I felt that…well I witnessed a member of staff being quite demeaning and saying things which I thought were inappropriate' (participant J 3rd year female student)

'I feel like every year through my degree, it's kind of got a little bit more serious so I think probably going from a third year to qualified, I would be more inclined to raise those (concerns) even more so than now…'

'It's only been the last sort of year…like not even that, maybe six months that I actually think; no I know what I need to be doing and I feel confident, whereas before, I did hesitate and I maybe wouldn't say something when I knew it was wrong' (participant L 3rd year female student)

This is significant as it suggests that students are cognisant of the fact that on their approach to registration, they are stepping closer to accountability and will be duty bound to raise a concern should they find themselves in a situation where safe care is compromised. However, it does not address the issue that they remain responsible for their actions as students.

Whilst the students' perception of safety incidents which focused on medication administration and patient handling was unsurprising, there was little reference found in the data to other issues such as: safeguarding, documentation and communication amongst some of the more junior students. It was unclear whether this paucity was due to limited exposure to issues related around these areas in practice or lack of comprehension on their part in terms of the interconnectivity and relationship with patient safety.

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What was greatly apparent upon analysing the data was that the participants all

believed that risk assessment and patient safety is a topic that is totally

embedded in their training and they recognised its significance as a professional

requirement and an indicator of care quality.

'Through lectures, at the moment, talking about patient safety, raising those concerns especially in the patient safety module. I think that was a good one for students because it makes them realise actually how many patient safety issues there are out there in practice and how many things can go wrong in such a small amount of time' (participant I 3rd year female student)

The data suggests therefore that students were demonstrating a comprehensive

grasp of the notion of risk and patient safety. The participants demonstrated an

awareness of the professional standards required of nurses yet by not speaking

up they were themselves compromising their sense of professionalism.

Whistleblowing

Whilst there was a strong sense of professional awareness and morality amongst

all of those interviewed, the decision to raise a concern or not was influenced by

a number of factors. All of the participants demonstrated an understanding of the

significance of the Mid Staffordshire investigation and the reports of abuse at

Winterbourne View. They acknowledged without exception that an emphasis on

risk assessment and patient safety featured heavily throughout the curriculum.

There was however no reference to other high profile and current reports relating

to patient safety. It was apparent that whilst some of the participants felt able to

speak up when witnessing practice they felt fell below the accepted standard,

others remained acquiesce for a variety of reasons.

All of the participants demonstrated that they were aware of the professional and moral expectation for them to speak up as well as the reasons why and this was particularly evident amongst the third year more senior students:

'I'm kind of at the stage where I'm not a first year anymore; I know the standards and I'd much rather give the right sort of care than go with the crowd or no' (participant L 3rd year female student)

'I think I would speak up. You would have to regardless of the kind of consequences like don't you tell me what to do...you would deal with it because that patient is going to be safe at the end of it which is more important than what that person is going to say to you' (participant F 1st year female student)

However, some of the more junior students demonstrated a greater degree of hesitancy and trepidation when asked about whether they would raise a concern:

'Do you know what, it depends on what it was. On something like minor- but here's me saying this was minor and I'm not even in a position to do that....I possibly wouldn't, not at this stage because...well...there's loads of reasons'(participant D 1st year female student)

Of the participants who discussed their experiences of raising concerns about practice, their accounts varied' particularly with regard to the responses from those they raised their concerns to:

'I did feel like they were a bit annoyed with me for taking so long to speak out and put my complaint in, but it's really hard as a student and I don't even think it would get any easier as a qualified but I think you'd go round it in a different way if that is what I had to' (participant G 3rd year female student)

This seems to suggest that practice staff may see student nurses as a catalyst for identifying poor behaviour. This appears to place students in an awkward and compromised situation, exacerbated by the knowledge that they are still a student and not yet a registrant.

Other students who raised a concern were not always received positively by those they raised the concern with:

'the practice placement facilitator was from my point of view, was very hesitant, very defensive initially. And then when my colleague and I explained a bit more, they took it very seriously in the end' (participant H 3rd year male student)

Although much of what the participants were discussing in relation to raising concern was shrouded in hesitation and trepidation, one participant described the reaction from staff when she raised a concern as a 'pleasant' experience:

'sort of Oh thank God you were here; thank God you noticed. It was really like, pleasant really' (participant L 3rd year female student)

This was reassuring and suggests that the student voice can be a strong catalyst for preventing harm. In addition, it demonstrates that staff on placements can potentially see the benefits of students' raining concerns if ultimately patients are prevented from harm and staff are subsequently spared from investigation and potential unpleasant consequences.

To summarise, the participants demonstrated an awareness of the requirement to raise a concern or whistleblow. Throughout the interviews there was consistency in the terminology they used, referring to 'raising concerns' and 'speaking up' as opposed to the term 'whistleblowing'. It was clear however, that those who had raised a concern experienced a varied degree of response. For some it was a positive experience and served their moral conscience, but for others it removed them from the safety of their inner comfort.

Staffing issues

Of significance, what did emerge during the interviews and was reinforced upon analysing the data from all of the participants was the issue of staffing levels. Students appeared to relate what they perceived as poor staffing levels to an increase in potential patient harm, and they felt a compelling urge to verbalise their concerns during the interview. This was unexpected as the issue of staffing and its impact on patient safety was not an explicit question in the interview schedule. It was felt however, that this was a significant theme emerging in the data and the decision was made to acknowledge it as such.

'The biggest thing is probably staffing. Not having enough staff. And it tends to be if you've got more qualified staff that are off, they get replaced with healthcares (assistants) instead of qualified nurses' (participant G 3rd year female student)

'I think a lot of things revolve around staffing levels…erm more specifically like reduced numbers of staff or maybe not the right skill set. Erm so there maybe wasn't like band sixes but more like band fives and lack of health cares (assistants) to do with the amount of patients there were. I think in just about every placement I have had, there have been problems with staff, not enough staff or not the right skill set. I think it's right that the public hear about it as much as they do because it's quite a big problem' (participant J 3rd year female student)

'Yes erm for me, I think staffing levels mean that patients are at risk of falls. I remember working on a ward where there were three falls risks in one day who were to be one- to- oned and there was no one person for the three people and I meant it was a staffing issue' (participant L 3rd year female student)

'And it tends to be if you've got more qualified staff that are off, they get replaced with healthcares (assistants) instead of qualified staff nurses. Obviously, that's the biggest thing I've seen' (participant G 3rd year female student)

There was a perception amongst a large proportion of participants that the skill mix was not appropriate and patient / staff ratio was inaccurate in many of their placements. During the interviews, this was not investigated further to elicit their

understanding of guidelines and recommendations regarding staffing levels in the NHS as it was felt this was not relevant to the research study, however their views were commensurate with discussions amongst students in the classroom setting and highlighted student perceptions about skill mix which often tends to be triggered by intuitive tacit instinct as opposed to measurable, evidence based argument. Despite their strong sense of concern with staffing issues, none of the participants reported challenging the staffing levels with their mentors or others. There was a sense amongst the participants that their supernumerary status was often compromised, with them being recognised as another team member making up the numbers. They saw this as a factor in the potential for patients to be put at risk.

It could not be verified whether the staffing levels they were discussing did fall below the establishment recommended in guidelines nor was it possible to identify if skill mix was significant. It is however, an issue that warrants further research.

Evidence of student challenging practice

Participant A shared an account where she was coerced into signing for a medicine that the registrant was administering incorrectly. The student challenged this and refused to conform. This student was in her first year when the incident took place and therefore relatively inexperienced. Nonetheless she demonstrated confidence in what must have been a challenging situation:

'I looked, I checked again and it was 500mg on the kardex and she put them on the table and gave her a glass of water and said you can just countersign that' And I said no and she said why? Erm I just said well because you've given her the wrong dose and she was just like oh well everyone just gets 1gram and you just do it automatically. And I said I know but that's not a good enough excuse and fair enough she wouldn't have had a toxic problem from you know paracetamol but it was enough to see that she wasn't paying attention'
(participant A 2nd year female student)

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It is clear that the student was not going to allow herself to be coerced into what could be described as unethical and unlawful practice.

Another participant in her second year of training was confident that in order to prevent harm by incorrect patient handling, she would feel at ease to speak up and prevent a potential error:

'*I think if it was an emergency then say if I could clearly see that a patient was not positioned properly say in a hoist and I thought that there is you know, going to be an instant cause and effect then I would say stop a minute can we please check this because I think that is human error and they might not realise it so I would definitely speak up*' (participant B 2nd year female student)

Perhaps the focus upon patient handling and medication administration featured predominantly in student accounts because these practices are physical and tangible as well as being governed by a code of practice, legislation and policy. Students are introduced to this very early in their training and they are well attuned to the potential serious consequences which arise from deviating from expected practices. The consequences for the student as well as the patient are recognised. There was a strong sense of moral obligation expressed by all of the students and as one student commented:

'*yes do you lose sleep because a patient came to harm or do you lose sleep because you raised a concern and are now worried about your reputation. I would never kind of step aside and be like 'oh it's not my place to say anything. You know, even as a student you have to be an advocate for your patients*' (participant J 3rd year female student)

'*Everyone makes mistakes, you can, but the most important thing is that you admit to it and you don't just keep quiet*' (participant E 1st year female student)

Support

All of the participants interviewed indicated that they were aware of the support available to them and they indicated that they would know who to report their concerns to:

'I think when I first started, I probably would have been a bit scared to…well I would have known who to report it to but I would have been more worried about sort of like having to stay on the ward and who was going to say something. I would feel more comfortable…like I would inform my mentor and if they didn't do anything I would go to the ward manager' (participant K 3rd year female student)

What did emerge, was their expectations that they would be assured of support from the university should they raise a concern in the practice placement. This was illustrated by the comments of first year students:

'I think there is quite a lot of support at the minute but I think especially in my first placement it is just a lack of confidence but it does help when someone from the uni comes onto the ward and talks to you' (participant E 1st year female student)

'Yes if I did come across anything and needed support I would speak to my placement facilitator and GT (Guidance tutor) I would expect you to be there' (participant D 1st year female student)

The data suggests that feedback did play a significant part in their willingness to speak up. Many of the students were of the opinion that no feedback suggested that little if anything had been done to address their concerns. However, most also acknowledged the requirement for confidentiality and made the assumption that this factored heavily in the decision not to inform the students of any outcome. They did however offer a strong sense of hope that by raising a concern, it would be a catalyst for change to improve the quality of patient care.

'I think I would want to know that something had happened; that it hadn't just sort of gone into the system and just sort of petered out.It would be further kind of reassurance that you had done the right thing and it would give you confidence to speak up in the future' (Participant J 3rd year female student)

I'd maybe like to know feedback. Like I'd like to know if something changed because of the concern I raised' (participant L 3rd year female student)

'Sometimes you can raise a concern but you don't quite know if anything is going to be done about it or if practice has changed' (participant G 3rd year female student)

'They talk about the mistakes that happen but not the solutions afterwards and the good things that have come out of it. Just the bad things' (participant E 1st year female student)

'Yeah I think it is important to see it through. Sometimes you can raise a concern but you don't quite know if anything is going to be done about it or kind of if practice has changed' (participant F 1st year female student)

Summary

In summary, the data provided in this key theme suggests that all of the participants were aware of the importance of risk assessment and safe practice. They were well informed about the concept of patient safety and the need to uphold professional behaviour and a requirement of them to speak up. It was evident that all had either witnessed an element of poor practice or had been coerced into performing practice that was substandard. Some had not witnessed poor practice directly but remained aware of the potential for errors to occur. Experiences of poor practice was varied but tended to focus on similar examples such as patient handling and medicine administration. All of the participants were aware of the concept of raising concerns or whistleblowing and the existence of policies and procedure to support them in doing so. However, whilst some participants indicated they had already done so, or would be willing to raise a concern, others indicated reluctance, choosing instead to remain silent. The key influencing factor in their acquiescence appeared to be shrouded in their fear of potential reprisal and retribution.

Theme: The fear of retribution

The findings suggest that students' reaction to poor practice is often a personal, sensitive and challenging experience. On the one hand, the participants unfalteringly demonstrated an awareness of their professional obligation to report substandard practice. This was coupled with a strong sense of moral obligation to do 'what is right'. On the other hand, there was a strong sense of 'survival', an urge to succeed and get through their placement and avoid 'trouble'.

Effect on progress

In order to succeed in their learning and practice placements, students possess a strong desire to 'fit in' and be accepted by their mentors and team. Ultimately they want their placement experience to run smoothly and successfully so that upon completion they will have successfully passed their placement and achieved a favourable report. There exists therefore a dichotomy between the desire to uphold professional standards by 'doing the right thing' particularly when it challenges others in that team, and self - preservation for fear of the potential consequences of failing the assessment.

Participant B illustrated this tension amongst students and their desire for survival:

'If I was on placement and raised a concern it would affect that placement then I might wait until the end or bring it to the university rather than approaching it on placement

It's human nature, when you go on to placement…you want to be liked and you want to get along with people and try …try to make the most of it and so doing something that is definitely going to compromise that would be difficult'
(participant B 2nd year female student)

There was particular tension amongst the more junior students in their first year who felt that their inexperience and a desire to fit in prevented them from speaking up:

'I felt like I couldn't ask because obviously it was my first ward and placement and I didn't want to cause trouble….especially that early on. They might think that oh you're brand new and you don't know the way of the ward they just think that's the way it goes in uni' (participant E1st year female student)

Some of the participants were conscious that they were to return to that clinical area at a later date and this influenced their decision on whether or not to raise a concern.

'If I speak out now…..I go back for another twelve weeks so…it would be fairly obvious who had given the complaint. Like eventually I do think the staff would have known was me, even if they said they would keep it confidential, they would have known coz of the nature of the complaint' (participant G 3rd year female student)

'I started thinking should I just wait till the end of placement when I'm signed off but I couldn't say something after coz I was scared what was going to happen then I thought I've still got another two months to go and if she keeps doing it then…..but I don't think anything actually came of it…she didn't go on a course or anything like that' (participant A 2nd year female student)

The mentor is a significant figure in the students' journey within practice. Ultimately it is the mentor who signs the student as pass or fail on completion of the placement and comments on the students' ability and performance. Therefore, students feel the need to keep 'on side' with their mentors for fear of retribution and failing their placement.

'You have to get on with your mentor and it is hard to get on with them, it's not easy. You have to be on top of your game…'

'I know it's confidential but you don't want to be going to your next placement with them knowing that you are 'the' student….you know….trouble maker. .looking for trouble and you get that kind of reputation' (participant D 1st year female student)

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The lasting effect upon the student is also significant, as students perceive they may be 'labelled' as a troublemaker which may overshadow them on subsequent placements and affect their experience:

All of the participants expressed their fear that speaking up may affect their progression and summative grading on their practice placement. This was particularly prevalent with some of the more junior students. In addition to the potential to fail their placement assessment, there was a strong concern regarding the punitive consequences of raising concerns.

Punitive consequences

Many of the participants exhibited a sense of trepidation that they would face punitive or uncomfortable consequences if they blew the whistle:

'I've seen it, if they decide that they don't like someone then they can make it quite hard. There were big rifts on my ward between certain members of staff and they could make it pretty hard' (participant D 1st year female student)

Participant H shared an account of an experience in which an interview took place after reporting a concern:

'We had a meeting with the matron…..they separated us and then we had to say our opinions, what happened and then they personally asked which staff….tell me which staff it was. You know so we did that and then my colleague came crying out of the interview with the matron. It was horrendous' (participant H 3rd year male student)

When asked if the student felt intimidated during this experience the response was

'yes'.

He went on to describe in more detail the circumstances and subsequent action that was taken which clearly had been a negative and uncomfortable experience.

Even more disturbing, some of the participants alluded to intimidating behaviour

by some of the placement staff and this included non- qualified staff:

'If you say something against one of them…they all know about it, do you know what I mean…

Like if it was a healthcare assistant…I know it sounds silly but they're quite forceful if they are all together' (participant K 3rd year female student)

Despite the inert fear of reprisal, students remained cognisant of the expectations

to 'do the right thing':

It can be suggested that the ability to speak up against poor practice is clearly

influenced by the stage of training, with first years perhaps more hesitant than

third years. However, in addition the data appears to be revealing that the ability

to speak up is also largely dependent on the students' sense of moral and ethical

beliefs. Clearly some students demonstrated skills of assertiveness that were

better developed than that of others.

