An Interpretative Phenomenological Analysis of the student nurses' perceptions on value-based recruitment in the context of their personal constructs of caring and professional values

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Summary

The National Health Service (NHS) has been the subject of several reports and continuing debate over its apparent failure to provide dignified and compassionate patient care. As a strategy to address these apparent failings and ensure a future caring nursing workforce, Francis (2013, p.105) recommended that the Nursing and Midwifery Council (NMC) test applicants to undergraduate nursing programmes for their care aptitudes and professional values through aptitude testing. As a direct result of Francis (2013) Health Education England (HEE) introduced a value-based recruitment framework (VBRF) (HEE 2016a) which seeks to recruit nurse students on the basis of their individual values and behaviours which align with those of the National Health Service (NHS) Constitution (HEE 2021). It is also evident that the Francis report (2013) has been the stimulus for many universities within the United Kingdom (UK) to adopt value-based recruitment (VBR) principles in their nursing and allied health practitioner recruitment practices, however the values recruitment criteria outside of England are unclear. Thus, whilst the appropriateness of VBR seems creditable, there is little evidence to suggest as to how successful VBR will translate into recruitment practices, or what the outcomes would be.

Therefore, this study sought to build a bridge between the nurse candidate meaning of caring and professional values, and the representation of these values through VBR practices. To do this, ten newly recruited undergraduate student nurses undertook aptitude testing and interviews in a university setting. An idiographic appraisal of aptitude testing data as a measurement of caring and professional values, as well as interpretive phenomenological analysis (IPA) as an autobiographical account, were utilised in combination to explore the students' meanings of caring and professional values, that is, how these values were mediated through the language of aptitude testing and how the students compared their experiences of aptitude testing and multiple-mini interviews (MMIs). A social constructionist lens was employed as a framework to critique students' personal nursing values, the significance of these as an expression of their identity within their world of the nurse and how their values guide their beliefs and behaviour through VBR practices of aptitude testing and MMIs.

The findings revealed the students' constructed and presented their caring and professional values in line with the nursing norms evident in value frameworks they were exposed to during recruitment. Social cognition, professional identity, gender and pedagogy also influenced students meaning of caring and professional values and their responses to the values statement when undergoing aptitude testing. Significant conflict and dissonance in values centred on the students perceived realities of care and professional values in practice

when compared with their aspirational values. All of which influenced ratings to constructs that measured their personal nursing values when compared to those of the ‘model’ nurse i.e., good nursing values within the test. When the students considered their recruitment experience, the observation of an assessor during MMI, and their absence during aptitude testing, were powerful influences on how the students presented their values. The students also reported language used within the test constructs were significant in how they interpreted value statements. Whereas their reported test results, were influential in how they viewed their values and perceived their suitability to be a nurse.

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"Courage doesn't always roar. Sometimes courage is the little voice at the end of the day that says I'll try again tomorrow".

By: Mary Anne Radmacher

Glossary of terms.

Name	Abbreviation	Definition
Nurse Match Instrument	NMI	An instrument for assessing personal nursing values, their meaning, relative importance and emotional significance. Values are scored against the established professionally preferred nursing values. Please see section 5.3.2 and Appendix 9 for full instrument description.
Nurse match Instrument Screening tool	NMIST	Like the NMI the NMIST is an instrument for assessing personal nursing values, their meaning, relative importance and emotional significance. Values are scored against the established professionally preferred nursing values. However within the NMIST the language used within the instrument is generalised to the world of work and not specific to nursing. This is to facilitate applicant who have not worked within care. Please see section 5.3.2 and Appendix 9 for full instrument description.
Objective structured clinical examination	OSCE	An OSCE (*objective structured clinical examination)* consists of several short independent assessments.
Multiple Mini Interview(s)	MMI(s)	Is an OSCE *(objective structured clinical examination*) style interview format that uses several short independent assessments, typically in a timed circuit, to obtain an aggregate score of each candidate's soft skills.
Constructs	C	Each attribute or value within the NMIST and NMI is presented as a value statement also described as a 'dimension' or a 'construct'. Please see section 5.3.2, and Appendix 9 for full instrument description.
Pole(s)		Attributes and values are presented as a choice between two alternative interpretations of the nursing value described as poles. One pole is the professionally preferred pole and the other less so. Please see section 5.3.2 and Appendix 9 for full instrument description.
Dimension		The aptitude, value or skill measured within the construct.
Value themes		Six value themes are a synthesis of a number of constructs aligning with NIPEC (2014) attributes comprising of Person-centredness, accountability, trust, integrity, personal development and teamwork. Please see section 5.3.2 and Appendix 9 for full instrument description.
Entities		Entities within the NMIST and NMI are people that influence the development of aspects of personal and nursing values. Please see section 5.3.2 and Appendix 9 for full instrument description.
Ideal-self		The respondent aspiration and personally preferred attribute or values when appraising their personal nursing values.
Real work-self		The attribute the respondent preferred when appraising their personal nursing values at work.
Model nurse		Respondents appraisal of aspects of the 'model' nurse – also described as the 'good' or 'ideal' nurse - in terms of the attributes or values they perceive them to have or hold.
Faking good		The practice of some participants in an evaluation or psychological test who 'fake good' by choosing answers that create a favourable impression, as may occur, for example, when an individual is applying for a job or admission to an educational institution (American Psychological Association 2020).

Contents

Chapter 1 – Introduction

1. ***Overview***

The National Health Service (NHS) has been the subject of several reports and continuing debate over its apparent failure to provide dignified and compassionate patient care. This is illustrated by the Clwyd and Hart review (2013), the Francis report (2013), the Keogh review (Keogh 2013), the Berwick report (2013) and the Andrews report (Andrews and Butler 2014). These reports focus on the apparent failings in nursing care, with Francis (2013) seen as pivotal to the debate over compassionate care in practice. As a strategy to ensure a future caring nursing workforce, Francis (2013, p.105) attempted to prevent applicants with undesirable characteristics from entering the profession by recommending that the Nursing and Midwifery Council (NMC) test applicants to undergraduate nursing programmes for their care aptitudes and professional values through aptitude testing.

As a direct consequence of the Francis recommendations (2013), Health Education England (HEE) introduced a value-based recruitment framework (VBRF) in October 2014. At its conception, the VBRF required all undergraduate healthcare students accepted onto NHS-funded programmes within England to be recruited on not only aptitude and skill but also care and compassion as core values. This continues to be the supporting principle of the VBRF, which is defined as seeking to *"attract and select students, trainees and employees, whose personal values and behaviours align with the NHS values outlined in the NHS Constitution"* (HEE 2021). This principle remains a prerequisite for current English undergraduate healthcare programmes (HEE 2016a, p.81). The original publication also suggested aptitude testing could be used as a selection methodology for recruitment (HEE 2016b). However, the most recent publication of the VBRF suggests that aptitude testing for values can also be utilised at the attraction stage of the VBRF process so that candidates can *"self-select with respect to values"* (HEE 2016a, p.88). Furthermore, aptitude testing may also be used to inform the interview process (HEE 2016a, p.88). Although HEE (2016a, p.88) suggestion - that aptitude testing is utilised as a candidate selection tool or that applicants self-assess the appropriateness of their values before their application - seems creditable, there is no evidence to suggest how successfully this would translate into recruitment practices.

It is acknowledged the VBRF is an England-only initiative. However, it is evident that the Francis report (2013) has been the stimulus for many UK universities to adopt VBR principles in their nursing and allied health practitioner recruitment practices. Nevertheless, the values recruitment criteria (i.e., institutional, professional or employer values) outside

England are unclear, making it difficult to navigate the values underpinning VBR. A report commissioned by the Department of Health (DoH) to evaluate the effects of the VBRF notes that whilst the VBRF is laudable and *"intuitively appealing",* there is no evidence to support the assumptions *"that the VBRF will improve the quality of healthcare provision"* (University of Leeds 2020). To date, no findings have been published as part of the review.

1.1 Structure of the thesis

This thesis is organised into nine chapters. Chapter 2 discusses the existing research on VBR within the Higher Education Institution (HEI) context, focusing on the operationalisation of VBR through recruitment practices. Chapter 3 follows on from this discussion, focusing on the contemporary literature available since the adoption of VBR in UK healthcare. Chapter 4 outlines the theoretical lens for the study. Chapter 5, the methodology and methods chapter, discusses the research design, rationale for the use of interpretative phenomenological analysis (IPA) and justification for the chosen data collection methods and analysis. Chapter 6, the findings chapter, presents ten unique case studies that explore participants' meaning of caring and professional values, as well as their experiences of aptitude testing and multiple mini interviews, all of which are considered idiographically. Chapter 7 discusses the study findings within the wider context of VBR literature. The conclusion, the contributions of the study to nursing practice and research, as well as the study's limitations are presented in Chapter 8. An epilogue is presented in Chapter 9, followed by the references and appendices.