Evidence of student not challenging practice

There appeared to be a number of reasons why students were reluctant to

challenge practice, not least their perception of their junior status and limited

experience:

'You have healthcare assistants who have been in the job for 10 – 20 years so you feel quite uncomfortable challenging them…you just feel intimidated…

'I think I'm one of those people who wouldn't because I'm quite shy and a bit reluctant to cause anything'' (participant B 2nd year female student)

Students discussed their reluctance to challenge registrants as they often

perceived them as the 'experts'. This coupled with their own doubts about their

knowledge base, added to their hesitance:

'I don't think I've quite developed the clinical knowledge to challenge a qualified'

(participant C 2nd year female student)

'No I didn't challenge her because she was my mentor and she was the expert and had been on the ward for over 5 years so I didn't even think twice about it…''You know I possibly wouldn't because they are qualified and I am learning off them…you want to get on with your mentor'(participant D 1st year female student)

This can however be at odds with their perception that even as a newcomer to

the clinical environment, they can identify practice that is suboptimal.

'Ive reflected and looked back and part of me thinks I should have said no but I wasn't strong enough on my first day' (participant G 3rd year female student)

'People are more likely to speak up now probably in the light of the Francis Report. But there is still a barrier definitely…If you raise a concern, they might think; why is she raising a concern? She's just started' (participant I 3rd year female student)

There appeared to be an element of student personality type as an influencing

factor regarding their ability to speak up with those who perceived themselves to

be shy as less likely to. IN addition, further evidence that students struggle

navigating their moral compass.

Summary

To summarise, it was becoming quite clear that students faced a dilemma between their moral and   professional conscience requiring them to raise concerns, and this being offset by fear of punitive consequences and the potential to fail their placement.

On examining the data further, it became apparent that there were a number of factors that instilled these fears in students and not least the relationship between them as students and others in the workforce team. It was clear that participants viewed some of their colleagues and mentors in practice as authoritarians and disciplinarians.

Theme: Hierarchy

The concept of the existence of hierarchy within the healthcare arena was unanimous and emerged in divergent forms. The data suggests that students shared a common belief that paternalism existed between professions, and in particular between doctors and nurses. Further analysis revealed that others alluded to the fluid hierarchy that appears to exist in nursing alone. It was also evident that hierarchy was linked to socialisation, role and the age of individuals. The data indicates that age of individuals appears to be a significant determinant amongst students when considering whether or not to speak up. This factor was unexpected and though often linked to experience in the context of the discussions, it was felt that this warranted the creation of a subtheme.

The issue of hierarchy and paternalism remained strong throughout the analysis of the transcripts but it became apparent that this was multi-factorial. This did not always relate to the seniority of individuals but sometimes manifested in inter-professional status, for example the doctor – nurse relationship and the paternalistic virtues that existed in the team. The role of long-established team members regardless of rank or seniority emerged as significant in relation to whether or not students were willing to challenge these individuals.

In addition, experience, status and surprisingly the issue of 'age' became evident upon analysing the data. Remaining cognisant of my own presuppositions and experience, it came as no surprise that role status featured as an important concept. However, the relationship between students' willingness to speak up being influenced by the age of the perpetrator was unexpected.

Age

A number of students indicated that their age and the age of their colleagues within the team was in fact significant in determining their actions. This was evident amongst the younger students in the 21-25 age range:

'I would feel quite uncomfortable challenging them especially if they were a lot older than me just because of their age and how much experience they have had on the ward compared to me who has been there for two week' (participant E 1st year female student)

'I think they would look at me as going what do you know anyway, you're just young' (participant L 3rd year female student)

'If they are older than you then it is difficult to say er do you mind or can you just you know, discuss that practice with you or whatever it might be then you can feel quite intimidated' (participant B 2nd year female student)

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'Raising concerns is an age thing. I have actually had this conversation with my mentor. When I am qualified, I am young and just out of university so I am young and they will see me as younger and even though I have knowledge they might not see me as having much experience' (participant C 2nd year female student)

Most of the students believed that age was inextricably linked to experience therefore the older the person was, the more likely they will have accumulated experience and expertise:

'I think they are very much interlinked. I mean obviously as age increases, it's likely that someone 's going to be higher up the hierarchy' (participant J 3rd year female student)

'When you're a bit younger, you might feel like you're not taken as seriously if it'd against an older person, like if the person you were raising a concern about was older and the had a you know…long career' (participant K 3rd year female student)

However, some of the more mature students denied that age would necessarily be a barrier to raising a concern:

'I wouldn't be intimidated age wise. My mentor was around the same age as me. We both had children so we had that in common……Well luckily I am old anyway haha I'm 40' (participant D 1st year female student)

'I think I'm a little bit different because I'm a little bit older than the other students on this course, me being 27 and I've been in a management role before' (participant L 3rd year female student)

This suggests that age is a significant factor in determining behaviour in the context of practice. It does however seem to be interconnected to experience but not necessarily to role status.

Student status and status of staff

The role of the student and their status amongst qualified staff can often be seen as hierarchical. Student nurses who were educated in the traditional schools of nursing found themselves at the very lower end of the ladder. Indeed, hierarchies existed even between junior and more senior students as a pre-requisite to their eventual elevated status as a registrant. Little has changed today with the grading and banding of staff, particularly amongst nurses providing an instant presence of status. It is therefore unsurprising that students are socialised into this pattern of behaviour. Participant J commented:

'I think the NHS kind of entrenches the hierarchy…even visually, they have outside every ward in my local trust a poster which has who's who and it purports to just identify who's who but it's a pyramid and at the top you have matrons and it goes down… at the bottom row you have students, domestics, even that kind of visual reinforces that some people are more important than others' (participant J 3rd year female student)

'I think maybe sisters and higher, I think I would be a bit cautious and maybe go to speak to another nurse…I maybe wouldn't go directly to a doctor' (participant I 3rd year female student)

'I've seen.. if they are a lower band and they want to complain about someone higher up, it always seemed a bit. .they don't want to do it coz they are scared because they are a higher band than them…'
You go to some wards, there will be the paternalism thing and it is : consultant, doctor, nurse, healthcare assistant, student. That's how it'll go' (participant K 3rd year female student)

Some students perceived medical staff as paternalistic and their observation was that medical staff rebutted nurses as being inferior:

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'I've seen a mix. Some of them were specifically medics. I don't wish to bash doctors at all, but some of them feel a bit kind of affronted and don't take kindly to being told how to do their job by someone they see as maybe a bit inferior' (participant J 3rd year female student)

The perception of hierarchy as a presiding factor was mainly discussed in relation to the qualified status of staff. This however was not always the case with students' alluding to the dominance they observed amongst health care assistants. The role of the nursing assistant was introduced during the last century and formerly known as the auxiliary nurse. The purpose of the role was to provide assistance to qualified nurses. Later replaced by the title 'healthcare assistant', the role has evolved to one that provides much more scope and skill set. This is in response to an already overstretched service. As a consequence, many of the individuals in this role, though unqualified nonetheless become powerful figures in the team often as a result of their relationship with others within the established team. This is often revealed in the classroom setting through dialogue with students. Many of the students view the healthcare assistant as a dominant member of staff who yield implicit power, particularly over student nurses. This was illustrated by one student who commented:

'There was one particular healthcare who had been there years....you have heard people talking about this particular person. I wouldn't go up to her and directly say to her' (participant F 1st year female student)

This echoed the perception of other students who discussed the power held by some individuals in this role, particularly as a collective.

It was also evident that the students often feel vulnerable challenging what are essentially non-qualified staff. However, by virtue of their length of service and

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established role in the team, this can be a barrier to students challenging their practice:

'They might think why is she raising a concern? She's come out on the ward, she's just started. She's a third year, she's not qualified and she's raising concerns about how we care for people, I've been here a long time and I know how to do my job so don't tell me otherwise sort of thing' (participant I 3rd year female student)

'Well I'm not sure what they are doing is correct practice but they have been on this ward for x amount of years and they've always done it like this and they would just say to me oh well you're a student you've been doing this for three years don't tell me how to do my job' (participant J 3rd year female student)

By the very nature of their student status, some of the participants felt that this was an automatic inhibitor. Other students however believed their student status afforded them opportunities to ask questions or make suggestions about aspects of practice.

'As a student you are in a position to say well I am just a student so do you mind if we do it like this the way I have been taught to' (participant B 2nd year female student)

Summary

In order to survive, the students accepted that hierarchy existed and was sometimes fluid. Hierarchy was not explicitly confined to a sense of paternalism but rather more to authoritarian and social identity status. Hierarchy existed out-with job title and status. It was associated with experience and with that was an inextricable link with the age of team members, regardless of rank. Importantly students had to learn the 'norms' and identify the 'who's who' in order to achieve success on their practice placement.

Intertwined with the social milieu of working with others and interacting with individuals as discussed above, the role of the team, as well as the perception of team culture emanated throughout the process of analysis.

Theme: Team culture:

It was emerging that team culture was a strong influence in the student experience. Participants indicated that the team in which they were working played a significant role in influencing their decision whether to raise concerns. In part this was attributed to inter-team relationships and personal relationships. Central to their perception of a successful placement was their ability to be accepted, supported and act within their role in a way that they felt was expected of them. Their relationships with team members was significant and stretched wider than just their relationships with their mentors. Most were cognisant of the inter-team relationships that existed, as well as personal relationships that existed between individual members of staff. They were mindful of the significant impact this may potentially have if they were to instigate any actions that could be perceived hostile.

The culture within the teams on placements were crucially important in determining safe practice. Participants reported the significance of the placement team in shaping their experience, whether positive or negative. Crucially their relationship with their mentors played an enormous role in their exposure to safe practice and their ability to challenge.

Relationship with mentor and team members

The data suggests that students valued their relationships with various team

members and it became apparent that the mentor played a pivotal role and

influenced their behaviours:

'I had a really good relationship with my mentor, which was something that definitely helped' (participant J 3rd year female student)

'Yes I think if your mentor.. like you get on well with them and they create an environment where it's open and you can ask questions… then I'll ask more or if they did something and they knew it wasn't best practice then if they would explain why they had done it that way and not the way it said in the books' (participant E 1st year female student)

The pastoral, supportive role demonstrated by some mentors inspired confidence in students and as one participant commented, they offered a protective shield:

'I think I have been lucky so far as the mentors that I have had have been quite… human shields and kind of protected me' (participant B 2nd year female student)

Conversely, mentors who lacked the level of support expected by students had a

negative effect:

'My mentor was nice…but she didn't want to be my friend. You know, she wasn't particularly embracing me with open arms so I wanted to keep the relationship nice and I wanted to behave myself coz they can make life quite difficult…'

My next mentor..

we had a more open discussion type of relationship. I would say what went on there? That doesn't look right and she would explain so that was a much more relaxed relationship than with the mentor at the hospital, she would huff and puff and I know fine well that she would go to her friends and you know…say who does she think she is' (participant D 1st year female student)

As well as the students' relationship with their mentors, the relationship between

other team members was influential in setting the type of environment in which to

work and learn:

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'In some different areas, areas which are more dependent, the staff seem to get on a lot better. If it's quick paced and it's a ward routine, staff can be quite competitive against each other' (participant I 3rd year female student)

Practice placement experience varies from student to student. Whilst the requirement is that all students work with a named mentor for 50% of their placement, students are often allocated an associate mentor. In reality, students often find that they work with a variety of staff during their placement experience. The exception to this can perhaps be seen when students are placed with a mentor who works autonomously, for example a health visitor or community nurse. The relationship in these situations can often be more intense. This can have either a positive or negative effect on the student depending on their personality, learning styles and the skill of the mentor. The student's relationship with their mentor is a significant influencing factor in determining their behaviour.

Interpersonal relationships

Maintaining a professional relationship with co-workers was identified by participants as a key factor in promoting a safety culture, particularly when demonstrated by leaders:

'I've been on wards where it has been good in the way that even though the manager is friends with the staff, they sort of put that aside ad still take it like professionally' (participant K 3rd year female student)

However, familiarity and more intimate working relationships amongst colleagues could often lead to individuals acting in a complicit way therefore compromising safe practice:

'I think a lot of staff on there were, you know, set in their ways and they were friends so they would cover each other's backs...

If you are friendly with the staff you are there to work and even at the end...I think that's a little bit why the staff stick up for them because they are friends outside of work and don't want to see them harmed' (participant A 2nd year female student)

There was also a feeling that some teams fostered a culture of complacency, possibly influenced by routine behaviour and an absence of incidents occurring:

'There are people who have been there for years and they know they are not doing what they should be doing but it just gets brushed aside because nothing has happened yet ....until it does happen and then it will be addressed...

Yeah, nothing's ever happened so we'll keep doing it but that doesn't necessarily mean that they should keep doing it. They are probably really lucky that nothing has happened' (Participant L 3rd year female student)

Summary

Students have a fundamental need to 'fit in' and belong to the team. This is essential for survival and exceeds beyond their relationships with their mentors. The mentor however, remains a figurehead and the key to survival in the clinical arena. Students who form a good rapport with their mentors and feel supported by them are more likely to raise a concern than those who feel alienated. The strength of the leader is also significant in promoting a positive and transparent culture of safety.

Summary of findings

This research study has revealed some powerful findings born out of the lived experience of student nurses. What the data is suggesting is that students embark on a trajectory of experiences during their three- year journey to registration. Undoubtedly they have a heightened awareness of the importance of patient safety. This is coupled with a strong sense of professionalism instilled in students and largely accepted by them. However, students appear to have a

desire to be accepted by their colleagues and ultimately to be successful in their practice placements. There is a strong ethos of moral and ethical values held by students but this is counterbalanced with the need to survive.

Students experience a combination of situational demands and pressures bestowed upon them within the environments in which they are placed. The situational demands that students experience can be divided into two categories:

➢ Intrinsic

➢ Extrinsic

Intrinsic factors arguably come from 'within' and are shaped by the students' ethical beliefs and a will to 'do the right thing' and act professionally.

Extrinsic factors on the other hand are those that are out-with the students' control and a born out of the organisations values, demands, practices and culture.

Students can generally identify with a practice that is overtly wrong regardless of their stage in training. Their perception of poor practice becomes more distorted however, when they witness behaviour that may not be commensurate with what they learn in university but may be in the judgement of their mentors 'tailored to the needs of the individual'. Students often feel reluctant to challenge their more senior colleagues as they perceive themselves to lack the necessary knowledge and experience to do so. Importantly, fear of the consequences was an overriding factor which emanated during analysis. Students possess a need to fit in and be accepted in the team in order to survive their placement and ultimately pass their assessment. To this end, students will conform to what is asked of them.

The findings in this research provide a lead to examine where the literature review left off. The participant responses and sharing of their lived experience echoes what some of the literature on this topic is saying but also extends beyond this. What is important is that this research goes one step further by pinning these findings to the conceptual framework. Viewed in isolation, student behaviours and expectations in practice provide an illustration of the challenges and experiences they are likely to encounter in the trajectory of their educational programme. By integrating these experiences with the conceptual framework of social and organisational identity, we are able to better understand and make deeper connections with the relational and substantive contextual issues that influence their behaviours when faced with the challenge of raising a concern.

What is encouraging is that with support from education providers, interventions are possible if we have a more comprehensive understanding of exactly what it is that prevents students from raising concerns and challenging practice.

The following chapter will provide an in depth discussion of the findings.

Chapter 5: Discussion and interpretation of findings

Introduction

The overall aim of this study was to gain an understanding of student nurses'

perception of what constitutes patient safety and to understand the factors which

influence their decision to raise or not raise a concern. The previous chapter

presented the findings and grouped them into four key themes: context of patient

safety, fear of retribution, hierarchy and team relationships. Rather than address

each theme in a linear fashion, this discussion will focus upon the theoretical

discourse emanating from these key themes.

The approach to this research was based on a phenomenological methodology

using the principles of hermeneutics as it was important to understand the lived

experiences of the students and glean an insight into what they understood about

patient safety in context. It was also important to understand what would

influence them to raise a concern if they witnessed sub-optimal practice, or

prevent them from speaking up. This methodological approach achieved the

intended outcome. To maintain focus and guidance, the conceptual framework

provided a navigational tool in which to make sense of the data.

Of the twelve student nurses interviewed, all of them demonstrated an

awareness of the importance of patient safety and the concept of risk. It is quite

apparent from analysing the data that all of those interviewed had a clear

understanding that patient safety was a clear indicator of quality care delivery in

the United Kingdom and also globally. Students' shared similar perceptions of

patient safety issues with many of them having witnessed errors, whereas others

had not been involved directly in a patient safety situation, thought they were cognisant of the potential for error to occur. Many of them discussed errors which were tangible and physical, such as those relating to medicine administration and patient handling. Others shared broader concerns relating to professional behaviour and practices. The findings indicated that perceptions amongst first, second and third year students was similar, though reaction to poor practice did differ in some aspects between first year and third year students, with the latter perhaps more mindful of registration approaching and the associated accountability required of the role.

There is overwhelming evidence in the findings that the students were aware of the professional behaviour required of a nurse and all of those involved in healthcare. The findings revealed that students demonstrated an awareness of this in their discussions, yet controversially, by failing to raise a concern, this potentially compromised the professional requirement of them as students. This is an underpinning factor of why this research is of considerable importance if we are to support students to fulfil the professional requirements expected of them.

The key findings in this research are important and offer further dialogue to help us to better understand student nurses' beliefs and behaviours in relation to patient safety and raising concerns. The discussion will be organised under subheadings. An understanding of the context in which student nurses experience or are aware of patient safety issues will be explored, along with an analytical exploration of social identity, team culture and factors that influence moral courage amongst student nurses. Ultimately this discourse takes us to the concept of learning from high reliability industries and the impact of 'Human Factors', an approach which is now adopted in present day healthcare delivery and suggests connectivity with the findings in this research.

The context of patient safety

Without exception, all of the students interviewed demonstrated an understanding of the concept of patient safety. They were cognisant of the requirement to speak out against unethical, unlawful or outdated practice. However, their willingness to do so varied and was underpinned by a variety of influencing factors. The differences in student reaction to poor practice in this study was attributed to their knowledge, status, confidence and above all what can be described as moral courage. With regard to the context in which students understood or had experienced a patient safety incident, it was unsurprising that the participants identified medicine administration and patient handling as a common area in which mistakes are often made. This has been identified in the literature (Obrey and Caldwell 2012, Leufer and Holdforth, 2013, Montgomery et al 2014). Interestingly, a recent Finnish study in which comparisons were made between Finnish student nurses and UK student nurses experience of patient safety issues, the researchers found that medication administration and patient handling featured predominantly in the UK students accounts (Tella et al 2014). This could be attributed to a heightened awareness of legislation and mandatory practice in the UK with regard to medicines management and patient handling. The negative consequences of perceived deviation from expected practice can be seen to contribute to significant morbidity and mortality. Great emphasis is placed on safe medicine management and patient handling in the curriculum therefore one could expect the students to be cognisant of the potential for error. However, it was not clear if this was the driver or if indeed medicine errors and incorrect patient handling are commonplace in practice and perhaps this phenomena warrants further research. All of the students believed that staff shortages were a significant contributory factor to compromised safety, though

quantifying staffing levels and skill mix were not discussed in any great detail by participants in this study and therefore further research in this area is desirable.

. All of the students interviewed in this study alluded to the significance of their student role and status. Whilst all of the students interviewed believed they had a moral and duty-bound requirement to raise concerns, for some this was the driving factor to them raising a concern. Others however remained acquiesce for fear of retribution. Students possess a strong urge to survive their journey to registration. They long to fit in and adhere to the social norms expected of them in order to survive. This leads to a compromise in their reactions to poor practice and suggests that a dichotomy exists between their courage to speak up and uphold professional practice, or keep quiet and conform for fear of retribution. What is clear in the findings of this study is that an overarching influencing factor in determining behaviour is that of role and identity. In addition, student nurses have an overwhelming need to 'fit in' and survive, avoiding confrontation.

Social identity emerged as a powerful theme in this study and therefore as a conceptual framework, it helped to provide justification for the choice of topic and the chosen methodology.

The influence of the students' perception of role, group behaviour, organisational identity, hierarchy and belongingness became apparent in the findings of this research. This would in part appear to support earlier studies (Melia 1987, Levett-Jones 2009). Subsequently, it is necessary to understand the intrinsic sense of self amongst student nurses and explore how this is compromised by external organisational influence. With this correlation explored, the characteristics and components of conformity, moral courage and human behaviour will then be

examined further. It is intended that this will then provide a platform on which further policy can be developed.

Torn between two identities: the 'self 'and identity in the organisation

The initial literature search conducted at the start of this research study revealed that the concept and influence of student identity and role was ubiquitous. Subsequent searches of the literature alluded to this concept though not always explicitly. This research study appears to support some of the literature reinforcing the fact that identity and role are important factors in determining behaviour. Identity is recognised as a long established concept of how we view who we are. (Jenkins 2008). Whilst there are contested understandings of identity through psychological, sociological and anthropological theories, there appears to be a broad consensus that a sense of self is shaped through a fluid process of interactions between the individual and societal structures to which we are all exposed (Brennan and Timmins 2012). Identity is developed during childhood but continually remodelled through the trajectory of adulthood in response to experiences, relationships and structures within society. Identity is also linked to our exposure to groups and organisations. These core aspects of identity developed during our early life span can also be reshaped and manipulated through our career aspirations. However, as Ashforth (2001) observes, private realms of life have gradually become proliferated by institutionalised and industrialised societies. This inevitable colonisation by organisations becomes increasingly mediated by roles. These different roles he argues can be learned and enacted by individuals. They can also become fluid and interchangeable and do not always sit with personal philosophies and

beliefs. If Ashforths' theories are correct, then it can be argued that on commencement of nurse training, identity is manipulated by the groups and institutional behaviours students' become exposed to.

Healthcare delivery in the UK has a long standing history of being delivered in institutional style environments, some of them often military – like in style where discipline and conformity were the norm. Nightingale herself imposed rules and regulations on her nurses with military precision. Nurses were expected to be obedient and follow orders parallel to the military style institution.

There have been attempts to theorise and understand the role of institutions and the social control imposed upon those who live and work in them. Goffman (1961) wrote prolifically about asylums and the 'total institution' vividly depicting institutional life where the sick and vulnerable were controlled. So too it is argued were the staff who worked in such environments. Goffman believed that total institutions were comprised of five groupings: life is conducted under one authority in the same environment; life is carried out in the company of large batches of other individuals; all activities are scheduled. This is overseen by formal rules imposed by officials and all activities are designed to fulfil the institutions aims and objectives.

Goffman asserts that total institutions are characterised by the bureaucratic control of humans and operate through the mechanism of the 'mortification of the self'. Mortification of self occurs when the individual is socially conditioned and stripped of their individual identity and personhood. His writings focused on the identification of total institutions which included: prisons, asylums, military barracks and some religious orders, recognising them as social arrangements that are regulated according to one rational plan under one roof. It seems fitting

therefore to find parallels with Goffman's observations to hospitals and nursing homes. Goodman (2012) argues that Goffman's assertions do apply to healthcare environments such as hospitals, nursing homes where vulnerable individuals are controlled for the purpose of treating or managing and illness or condition. Though Goffman's accounts relate to a bygone era, with asylums now largely demolished and paternalism arguably a thing of the past, one can ponder to what degree social control and the notion of the institution has been lost. Reports about poor care delivery and failures in patient safety suggest that modern healthcare delivery has not moved on as far as some would like. Individuals who find themselves in the system often experience social isolation, altered status and identity with activities largely scheduled and administered in a way that serves the organisation. The seminal work of Foucault (1973) suggests that in the context of these institutions, people often willingly subjugate themselves to subtle forms of power. He does however make the distinction between obvious forms of power such as law or arms, with the insinuation of power experienced through taken for granted actions such as going to the doctor, attending school. Foucault's writings centred on the process of cultural discipline and he attempted to mobilise resistance to the expanding domain of power / knowledge (Gergen 2013).

Hospitals like other institutions create an environment where activities are carried out in the presence of others and serve two broad and quite differently situated categories of participants; patients and staff. Traditionally student nurses were recruited to the school of nursing within the hospital. There was an expectation that they would not be married, they were required to live in the nurses' home and they were required to adhere to strict discipline both in the hospital and when off duty. Many of the qualified nurses, particularly amongst the senior ranks,

would live in the hospital and oversee the younger recruits as well as execute their responsibilities to patients. The patients' day was often punctuated by scheduled activities such as medication rounds, ward rounds, meal times. In addition, there was little access to the outside world. It is inevitable therefore that a similar existence was bestowed upon its staff and in particular student nurses who were often required to work long hours with very little free time allowed. Goffman (1961) believed that on entering total institutions, individuals were stripped of their own social identity by the removal of possessions and personal attire. This also related to the wearing of a uniform which contributed to the removal of individual identity. It is unsurprising therefore that student nurses were socialised and conditioned to fulfil the aims of the organisation. Through the process of professional socialisation, their identities were reshaped.

These observations are important, because the findings in this research appear to echo similar behaviours despite the advancement of nurse education and a move into the twenty first century with a new generation of young adults. It is perhaps significant that as nurse education and nursing has developed over the past few decades, many of its staff remain in the system, still carrying the legacy of a different culture in a bygone era, traits of which are inevitably passed down the chain.

The desire to be accepted by the team and remain 'on side' was a strong theme in the findings of this study. All of the student nurses interviewed, alluded to a desire to be accepted within the practice placement team. This desire to belong was often an impediment to challenging practice. This is commensurate with findings in much of the existing literature. Melia (1987) in her seminal work over three decades ago, described the experiences and socialisation of hospital trained nurses. The dominant strategy amongst nurses was 'getting the work

done', 'fitting in and 'learning the rules'. Student nurses conformed rather than challenged practice and in fact were discouraged from questioning more senior staff members. It is argued therefore that the theoretical underpinning of social identity and its relationship with organisational identity is key to understanding the willingness or reluctance of student nurses to raise concerns. Ultimately they possess a desire to be part of the team: 'the in group'. Consequentially, acceptance within the team is necessary for survival and success. Much of the theory of social identity within groups is attributed to the work of Tajfel and Turner (1979). Fundamentally, they proposed that there are three cognitive processes which determine an individual being part of an in group or out group. They assert that the individual has to first of all decide which group they wish to belong to, the process of social categorisation. They then must identify the norms and attitudes of the members in that group to elicit whether they are compatible with their own social identity. The individuals own self-concept or the social concept of other people becomes aligned to the perceptions of membership within the group. In other words, how do in groups and out groups behave or perform to rate in society. Ashforth and Mael (1989) suggest that social identity theory involves the categorisation of individuals to a particular group defined by prototypical characteristics such as: organisational membership, religious affiliation or age cohort. Social identification therefore, is the perception of oneness with or belonging to some human aggregate. If this theory is correct, then it can be argued that the student nurse may define herself in terms of the hospital or organisation she belongs to, whether this is the university setting or placement trust. This in turn may lead to the desire to be part of the in group, though she may disagree with the prevailing values of that organisation in terms of authority, hierarchy and practices. Social identity theory does maintain that the individual

identifies with social categories partly to enhance self - esteem (Hogg and Abrahams 1999, Tajfel 2010). This can be achieved by the individual vicariously partaking in the successes and status of the group and may be identified at trust level or department level. There exists a potential dichotomy here then if we are to apply this theory because, the student may also identify most strongly with the university and her peer group. If this is the case, it can be argued that the student then becomes a member of the out group. It is also argued (Katz 1980), that newcomers to a group are unsure of their roles and apprehensive about their status. This was evident in the findings of this research, with all of the students' cognisant of their status as a student in transit. Katz (1980) suggest that in order to understand the organisation and act within it, they are required to learn behavioural norms, expectations and power relationships. This correlates with the earlier views asserted by Goffman (1961) in his study of institutional life.

Acknowledging that Goffman's views are historic and nurse training has long since shifted from the traditional schools of nursing, the findings from this study appear to suggest that the legacy of paternalism, hierarchy and institutional behaviour remain in existence though permeation is different to that which was apparent decades ago. Whilst conducting the literature search at the outset of this study, there was a strong body of evidence suggesting that student nurses often face a dichotomy between their own personal identity and the demands of the organisation. On analysing the data, it became apparent that the antecedents of identification and group behaviour permeated strongly amongst the participants. However, the context in which student nurses experience these challenges with identity is varied and is perhaps attributed to the way in which nurse education is delivered.

Since the early part of the 21st century, nurse education has moved into the Higher Education system with students educated in the university setting and their practice placements taking place in partnership healthcare trusts. This in itself places the student in a position where they are exposed to two institutions: the university and the hospital and healthcare setting. The student is then faced with a multiplicity of demands on their identity. Firstly, they enter the programme possessing their own individual identities comprising gender, social role and status. Secondly, they are then exposed to the concept of group identification and catapulted into finding their role within that peer group, which can often be challenging. Thirdly, they are then socialised into the hospital - healthcare environment where they are then exposed to the accepted social norms and expected behaviours. The transition can often be challenging and complex with different institutional demands placed upon them. The experience can often be fluid as they move back and forth as university students in a higher education environment and nursing students in the healthcare setting. Their social identity can be rather fragile during this transition process as the student attempts to establish and re-establish the social and professional hierarchies expected of them (Ashforth and Mael 1989). In order to achieve the stage of identification, a cognitive sense of membership is necessary and also an evaluative one which is related to value connotations and a desire to remain in the 'in group'(Tajfel 1982). If the student nurse is unable to define herself in these social groups, it can lead to unrest, dissatisfaction which will manifest in her behaviour. It is acknowledged that educating student nurses does not solely shape nursing identity but the process does contribute significantly. In addition, the tensions stretch far beyond the realms of personal social identity. Whilst the traditional training of the student nurse required them to conform and obey in the hospital based training school

model, the move into Higher Education requires the student nurse to become a critical thinker. This sense of institutional pride and compliance was replaced with an identity shift. That shift of identity required the student nurse to abandon institutionalised routine in favour of professional decision making and independent thinking. In addition, the freedom associated with university student status may also cause conflict with professional ideals and compliance. However, this emancipation does not come without a cost, resulting in many students experiencing a sense of isolation as opposed to a sense of belonging. This is largely due to students also being required to function as part of a team in a tightly controlled and regulated healthcare setting (Brennan and Timmins 2012). Participants who witnessed ritualistic practice which is at odds with the evidence based practice they are taught in university reported mixed responses to these actions. This can be attributed to some of the findings in the literature which suggest that the reluctance to challenge practice is born out the desire to fit in and not 'rock the boat' (Bickoff et al 2016).

Conversely, the application of social identity theory to nursing contexts is not without criticism. Willetts (2014), whilst acknowledging that self- categorisation and social performance amongst nurses can be attributed to social identity, she argues that there is little research which focuses upon the correlation between social identity and professional identity. This is significant as arguably a lack of clarity risks de-valuing nurses' work potentially exacerbating the perception of nurses as inferior in the healthcare arena. This was evident in the findings of this study, with some students believing without question that they were at the bottom of the hierarchy and doctors were placed at the top. It is argued however that if nurses, and in particular nursing students understand the concept of social identity theory and its application to nursing, this may go some way in promoting

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a fuller understanding of their professional identity in the workplace setting and help them to appreciate the value of their professional status.

A further interesting and significant development observed at the time of conducting this research study is that nurse education is undergoing further transformation, with the removal of funding by means of bursaries. Student nurses are now required to pay their university fees which were previously paid for by the Health England Commission. Parallel to this, a growing number of healthcare trusts are also offering an apprenticeship scheme which will result in the trust leading their nurse training with universities working in partnership. This has the potential for a further cultural shift in terms of organisational demands placed upon the student. A return to the hospital – based style of training arguably could in turn lead to a culture of loyal conformity and a shift away from critical thinking and challenging practice but it is too early to speculate and requires further research.

It appears that a shift in nurse education over decades has also evoked a significant shift in the identity of student nurses. Whilst it is acknowledged that students are a pivotal catalyst in guarding against the move away from ritualistic practice, the significant institutional ideologies to this day exist leaving students suspended at the chasm of a conflict of identities. One can speculate at the morality of this dilemma as there is potential for students to be used as a pathway to managing change in practice placements. On the other hand, this catalytic process could be viewed by some as a positive endeavour which can be used constructively in the quest to improve patient care. There is a danger however, that if this is the case, then the vulnerability of students is at risk of being exploited.

The team: 'rules and norms'

The findings in this research study revealed that student nurses expressed a strong sense of wanting to fit in and survive their placement. They did not want to be seen as trouble makers and they had a desire to adopt a harmonious relationship with their mentors, not least to guard against failing their placement. They also acknowledge that their mentors could be sound role models. Their mentors however, though important, were not the only team members' participants wished to please, they were also cognisant of relationships and dynamics in the team as a group of individuals.