1.2 Catalyst for the enquiry: It's all in a name.

My career started in 1995 in the middle of a maelstrom of professional reform for Operating Department Practitioners (ODP), which begun in earnest during the 1980s. Professional titles changed from Theatre Technicians (TTs) to Operating Department Assistants (ODAs) to today's ODPs. Most viewed TTs, ODAs and ODPs as technical roles and, dare I say, some continue to do so today. Consequently, patient 'care' was not considered the remit of the ODP but that of the theatre nurse (Robinson and Straughan 2014). With changing titles came educational reform. The City and Guilds 752 was the ODP licence to practise before 1991 and was superseded by the ODP National Vocational Qualification (NVQ) level 3. In 1995, a formal review of the NVQ standards introduced the 'value-based unit, Unit O' as an addition to the ODP NVQ level 3 units (Tor and Southwest College of Health 1995). Whilst good care practices were considered to be implicitly embedded within all the units of ODP NVQ 3, care practices now became explicit learning outcomes within the 'value-based unit' (Tor and Southwest College of Health 1995).

Since I took the 'O unit' as part of my training, I viewed myself as a different breed of ODP. I saw myself as a caring practitioner, as opposed to my more technically minded ODA colleagues. Despite my feelings, the care role in theatre continued to be a nursing responsibility (Timmons and Tanner 2004, pp.656-657). I became aware of a tension in theatre, which was very much one of 'them and us' (Hauxwell 2002). They, the nurses, were predominantly female and, in the scrub role, did *"the nursey bits*" (Timmons and Tanner 2004, p.654). Meanwhile, the predominantly male ODPs were concerned with anaesthesia and the technical aspects of theatre work, described as *"anything with a plug"* (Timmons and Tanner 2004, p.655).

As a female ODP, I felt I had a foot in both camps, not really fitting into either the world of the technically orientated male ODP or that of the caring female nurse. Interestingly, I was always thought of as a nurse by my colleagues, who were often surprised to find I was an ODP. I felt frustrated with my insider/outsider status and the continued perception that even though I was a healthcare professional, I did not 'care' for patients. The professional hierarchy and perceived ownership of care and compassion had become a power dynamic. I felt that care practices in theatre were custodial activities, in which professional status and gender played a part. I was not alone in these feelings, as power struggles between ODPs and theatre nurses were not limited to my experience but considered an occupational norm (Anonymous 2002; Timmons and Tanner 2004; Undre et al. 2006). In an attempt to redress the balance and provide a strong female presence as an ODP, I steered my career towards education, securing a post as lecturer in July 2010.

For those ODP candidates aiming to join Cardiff University, part of the selection process was differential aptitude testing (DAT). As a member of the admissions team, I took the DAT user qualification, registering as a member of the British Psychological Society. Hence, I administered the same test I had taken 15 years previously for my own ODP selection. In 2013, when the ODP qualification became an undergraduate degree, the decision was taken to remove aptitude testing as a selection method. Therefore, ODP students are currently selected via their UCAS application (which includes their personal statement and academic achievement) and multiple mini interviews (MMIs), reflecting the same recruitment process as other healthcare programmes within the school. This gave ODP candidates the same recruitment experience as other healthcare candidates, since they were recruited based on the same value framework - the 6Cs (DoH 2012). Interestingly, at this time, Francis (2013) endorsed aptitude testing for nurse selection. As a result of my experiences as a candidate, ODP and lecturer, the use of aptitude testing as a measure of care values interested me.

Thus, I felt that aptitude testing, as an HEI VBR practice, warranted further review; this consequently became a catalyst for my doctoral studies.

Chapter 2 – Background

*2.1 **Overview of value-based recruitment (VBR) within the Higher Education Institute (HEI) setting.***

This chapter will set the scene and discuss the debates within VBR literature and the healthcare industry. In the context of aptitude testing and MMIs, the chapter will also consider the aptitudes and values deemed necessary for a career in nursing, in addition to the application, screening and selection processes of HEIs.

2.2 Value-based recruitment

VBR has gained significant academic interest since its introduction to the NHS. Whilst VBR originated in major private companies (Miller and Bird 2014), there is a dearth of literature on the application of VBR within the NHS context and the potential implications of its use in healthcare (University of Leeds 2020). VBR, or hiring for values, is also referred to as cultural or person-organisational (P-O) fit. Kristof (1996) defined P-O fit as the compatibility between people and organisations. P-O fit is considered to have two distinctions, supplementary and complementary fit. Supplementary fit is defined as an individual who enhances or possesses the characteristics of others in an environment, in which the notion of fit is based on 'sameness'. Thus, it is a model of person-to-person fit, when characteristics are comparable to a norm group (Muchinsky and Monahan 1987). Complementary fit means a deficit skill exists in an organisation, so a skill is needed to complement the characteristics of the environment (Muchinsky and Monahan 1987). Universities UK (2012, p.4) described the relationship of demand and supply between HEI, the professions and the NHS as a *"virtuous partnership"* that requires collaboration across environments. Within the VBR context, the NHS demands practitioners who display aptitudes, characteristics and values that reflect the profession and the organisation, i.e., sameness. Therefore, for HEIs to supply newly qualified practitioners who possess the values espoused as professional norms would meet the organisational needs.

2.3 Definition of values

Pattison (2020, p.22) highlights the conceptual *"slipperiness"* of the notion of values, emphasising the many synonyms for values. Values are viewed in relation to people and objects, which are context-driven, i.e., what might be valuable to some is not valuable to others (HEE 2016b). Thus the notion of values depends on their measurability (Schroeder et al. 2019, p.14). Values are also described as life goals that are important to people and guide their perceptions, judgements and behaviour (Rokeach 1973; Schwartz 1992; Schwartz 2012; Leduc, Feldman and Bardi 2015). Thus, values also have moral

connotations (Schroeder et al. 2019; Pattison and Pill 2020). Meanwhile, aspirational values are defined as ideals or goals which are sought but not yet realised (Schroeder et al. 2019; Pattison 2020, p.28). Values are also defined as the capacity or aptitude to acquire competence or skills through training (Reschly and Robinson-Zañartu 2000; Pam 2013; HEE 2016b). Aptitudes describe almost any individual psychological characteristics that can predict differences in cognitive abilities, processes, personality and emotional characteristics (Snow 1992; Pattison 2020). Personal values in this regard are broadly defined within two basic principles: values as preferences and values as principles (Parks and Guay 2009). Ravlin and Meglino (1987, p.354) described personal values as "*a person's internalised belief about how he or she should or ought to behave".* This description, however, seems to conflate values and virtues. Virtues are considered aspects of character that enable people to act appropriately within a given context, as opposed to values, which are characterised as the guiding principles, behaviours and learned beliefs which govern, regulate and moderate behaviour (Ravlin and Meglino 1987; Samuriwo 2021). Values are constructed through social interactions and role models (Meglino and Ravlin 1998), which become more stable over time (Kapes and Strickler 1975). Values change according to social interaction and exposure to new environments (Patterson et al. 2016a). Consequently, when considering values within the world of work, values as preferences indicate an individual's preference for a work environment and thus their career choice and job satisfaction. In this regard, a candidate's personal values, within the context of VBR, are inherent in their object of desire: becoming a nurse. This can guide candidates' personality traits and how they think, feel and behave during the selection process (Arnold et al. 2003; Billsberry 2007). Therefore, it is considered that values as preferences and values as principles have equal importance within the VBR context (Patterson et al. 2016a).

2.4 Nursing value frameworks

Values are described as social norms, expectations and judgements, which also bring people together in groups and allow behaviour to be predicated and conformist (Pattison 2020, p.24). Rooted within social norms, values are a collective understanding of what is good or bad and therefore what is ethically moral. Hence, social norms of nursing (i.e., caring and professional values) are sited within the discourse of professionally desirable values. In this respect, virtues are often used interchangeably with values to define the character and aspirational values which influence cultures and organisations (Schroeder et al. 2019, p.15). Professional values are considered repositories of values that identify purpose, practice and identity. They are often presented as standard and principle frameworks, or lists of values, which hold members to account (Wainwright and Pattison 2020, p.141). Within the context of this study, HEE (2016a) has established the VBRF as an

assurance that students are recruited on the basis of values aligned with those embedded within the NHS Constitution (NHS 2015a) (Table 1). Thus, within this is an assumption that compassionate care should be measured. In this context, it must also be acknowledged that whilst VBR is an HEE framework, it has diffused across the UK. Evidence suggests that some HEIs, in the rest of the UK and in England, subscribe to the 6Cs (DoH 2012) (Groothuizen et al. 2017). Therefore, whilst HEE (2016a) stresses the importance of basing the VBRF on constitutional values (NHS 2015a), this is not always the case in practice. The 6Cs (DoH 2012, p.13) are defined as a national framework of values and behaviours, which was introduced as part of a 'compassion in practice' strategy to underpin care practices. The 6Cs (2012a) incorporate values deemed essential to nursing: care, compassion, competence, communication, courage and commitment (Table 1). Many believe the 6Cs initiative was triggered by high-profile failures of care, in which nursing was described as *"not in a good place"*, and by the need *"to restore public confidence"* (Baillie 2015, p.332). The 6Cs initiative has gathered pace and is now widely accepted throughout healthcare professions and among all NHS staff (NHS England 2014; NHS 2015b). Furthermore, the 6Cs represent established values and principles inherent to nursing education and training (Willis 2015, p.14). The 6Cs initiative has also been acknowledged as underpinning strategies such as giving the 'right care' to ensure equality and reducing variation in care practices, which emphasises the conformist nature of value frameworks (NHS 2016a, p.48). However, Baillie (2015) highlights the lack of available research involving critical reviews of the 6Cs generally or within the context of VBR.