 The psychology of group dynamics is widely discussed in the literature (Hogg and Abraham 1999). Kurt Lewin in the 1940's theorised group behaviour and his work is widely acknowledged in contemporary literature today. Student nurses are introduced to the theoretical component early in the curriculum in an attempt to aid their understanding of intergroup and intragroup relationships. However, whether student nurses embrace the concept of group theory, let alone apply it to their own experiences in and out of placement is questionable and requires further inquiry.

There are many factors which influence the success of a group including small group dynamics which address structure and cohesiveness as well as goal effectiveness. However, the groups to which students belong are much more complex. As previously mentioned, students identify with their peer group in the educational setting, but in addition they become part of the healthcare trust to which they are allocated for their practice experience. Their group membership does not stop there because arguably each different clinical area, whether it be a ward, department or community setting has their own additional unique group. Hence, the goals and objectives of the smaller group may conflict with the larger

group. Hogg and Abrahams (1999) purport that group cohesiveness is determined by factors such as: group size, group structure and leadership. The role and influence of the leader cannot be ignored because leadership is an important factor in determining the structure of the group and this is particularly so in health service organisations.

Notwithstanding, groups are differentiated by status, power and prestige hierarchies, cliques and subgroups. These determinants can be observed in healthcare settings and differ greatly within the same organisation as well as in the wider context of healthcare. It has been recognised that cohesiveness of a group has a profound effect on group behaviour as well as productivity. It can also improve job satisfaction and improved morale (Festinger 1950). Students who experienced placements where there was a lack of team cohesiveness and ritualist practice largely felt negative about their placement. This often left them with a sense of internal conflict as they strived to fit in and learn the rules of the game.

This research provides strong evidence that team culture is an important factor in the student nurses experience on placement. Students who were placed in clinical environments where the team was fragmented, relationships were strained and practice was ritualistic, had a far less positive experience and were less likely to raise a concern. However, two students did discuss their experience of raising a concern in relation to staff attitude and behaviour. They did describe the experience as being uncomfortable and their concerns appeared to be taken seriously though not received positively at first.

Students who developed a supportive and trusting relationship with their mentors and other team members felt more empowered to raise a concern. This was

particularly apparent if there was strong leadership in the team and an open and transparent culture.

This suggests that this study reaffirms the findings from previous research conducted by Levett- Jones and Lathlean (2007) and Bickoff et al (2016), who uncovered that student nurses have a desire to 'belong'. The literature review revealed that the disciplines of psychology and social sciences is replete with assertions that individuals are emotionally motivated to 'belong (Baumeister and Leary 1995. Levett – Jones and Lathlean 2007, May 2013).

In their study, Levett –Jones and Lathlean (2007) conducted semi-structured interviews to elicit narrative accounts of student nurses experience of belonging. The findings suggested that belonging to the team was crucial to a positive and productive learning team. Students require the ability to fit in and connect in a friendly and comfortable placement environment. They found that this linked with the student - mentor relationship. Conversely they observed that a diminished sense of belonging could lead to a range of deleterious emotional and behavioural consequences.

Though the above study sought to understand the impact of belongingness on student nurses and did not focus on factors influencing students to raise a concern, it can be argued that there are similar observations uncovered in this research study. For example, students may be more likely to raise concerns if they possess a sense of belonging and have a positive supportive relationship with their mentor and team members. This assertion however must carry a degree of caution, as if students who feel a sense of belonging in a team even though tensions with ritualistic practice exist, this could impede their willingness to speak up for fear of 'rocking the boat'.

A sense of belonging is built on both our sense of ease with our social and cultural surroundings, as well as our sense of similarity. Bourdieu (1977) argued that the reason for this is based on our sense of 'bodily comfort and ease' because we have a 'feel for the game'. Conversely, if we are placed in situations where we do not have this tacit knowledge, this can have a destabilising effect on our sense of self. This may lead us to be more consciously reflexive about ourselves when we are removed from our secure moorings. Bourdieau suggests that this sense of mastery of the game does not emerge naturally but rather it is learned from habitual ways of thinking. If this is correct, then habitus can explain the sense of belongingness. Bourdieau is not without his critics however, Bottero (2009) and Murphy (2011) cited in May (2013) have criticised Bourdieau's concept of habitus as not being relational enough. They claim that he fails to acknowledge the interactional element of relationality and social relationships.

An important concept of belongingness is its relationship with 'home'. This is because arguably, home is a place where we can be ourselves and is surely a place that is central tour belonging. We feel comfortable and secure when we are surrounded by objects that are close to us and have meaning. Goffman (1961) believed that home is where we can let things 'slip' by having a slightly less measured manner than we would display in the public arena. However, this viewpoint does not take in to account that the home is not a place of security for everyone but it is perhaps a place of familiarity. This is relevant because student nurses will experience placements differently depending on their support mechanisms, home background and other social identity roles. Those who 'belong' to a secure and comfortable group outside the healthcare placement, may not experience the desire to belong to the team in the same way that other students who do not have such comforts may wish.

The literature explaining the concept of belonging reminds us that belonging is not solely an individual feeling achieved by the lone individual. It arguably has a collective element which involves others. In other words, in order to feel a sense of belonging, this requires that the individual is accepted by others in the group. May (2013) suggests that issues of power, negotiation and conflict are pertinent in the concept of belonging. There is a political element of belonging to a group and in order to belong we need to feel able to participate in the reflexive arguments of society. This is important because in doing so, we are contributing to one's own world. Failure to be able to do this can prevent us from belonging. In other words, it is our views and the things we have in common with the group that determine our level of belongingness. We may still be part of the group, however we may not belong. This can be seen in healthcare settings where group members are diverse, possess differing opinions and their social role and status is dominant. May (2013) discusses this in terms of hierarchies of belonging. This may go some way to explain the existence of paternalism, elitism and oppression within some groups in the health service.

This theoretical perspective takes us again to the sociological roots of rules and norms in society and within organisations. Rules and law are a social construct, emerging by the rise of a systematic form of social control administered by organisations and institutions. Law and ethics are terms that are often used interchangeably but in fact they are quite diverse. Moral principles and ethics are social constructs and belong to the individual, in addition they have their own sense of vagueness or 'open texture', whereas law is made up of primary and secondary rules to which citizens in society must abide (Hart 2012). Hart asserts that law and adjudication are political and not always created for the welfare of individuals. It is of little surprise therefore that conflict may emerge when

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healthcare professionals and students alike are faced with dilemmas in which their professional and legal obligation to act is at odds with their moral and ethical conscience. This dichotomy can exacerbate the student's dilemma of exhibiting behaviour that may compromise their sense of belongingness and 'fitting in' with the team.

The notion of belonging and fitting in is important in this research because it goes some way in contributing to our understanding of why some student nurses are reluctant to raise concerns yet others are more willing.

It is clear that students recognise the importance of maintaining a good inter-team relationship whilst on placement and this means with the team as a whole. They have an inherent desire to be accepted as an insider, be seen to play the game and be accepted in the 'in group' abiding by its rules and norms. Crucially, an important element of this is their relationship with their mentors. The mentor is often seen as the lynchpin to the students' success or otherwise whilst on placement. This is well documented in the literature and again reaffirmed in this research study.

Mentoring or coaching is a recognised practice in nursing, as it supports student nurses to achieve their practice learning outcomes and ideally develop professional practice. There are published studies that highlight the benefits of effective mentoring (Topa et al 2014). Conversely, there are few studies that discuss the negative consequences of poor mentoring and dysfunctional relationships. There is arguably a need for more empirical research in this sphere because there is a plethora of anecdotal evidence which suggests that disharmonious relationships with mentors can and does have a negative effect on learning and behaviour.

The relationship with mentors was a significant finding in this research, not least because the student's willingness to raise a concern was often influenced by their relationship with their mentor. Notwithstanding, the mentor – mentee relationship can be fraught with many problems. All registrants in the UK are currently required to contribute to the education of student nurses (NMC 2010). Despite this requirement, not all nurses are equipped to take on the role of mentor. This is currently under scrutiny with the NMC proposing changes to the way in which student nurses are supervised in clinical practice. Although nurses are required to undertake mentorship education in order to prepare them for the role, not all nurses possess the skills or desire to teach or support students. Whilst there is an expectation that those in the position of mentor will be the prototypical member within the group with adequate experience, this is not always the case. In addition, there are other factors which may lead to a disharmonious relationship between mentor and mentee in terms of personality types and working practices. Mentors are also required to facilitate students' social and professional integration, yet this can be compromised if the mentor and mentee have differing beliefs and values. If social identity theory and group behaviour is to be considered in the quest to explain the negative impact upon relationship between mentors and students, then it is perhaps unsurprising that group identification is an antecedent of work place bullying. This has been documented by Ramsay et al (2011).

Research by Topa et al (2014) focused on mentoring and group identification as antecedents of satisfaction and health among nurses. They carried out a longitudinal study of nurses employed in Spanish hospitals and measured participant responses to group identification using the group identification scale of Ashforth and Mael. Their study concluded that the findings supported the notion

that negative mentoring experiences and group identification affect job satisfaction and health complaints among nurses due to bullying at work. Although it was not clear in the study who was being bullied by whom, the conclusion can be drawn that positive mentoring can promote well -being and reduce stress on mentees.

Bickhoff et al (2016) found that the key to student nurses' challenging poor practice seems to lie in their sense of moral courage and desire to act as a patient advocate. In their research they discovered that students were more likely to speak out depending on their previous life experience. Many of them had a sense of 'doing what is right' but fear of negative consequences inhibited some from raising a concern. These findings are not dissimilar to the findings in this thesis and suggest that fear of retribution is often an inhibitor to exercising moral courage and a precursor to conforming to substandard practices.

Students recognised the power of the healthcare assistant which was observed in much of the data. Often these individuals were established members of the team, embedded in the hierarchy and some could be a powerful influence over the team as a whole. Students would acknowledge this and compare with their own status which they saw merely as a student, a transient passenger on a journey to registration. Students therefore were keen to maintain the status quo and avoid upsetting team members. As far back as 2003, Swain et al conducted research to explore whether or not students practiced the correct moving and handling techniques taught to them. Their discoveries did reveal that some students would conform to poor practice, essentially to 'fit in' the team. Interestingly, the study revealed that the power of the auxiliary (healthcare assistant) was significant, with some students conforming to the practices of the auxiliary. The students were aware that although the often long established

member of the team was not directly involved in assessing them, they did wield power and could potentially jeopardise their acceptance by the team (Swain et al 2003). One of the reasons the students feared the auxiliary was because the participants were younger students in the 18 – 21 age bracket and the auxiliaries tended to be older. This is an interesting observation because the concept of 'age' did emerge strongly in the findings of this research study.

It appears therefore that social identity and acceptance within the team are strong precursors to student behaviour and action. There is a strong sense of desire to belong and be accepted within the team.

Conformity: the means to avoid retribution?

A dominant theme in the findings of this research revolved around fear of reprisal, punitive action and failure to progress.

If student nurses do fear the potential negative consequences of challenging substandard practice, perhaps Goffman and Foucault were right in their assertions about conformity and institutional behaviour (Goffman 1961, Foucault1973). They suggested that confirming behaviour was motivated by the desire to be correct and the desire to remain in good grace of others. May (2013) asserts that conformity and non-conformity are normal and complementary phases of everyday life whereas Jenkins (2008) suggests that conformity can be born out of insecurity and that non-conforming behaviour may be seen as deviant. It can be argued that conformity and non-compliance are more complex than this with non-compliance an essential component if we are to move on. The findings in this research study revealed that the majority of students refused to comply with poor practice. However, some were less comfortable raising

concerns about practice they had witnessed for fear of reprisal. This again reveals the dichotomy of the student nurses desire to fit in and belong versus practice in a way that is safe and evidence based.

Hogg and Abrahams (1999) argue that the distinctive feature of conformity is that it involves norms which are derived from the socially acceptable modes of action to achieve society's goals. They can be concretised through legislation and societal rules. The same principle can be applied to organisations such as hospitals and healthcare environments. Though there is a paucity of research relating to conformity and nursing, early work in the literature examines obedience and complicity with eugenics (Berghs et al (2006). The authors examined morality in nurses in Great Britain from around 1860 – 1915. They discuss the virtues of nursing in this era, shrouded in obedience, passivity and subservience. Disturbingly, it is acknowledged that there exists documentary evidence, testimony to nurses' involvement in eugenics coerced into this 'for the betterment of humanity'. In this paternalistic era, nurses would carry out orders with unobtrusive devotion to duty, following instruction without questioning.

Though nursing and its place in professional healthcare has moved on, more recent evidence suggests that nurses still tolerate suboptimal care. The investigation into Mid Staffordshire Hospital (Francis 2013) highlighted inadequate nursing standards and tolerance of staff to these standards prompting national concern. Price et al (2015) explore the social theory of conformity to understand reasons why sub-optimal care may be tolerated. They suggest that informational conformity is common in people who lack knowledge, (student nurses or new registrants) and therefore look to a group for guidance or compare their behaviour with the group. This may lead to internalisation where they accept and adopt the views of the group. On the other hand, ingratiation conformity is

demonstrated in relation to a reward which may be a successfully graded placement or promotion. This theory seems to have some correlation with the experiences of students in this research study whose overarching aim was to pass their placement successfully. The authors also suggest that there exists a sense of cognitive dissonance amongst nurses. A study by Champion (1998) cited in Levett- Jones and Lathlean (2009) reveals that some student nurses made a conscious effort to adopt the team's norms and values as they rotated through some of their placements, thus adopting chameleon like existence in order to fit in. A controversial view, but one nonetheless worth considering is purported by Duffy (1995) cited in Price et al (2015) who suggests that nurses remain an oppressed group because of their gender (predominantly female), work predominantly with women and share the personality traits of women which she describes as: jealousy, ambition and lack of respect. Furthermore, the dominance of the medical model ensured conformity in a bureaucratic hierarchy in this era. Though this view is subjective, it may go some way to explain why sub-optimal care is tolerated. In addition, cognitive dissonance may be a learned strategy to compensate for nurses' inability to provide optimum care.

The topic of medicine administration and patient handling was discussed in a number of contexts and the data grouped accordingly. Participants discussed these areas when describing their understanding of patient safety, witnessing poor practice and in their reaction to practice that was suboptimal.

The findings differ to some extent with a study by Cornish and Jones (2010) who examined compliancy with patient moving and handling amongst student nurses. Their findings suggested that students felt relatively powerless in practice situations alongside other members of staff influenced by 'power relationships' and perceived 'hierarchy'. It was apparent that students did witness poor practice

and were actively encouraged to participate by people who might be viewed as their role models. As staff are required to undertake mandatory training on an annual basis, it is surprising that some continue to use outdated practice putting themselves and others at risk.

Unlike Cornish and Jones findings which revealed that students would comply with poor handling practice, in this present study, there appears to be a consensus amongst students that they did refuse or would refuse to move a patient incorrectly, citing the university training and trust policy as the underpinning driver based on legislation. It is perhaps the legitimacy of policy governing patient handling that reminds students that they are legally and contractually required to follow procedure and accepted technique. Failure to do so could lead to disciplinary action and even litigation. It is reassuring therefore that there is evidence that students refuse to comply with poor handling techniques despite the fear of retribution.

Similarly, students are introduced to the practice of medicine administration early in the curriculum, with the theoretical and practical components taught both in the university and practice setting. Students are required to adhere to local trust policy and NMC guidelines and code of practice (NMC 2010, NMC 2015). Legislation governing medicine administration is complex, but all nurses are required to possess an awareness of this legislation, as failure to administer medicines correctly can prevent therapeutic effect and potentially lead to serious harm. Despite this requirement, there is evidence that medicine administration errors continue to occur in healthcare organisations in the UK (Health England 2016, NMC 2016,). The factors leading to error are multiple and complex, however, most arise from an intrinsic perspective, with the most common being lack of knowledge and care. The findings in this study revealed that two of the

students who had been coerced into administering a medicine incorrectly, refused to do so, even though they acknowledged that the error was minor and likely to have little ill effect on the patient. Their student status and stage in training did not impede them. A student who witnessed a medicine error by the ward manager was impressed that the ward manager was open and transparent about the incident and used it as a learning opportunity to encourage others to be open and candid about errors. This reinforces the power of the leader as a role model for student nurses.

Fear of retribution is not unfounded because the poor treatment of students is well documented in the literature (Bradbury-Jones et al 2011, Castronovo 2016, Morrow et al 2016, Tong et al 2017). Furthermore, though students fear retribution if they speak up, it is clear that this is not always attributed to punishment by more senior members of staff. A significant number of students discussed their fear of healthcare assistants and the power they yield in many teams. Though the literature is sparse in relation to the health care assistant's dominance in the clinical arena, there is a plethora of literature examining occupational harassment and horizontal violence (Myers et al 2013, Bjorkelo 2013, Applebaum et al 2016, Tong et al 2017). The World Health Organisation (2002) acknowledged that workplace bullying has been recognised internationally as a longstanding passive issue. It is described in the literature under many labels including: horizontal violence, mobbing, emotional abuse and disruptive behaviour. It can lead to: health problems, dissatisfaction, poor work performance and contribute to compromised patient safety (WHO 2002, Tong et al 2017). Whilst much of the literature focuses upon qualified healthcare staff, there is evidence of the impact bullying can have upon students. In a study

examining the power of voice amongst student nurses, Bradbury – Jones et al discovered that the primary reason for exiting over voice for students was fear of reprisal (Bradbury – Jones et al 2011).

Hutchinson and Jackson (2015) assert that public sector institutions are recognised as high- risk settings for work place bullying and include: teaching, policing and healthcare. They argue that one of the antecedents to workplace bullying amongst nurses is the ethos of attempting to deliver quality care amidst neoliberal management reforms which impedes care and compassion while located in 'institutions'. This research has revealed that students believed that their practice placements were often understaffed, a contributory factor most believed in the compromise of patient safety. If this is the case and nurses and the healthcare team are striving to meet targets, remain cognisant of budget restraint whilst at the same time attempting to deliver safe and compassionate care, it is little wonder that the added pressure of supervising a student exacerbates their frustration. Theorising bullying in the workplace has potential implications for the nursing workforce. It is argued that reforms in healthcare, proffered as a revitalisation of public sector performance and market value, push healthcare as an efficiency-driven enterprise. This agenda creates a multitude of tensions amongst nurses and healthcare workers as they strive to deliver excellence in a pressurised and arguably inadequately resourced climate. It can be argued therefore that this in turn fosters a culture of dissatisfaction and organisation failings.

Though bullying, mobbing and horizontal violence is discussed in the literature per se, there exists a significant amount of literature that links bullying to raising concerns and whistleblowing (|Bjorkelo 2013, Castronovo 2015, Applebaum et al 2016, Morrow et al 2016).

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Theoretically, the concept of bullying is drawn from the discipline of psychology. Kohm (2015) examined the social dilemma of bullying and observed that children who witness bullying, defend victims only in 12% - 25% of episodes. For bystanders who do not intervene, this is attributed to their action being futile and potentially dangerous. . Most children are seen to side with clique members in disputes in an effort to avoid becoming victimised themselves (Kohm 2015). These traits are replicated in adulthood. However, there is some discussion that with greater support from others they may feel more confident to intervene. This suggests that power- coercion and social identity go some way in influencing behaviour.

Power in the public sector has always had important implications for nursing, particularly in light of on-going reform, perhaps Foucault's broad interpretation of power and institutions would appear to hold some currency (Faucault 1973). According to Hutchinson and Jackson (2014), power features strongly in the public sector, particularly as it is under reform. In addition, power features strongly in the dynamic of workplace bullying, with bullying recognised as a symptom of institutional failure. They argue bullying is an antecedent to system failures, and this may be a cogent observation. There have been a number of failures in the healthcare system in recent years including: Mid Staffordshire Trust (Francis 2013) and Winterbourne View (Flynn 2012). In both inquiries, the findings revealed that those who raised concerns experienced negative consequences for their actions.

The phenomenon is not restricted to the United Kingdom. There are a number of studies in the literature that examine bullying behaviour globally (Jackson et al 2010, Castronovo et al 2016, Tong et al 2017, Weiss et al 2017). Whilst acknowledging the potential global, cultural and political-economical differences,

comparators in bullying amongst nurse was reported. Similarly, a recent Swiss study examined the concept of 'mobbing' as a form of workplace bullying. Mobbing has been described as: 'repeated, unreasonable behaviour towards an employee or group of employees that creates a risk to health and safety (European Agency for Safety and Health at Work 2002). The study focused on mobbing amongst registrants and care workers in Swiss nursing homes. The observational study utilised secondary data from a random sample of 162 nursing homes and included all care workers though they did exclude students. Their findings indicated that by international standards, although mobbing in this setting was comparatively low, leadership style appeared to be important in determining the prevalence of mobbing. Importantly, their findings suggested that mobbing by colleagues and superiors was linked to the intimidation and control of informants thereby discouraging them from reporting errors. This supports the notion of fear of punitive action as a deterrent to raising concerns. It also adds to the growing evidence that bullying and mobbing has an explicit link to raising concerns and is a predominant reason why bullying is present in the healthcare environment.

Further seminal work by Heinemann 1973, Olweus 1973 and Thylefors 1987 (cited in Bjorkelo) revealed that there are similarities and antecedents recognised in bullying at school and workplace bullying. It is argued that there are similarities between aggressive behaviour and workplace bullying defined by: an imbalance of strength, inability to defend oneself from negative acts and repeated acts. Workplace bullying differs from a conflict between two individuals of equivocal strength. There is also a correlation between whistleblowing and retaliation. This theory has been discussed further and retaliatory acts have been described in the literature as either formal or unofficial (Bjorkelo 2013).

The degree to which victims are' punished' can range from being ostracised by colleagues or more seriously, demotion or downsizing. In addition, reaction can be seen as singular or repeated. Bullying post whistleblowing has been seen to result in victims experiencing social isolation and involuntarily removed from work tasks. In any case, it is argued that the consequences are unique to the individual and this can be illustrated in the case of Stephen Bolsin who raised concerns in the Bristol Heart Scandal and subsequently made the decision to take his family to Australia in an effort to avoid retribution (Kennedy 2000).

To note, many of the students interviewed in this study, alluded to fear of the health care assistant, with one commenting about their perceived power as a collective. It is not widely understood why the healthcare assistants may wield such pervasive power over student nurses and sometimes qualified staff, but perhaps in the absence of research, the answer lies in the notion of social identity and power differential. Healthcare assistants are an invaluable contribution to the NHS workforce, arguably without them, the healthcare arena would dwindle. However, their original introduction to the health service was as auxiliary nurses whose purpose was to 'assist' the qualified nurse. Over the last few decades, this role has grown, with many healthcare assistants participating in a number of clinical tasks that were previously the domain of the registrant. The evolving role is in direct response to the political – economic climate in an ever-stretched health service where cost savings and efficiency are the drivers. With this acknowledged, it is however pertinent to accept that health care assistants lack the education of healthcare professionals and therefore the ability to assimilate and apply knowledge in the same way as those who enter and are educated in

the health professions is limited. This in itself can lead to competition and conflict when working with student nurses.

What this study has revealed is that student nurses view hierarchy in healthcare organisations as not just the 'pecking order' of seniority, but the perceived social position held by individuals within the team. They fear retribution for speaking up in essentially two ways: punitive action by their seniors and social rebuff by untrained members of staff.

Hierarchy exists

A significant message that the findings in this study presents, is that hierarchy does exist. One of the students articulated this by observing that it is displayed visually in the hospitals and clinical areas, with a photographic display of who's who situated at the entrance to the hospital. It is common to observe this visual display in many healthcare settings as an attempt is made to improve communication and access to services and personnel. It is also commonplace to situate within the pyramid, the most senior professionals at the top, with the lower ranks, including students at the bottom. This reinforces to the student that their role is identified as less important and inferior. Though the paternalistic era described by Goffman (1961) has diminished, it can be argued that it has not been eradicated completely. There is little in the nursing literature that focuses on hierarchy per se, however the notion of hierarchy is implicit in many of the papers reviewed and related again to the team dynamics. The findings suggest that some of the students would refer their concern to their mentor or someone who they felt comfortable with. Fewer felt able report or challenge a doctor or senior

nurse directly. However, as the findings reveal, the underpinning influencing factors are complex. Perhaps the key to the existence of hierarchy can be found in the roots of professional authority. It has been suggested that power lies in claim to a specific kind of knowledge which is to be used without discrimination for the benefit of those who are in need. It can of course be argued that the level of knowledge that professions have is not necessarily unique or inaccessible. It is accepted however, that if individuals work in a particular sphere over a number of years then one would expect them to acquire a great deal of experience and that experience is indeed power. This is not to say that hierarchy does not have its merits. Arguably, there needs to be professional accountability in public sector organisations and the health service is no exception. Perhaps it is the blurring of the acceptable boundaries and effect of hierarchies that requires address if we are to successfully and meaningfully create an open and transparent reporting culture.

The findings in this research reveal that all of the students possessed an awareness of the implicit power held by others more senior to themselves and this seemed to be closely associated with experience. The discipline of sociology informs us that professions are characterised by setting standards of behaviour for its members and therefore for students to be part of the 'in group', they must learn the rules. On reviewing the literature prior to conducting this research, a strong theme in the literature suggested that there exists a power differential between students and registrants (Bickhoff et al 2015). This was evident in this current research.

The recognition of power differential has long been acknowledged in the high reliability industries and much has been invested to promote effective teamwork. This is especially important in high stakes action teams such as cockpit crews, nuclear power teams and more recently healthcare. As much as 80% of all reported incidents in healthcare are attributed to the consequence of poor communication (Weiss et al 2017). Furthermore, the influence of hierarchy appears to play a significant role in preventing individuals to speak up when they witness an error. Weiss et al (2017) suggest that this phenomenon is as a result of the individuals fear of harming relationships with superiors and others fearing that others may disapprove of one's input. However, more importantly it appears to be the fear of negative sanctions from those with higher status. Status hierarchies are ubiquitous in many teams and particularly in organisations. It is believed that professional group membership indicates a level of social status which generates prestige, success and admiration from others. There is evidence that individuals within the lower hierarchical status are reluctant to voice opinion for fear of retribution from those further up the hierarchical status (Weiss 2017). Disturbingly, it is argued that that there are gender differences in in hierarchies endorsed by beliefs that women are inferior to men which Weiss argues is a barrier to team functioning.

The findings in this study appear to concur with some of the theories generated above, as students allude to a vertical hierarchy where they as students are always at the bottom. The intimidation caused by the power differential between them and those who they see as superior, in some cases diminished their willingness to act with moral courage. This appears to support the earlier work of Levett -Jones and Lathlean (2009). However, not all students remained

acquiesce and therefore it is prudent to examine in more detail the underpinning factors that were influential in their decision to speak up.

The pre-determinants of the ability to 'speak up'

This study has revealed that students who have or said they would speak up against what they see as suboptimal practice, are driven to do so by a sense of moral obligation, a desire to be professional, prevent harm and implicitly be an advocate for the patient. Those who did not speak out or are apprehensive about doing so are influenced by a desire to survive placement, fit in and avoid retribution in some form or other. The literature on occupational whistleblowing in the healthcare environment is largely descriptive and anecdotal, with narrative accounts proffered by victims. In addition, the literature on whistleblowing is not confined to nurses and similarities in whistleblowing behaviour have been discussed in studies of medics and allied health professionals (Applebaum et al 2016). Notwithstanding, the discipline of Occupational studies offers a different dimension of discussion in an attempt to unravel the characteristics of those who speak up.

Whistleblowing or speaking up are terms that are often used interchangeably in the literature and this was observed early in the study. The term 'speaking up' will be used for the purpose of this discussion. The motivational factors that prompt individuals to speak up are complex and comprise of a number of psychological processes. There have been attempts to understand the characteristics of 'whistleblowers' (Sieber 1998, Bjorkelo et al 2011, Bjorkelo 2013, Morrow et al 2015) and in addition the experience of their action, antecedents and aftermath.

However, despite a surge in legal and academic interest in many parts of the world, there appears to be an implication that to raise a concern is to 'go against formal power structures which can often be interpreted as deviant.

A study in the United States exploring the psychology of 'whistleblowing' criticised organisations for inadequate administrative structures and support mechanisms to encourage the constructive examination of what could be classed as wrong doings (Sieber 1998). It is debatable whether these systems have greatly improved today with others calling for more efficient systems to enable individuals to raise legitimate concerns.

Bradbury Jones et al (2011) examined the issue of 'voice' and loyalty model to explain customers and employees' responses to dissatisfaction with organisations. Using the work of Hirschman (1970), they focused upon the empowerment of nursing students in clinical practice. The qualitative study was relatively small, with a sample of thirteen UK first year students selected using a purposive method. Nonetheless, their findings revealed that in situations which called for nursing students to speak up there appeared to be what they described as a double edged sward. Paradoxically students who voiced their concerns feared repercussions though the authors argue than negotiated voice is preferable to no voice at all. It can be argued that this view is essentially idealistic and does not acknowledge the complexities associated with raising concerns. They discovered that students in compromised situations either spoke up or exited the profession. They go on to add that as well as physically exiting the situation, many of them metaphorically exited in terms of their psychological behaviour. This was achieved by withdrawal, and disengagement. They did

observe however, that students often opted for the middle ground. This study supports the work of Levitt – Jones et al (2009) and seems to enhance the notion of the will to survive as revealed in this thesis. A more recent study (Morrow et al 2016) concurs with the findings but goes one step further by adding that the safety voice is impeded by hierarchies and power dynamics. Their research provided a meta-synthesis of qualitative research studies that utilised a social constructivist approach to thematic analysis with the purpose of conceptualizing the desired speaking up behaviours for healthcare workers. In other words, they examined the 'nursing safety voice'. This is important if we are to further understand the speaking up behaviours for nurses and others in an effort to better understand how we can facilitate learning and teaching effectively.

Perhaps the factors which influence the student nurses' willingness to speak up or remain silent can be summarised by the fundamental need for psychological safety. A study by Appelbaum et al (2016) tested the relationships between power distance and leader inclusiveness on psychological safety and concluded that the notion of psychological safety was indeed a predictor of intention to report adverse incidents. Nonetheless, perceived power distance and leader inclusiveness were also found to be of significance which reiterates the need for a safety culture to exist within organisations and for this to be reinforced by sound leadership.

This study did not find any explicit correlation between personality types and the willingness to speak up, though it could be argued that implicitly there are characteristic traits underpinning students' values and actions. The literature

reveals that those who raise concerns in organisations are often characterised by age, gender and job satisfaction (Sieber 1998, Bjorkelo et al 2011). However, the literature searched does not provide any conclusive evidence that raising concerns is more prevalent in men or women. Bjorkelo et al (2011) studied a random sample of Norwegian employees across a range of occupations who had raised concerns, to determine the characteristics of whistleblowers. Their findings suggested that whistleblowers tended to be older males in reasonably senior positions and that males are more likely to raise concerns than their female counterparts. However, the authors acknowledge that their study potentially lacked representation of female employees as their sample included military personnel and government employees.

There does however seem to be evidence that the age of the individual executing the subordinate practice is a significant factor in determining whether employees are willing or not to speak up. This current study appears to support this. Students reported that age is inextricably linked with experience: the older the individual is, the more likely they are to have a wealth of experience. If we consider social identity, it is apparent that age is significant in categorising individuals. For example, Ashforth (2012) argues that age and time are social constructs, placing us all in 'fuzzy sets' such as: teenager, pensioner, adolescent depending upon how we happen to match prototypical images. He goes on to suggest that that individuals react to others automatically on the basis of their perceived category without often being aware of it. This is because similar to other social constructs, age connotes certain stereotypes. Age is also used to gauge norms across the career trajectory, however with many nurses commencing their careers later on in life, this offers a different perspective and

perhaps suggests that students are cognisant of the age of co-workers and the association with life experience as well as career experience. The barrier age presents in situations where errors occur is recognised within the high reliability industries; in particular aviation. Subsequently, it is acknowledged that this human factor remains significant even today.

To summarise, student nurses who are willing to raise concerns or have done so, exhibit a sense of moral conscience, the need to 'do the right thing', acknowledge their role responsibility and the professional expectations required of them. They also recognise the requirements expected of them as an accountable registrant, which is what they are working towards. The factors which may inhibit their ability to speak up are encapsulated in psychological safety: the need to survive, achieve a successful placement assessment and fit in with the team. This supports the existing studies on student nurses.

What is consistent in the literature, is that those who do raise concerns are motivated predominantly by a sense of moral courage.

Moral courage

Increasingly, the concept of moral courage is being acknowledged in the nursing literature. The various meanings of 'courage' can be traced to philosophers over the centuries who used the term in relation to battlefields. Morally courageous professionals, such as those in the health services, experience moral dilemmas and stand up for what they feel to be right even though they may not be supported to do so.