Nursing caring and professional values are determined through a national code of practice set by the professional regulator, the Nursing and Midwifery Council (NMC) (NMC 2018a; NMC 2018b). The NMC requires registrants to be suitable individuals who can demonstrate, and have the capacity to learn, the aptitudes required for nursing (Table 1) (NMC 2018a; NMC 2018b). The Royal College of Nursing (RCN), a union and a professional body for nursing and midwifery, has also established a set of nursing practice principles (Table 1) (RCN 2010). Additionally, Health Education and Improvement Wales (HEIW) (2018) recognised the impacts of VBR and, in conjunction with the NMC, has developed a set of principles that underpin recruitment and selection for pre-registration nursing and midwifery programmes in Wales (Table 1). The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), whose remit is to promote high standards of practice, education and professional development, as well as provide advice and guidance on best practice for nurses in Northern Ireland, has similarly outlined a framework of the attributes valued for a career in nursing (Table 1) (NIPEC 2014). NHS Scotland has also invested in 'Our Way' as a VBR process to ensure candidates' values align with those of the

organisation (NHS Scotland 2020). Additionally, each devolved government has also established institutional values for their respective health service (NHS Scotland 2019; NHS Wales 2019; Northern Ireland Health and Social Care Trust 2020). Consequently, in the rest of the UK, debate exists over the applicability of the values established within the NHS constitution (NHS 2015a) as a framework of values against which candidates are assessed as part of VBR. This casts doubt upon the values on which HEIs are basing their VBR processes, both inside and outside England. The extent to which this *"tsunami of values has been imposed on UK health professionals"* has also been highlighted (Gallagher 2013; Groothuizen et al. 2017, p.1071), making it difficult to negotiate the values that underpin VBR. Consequently, a complex matrix of professional value frameworks which could be considered prerequisites for recruitment emerges from the literature (Table 1). Current research illustrates a lack of consensus on which aptitudes demonstrate care and compassion and which terms describe caring attitudes (Watson 2008; Porr and Egan. 2013; Shahriari et al. 2013; Patterson et al. 2016a; Groothuizen et al. 2017). This further reflects the lack of agreement on which values should be assessed during VBR (Callwood et al. 2016; Callwood et al. 2018b), suggesting a disconnect between university selection, the profession and the healthcare industry over which values take primacy. This adds to the complexities that HEIs face in determining which values should be assessed, how best to assess them and how to recruit the 'right' candidates. Despite this, there is a belief that a common framework of values for all healthcare professions could be identified, which would thus provide a robust, reliable, valid and legally defensible VBRF (Patterson et al. 2016a, p.867; Groothuizen et al. 2017). In answer to the call of Groothuizen et al. (2017) for a common language to be established for VBR, the 6Cs (DoH 2012) have commonality across the professions, the healthcare industry and the four nations. However, it is also acknowledged that whilst the 6Cs (DoH 2012) offer commonality between healthcare organisations and the nursing profession, the context and language within the values statements differ. The values statements endorsed by the professions refer to personal values, attributes and traits, that is, supplementary fit and sameness. By contrast, organisational values refer to quality and service delivery, that is, complementary fit, reflecting the needs of the employer. Hence, what is considered 'sameness' in the care values and professional values held by the professions might conflict with the demands and 'fit' of the healthcare industry.

Table 1 Professional and organisational value frameworks.

Professional/ organisational body	Classification
NHS Constitution (NHS 2015a).	**Value framework:** **Working together for patients:** Patients come first in everything we do. **Respect and dignity:** We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. **Commitment to quality of care:** We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience right every time. **Compassion:** We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. **Improving lives:** We strive to improve health and wellbeing and people's experiences of the NHS. **Everyone counts:** We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind.
Nursing and Midwifery Council (NMC) (NMC 2018a, NMC 2018b)	**Professional standards of practice and behaviour for nurses and midwives (The 4Ps):** **Prioritise people:** You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged. **Practise effectively:** You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice. **Preserve safety:** You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate. **Promote professionalism and trust:** You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.
Compassion in practice (DoH 2012)	**The 6Cs** **Care:** is our core business and that of our organisations, and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them, consistently, throughout every stage of their life. **Compassion:** is how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and is central to how people perceive their care. **Competence**: means all those in caring roles must have the ability to understand an individual's health and social needs and the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

	Communication: is central to successful caring relationships and to effective team working. Listening is as important as what we say and do and essential for "no decision about me without me". Communication is the key to a good workplace with benefits for those in our care and staff alike. **Courage:** enables us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working. **Commitment:** to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients, to take action to make this vision and strategy a reality for all and meet the health, care and support challenges ahead.
Royal collage of nursing (RCN 2010)	**Principles of nursing practice:** **Principle A:** Nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally. **Principle B:** Nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law. **Principle C:** Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care. **Principle D:** Nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care. **Principle E:** Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about. **Principle F:** Nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care. **Principle G:** Nurses and nursing staff work closely with their own team and with other professionals, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome. **Principle H:** Nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.
HEIW (2018)	**Commitment and courage:** Applicants are expected to demonstrate a rationale for wanting to enter their chosen course and future profession/ field of nursing. Demonstrates good reasons for entering nursing/ midwifery by providing evidence of research into nursing/ midwifery as a career, the Bachelor of Nursing/ midwifery programme, and the role of the nurse/midwife. **Communication and working with others:** Applicants are expected to demonstrate effective verbal and non-verbal communication and the ability to relate to others during the selection process Is able to communicate effectively in writing within the UCAS application and verbally with the selection panel; is able to articulate answers, respond appropriately and recognise the needs of others recognising and displaying appropriate non-verbal behaviour. **Courage, commitment, and resilience:** Applicants are expected to be able to demonstrate that they understand the significant personal commitment required when undertaking a degree in nursing/midwifery. Demonstrates evidence of exploring the requirements for study which leads to registration with the Nursing and Midwifery Council; to include understanding the need for theory and practice learning, the time requirements of the course to include placements to cover the 24 hour /seven day provision of care.

	Competence, compassion, empathy, care, communication and commitment to quality care: Applicants are expected to be able to demonstrate they have an understanding of the role of the nurse in relation to the field of nursing to which they are applying. Demonstrates an understanding of the role requirements of the nurse/midwife and is able to draw on experiences to demonstrate the qualities and values which underpin care. **Commitment and resilience:** Applicants are expected to be able to demonstrate that they have considered their personal circumstances to be able to commit to the programme of study to which they have applied taking into account the need to balance theory and practice requirements. Gives clear indication that they understand the nature and the implications of their chosen programme. Is motivated towards programme choice and this is demonstrated in the personal statement and selection event. **Competence, compassion, empathy, care, and communication:** Applicant are expected to be able to demonstrate their preparation for the application process and the selection event by being informed of topic issues relating to the programme of study/field to which they are applying Is able to provide an informed account of a current professional issue demonstrating a clear understanding
The Northern Ireland Practice and Education Council (NIPEC) for Nursing and Midwifery (2014)	**Attributes and values for a career in nursing:** **Person-Centredness:** Self-awareness, Understanding, Openness, Interpersonal communication skills including listening, Considerate, Collaborative, Concern for others, Emotional intelligence, Care and compassion, Empathy, Intuitive, Respectful, Awareness of perceptions of others. **Commitment to Personal Development:** Self-awareness, Commitment, Reflective, Willingness to learn and develop, Perseverance, Self-confidence, Desire for self-improvement **Accountability:** Self-awareness, Responsibility taken for actions and decisions, Truthful, Self-confidence, Prioritise and manage time, Interpersonal, communication skills, Situational awareness, Conscientious, Self-reliance. **Integrity:** Transparency, Honesty, Understanding, Sincere, Courage to challenge **Trustworthiness:** Self-awareness, Respectfulness, Interpersonal communication Skills including listening, Emotional intelligence, Reliability, Self-discipline.
NHS Scotland (2018)	**Values shared across Scotland's Health Service** Care and Compassion; Dignity and Respect; Openness, Honesty & Responsibility; and Quality and Teamwork