Moral courage has been described as:

' *the ability to rise above fear and take action based on one's ethical beliefs'*
(Lachman 2009)

Murray (2010) defines moral courage as:

'the readiness to stand up for and do the right thing, even if this means standing alone' (Murray 201)

Arguably, despite the concept of moral courage receiving high acclaim in some areas, it is still considered to be a topic that has received limited study (Simola 2015). In particular, the theoretical perspectives associated with moral courage are scant. Nonetheless there are some commonalities amongst those who demonstrate moral courage.

Some individuals however, may not feel able to speak up and often as a result of this inability they experience moral distress. Gallagher (2010) discusses moral distress as feelings that are painful as a result of psychological imbalance that occurs when nurses find themselves in situations where they are unable to do the right thing. Furthermore, nurses who do demonstrate moral courage and do the right thing, can themselves experience moral distress.

This current study appears to support this theory, the findings of which reveal that students experienced a range of emotions whether they spoke up or remained quiet. Nursing is complex and challenging, therefore it comes as little surprise that nurses will often find themselves in compromised situations. Nursing has at its roots a firm foundation of values and standards embedded in its codes and all nurses and those working towards registration are expected to follow these

values. Moral courage requires a fastidious commitment to ethical principles, regardless of the potential risks of retribution.

However, Murray (2010) offers a word of caution. He suggests that moral courage must not be confused with moral arrogance and certitude. Moral certitude or certainty relates to an individuals' firm belief that they are right without insight into the rightness of their belief. Moral arrogance on the other hand is a display believing one's judgement is the only correct opinion (Murray 2010). In addition, nursing does not take place in a vacuum and care is not the sole responsibility of the nurse. In order to act with moral courage, it is necessary for the student to overcome their own personal fear. This raises the question of whether or not moral courage can be taught to students in the curriculum. Central to a student's ability to act with moral courage, is the student's underpinning knowledge, emotional intelligence and skills of assertiveness. The nurse or student who lacks courage, generally is aware of the correct action to take but lacks the confidence to do so, often for fear of retribution.

The findings in this research revealed a mixture of student reactions to substandard practice, with some demonstrating a willingness to speak up and others remaining fearful. There is evidence that third year students feel a sense of responsibility and accountability as registration approaches. More junior students, whilst willing to speak up if a patient was in immediate danger, were more likely to remain silent if they questioned their own knowledge in the context of the situation. The exception to this seems to be with medicine administration and patient handling when it is apparent that poor practice is obvious and a threat to patient safety. The Mid Staffordshire enquiry (Francis 2013) revealed evidence

of nurses who did act with moral courage as well as others who for a variety of reasons remained acquiesce. Since the Francis recommendations, nursing students are fully aware of the requirement for them to speak out.

Bickhoff et al (2016) implies that moral courage can be taught, though the authors acknowledge the paucity of research that describes extrinsic and intrinsic factors which determine the strength of an individual's moral courage. It can be argued therefore that teaching moral courage is potentially fraught with difficulties, as moral courage surely has to be inherent in the individual in the same way that being a 'caring person' surely comes from within and cannot be taught. Perhaps it is more appropriate for students to be guided to demonstrate moral courage. Though there is a noticeable gap in the literature relating to this topic, some of the American nursing literature is becoming more focused on the concept of moral courage. Eby et al (2013) conducted a qualitative study to investigate faculty perceptions of the challenges encountered regarding moral integrity in academia and strategies to promote nursing student' moral integrity and moral courage. The findings seemed to suggest that there is an urgent need to discover strategies to thread concepts related to moral integrity into education programmes. Interestingly, the students in Eby's study saw the educators as standard bearers of professional and ethical behaviour. Though the study was limited by sample size and level of detail, the study did provide evidence that further research is required to help nurse education fill the gap between moral integrity and moral courage in nurse education. Lachman (2010), created an acronym (CODE), in an attempt to help nurses remember the key components of moral courage: Courage to be moral requires: Obligations to honour, Danger management, Expression of action. Her discussion of courage focuses on a

virtue- based approach to moral and ethical decision making. It is therefore imperative that students have an underlying fundamental knowledge of ethical principles. There was however no evidence to support whether or not this approach to teaching moral courage was successful. Latchman (2010) does acknowledge that nurses who do demonstrate moral courage understand that there may be undesirable consequences for their actions. She purports that this is outweighed, as a high level of integrity is more important than avoiding the consequences. This is supported to some degree by the findings in this research, as some of the students discussed their willingness to risk the consequences of speaking out if it prevented patient harm.

Perhaps one of the difficulties associated with raising awareness of the concept of moral courage amongst students is that we may be inadvertently giving them a license to be assertive which less experienced students may interpret as encouraging them to 'confront'. It is little wonder that this may be perceived as confrontational by some staff if not handled carefully by the student. This current study reveals the importance of appropriate communication skills required of the student when raising a concern. In addition, much of the discussion in this chapter suggests that the characteristics of human behaviour and human factors underpin the ability to speak up or remain silent.

Student Behaviour: the human factor

This thesis demonstrates the myriad of factors that students encounter when faced with challenging practice that may compromise patient safety. What appears to be emerging are characteristics commensurate with the proven

methods of improving quality and safety embedded in high reliability theory. There has been a growing trend in health care over recent years to implement some of the principles from high reliability theory into the healthcare arena, in particular human factors (World Health Organisation 2010). It is well documented that human factors are an important feature in errors in high reliability industries such as aviation, nuclear and military (Reason 2008, Vincent 2010, Dekker 2011). Since the Department of Health (2000) produced the report: Organisation with a Memory, attempts have been made to raise awareness of human factors in healthcare delivery on a global level.

The human factors approach can be described as a systems approach to maintaining safety in an organisation and seeks to look for sources of safety and risk everywhere in the system. It is not within the scope of this thesis to discuss human factors in its entirety, rather the discussion will focus upon elements of non-technical skills which relate to the findings in this research study. Teamwork has long been recognised as a vital component in maintaining and promoting safety within organisations. The Institute of Medicine (1999) asserted in their report 'To err is Human' that medical errors are attributed to complex systems rather than an individual action; a term we have come to recognise as 'system failure'.

Though complex, the human factors approach seeks to improve organisational safety by raising awareness and improving technical skills and non- technical skills. Non – technical skills are the cognitive and interpersonal skills paramount to ensuring the safety of patients and focus upon team work and communication. The roots of these behaviours and actions are embedded in the discipline of psychology. Poor teamwork and poor communication are major risks in patient safety incidents in the UK and beyond (Reason 2008, Vincent 2010, Riley et al

2010). It is this aspect of human factors which is worth discussing in more detail with regard to the findings in this study. The students discussed feelings, beliefs, fears and values which can be identified in much of the literature about human factors and error prevention. For example, it is well established that there are cogent links between failure to speak up, fear of hierarchy and errors in the aviation industry. In addition, the age and experience of team members has been acknowledged as a barrier to speaking up in some safety scenarios. The aviation industry has invested heavily in reducing hierarchical authoritarian behaviours in an effort to reduce error. By doing so, it is argued that this fosters a culture of trust (Skinner et al 2015). All multi-professional employees of an aviation team collaborate to improve safety, bringing their expertise and knowledge to a culture that supports and fosters open and transparent communication and reduces authoritarian practice. Indeed, co-pilots consider it their duty to speak up. However, this culture emerged only after a number of adverse incidents resulting in tragedy on a large scale.

Embedded in the aviation industry, there are many examples of how human error has contributed to many aviation accidents. One of the most significant incidents is that involving the collision of two aircraft in what is universally acknowledged as the 'Tenerife Air Disaster of 1977 (Beaty 1995, Reason 2008). This incident is significant because it resulted in a number of fatalities and in addition, so many human factors were present. The investigation of this fatal accident exposed the relationship between the captain and first officer of the plane allegedly responsible for the disaster and exposed a number of significant contributory characteristics, including: age, hierarchical and authoritarian factors. This is an example of a significant number of determinants, the principles of which have been used to inform aviation training globally More recently, it has been

recognised that many of these human factor principles can be applied to healthcare organisations. The findings in this research study indicate that some of these human factors are present today in the healthcare setting. The students' accounts reinforce the existence of authoritarian practice whether via their own experience or through practice they observed.

Much of the human factor training delivered in healthcare organisations focuses upon the non-technical skills of communication, situation awareness as well as mechanisms for reporting concerns and challenging practice. This awareness is also delivered within the nursing and allied health curricula. However, the health service has not yet embedded the principles of human factors habitually in the same way that the aviation industry has. This is clear from the literature and indeed this current research appears to reinforce this.

Whilst the principles and positive practice of human factors can be taught in the classroom and simulation lab, there is no guarantee that students will experience its application out in the practice arena. It appears therefore that the notion of individualism remains in existence in some areas of healthcare as opposed to the 'expert team'. Almaberti et al (2005) recognised that communication in whole systems thinking appears to diminish in a culture of authoritarian provider practice. However, if the aviation industry was able to successfully shift to a culture of openness and transparency, then there is hope that healthcare organisations can successfully achieve a paradigm shift. This is significant in relation to the education and preparation of student nurses because they are the future of nursing and must be encouraged to develop the skills required to contribute to this cultural shift.

Summary of discussion

The aim of this research study was to understand student nurses' perceptions of patient safety and the factors underpinning their willingness to raise concerns or remain silent. Four key superordinate themes emerged in the findings and were subsequently presented in chapter 4.

This chapter has offered a critical exploration of underpinning theories, drawing on the conceptual framework as a guide, in an attempt to explain the findings of the four superordinate themes: context of exposure, hierarchy, team relationships and fear of retribution. A key interpretation of these findings is that student nurses' willingness to raise a concern is determined by the position of their moral compass.

It is believed that the aims and outcomes of this research study have been achieved. The discussion and analysis has contributed to helping us understand what student nurses understand by patient safety. In addition, the underlying psychological and social factors which influence the students' willingness to raise concerns has been examined. The following chapter will provide recommendations for further research and educational policy development.

Chapter Six: Conclusion and recommendations

The purpose of this qualitative study was to elicit the lived experience and perceptions of student nurses with regard to what constitutes a patient safety issue and also to examine what factors influence their willingness or unwillingness to raise concerns. The aims and outcomes of the research study have been met. Four key themes were identified from the analysis of data: context of exposure, hierarchy, team relationships and fear of retribution. A conceptual framework was developed and served to guide the research approach. In order to be willing to raise a concern about practice, student nurses must learn to navigate using their moral compass. They must possess an awareness of their social identity and how this is influenced by organisational culture.

This chapter aims to provide recommendations following completion of the study. In addition, acknowledgment of the quality of this research as well as recognition of its imitations and transferability will be discussed.

 This study has provided evidence that during their three -year period of study, student nurses have developed a fundamental understanding of patient safety issues and confirms that as an educational provider, the university has successfully embedded the concept of patient safety within the curriculum. In addition, what is reassuring is that this study has provided evidence that students will and do speak up when they encounter poor practice. Arguably in comparison to much of the previous literature, it appears that students are developing the confidence to challenge sub-optimal practice and prevent harm regardless of the

tensions this provokes. However, the findings have also provided insight into the difficulties and complexities students experience when faced with experiencing sub-optimal care. The findings and discussion have also provided a platform in which to unravel the barriers that exist for students to speak up.

Within the research journey, there has been an attempt to critically review existing literature and identify a theoretical framework in which to analyse the findings of the research to add to the existing body of knowledge.

The aims of the research study were revisited throughout the process. Essentially this was to elicit the lived experience of student nurses with regard to patient safety and their willingness to raise concerns using a phenomenological approach. The findings support existing theories about the student nurse experience and raising concerns. In addition, the study provides a further insight into the values, beliefs and behaviours of students faced with the dilemma of witnessing suboptimal care and their subsequent actions.

Moral courage and a sense of professional identity applied to the student role are paramount in nurse education if we are to promote a candid and transparent culture in the NHS. Student nurses are crucial to the professional identity of nurses in the future and it is paramount that educationalists endeavour to address this in the present.

The context of patient safety

The first major finding of this research is that all of the students were aware of the importance of patient safety as a rudimentary topic which features predominantly

in their educational programme. The topic of patient safety was elevated into the curricula domain following high profile cases of The Mid Staffordshire and Winterbourne View investigations. Students are fully aware of the expectations imposed upon them to practice safely themselves but also to act upon suboptimal practice they may be exposed to during their clinical placements. All of the students had either experienced or witnessed suboptimal practice but their reactions differed. All of them identified factors which in their eyes constituted a patient safety issue including: patient handling, medicine administration and staffing levels. In addition, some students recognised unprofessional behaviour expressed in attitude by some. Their beliefs regarding patient safety and their own actions varied, however all students presented a sense of professional obligation; a sense of 'doing the right thing'. This however was guarded by the fear of reprisal and punitive action. In addition, students held a sense of a burgeoning desire to know the outcome of concerns raised in an effort to ensure behaviour would change. A conclusion that can be drawn from this research is that although students are introduced to the concept of patient safety early in their three -year programme, not all are adequately equipped to deal with adverse events, particularly as novice students. The primary purpose of discussion around patient safety is preventing harm and promoting quality.

Recommendations

A recommendation resulting from this research is that greater emphasis should be placed on instructing students in the first year of their programme on policies, procedure and support available to them with regard to incident reporting and challenging sub-optimal practice. Although policies exist already, the extent to which students comprehend process and procedure is questionable. It is also

imperative that students are made aware of the support available to them should they choose to speak up.

Students should be provided with feedback following any adverse event. Whilst acknowledging issues of sensitivity and confidentiality, particularly if action has been taken following the student's action, there is still scope for providing feedback and debriefing to students.

Pivotal to this, is the role of the Personal Tutor or Guidance tutor. Students, particularly in the early stages of their educational programme, require assistance and support to help them interpret situations. They may not have developed the ability to contextualise events they find themselves party to. The Guidance Tutor or Personal Tutor can help them to reflect meaningfully on their practice and should act as positive role models.

In addition, students should be afforded the opportunity to discuss critical incidents in a safe and supported environment and receive structured feedback. In order to strengthen the student voice, peer support from students who are able to discuss their own experience of raising concerns could be advantageous, providing it is carefully organised and issues of confidentiality and sensitivity are addressed.

In addition, education and Practice Placement providers should undertake audits to quantify the number of concerns raised by students in order to move forward.

Team culture

The second major finding was the influence of identity, both personal identity amongst students and identity within the team. The literature review revealed that social identity has long been recognised as a construct which underpins student nurses function and behaviour. Students are faced with finding their way to being accepted in organisational 'in groups'. Not only are they part of the organisation which is 'the university', but in addition they become part of a student group, their peers with whom they will share relationships with over the three- year programme and in some cases beyond. Furthermore, they then become part of the healthcare trust to which they are allocated and adapt to the expected organisational identity that is 'the trust'. Each placement they experience has its own team culture, team players and ethos. The student then has to learn the rules and norms within each team. A conclusion that can be drawn from this finding is that students should be offered a better understanding of social identity theory. Whilst the curriculum prepares student nurses to examine their own professional identity and its correlation with other fields of nursing and the multi-disciplinary team, what is not discussed in any detail is the concept of social identity. Students are introduced to the concept of group behaviour based on Lewis theory (Lewin 2008) however, arguably this does not go far enough in providing a catalyst for reflection in and around their social behaviours and role within teams.

Education providers need to introduce the concept of social identity within the first year of the curriculum to facilitate students understanding of not only their professional role, but also their social role in the healthcare environment.

This should also be cascaded to those in supervisory and coaching roles to facilitate a deeper understanding of the complexities associated with adjusting to the team culture alongside the multi-faceted demands thrust upon students particularly during the early stages of the programme. Arguably, theories related to group formation and behaviour are important, but the introduction of the concept of identity theory will complement their understanding of roles and behaviours.

Hierarchy

A third key finding in this research is the influence that perceived hierarchy has on student nurse behaviour. Whilst hierarchy is inevitable in the health service and to some extent serves a purpose, lessons must be learned from the high reliability industries with regard to challenging those in authority. This research has revealed that hierarchies as perceived by student nurses is not solely identified as the 'doctor- nurse relationship embedded historically in a culture of paternalism, but rather it relates to the social hierarchy within teams. Undoubtedly, the experience and seniority of staff is influential with regard to student behaviours, however what this research adds to existing knowledge, is the influence of untrained staff within the team and also surprisingly, the age of team members. These factors are predominantly human factors. There is plethora of evidence from high reliability industries which identifies age and

experience as a barrier to speaking up. However, as teams within the health service are implementing human factors training, students are gradually being exposed in the practice arena to teams who have a transparent, open and no – blame culture. More needs to be done to explore ways in which human factors and speaking up is delivered in the curriculum. One of the complexities associated with teaching human factors is that there is a contradiction between teaching it in the class room or simulation skills lab, and experiencing real events in practice. Teaching students what they should be doing in the classroom environment is relatively straight forward, but for students then to apply what they have learned in difficult clinical situations is a test of courage. Encouraging junior members of staff to speak up if they feel something is wrong can be achieved through team briefing and time out. If this is embedded in clinical team practice, students would be more confident to challenge senior members of staff. Clinicians themselves, are key to allowing this to happen. Students in turn must possess the ability to overcome their fear of challenging practice through refined communication skills and an awareness of the differences between assertiveness and confrontation.