2.5 The recruitment processes

All HEI admissions policies are governed by the Schwartz principles, which outline fair admissions processes. These principles include *"support, transparency, selection for merit, potential, diversity, reliability, validity, relevance, minimising of barriers and professionalism"* (Schwartz 1992; Admissions to Higher Education Steering Group 2004, p. 32; Schwartz 2012). In addition to the Schwartz principles, the Quality Assurance Agency (QAA), which safeguards the standards and quality of UK higher education, stated that HEI recruitment practices should also support the selection of students who can complete programmes (QAA 2018, p.3). Thus, HEIs should carefully consider how desirable characteristics can be demonstrated and how to ensure selection methods are fit for purpose. Recruitment practices for undergraduate healthcare programmes are predominantly processed via the Universities and Colleges Admissions Service (UCAS). UCAS is an online admissions portal

that provides a centralised admissions service for all UK university admissions (UCAS 2019a). Applications through UCAS typically consist of the applicant's university choice, personal statement, academic achievements and references (UCAS 2019a). Personal statements, as autobiographical submissions forming part of the UCAS application process, often provide recruitment teams with insights into candidates' motivation (Patterson et al. 2016a; Patterson et al. 2016b). Personal statements, however, are considered low in reliability, as candidates present themselves in a way they feel is favourable or expected, rather than a true reflection of their values. Therefore, such statements are susceptible to coaching and plagiarism (Patterson et al. 2018). Student preparedness for university is generally assessed on academic achievement, which is viewed as a universal feature of selection due to its high level of predictive validity (Patterson et al. 2018). However, there are concerns that the discriminatory power of prior academic achievement is diminishing with the increase in the number of applicants achieving the top grades (Patterson et al. 2016b). If the candidate fulfils the entry criteria set by the university and for the programme of study, they can potentially be invited to an interview, which completes the selection process.

2.6 Aptitude testing

Francis' (2013, p.1695) recommendation 188 states:

> *Consideration should be given by the NMC to introducing an aptitude test to be taken by aspirant registered nurses prior to entering into the profession to explore the candidate's attitude towards caring, compassion and other necessary professional values.*

As a result, aptitude testing for nurse candidates has gained a resurgence in the VBR literature. HEE (2016b) offered two exemplar aptitude tests as part of the VBRF, the Cambridge Personality Styles Questionnaire (CPSQ) and the Nurse Match Instrument (NMI), with the latter used in this study. Aptitude tests are designed to provide objective measurements for predictions of educational or occupational aptitudes by measuring qualities such as personality, beliefs, values or motivations (Kaplan and Saccuzza 2009; American Psychology Association 2019; British Psychological Society 2019). Aptitude tests have been used for university recruitment and selection for many years (Cattell 1928; Urbina 2011). Against a backdrop of nursing education, professional reform and the establishment of the first professional register (Shepherd 1949; London Metropolitan Archives 2008; Pickett 2017), aptitude testing as a selection method for nursing has been used since the 1930s as a tool to enhance nurse retention (Habbe 1933). It also aided mass recruitment to the newly established NHS in the 1950s (Petrie and Powel 1950). Aptitude testing, and specifically the Dennis Childs (DC) test, was also used for selection and screening purposes in the early

2000s, the aim being to increase the number of applications to nursing and allied health professional courses. The DC test was viewed as an alternative recruitment method that encouraged applicants from outside the traditional academic entry route (Elkan and Robinson 1995; Rodgers et al. 1995; Houltram 1996; Robinson et al. 2006). However, the DC test encountered some criticism since it was viewed as creating barriers for those who were not part of the norm, such as ethnic minorities and those living below the poverty line (Elkan and Robinson 1995; Rodgers et al. 1995; Houltram 1996; Robinson et al. 2006). Aptitude testing remains controversial as a university selection method, mainly due to concerns involving bias, identity verification, coaching, socially desirable responses and cost (Patterson et al. 2012; Smajdor 2013; Smythe 2015). However, some evidence suggests students selected on aptitude testing are more able and better motivated to study (Kraft et al. 2013). Patterson et al. (2016b) also reported that coaching has little effect on aptitude testing as aptitudes remain stable over time. Students' acceptance of aptitude testing as a selection method is mixed: some studies suggest students view aptitude testing as fair (Patterson et al. 2016b) but others report that students think it is a barrier to admissions, difficult and irrelevant (Kelly et al. 2018). Within these tensions is the suggestion that if testing for care and compassion is introduced, candidates could modify their behaviour by 'faking good', thus presenting their values positively and imitating care and compassionate behaviours to favour test results (Griffin et al. 2004; Bradshaw 2009; Smajdor 2013; HEE 2016b; Patterson et al. 2016a; Groothuizen et al. 2017). However, it must also be stressed that most VBR methods are considered susceptible to coaching and candidates providing socially acceptable responses (Patterson et al. 2016a; Groothuizen et al. 2017). Interestingly, Husbands and Dowell (2013) report that students who want to perform well yet seek coaching or fake values also study hard for exams. This suggests that aptitude testing can contribute to predicting distal outcomes of recruitment practices if used as a VBR tool. However, concerns have also been raised that aptitude testing for the selection of healthcare candidates could mean the loss of potentially good candidates as they have yet to be taught the skills required to become caring practitioners (Eley et al. 2012; Andrade and George 2013). This calls into question the legitimacy of aptitude testing as a selection method due to the dynamic nature of attitudes and their expression through values (Conard 2006; Ferguson and Lievens 2017).

2.7 Multiple mini interview (MMI)

Multiple mini interviews (MMIs) have gained significant popularity since their conception as a healthcare recruitment tool (Eva et al. 2004; Knorr and Hissback 2014; Patterson et al. 2018; Yusoff 2019). An MMI is a form of objective structured clinical examination (OSCE) interview, in which the traditional interview is divided into several small interviews, normally

referred to as stations. The number and duration of stations differ depending on the university but each MMI generally has between six and ten stations, lasting about five to ten minutes in duration. Each station requires candidates to demonstrate an understanding of a particular skill or aptitude. Candidates are normally given time to prepare between stations, the length of which varies between HEIs. HEE (2016a, p.6) has endorsed MMIs as an effective method for recruiting for values as part of the VBRF. However, MMIs are considered a measure of soft skills, such as interpersonal skills, professionalism and ethical or moral judgements, not values (Eva et al. 2004 p.316; Rees et al. 2016; Callwood et al. 2018a). MMIs are also open to subjectivity, with little evidence to support psychometric properties as a measure of a candidate's values (Eva et al. 2004, p.316; Pau et al. 2013; Sebok et al. 2013; Rees et al. 2016; Callwood et al. 2018a). It has also been suggested that MMIs do not correlate with any traditional admission tools such as interviews or grade point average (Pau et al. 2013; Patterson et al. 2016b, p.46; Reese et al. 2016, p.1170). Callwood et al. (2018a) also identified thirty-two domains assessed through MMIs for healthcare selection purposes. In this regard, HEE (2016a, p.94), whilst providing several exemplar case studies for MMI stations as part of the VBRF, failed to provide guidance on how many stations should be included and which values should be measured as part of MMIs for selection purposes (Knorr and Hissback 2014). Alongside this criticism of the lack of guidance, and the perceived need for MMIs to align with institutional values, there has been a call for a 'blueprint' of non-cognitive attributes that outlines a core set of values mapped against VBR practices (Patterson et al. 2016a, p.867; Rees et al. 2016, p.449; Reiter and Roberts 2018).

The popularity of MMIs could be apportioned to cost, as they have proven to be cost-efficient in comparison to traditional interviews and psychometric testing (Pau et al. 2013; Sebok et al. 2013). MMIs also offer face-to-face meetings, enabling interviewers to explore candidates' responses in greater depth, in addition to offering candidates an opportunity to explore their 'fit' with the HEI (Burgess et al. 2014). MMIs do not appear to be biased against an applicant's age or gender, or those from lower socio-economic groups, but do appear to disadvantage rural applicants (Rees et al. 2016). MMIs are perceived as a positive experience for the interviewee as they are seen as fair and transparent (Eva et al. 2004; Pau et al. 2013; Patterson et al. 2016b). However, Rees et al. (2016) report that whilst some candidates found MMIs stressful, they were still preferable to traditional interviews. Evidence suggests the optimum number of MMI stations to increase reliability is between seven and twelve, with each station requiring a duration of between six and eight minutes (Rees et al. 2016, p.447). The duration of stations is an important consideration as it gives candidates time to talk without being pressured to talk quickly, and assessors have

sufficient time to assess candidates (Rees et al. 2016). Meanwhile, the time between stations gives candidates a chance to recover from perceived poor performance in previous stations, thus starting the next station with a clean slate (Eva et al. 2004; McAndrew and Ellis 2013). The concept of assessors within VBR has also gained attention in the literature, which primarily focuses on academic and clinical staff (Patterson et al. 2016a; Rees et al. 2016; Patterson et al. 2018). Assessors also report MMIs to be enjoyable and fair, though concerns remain over how stressful MMIs are for candidates (Rees et al. 2016). Assessors also think MMIs facilitate accurate evaluations of candidates since the scoring systems enable assessors to differentiate between candidates; therefore, MMIs reduce their levels of anxiety about decision making (Rees et al. 2016). Exploring assessment teams more broadly reveals a drive to introduce service users to university recruitment practices (Tew et al. 2004). Service users are perceived as focusing more on values than striving for academic excellence or promoting values based on the patient's experience. Consequently, service users are perceived as emphasising caring values in addition to professional values in terms of their expectations of students whilst promoting a strong sense of social accountability (Tew et al. 2004; Griffiths et al. 2011; Kelly et al. 2018).

Chapter 3 - A scoping review of the literature

*3.1 **Chapter overview***

This chapter commences with a detailed account of the search strategy. The key themes that arose from the literature, that is, values, psychometric non-cognitive domain testing, multiple mini and face-to-face interviews and service users as assessors in nursing recruitment, are then explored. This is followed by a conclusion and summary of the literature findings. The chapter concludes by identifying gaps in the literature and describing the aims and objectives of this research.

3.2 Search strategy

A scoping review of the literature was adopted for this study. Scoping reviews are increasingly utilised within nursing research (Davis et al. 2009; Courtenay et al. 2013; Khalil et al. 2016; Munn et al. 2018). The main strengths of scoping reviews are their ability to *"extract the essence"* of diverse bodies of evidence (Davis et al. 2009, p.1386), whilst they also provide a framework for collecting and organising key literature and an overview of the existing literature (Courtenay et al. 2013, p.2). Scoping reviews facilitate an examination of the extent and range of the research activity within a particular field of study and identify the knowledge gaps whilst maintaining a systematic approach (Arksey and O'Malley 2005). The framework developed by Khalil et al. (2016, p.120) for scoping reviews was utilised to identify and review the literature relevant for inclusion in this study (see Table 2 for a description of the different stages of this framework).

Table 2 Khalil et al (2016) Proposed methodology for scoping reviews

Stage 1	Identify the research question	Clarifying and linking the purpose and research question
Stage 2	Identify relevant studies	Using a three-step literature search, balance feasibility with breadth and comprehensiveness
Stage 3	Study selection	Careful selection of the studies
Stage 4	Presenting the data	Charting the data in a tabular and narrative format where applicable
Stage 5	Collating the results	Identifying the implications of the study findings for policy, practice, or research

The Khalil et al. (2016, p.120) framework for scoping reviews aligns with IPA as it adopts an iterative process whilst ensuring a comprehensive approach to the literature reviewed. This approach to the literature review is conducive to IPA as in this context the literature review can be short and more evaluative, as the aim is to introduce the reader to the topic under review and provide information about the strengths and weaknesses of the key academic contributions (Smith et al. 2009a, p.43).

3.3 Stage One - Identify the research question

The aim of the scoping review was to provide an understanding of the body of knowledge surrounding the topic area of VBR relevant to the research question:

> *How do student nurses perceive value-based recruitment in the context of their personal constructs of caring values and professional values?*

The objective of the scoping review was to explore the literature relating to:

1. Undergraduate healthcare students' perceptions of caring and professional values within the context of VBR.
2. HEI VBR practices for undergraduate healthcare recruitment.
3. Healthcare undergraduate candidates' experiences of HEI VBR practices.

As indicated by Khalid et al. (2016), inclusion and exclusion criteria, with regard to studies included in a review, provide a guide for the topic and a framework on which to base decisions about which literature to include. The inclusion and exclusion criteria for this review are outlined below:

3.3.1 Inclusion criteria

- All research exploring HEI VBR practices, i.e., psychometric testing and multiple mini interviews (MMI) within healthcare recruitment in the United Kingdom (UK).
- Research involving nursing value constructs, i.e., compassion, caring and dignity, as part of undergraduate recruitment.
- Publications in the English language only.
- Papers published after 2013.

3.3.2 Exclusion criteria

In this study, which focuses on the HEE VBRF (2016a) in the UK context, the VBR phenomenon is considered a direct result of the Francis (2013) review; therefore:

- All publications from before 2013 were excluded from the review.
- All international research was excluded from the review.

3.4 Stage two – Identifying the relevant studies

Khalid et al. (2016) identified a three-step approach to the literature search in order to balance feasibility, breadth and comprehensiveness. The use of these steps in the context of this study is outlined below.

3.4.1 Step one and two - identifying search terms

As outlined by Khalid et al. (2016, p.120), the first step of the search focused on identifying search terms. Initially, the search terms included those denoting care and professional values. These were taken from two sources: a) the English Department of Health document Compassion in Practice (DoH 2012), which identifies 'The 6Cs': care, compassion, courage, communication, commitment and competence; and b) the Northern Ireland Practice and Education Council (NIPEC) for Nursing and Midwifery Gateway to Nursing (2014) attributes and value themes for a career in nursing: person-centredness, accountability, trust, integrity and teamwork. This first step of the review failed to provide a focused search of the phenomena under review due to the breadth of literature available. This reflected the complex concept of care values and the lack of consensus within the VBR literature as to which values demonstrate and describe caring and professional attributes (Callwood et al. 2016; Groothuizen et al. 2017; Pattison and Pill 2020). Consequently, a pragmatic approach to the search terms was taken by removing specific value terms. This provided a balance between specificity when identifying the relevant evidence but remained sensitive to, and focused on, the phenomena under review; thus, no irrelevant sources or evidence were identified (Boland et al. 2017, p.65). The second step of the search identified the final search terms (see Table 3), which provided a focused search encompassing the emergent literature on VBR. It is acknowledged that whilst the search terms are short and have few synonyms, they were reflective of several systematic literature reviews (Patterson et al. 2016a; Patterson et al. 2016b; Patterson et al. 2016c; Rees et al. 2016; Groothuizen et al. 2017; Callwood et al. 2018a; Cunningham et al. 2018; Kelly et al. 2018; Yusoff 2019).

Table 3 Final search terms

Perspective	Health professions	Health Occupation* or Nurs* or midwife* or Allied Health Profession* or Healthcare or health care AND
Variable 1	Selection	Student selection* or Student recruit* or universit* admission* test* AND
Variable 2	MMIs and psychometric tests	Multi* Mini Interview* or MMI* or Psychometric test* or Psychological test* or Aptitude test* or personality measure* or personality test* AND
Variable 3	Value based recruitment	value* based recruit* or VBR
Complete search string	Health Occupation* or Nurs* or midwife* or Allied Health Profession* or Healthcare or health care AND Student selection* or Student recruit* or universit* admission* test* AND Multiple Mini Interview* or MMI* or Psychometric test* or Psychological test* or Aptitude test* or personality measure* or personality test* AND value* based recruit* or VBR	

3.4.2 Step three - Locating and selecting relevant literature

As stated, the scope of the search was specific, sensitive and focused, to account for the abundance of literature. To ensure a breadth of literature was scrutinised, several databases were explored (Diagram 1). Papers identified during the refinement of the search strategy were also included in the review (as shown in Diagram 1). As indicated by Khalid et al. (2016), the third step included citation chaining (i.e., the tracing of reference sources in the retrieved articles backwards and forwards in time to identify other literature sources relevant to the topic area) of the final articles included in the review to complement the database search, though this failed to locate any further studies. The search approach was also scrutinised by a Cardiff University systematic reviewer. To maintain an up-to-date and timely retrieval of literature relevant to the phenomena of interest, search alerts were established on key databases. These were EBSCO, Scopus, CINAHL, MEDLINE and Web of Science. The searches were performed at regular intervals, with email alerts sent to highlight newly published evidence.

3.5 Stage three and four - study selection and presenting the data

Diagram 1 presents a modified PRISMA flow chart summarising the search strategy process, the bibliographic databases and the associated results. The papers' characteristics, i.e., author, year of publication, setting, aim, method, population/sample size and results, are presented in Table 4. Unlike systematic reviews, scoping reviews do not focus on appraisal and methodological rigour (Khalil et al. 2016). Scoping reviews, however, are valuable when attempting to understand emerging concepts, such as VBR, as they can provide a wide spectrum of knowledge and evidence (Khalil et al. 2016). Nevertheless, as illustrated by Munn et al. (2018, p.6) and Smith et al. (2009a, p.43), whilst critical appraisal is not mandatory as part of a scoping review, authors can choose to identify biases, strengths and limitations. Therefore, a light-touch critical appraisal was undertaken for each article to add a measure of criticality.