Recommendations

Institutional structures should provide a positive learning environment for students where authoritative hierarchical leadership is reduced. This should be consolidated through Francis (2015) 'Freedom to Speak up' recommendations.

Students should be encouraged to raise questions about practice with a named individual who can advise and support them through the process. This will go some way to facilitate the distinction between practice that is tailored to the

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patient's needs through professional decision making, as opposed to suboptimal practice.

Structures and frameworks of debriefing and 'time out' should be in place in a wider range of clinical areas to allow time for reflection and clarification of queries arising. This should be incorporated with other initiatives such as the World Health Organisation Patient Safety Curriculum Guide (WHO 2010) . At the present time, this practice tends to be implemented in critical care areas such as operating theatres and high dependency departments.

More opportunities for combined practice workshops in human factors involving qualified staff and students collectively may be beneficial. Learning alongside qualified colleagues in the multi-disciplinary team in the practice arena can offer benefits in terms of developing trust and self –efficacy.

Fear of retribution

The fourth and predominant major finding was the student's fear of retribution as a barrier and deterrent to raising concerns. This was presented in a variety of forms but essentially focused on their desire to pass their placement, be accepted in the team, be perceived and labelled as a trouble maker. The students overwhelming desire to survive their placement was often the determining factor influencing whether they would speak up or not. However, this was often superseded by their sense of wanting to do the right thing. Some students would compromise their 'comfort' in order to prevent harm at the risk of 'rocking the boat'. All of the students knew what they should be doing in the event

that they witnessed sub-optimal practice, but not all possessed the confidence and moral courage or indeed skills to raise a concern. This in turn presented a dilemma with their own professional behaviour and the expectations put upon them by professional regulators. The determinant was reliant upon the position of their moral compass. Not all of those who raised a concern actually experienced punitive action, with one student actually being praised by clinical staff and questions raised about why they had not spoken up sooner. This is encouraging and is evidence that the safety culture is becoming more transparent and candid, though is also sporadic.

Figure 9 illustrates the influencing factors which determine whether students speak up or not, depending on the position of their moral compass. Students need to be coached to enable them to navigate around this.

Figure 9: Moral Compass

Fear of reprisal

Fear of failing placement

Fear of not fitting in

Fear of being

Professional obligation

Ethical and Moral obligation

Patient Advocacy

Prevention of harm

Student witnesses sub-optimal practice

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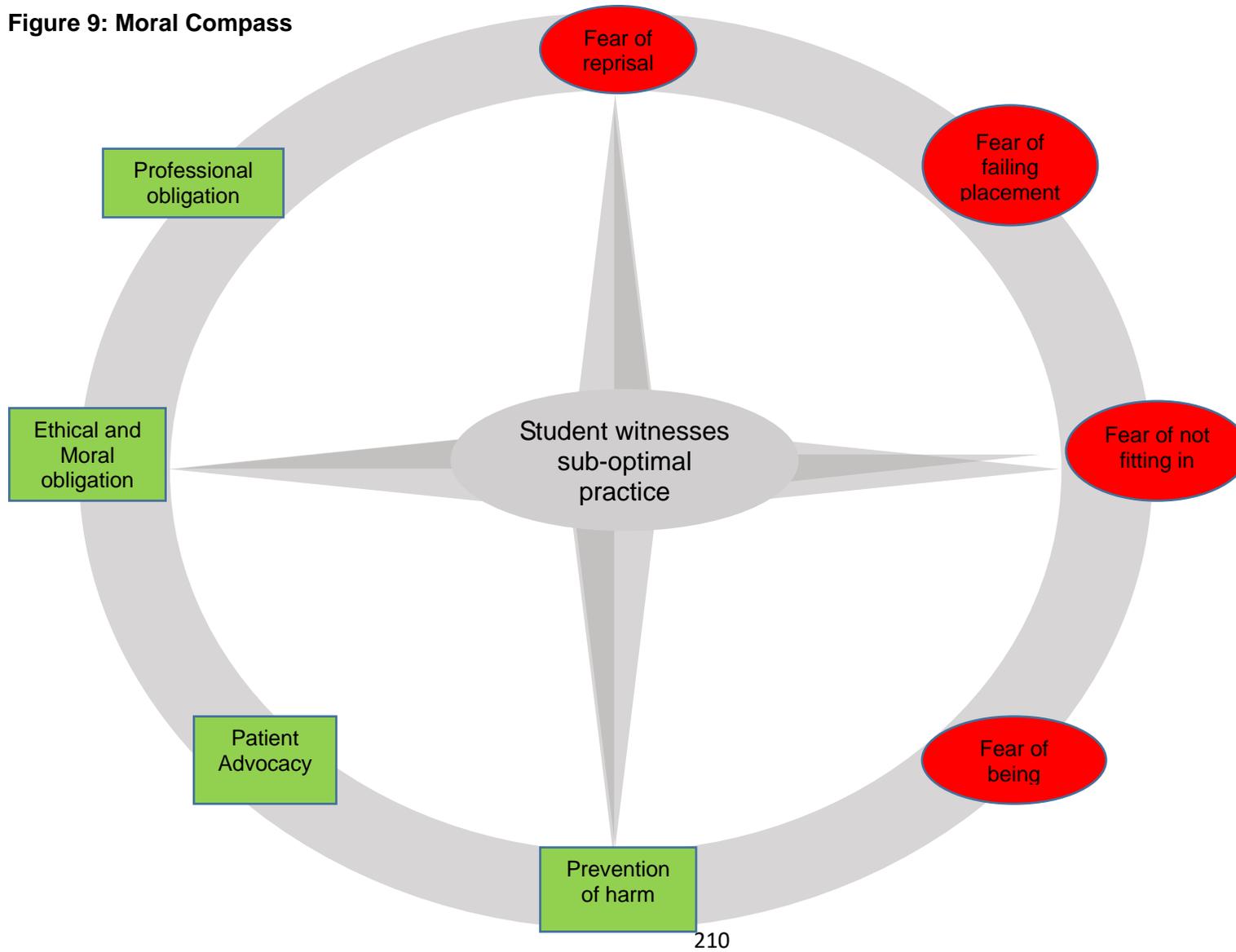
Recommendations

Of all the recommendations offered in this study, perhaps the most challenging is the focus upon preventing and avoiding punitive action. The success of this recommendation is dependent on collaboration between education providers, clinical practice staff and professional regulators.

What is essential to a successful outcome is that greater emphasis needs to be placed on how student nurses learn the skills of handling negative behaviour. Whilst the curriculum instructs student in how to de-escalate aggressive behaviour, the focus is upon patients and not that exhibited by colleagues.

It can be argued that this is a difficult concept to teach because the reaction by the student is dependent on a number of factors including: personality type, confidence and previous experience.

The fundamental skills of communication, professional attitude can be taught. However, combining this with sound policy which is developed to address raising concerns and in addition incorporates managing retaliation behaviour, may go some way in protecting students.

Students should be taught how to manage behaviour by staff that suggests retaliation following raising a concern. Policies must be in place to protect students from retribution.

This, in itself leads to the consideration of how this sensitive information may be handled in the dissemination of findings. Much of the student narrative alludes to negative experiences. However, as strict ethical guidelines were adhered to, it is not possible to identify specific trusts, wards, departments or localities. The

university works in partnership with a number of trusts and placement providers. There already exists a positive working relationship and partnership between the placement providers and university both at a strategic and operational level. The information provided by the students was volunteered to facilitate the research and was not used as a vehicle to raise a complaint. It is based on opinion and has not been verified. This should be acknowledged during dissemination.

Trustworthiness and credibility in qualitative research

If research is to be plausible, trustworthiness and validity are key issues contemplated by the audience to which research summons. Ethical conduct was paramount in this research and explained in chapter three. Throughout the research study, every effort was made to maintain confidentiality, anonymity and exercise due care and attention to participants. The participants were fully aware of the purpose of the research and the potential sensitivity of the topic. It was anticipated that participants may share information which required further action with regard to poor practice. However, no immediate action was necessary, though it is acknowledged that some aspects of custom and practice require future discussion and further research.

Several strategies are discussed in the literature to harness trustworthiness and it was decided that the principles of Lincoln and Guba's criteria was an appropriate approach to ensure quality in this study (Lincoln and Guba 1985). Though various terminology is used in defining reliability and validity in research studies, the 'trustworthy' would appear to sit more comfortably with the chosen methodology, methods and epistemology (Lincoln and Guba 1985).

Outlined in chapter three, Lincoln and Guba (1985) suggest that four criteria are necessary if we are to develop the trustworthiness of qualitative inquiry: credibility, dependability, confirmability and transferability.

Credibility is associated with true interpretations of the findings in data and equates with validity in quantitative data. The essential question asked is whether this research study accurately represented the feelings and experiences of participants. Throughout this research study, every effort was made to demonstrate congruence by aligning the data collection methods and analysis with the philosophical underpinnings of this research. The application of hermeneutic phenomenology allowed the researcher to elicit the lived experiences of the participants and is well matched to the logic of the aims of this study. To enhance the validity of the study, throughout the process, reflexive accounts were recorded and considered. Reflexive discourse is an important contribution to the trustworthiness of research studies as it helps the researcher explore their personal feelings and attitude towards the subject matter and remain aware of their own presuppositions and experience (Polit and Beck 2010). Ultimately, this helps to enhance the believability of the findings and demonstrates credibility to external readers (Polit and Beck 2010). Reflecting on the process of research implies a shift in the researchers understanding of data and data collection and is achieved by internal dialogue and a sense of detachment (Jootun 2009). It is argued that reflexivity facilitates the maintenance of transparency in research as it clarifies the philosophical position of the researcher in relation to the process (Darawsheh 2014).

Lincoln and Guba (1985), Polit and Beck (2010) advocate that researchers consider member checking to establish credibility of qualitative research data. This enables the researcher to establish whether or not their interpretations are

accurate representations of participants' realities. An attempt was made to use this method to offer a degree of triangulation. At the commencement of interviews, participants were asked if they would be willing to engage further on in the study. Most agreed that they would be interested in doing so, however, it became difficult to contact students who had subsequently completed the programme and of those who remained on the programme, none offered to participate. It is possible that as the students have progressed to year three of the programme and engaged deeply in the demands of their studies, this may have prevented them from engaging further in the study.

Dependability equates with reliability and is associated with whether or not the findings would be replicated if the study was repeated. This is difficult to measure in qualitative studies but by asking supervisors of this research to examine the data and identify themes, this provided a form of interrater reliability (Huberman and Miles 2002). Although indexing and sorting was generally found to be consistent, it was necessary to reconcile differences in interpretation, selection of superordinate themes and subthemes. This also goes some way to address the notion of confirmability which is concerned with objectivity and the potential for congruence about the data's accuracy when looked at by others.

Confirmability corresponds to objectivity and the potential for congruence between the participants and researchers' interpretation. At the outset of this study, it was acknowledged that there was the potential for researcher bias. As such attempts were made to address issues of credibility with regard to this research study acknowledging the complexities of demonstrating how this can be achieved in qualitative research. In addition, the application of Framework as a

data analysis tool offers additional evidence of transparency by way of data summary and display, providing the reader with an opportunity to follow the analytical journey throughout the research.

Transferability refers to the extent to which the findings can be transferred or be applicable to other similar groups. The application of transferability in phenomenological research is questionable and should be determined by the reader. The participants under study are representative of other groups of students undertaking a three- year programme in Adult Nursing therefore it can be argues that the findings are representative of this homogenous group. However, it is the responsibility of the researcher to present the data and discussion in such a way that the reader can draw their own conclusion regarding transferability. Lincoln and Guba (1985) assert that the researcher should provide sufficient data in the research thesis to enable readers to evaluate the applicability of the research to other contexts. The researcher has attempted to offer detailed, deep discussion and congruence with the findings to existing literature. It is expected that this will provide the reader with an opportunity to contemplate transferability as a possibility.

Reflexive Account

Whilst contemplating embarking on doctoral studies, there was no doubt in my mind about my choice of topic. Patient safety is my key area of interest and is embedded in much of what I teach as an educationalist. Student nurses are also a key part of the health care team and the future registrants of the nursing workforce. It is therefore imperative that they are shaped and nurtured to deliver high quality safe care. As an educationalist I have recognised first- hand the difficulties that exist when a student nurse finds herself in a situation where care is sub-optimal. I also reflect on my own experience as a practitioner who has witnessed care well below the standard expected. Though systems are in place to support and protect students, particularly in a health arena in pursuit of transparency and candidness, these systems do not always adequately address the complexities associated with raising concerns.

Throughout the research project, I maintained a reflective diary, the purpose of which was to recognise my thoughts, experience and transition as a researcher. It also served as a log of my understanding about research paradigms and methods. As the research study progressed, I became aware of my own level of knowledge in relation to research and I was able to apply this during my own teaching activities. I feel I have grown as a researcher and developed my ideas and understanding of the research arena.

Paramount to this research journey experience was the importance of remaining objective while collecting data and analysing it. Paradoxically, I have gleaned an understanding of my own ideas and bias which exist in this trajectory. Attempting

to bracket this would have proved perplexing, therefore the chosen methodology sought to address this disquisition. I was aware that in order to maintain transparency throughout the research process, I needed to clarify my own philosophical position as a researcher. The epistemological stance underpinning any research study is an essential criterion of rigour. The selected methodology of hermeneutic phenomenology allowed me to reach into the world of the students as they saw it. It was perhaps unavoidable that my own experiences, background and beliefs would subjectively influence my findings. However, I made a conscious effort to develop my skills of creativity, intuition and imagination during the analytical process. Any presuppositions I had were put aside as I immersed myself in the data. Throughout the research process, it became distinctly apparent that this was the appropriate methodology for this particular research study. Not only did I have to reflect on my thoughts but I also had to think about the factors that influence the way I think. In addition, I had to consciously develop creativity in the way I reached decisions.

During the interview process, I was mindful of my existing relationship as a lecturer with the students. It was necessary prior to each interview to clarify my role as a researcher and the purpose of the research. I also experienced trepidation particularly during the first few interviews in anticipation of participants 'disclosure'. As the topic area is sensitive and seeks to ultimately improve transparency and candidness in healthcare, it would have seemed ironic if I was then placed in a position where I would have to take action with regard to a patient safety event. It was necessary to use effective communication and interpersonal skills to make the students feel at ease and volunteer information without being influenced by my role as a lecturer and programme lead. It is not possible to measure whether this was achieved, however the interview

responses would indicate that the students felt comfortable to share their thoughts and beliefs.

Considering reflexivity enabled me to apply alterations and changes to the way in which I asked questions during the interviews. Some of the participants were eager to volunteer information but others were more hesitant, and this is apparent when re-reading some of the transcripts. As such, it has heightened my awareness of my own skills and weaknesses as a researcher. In future research studies, I am cognisant of the requirement to adapt my interview skills to match the participants' reactions and adjust my technique accordingly. I need to be able to recognise the cues that are visible in the interviews and gain an awareness of my own performance.

My approach to data analysis using 'framework', provided a model in which I could display my thoughts and thinking processes. Each step in the organisation of the thematic framework and display allowed me to demonstrate how I was thinking and processing information. Furthermore, it allowed me to contemplate why I reached decisions in the way I did. Being reflexive has helped me to identify my own personal traits that could subjectively influence the outcome of the research. I have come to realise that I have my own personal views with regard to patient safety and whistleblowing, based on my own experiences, values and beliefs. I am also an experienced clinician and teacher who is also embraced in organisational culture. Inevitably I am likely to see the world through a different lens to that of the students. This said, I was able to identify similarities in thoughts and associations. It is potentially these similarities that students also identified with and may go some way in explaining why some students were more eager to share their experiences than others. I was also conscious that as well as being 'the researcher', I was also a registrant who is duty bound to preserve and

promote safe practice. However, this enabled me to probe at a deeper level to elicit information and orchestrate a deeper understanding of what was being said.