Diagram 1 Data base search strategy - modified PRISMA flow diagram

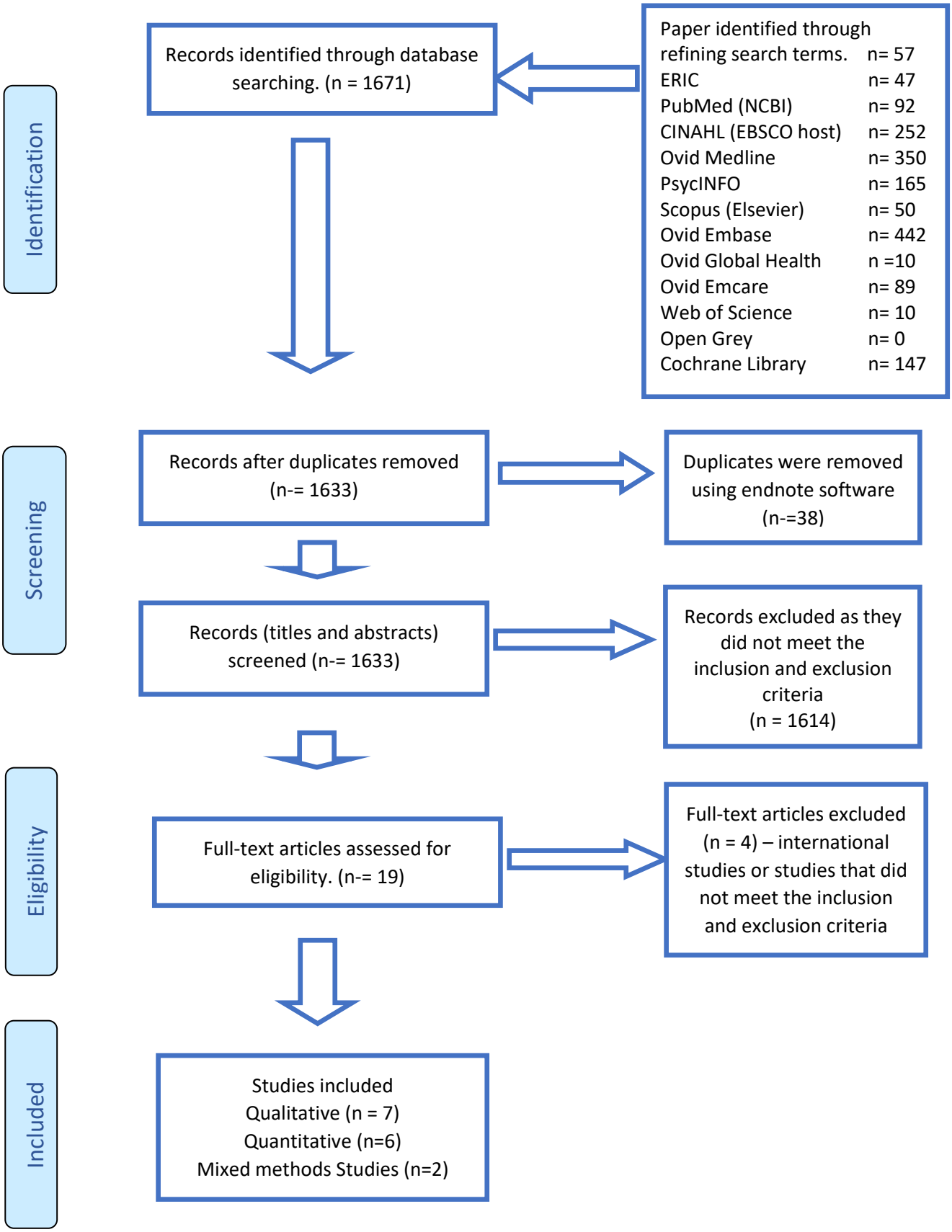


Table 4 Screened papers included in literature review.

Author	Title	Aim	Setting	Method	Sample	Results/Outcomes
1. Callwood et al. 2018b	The reliability and validity of Multiple Mini Interviews (MMIs) in valued based recruitment to nursing, midwifery and paramedic practice programmes: findings from an evaluation study	To evaluate the reliability and predictive validity of MMIs using end of year one practice outcomes of adult, child, mental health nursing, midwife and paramedic student.	University of Surrey, Guildford, Surrey. United Kingdom	Cross discipline evaluation study – Data collected via end of year one practice outcomes and MMI scores recorded on admission.	The data was collected in two streams. Stream a) participants included 101 midwifery students across two cohorts. 47 students from 2015 cohort and 54 students from 2015 cohort. Stream b) included 281 participants, 180 adult, 33 child and 34 mental health nursing and 34 paramedic practice students.	Significant correlations are reported between midwifery applicant's MMI scores and end of Year One practice outcomes. No significant correlations were found between MMI score and practice outcomes measured by mentor grading. Predictive reliability and validity is improved with a seven station model is used.
2. Callwood et al. 2017*	The 'values journey' of nursing and midwifery students selected using multiple mini interviews; Year One findings	To explore how adult, child and mental health nursing and midwifery students, selected using multiple mini interviews, describe their 'values journey' following exposure to the clinical practice environment.	University of Surrey, Guildford, Surrey. United Kingdom	Longitudinal Cross discipline evaluation study – Data collected through semi structured focus group interviews	42 students (8 adult, 8, child, 9 mental health and 17 midwifery)	Participants described a 'values journey' where their values (communication, courage and wanting to make a difference) were both challenged and retained. Participants also acknowledged the 'courage it takes to use values'; 'reality of values in practice' and 'need for self-reflection on values'. The authors concluded that the students 'values journey' may begin early in a healthcare student's education and that students needed to be supported by both the universities and clinical practice. As a result values incorporated in VBR should be continually evaluated for fitness for purpose.
3. Callwood et al. 2019*	The 'values journey' of nursing and midwifery students selected using multiple mini interviews; year two findings	To explore how adult, child, mental health nursing and midwifery students describe their 'values journey' after completing their second year following exposure	University of Surrey, Guildford, Surrey. United Kingdom	Longitudinal Cross discipline evaluation study – Data collected using semi structured focus group interviews	The authors followed 28 of the original 42 participants from the reported year one findings (3 adult, 6 child, 3 mental health, 16 midwifery)	Students were more confident their values which were influenced by knowledge and skill in relation to guidelines and procedures as they considered themselves more part of a team. Students felt more courageous when practicing their own values which related to integrity and advocacy. Clinical skill compromised the provision of compassionate care. It was reported that compassion, empathy, courage, communication and competence were still deemed important by the students. The authors reported that the students were more negative about their colleagues with some starting to attribute the bitterness of their colleagues to personality traits in year two. However, mentors were considered essential.

		to the clinical practice environment.				
4. Callwood et al. 2020*	The predictive validity of Multiple mini interviews in nursing and midwifery programmes: year three findings from a cross-discipline cohort study	To examine the predictive validity of MMIs using end of programme clinical and academic performance indicators of pre-registration adult, child, and mental health nursing and midwifery students.	University of Surrey, Guildford, Surrey. United Kingdom	Longitudinal Cross discipline evaluation study – Data collected included aggregate mark of overall clinical performance, academic performance measured by dissertation mark and MMI scores.	225 participants (adult 120, child 32, mental health nursing 30 and midwifery 43).	The authors reported that students with high admission MMI scores performed better in practice irrelevant of either the 6 or 7 station model of MMI. However this was not reflected in academic attainment.
5. Heaslip et al. 2018	Service user engagement in healthcare education as a mechanism for value- based recruitment: An evaluation study	To evaluate the inclusion of service users in VBR.	Bournemouth University, United Kingdom	Evaluation case study – Data collected via online questionnaire, focus groups and interviews.	274 (42% response rate) of nurse candidates responded to an online questionnaire. 9 service users took part in focus groups. 2 service users took part in telephone interviews. 35 surveys were completed, 15 by clinical nurses and 20 by academic staff (35% response rate)	Service users reported looking beyond candidates' academic ability to focus on what they wanted from nurses. Academics and practitioners saw service users as focused on the caring compassionate aspect of nursing. Candidates saw service user involvement as adding "a human dimension" (p. 109). Service users felt working together was essential, giving them a voice as advocates for vulnerable patients and contributing to the care services. Service users also reported an emotional and physical cost to taking part, but it was felt to be worth it. Academics and practitioners felt service users provided a more rounded approach to the interview process, whilst candidates thought that service users offered an alternative perspective to the interview. Service users were seen as active partners integral to the process rather than passive recipients of care and candidates considered user involvement in VBR to be indicative of a true partnership. By contrast, academic staff and practitioners, although mostly supportive of some further service user involvement in the VBR process.
6. Husbands et al. 2015	Evaluating the validity of an integrity-based situational judgment test for	To explore the psychometric properties of situational judgements tests	Dundee medical school United Kingdom	Evaluating the validity of an integrity-based situational judgement test for medical	198 medical school candidates from 2012/13 admissions cycle. (87 male, 111 female)	Female participants scored significantly higher than males. Statistically significant correlations between SJT scores and personal dimensions by order of significance these relationships related to honesty-humility (integrity), conscientiousness, extraversion, and agreeableness dimensions. Significant statistical correlations were also

	medical school admissions	designed to measure the construct of integrity.		school admissions – Data collected through SJT scores, MMI scores, HEXACO-PI acceptability questionnaire and UKCAT scores.		seen between SJT and MMI scores. Participant identified that SJT were realistic and relevant to their role as medical students though this might not be quite so obvious from an outsiders point of view.
7. Kneafsey et al. 2015	A qualitative study of key stakeholders' perspectives on compassion in healthcare and the development of a framework for compassionate interpersonal relations	To explore perspectives on 'compassion' in the health care context.	Department of Nursing, Midwifery and Health Care Practice, Coventry University, Coventry;	Pragmatic qualitative approach. Data collection via 9 focus groups.	45 participants. 12 healthcare students, 11 university staff, 10 clinical staff, and 9 members of the public.	Compassion and communication were considered essential core attributes for the nurse. Compassion was considered an innate emotion which connected to feelings of empathy and altruism which was a force for action. Students considered communication skills and behaviours as core in the nurse patient relationship. Engagement and interpersonal interaction between nurse and patient were also viewed as key to compassionate care. Insufficient time for care tasks was seen as a reason for the loss of compassionate behaviour. Resulting in subsequent burnout and care without engagement. Compassionate care in practice was viewed as needing strong leadership, positive role modelling and education.
8. Lievens et al. 2016	Widening access in selection using situational judgment tests: evidence from the UKCAT	The aim of the study was to explore demographic variables of socioeconomic status, ethnicity, and gender with the use of situational judgement tests as part of the UK Clinical Aptitude Test (UKCAT).	UK National study including 2 cohorts of UKCAT data provided by Pearson VUE	Retrospective cohort study - Data collection via UKCAT consortium - SJT scores, UKCAT scores, socioeconomic status, ethnicity and gender.	All UK medical and dental school applicants in: 2012 cohort, n= 15581 2013 cohort, n= 15454	Lower socio economic status applicant are favoured by SJT in comparison with cognitive tests. Both SJT and cognitive tests favour white candidates. Males do better at cognitive test were females perform better in SJT. SJT used in conjunction with cognitive tests results select more female candidates and those from lower socio economic backgrounds
9. McNeill et al. 2019.	Developing nurse match: A	To develop the Nurse Match instrument as a	University of Ulster, Newtownabbey,	Case study-based qualitative process with	63 first year nursing students.	Medium to strong statistically significant relationship between participant value themes. There was also a week correlation between accountability assessed through MMI and person-

	selection tool for evoking and scoring an applicant's nursing values and attributes	tool to assess candidate's nursing values, their meaning, relative importance and emotional significance.	UK School of Nursing and Midwifery, Queen's University Belfast, Belfast, UK	quantified output - Data collected through aptitude testing – the Nurse Match Instrument		centeredness in the NMI, though ultimately there was little or no relationship between equivalent NMI objective assessment and the MMI subjective assessment. As a result the NMI and the MMI do not seem to be measuring the same values. The authors reported the participants view of undertaking the NMI as a positive experience, found it interesting to complete, easy to understand and seen as a different experience. However 26% found the format puzzling with some 20%, feeling the even though the values were valid to nurses in training.
10. Mirghani et al. 2019	The factors that count in selecting future dentists: sensorimotor and soft skills	To evaluate what skills and abilities are assessed during MMIs and explore how these map on to the requirements of dental practice	School of Dentistry, University of Leeds, West Yorkshire,	Retrospective factor analysis – Data collected via scores from a 10 station MMI.	239 undergraduate UK dental school applicants.	Analysis revealed that this assessment approach captured two fundamental underlying traits. The first factor captured scores on six stations that could be labelled usefully as a 'soft skill' factor. The second captured scores on four stations that could be described usefully as a 'sensorimotor' factor.
11. Rouse and Torney. 2014	Service user and carer involvement in pre-registration student selection	To evaluate the involvement of service users and carers in student selection	Institute of Health and Society, University of Worcester, Worcester.	Process evaluation – Data collected via online questionnaire	56 (29.63%) responses from 189 participants invited to take part in the survey (4 services users, 5 practitioners, 13 lecturers and 34 enrolled students).	Service users and carers were viewed as appropriate and beneficial to candidate nurse selection. Though candidates view was split in this regard as it made some apprehensive. Despite the authors also report concerns about how and when services users should be involved within the selection process. They conclude that service users and carers have an important role within recruitment.
12. Snowden et al. 2018	Emotional Intelligence and Nurse Recruitment: Rasch and confirmatory factor analysis of the trait emotional intelligence questionnaire short form	To examine the relationship between baseline emotional intelligence and prior caring experience with completion of pre-registration nurse and midwifery education.	School of Health and Social Care, Sighthill Campus, Edinburgh Napier University, Edinburgh, UK	Prospective longitudinal study - Data collection Trait Emotional Intelligence Questionnaire-short form (TEIQue-SF) and Schutte's 33-item Emotional Intelligence Scale (SEIS).	938 participants of which 876 were nurses (adult, child, mental health and learning disabilities) and midwives with 68 computing students as a control group.	Five items in the questionnaire that related to social connectivity were answered more positively by female respondents than their male counterparts. Which accounted for the gender difference in response to the questionnaire. Nurses who completed their programmes of study scored significantly higher for emotional intelligence and social connection. Though there was not any statistically significance between previous care experience and nurses completing their program of study. Therefore highlighting the potential for gendered selection bias if social connectivity is measured as a component of VBR.

13. Taylor et al. 2014	A national study of selection process for student nurse and midwives	Gain an understanding of key stakeholder views and perceptions of recruitment, selection and retention of nurses and midwives to review existing models across HEIs in Scotland.	Scottish universities	Multiple case study. data collected through questionnaires and focus groups.	97 participants (lecturers, clinical staff and student nurses) completed the questionnaire. Six admission tutors took part in individual interviews. 107 participants (lecturers, clinical staff, student nurses and experts in recruitment, selection and retention) participated in focus groups.	A high standard of literacy was perceived as essential entry criteria as judgments were able to be made on candidates' preparedness. However, some concerns were raised in relation to literacy testing for applicants with dyslexia, consistency of marking, and informing candidates they had failed. Students felt that literacy assessments enabled them to show interest, aptitude and understanding of the profession, whilst some found it stressful. Numeracy tests were also viewed by participants as valid and reliable, though their need was questioned in light of prior achievement i.e., maths qualification as a university entry requirement. Students, despite seeing the relevance of numeracy testing, viewed them as stressful because of exam conditions. Face-to-face interaction with candidates was deemed necessary by assessors to make effective selection decisions. Assessors viewed group interviewing as less stressful, particularly facilitated assessment of communication skills, team working and maturity of the candidates. Assessors also considered the group interview facilitated gaining an overview of candidates' personality, values and principles. However in opposition, some participants expressed difficulty in determining motivation for joining the program of study as it challenged quieter candidates *"to sell themselves"* (p.1158). Students perceived group interview harder to prepare for as pre-selection information was vague providing little useful information. Analysis also revealed that staff felt that there was a lack of ongoing training for purpose of selection, which they considered important. The use of criteria and scoring systems and decision making, was seen as subjective and intuitive. It was also found that candidates, as well as the interview panel, made judgements about the program, profession and university suitability, providing affirmation, and vindication of their career choice.
14. Traynor et al 2018	The Multiple Mini Interview for admission to nursing – male perspectives	To gain perspectives of male nurse candidates recruitment experiences of multiple mini interviews.	Queen's University Belfast	Qualitative methodology using a thematic framework - Data collected via focus groups	Eight male nurse students	Participants viewed MMIs as stressful with some stations creating more stress than others. Findings also suggested that male candidates were aware of their gender as an influential factor during the MMI when seeking entry to a female dominated profession. However, they perceived age and experience as being of greater significance. Being interviewed by male staff was viewed as comforting.
15. Waugh, et al. 2014	Towards a values-based	To identify registered,	Napier University,	Online survey	502 participants.	7 highest ranking attributes for both groups were honesty, trustworthiness, communication, listening, patience and

	person specification for recruitment of compassionate nursing and midwifery candidates: A study of registered and student nurse' and midwives' perceptions of prerequisite attributes and key skills	student nurse and midwives' perceptions of key skills and attributes for nursing and midwifery candidates.	Sighthill Campus, Edinburgh,		55% (n = 276) of participants were registrants and 45% (n = 226)	tactfulness, sensitivity and compassion, teamwork, seeking and acting on guidance. Literacy, numeracy, multitasking, teaching, reasoning and IT competence were considered less important. Practice educators ranked knowledge, seeking guidance, and communication higher than the median rankings. Students ranked initiative, knowledge and insight lower than registrants. With Managers also rating knowledge and experience highly.
* Please note Callwood et al (2018b) is an initial evaluation study, which was proceeded by Callwood et al 2017, Callwood et al 2019 and Callwood et al 2020 who report their findings at years one, two and three of a longitudinal study.						