My journey in this research trajectory has undoubtedly helped me develop as a researcher. However, as a nurse, listening to student nurses' experiences has left me with a sense of discomfort. This discomfort emanates from the reality that despite the drive for openness, candour and transparency in the health services, there remains a reluctance for nurses to raise concerns. In addition, it is disturbing that whilst attitudes and culture has changed, there is still evidence that bullying and intimidation exist. I felt sympathy and empathy for those who shared their stories with me and it has made me more determined to ensure that policies and effective support mechanisms are in place to protect these vulnerable individuals.

To summarise, reflexivity is a term that is contested because there is a lack of clarity on its definition (Jootun 2009 Darawsheh 2014). However, it is widely accepted that qualitative studies are predisposed to potential subjectivity and therefore being reflexive allows the researcher to demonstrate some degree of transparency and rigour. It has afforded me the opportunity to pursue a journey in which I can explore my own inner feelings, values and beliefs.

Limitations within this study

At the commencement of this study, it was acknowledged that the study contains certain limiting conditions, often related to the common critiques of qualitative research methodology. There is a limitation of qualitative research with regard to the non-generalisability of findings using this approach. In addition, it is recognised that this study is a small – scale qualitative inquiry. The interpretive paradigm was selected as it is congruent with the research aims and in doing so

is designed to offer different information to the type associated with quantitative research.

The study is restricted to student nurses from one university in England. The study focuses upon students undertaking the BSc Adult field of nursing thus limiting the data to one particular field of nursing. Nonetheless, there are comparable similarities in students' experiences with those identified in the literature. It is therefore suggested that this can be transferable to the broader student population. It is for the reader to decide.

From the outset of the research study, it was recognised that the researcher was known to some of the participants and therefore there was always a risk that this could inhibit participant responses and engagement in the research. Researcher – participant relationships can present as a conflict of interest. Interviewees may have experienced participant reactivity. This phenomenon is related to their relationship with the researcher who is known to the participants as a lecturer and Programme Lead. Their responses may have been influenced by this interaction, participants may have been less candid and guarded in their responses.

Furthermore, as data analysis rests ultimately with the researcher, interpretation may be limited by the researcher. The methodology used in this study was however developed to counteract unintentional bias. In addition, the application of framework analysis served to reduce the risk of priori knowledge potentially introducing bias to the findings. Framework provides transparency to the reader and demonstrates a rigorous use of systematic methods of data collection and analysis.

Recognising such limitations, every effort was made to take measures to prevent researcher bias as outlined above. This was a continual process throughout the research journey and enhanced by discussion with supervisors.

Framework provided a useful approach to data management in which both the content and context of the data was analysed and themes identified. The themes were identified in terms of presentation, frequency and occurrence. Whilst the cognitive factors relating to individuals' attempts to make sense of their experience was addressed, what is perhaps lacking in any detail is the emotional sequelae resulting from their experiences. The findings indicate that many of the participants had experienced a degree of psychological trauma or stress. This was implicit in the student narrative. Emotions are central to our understanding of human experience and intersubjective acts. It is acknowledged that from a phenomenological perspective, emotions and cognition are closely interrelated and it could be argued that this aspect of the participants' lived experience could have been examined in more detail.

It is acknowledged that further research is required to compare the student nurse experience with regard to understanding the context of patient safety and raising concerns. This should be expanded to include all fields of nursing to enable exploration of the different contexts in which care is delivered.

To summarise, this chapter has offered recommendations arising from the findings of this research, both for educational institutions and practice placement providers.

Issues of trustworthiness and rigor have been discussed and in addition limitations of the study have been considered.

Conclusion

This research study has identified that student nurses are conversant with the need to uphold patient safety and that it is a tenet of quality care. They understand that all care must be underpinned by evidence. The findings have also revealed the influencing factors that determines their decision to raise a concern or remain acquiesce. This interpretive approach has allowed me to achieve the aim of the research which was to provide an insight into the student nurses' lived experience. It has been possible to view the students' world through their lens.

What is apparent is that student nurses' willingness to raise a concern is influenced by intrinsic and extrinsic factors. Students possess ethical and moral values aligned with the will to act as the patient's advocate and prevent harm. However, this is hindered by their desire to survive their placement, fit in with the team and avoid potential retribution.

On commencement of this project there was paucity in the literature in relation to the student nurse voice. Towards the end of the study, little has changed but this research study goes some way in adding to the body of knowledge that is in existence. The findings in this research support the work of other researchers who have identified that students strive for a sense of belongingness in their clinical placements and this can inhibit them from speaking up. They also fear reprisal and punitive action from co-workers and this is not restricted to their mentors, other registrants or those in authority but includes unqualified staff who

are established in their roles and teams. The research has revealed that essentially human factors pervade their behaviour, with students recognising their junior status and its perceived inter-connection with others in the team. In addition, they discussed the significance of age as well as experience as a determining factor in their willingness to speak up. Students require the assurance that robust and effective support mechanisms are in place as a safety net when they do raise their concerns.

What is encouraging from this study is that student nurses are willing to and do speak up when care is suboptimal. This suggests that nurse education is influential in promoting a candid and transparent workforce.

The discussion and recommendations in this study offer further dialogue to help us better understand student nurses' beliefs and behaviours in relation to patient safety. Ultimately it is intended that this research will inform policy and practice with the overall aim of preserving and promoting patient safety.

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Appendices

Appendix 1 Participant invitation

northumbria
UNIVERSITY NEWCASTLE

Date

Dear ....

INVITATION TO PARTICIPATE IN RESEARCH STUDY

Title : An exploration into the student nurses perception of patient safety and experience of raising concerns

The aim of the project is to explore the student nurses perception of patient safety and their experiences, beliefs and values in relation to raising concerns. You are invited to participate in this study. Before you decide you need to understand why the research is being done and what it would involve from you.

The research is not directly funded by Northumbria University however is part of a Professional Doctorate study.

 You are being invited to participate in this study because you are a student nurse undertaking a programme of study in Northumbria University.

Enclosed is an information sheet which details the research and what you will be agreeing to do if you agree to take part. Please read this carefully.

In 2-3 days time, Melanie Fisher will contact you via telephone or e-mail to find out if you are interested in taking part in this research. If you are, Melanie will make arrangements to meet with you to provide further information and to answer any questions you may have.

You will then be offered a period of one week to consider whether you wish to be involved. If you do get involved all of the information collected from you will be held in the strictest confidence. In addition, you will be free to withdraw from the study at any time without this affecting you in any way.

Thank you for taking the time to consider being involved in this study

Yours faithfully,

Mrs Melanie Fisher

Principal Investigator / Lead Researcher

Tel: 0191 215 6377

E mail: melanie.fisher@northumbria.ac.uk

Appendix 2 Information sheet

Date

Information Sheet for Participants

Aim of the Research

The aim of this research is to understand student nurses' perception of what they believe is a patient safety incident in their hospital and community placements and understand their thought processes behind their willingness or reluctance to raise concerns about patient safety.

What information will be required?

You will be required to participate in a face to face interview with the researcher, the aim of which is to draw upon your personal beliefs and experiences in relation to patient safety and raising concerns. It is important to make it clear that information required is of a general nature and should not be used as an opportunity to raise a specific issue relating to a patient safety incident you may

have witnessed on placement. Any such incident should be addressed using university and or trust policy.

What are the benefits of taking part in this research study?

Individuals participating in this study will get an opportunity to identify their perceptions of what constitutes patient safety and how they have contributed to enable us to better understand and support students to raise a concern. Ultimately it is anticipated this will go some way in improving patient safety and the prevention of harm. You will also be able to record in your Personal and Professional Development Portfolio that you have participated in a research project as part of your on-going development.

CONFIDENTIALITY

Collecting the data

The data for this study will be collected using a Digital Dictaphone Recorder during the interview. The researcher may also take notes during the interview. Once the interview has ended the recording will be transcribed and a written record of our discussions will be created. The data will not contain your name etc.

and any paper based record will be securely stored. Electronic data will be stored on the university U drive which is password protected.

Storage of the interview tapes, transcripts and other papers

Any paper based transcriptions will be kept in a locked cupboard at Northumbria University until the research is completed, however all digital recordings will be deleted once the paper based transcriptions have been transcribed. These documents are anonymised and are marked by a unique identifier (allocated to you by Melanie Fisher).

The only individuals who will have access to the tapes and papers is Melanie Fisher , Dr Matt Kiernan (Melanie's supervisor) and an administrative assistant involved in the transcription process. The administrator will not have access to your names.

Any information which is produced as part of the dissemination of information and publications associated with the project will not bear your name or details.

What if I disclose a patient safety issue that I didn't report?

The purpose of this study is to understand your perceptions about patient safety and your feelings about raising concerns. The university and local trusts have policies in place to help you raise a concern and this interview should not be looked upon as an opportunity to raise a concern that requires action. It is important that you are open and candid when discussing your experiences as this will add to the richness of the data collected. However, it is important to be aware that the researcher is an NMC registrant and is duty bound to report any information that exposes criminal activity or negligence that may harm patients. If this should happen, you will be invited to withdraw from the study and offered support from the University Services. Your anonymity will be observed at all times.

What will happen to the results of the research study?

The results will form part of a report which will be completed by September 2017. The results will form part of a report which will be disseminated by Melanie Fisher and will be made available to study participants. The results will also be published in education and health care journals and within a doctoral thesis. You will never be identified in any publication although your words may be published exactly as you said them during the interview.

Who is funding this study?

Melanie Fisher is being supported by Northumbria University through its programme of staff scholarly activity

Who has reviewed this study?

The proposed research has been reviewed by Dr Matt Kiernan and also the Faculty Research Committee.

.

If I take part can I withdraw from the study at a later date?

You can withdraw from the study at any time. Simply contact Melanie Fisher to tell her you would like to withdraw. Details are at the end of this information sheet.

When you indicate your intention to withdraw from this study she will ask you if you would like her to destroy all of the data collected to the point of withdraw or whether we can continue to use it in an anonymised form.

Complaints

If you have concerns about any aspect of this study please speak to either Melanie Fisher or Matt Kiernan doctorate supervisor (details below) and we will do our best to address these.

Information disclosure

Melanie Fisher works as a Senior Lecturer in the Faculty of health and Life Sciences at Northumbria University. She is a Registered Nurse and is governed by the Nursing and Midwifery Council (NMC), she will inform you at the initial meeting of the NMC code (2008), and also the NMC raising and escalating concerns guidance (2010)

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Research Team

Principal Investigator: Melanie Fisher

Senior Lecturer

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Appendix 3 Consent form

northumbria
UNIVERSITY NEWCASTLE

A GENERIC INFORMED CONSENT FORM

Project Title: _____

Principal Investigator: _____

please tick
where applicable

I have carefully read and understood the Participant Information Sheet.	☐
I have had an opportunity to ask questions and discuss this study and I have received satisfactory answers.	☐
I understand I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice.	☐
I agree to take part in this study.	☐
I would like to receive feedback on the overall results of the study at the email address given below. Email address..	☐

Signature of participant... Date............................ (NAME IN BLOCK LETTERS)..
Signature of Parent / Guardian in the case of a minor ....
Signature of researcher.. Date............................ (NAME IN BLOCK LETTERS)..

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Appendix 4 Participant summary

Participant Sample

Participant Identification Letter	Gender	Age group	Stage of Training
A	Female	21-25	2nd Year
B	Female	21-25	2nd Year
C	Female	21-25	2nd Year
D	Female	21-25	1st Year
E	Female	21-25	1st year
F	Female	25-30	1st Year
G	Female	21-25	3rd Year
H	Male	21-25	3rd Year
I	Female	21-25	3rd Year
J	Female	21 - 25	3rd year
K	Female	21-25	3rd Year
L	Female	25-30	3rd Year

Appendix 5 Interview Schedule

Welcome the participant

Reinforce the purpose of the research study and remind the participant of the ethical rules observed

Obtain written consent to record and use the interview data

<u>Use the questions as a guide:</u>

- ➢ Tell me about you practice placements. Have you ever witnessed a situation where patient safety may have been compromised?

- ➢ How did you react?

- ➢ How did you feel?

- ➢ Have you ever raised a concern about what you consider to be substandard practice? Tell me what influenced you to react in this way?

- ➢ What would prompt you to raise a concern?

- ➢ What might prevent you from raising a concern?

- ➢ Is there anything else you might wish to discuss in relation to patient safety and your experience on placement?

These questions are a guide and will be used at each interview. Depending on the responses given, they may be expanded upon.

Thank the participant for their contribution and enquire whether they would be willing to be contacted in the future to check the accuracy of the interview responses once transcribed.

Participant		Fear of punitive action	Evidence of student not challenging poor behaviour or practice	Student concerned about progress
A Female Age 21-25 2nd yea		*you think well they are going to be horrible to you or fail me…* *the student doesn't define what she means by horrible but there is a clear fear in her voice on the recording*		*So I just thought that I'm just gonna have to go for it and I thought well they can't..you think well they are going to be horrible to you or fail me or but I thought if they do do that I'll just speak to the university coz they can't fail me for telling the truth. Yeah and I started thinking should I just wait till the end of placement when I'm signed off but I couldn't say something after coz I was scared what was going to happen then I thought I've still got another two months to go and if she keeps on doing it then…but I don't think anything actually came of it she didn't go on any courses or anything like that…you think well they are going to be horrible to me or fail me…*
B Female Age 21-25 2nd year			*You have healthcare assistants who have been in the job for 10 – 20 years so you feel quite uncomfortable challenging them…you just feel intimidated* *I think I'm one of those people who wouldn't because I'm quite shy and a bit reluctant to cause anything…*	*If I was on a placement and think it might affect that placement then I might wait until the end or bring it to the university*

C Female Aged 21-25 2nd year			*I don't think I've quite developed the clinical knowledge to challenge a qualified…*	
D Female Age 30 -35 1st Year			*No I didn't challenge her because she was my mentor and she was the expert and had been on the ward for over 5 years so I didn't even think twice about it..* *You know I possibly wouldn't because they are qualified and I am learning off them…you want to get on with your mentor…* *There is a perception that because a nures has been qualified for a period of time then they must be doing things correctly*	*It's challenging enough being out there assessed without having people not being on your side* *Student clearly feels it is essential to get on and belong in order to survive*

E Female Age 21 – 25 1st year		*I didn't want to ask too many questions because I had to go back there in June…*	*I didn't know what to say because the qualified staff were just going along and doing it…*	
F Female Age25 30 1st year				
G Female Age 21 -25 3rdyear		*If I speak out now…..I go back for another twelve weeks so…it would be fairly obvious who had given the complaint. Like eventually I do think the staff would have known was me, even if they said they would keep it confidential, they would have known coz of the nature of the complaint…*	*I did feel like they were a bit annoyed at me for taking so long to speak out and put my complaint in, but it's really hard as a student and I don't think it would get any easier as a qualified………* *Ive reflected and looked back and part of me thinks I should have said no but I wasn't strong enough on my first day*	

H *Male* *Age 21 -25* *3rd year*		*We had a meeting with the matron..they separated us and then we had to say our opinions, what happened and then they personally asked which staff….tell me which staff it was. You know so we did that and then my colleague came crying out of the interview with the matron. It was horrendous.* *When asked if the student felt intimidated they said yes*		
I *Female* *Age 21 -25* *3rd year*			*If you raise a concern, they might think; why is she raising a concern? She's just started…* *People are more likely to speak up now probably in the light of the Francis Report. But there is still a barrier definitely…*	
J *Female* *Age21 -25* *3rd year*		*It is difficult particularly if you're working with someone who might be intimidating…* *The students use the term 'intimidating' which suggests passive threatening behaviour*		

K Female Age 21 -25 3rd Year	*Like if it was a healthcare assistant…I know it sounds silly but they're quite forceful if they are all together…* *I didn't want to ask too many questions because I had to go back there in June… It's easier for a student who knows they are leaving that ward. They might never have to go back there.* *Sometimes you are quite scared of them on placement..do you know what I mean?* *Student is talking about a health care assistant*	*Sometimes if you are more quiet and more timid, you wouldn't speak up because you feel you weren't confident enough to speak up. When you got questioned you might be too nervous or not want to speak…*	*I would have been a bit scared to…having to stay on the ward and who was going to say something…* *Whatever you say it always gets around and it could have consequences for your career…* *Sometimes they just start picking faults with you…even just silly things…*
L Female Age 25 -30 3rdyear			*I might have thought if this is my hub, I've got to come back here, are they going to treat us differently?*

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