3.6 Literature review themes

In line with the research question, the literature review aimed to establish an emerging picture of VBR within the UK setting. Despite the disparate range of articles, with the majority focusing on distal outcomes of VBR, it was possible to identify commonalities within the literature that focused on perceptions of nursing values, HEI VBR practices and service users as part of the recruitment team. These themes were:

- Theme one: Values
- Theme two: Psychometric non-cognitive domain testing
- Theme three: Multiple mini and face-to-face interviews
- Theme four: Service users as assessors in nurse recruitment

Each theme is discussed below, followed by a summary of the key findings of the literature.

3.6.1 Theme one: Values

Four studies examined perspectives of values as part of VBR. These were Callwood et al. (2017), who explored nursing and midwifery students' description of their values after their exposure to the clinical practice environment; Callwood et al. (2019), who explored nursing and midwifery students' values after they had completed their second year of study; Kneafsey et al. (2015), who investigated stakeholders' perspectives on compassion; and Waugh et al. (2014), who reported on attributes and skills deemed essential in nursing.

Callwood et al. (2017) detailed the year one findings of a longitudinal cohort study exploring how nursing and midwifery students described their 'values journey' following their exposure to the clinical practice environment. The researchers arranged six semi-structured focus groups with 42 students (25 nursing and 17 midwifery) to explore how they adjusted their values during their programme and if VBR alleviated any erosion of values. It was reported (see Table 4) that students across all groups perceived communication as an essential value. The students also stated that whilst their personal values had remained unchanged, the organisational culture had influenced their values. Students' perceptions of courage centred on observing missed opportunities to provide care, adding that significant courage was needed to overcome the challenge of raising concerns, as the organisational structure was unsupportive. Further findings suggested that students' values changed when confronted with clinical pressures, with students adapting their values to *"fit in"* (p.1146) whilst using resilience to protect their emotions.

Callwood et al. (2019) reported on interviews with student nurses and midwives (n=28), who described their values after completing their second year of study and following their exposure to the clinical practice environment. One finding (see Table 4) was that as students became more confident, their values were influenced by their knowledge and skills

related to guidelines and procedures. This was because they considered themselves part of the practice team. Students reported that being courageous in practice was related to integrity, advocacy and experience. However, this exposed a dichotomy: on one hand, clinical skills and values coexisted without compromise; on the other hand, clinical skills compromised the provision of compassionate care. Students in this study also described a *"tempering"* (p.1080) of idealistic views with the realities of clinical practice. However, compassion, empathy, courage, communication and competence were still deemed important by the students. Furthermore, students described reflecting on and comprehending patient behaviour in an attempt bid to build tolerance and understanding.

Kneafsey et al. (2015) undertook a pragmatic qualitative study to explore stakeholders' perspectives on compassion. These researchers arranged nine focus groups, which included 45 participants: academic staff, students, clinicians and members of the public. A weakness of this study is that the majority of participants (42) were female, so the findings are gender-biased and not generalisable to the male population. The key findings revealed compassion and communication were considered essential core attributes for a nurse. Compassion was also considered an innate emotion by participants as it connected to feelings of empathy and altruism, ultimately becoming a force for action. Engagement, communication and interpersonal interaction between nurse and patient were also viewed as key to compassionate care. Insufficient time for care tasks could explain a loss of compassionate behaviour, which resulted in burnout and care without engagement. The authors concluded that there was a link between empathy, compassion and making meaningful connections with others.

Waugh et al. (2014) used a survey to explore attributes and skills deemed essential by students and experienced nurses/midwives. The survey, an unvalidated online questionnaire, required participants to rate the relative importance of 23 attributes and key skills using a five-point Likert scale. A final open-ended question asked participants if they felt all personal attributes were equally important to all fields of nursing. Whilst it was acknowledged that the personal attributes and skills listed in the survey were identified by the research team, it was not indicated whether the attributes included were identified in frameworks like the NHS Constitution (NHS 2015a) or the 6Cs (DoH 2012). This may be because the study was conducted by Edinburgh-based academics. Thus, a limitation of this study was generalisability, as the reported findings were limited to one geographical area. Participants were invited to complete the survey through an email cascaded to staff and students within Edinburgh Napier University and to all registered nurses throughout NHS Lothian via chief nurses. Researchers reported that although they reached a population of

10,000 nurses, the response rate of 502 was small, reducing the generalisability of the findings. Fifty-five per cent (n = 276) of participants were qualified and 45% (n = 226) were students. The researchers reported commonality between the seven highest-ranking attributes for both groups. These were honesty, trustworthiness, communication, listening, patience and tactfulness, sensitivity and compassion, teamwork, seeking and acting on guidance. Skills such as literacy, numeracy, multitasking, teaching, reasoning and IT competence were considered less important. There were, however, some clear differences in opinion. Practice educators ranked knowledge, seeking guidance and communication higher than the median rankings. Students ranked initiative, knowledge and insight lower than registrants. Managers also rated knowledge and experience highly.

3.6.2 Theme Two: Psychometric non-cognitive domain testing

Non-cognitive aptitude testing was inextricably linked to VBR by Francis (2013), with the suggestion that aptitude testing can be used in an attempt to prevent applicants with undesirable characteristics from entering the profession. However, little is known about the impact of aptitude testing as part of the HEE (2016a) VBRF. Thus, this theme focuses on the state of knowledge about psychometric testing for values, as part of the VBR phenomenon. Four articles explored non-cognitive domain testing as part of VBR. Snowden et al. (2018) examined the use of emotional intelligence testing as part of nurse recruitment, while McNeil et al. (2018) investigated professional identity and nursing values through the use of personality testing. Finally, both Lievens et al. (2016) and Husbands et al. (2015) evaluated situational judgement tests (SJT) as part of dental and medical school admissions.

Snowden et al. (2018) examined how emotional intelligence and prior caring experience was related to the completion of pre-registration nursing and midwifery education. The researchers collected data through two validated questionnaires, the 30-item Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF) and Schutte's 33-item Emotional Intelligence Scale (SEIS). The use of these validated questionnaires is a major strength of the study, as both have long been used in healthcare. The authors performed a confirmatory factor analysis of their results to test for four factors: well-being, self-control, emotionality and sociability. The sample included 938 volunteers, of whom 876 were nurses with various specialisations (adult, child, mental health and learning disabilities) and midwives, with 68 computing students as a control group. The mean age of the participants within the study was 25 to 39, with the majority being female (n=785). The key reported findings were that five items in the questionnaire relating to social connectivity were answered more positively by female respondents than their male counterparts. Highlighting the potential for gendered selection bias if social connectivity is measured as a component

of VBR. Nurses who completed their study programmes scored significantly higher for emotional intelligence and social connection than those who had not. However, there was no statistical significance between previous care experience and nurses completing their programme of study.

McNeil et al. (2018) study's primary aim was to pilot the Nurse Match Instrument (NMI), while its secondary aim was to explore the relationships between personal statement scores, MMI and NMI. Although the sample included 63 volunteer student nurses, the gender, age and field of study were unclear. The NMI was presented as an online test that measured participants' personal nursing values across 20 domains, which were classified into six value themes (person-centredness, accountability, trust, integrity, personal development and teamwork). The NMI is based on the NIPEC (2014) attributes and values required to support a career in nursing. One strength of the study was that students took the test in a proctored environment to ensure the validity and standardisation of the testing environment. Some key findings (see Table 4) highlighted a medium to strong statistically significant relationship between the participant value themes. There was a weak correlation between accountability assessed through MMI and person-centredness in the NMI, though little or no relationship was ultimately identified between the equivalent NMI objective assessment and the MMI subjective assessment. Hence, the NMI and the MMI do not seem to measure the same values.

Lievens et al. (2016) conducted a retrospective cohort study to explore the widening access benefits of using SJT in terms of three demographic variables: socio-economic status, ethnicity and gender. The researchers included data from all UK medical and dental school applicants from 2012 and 2013. The 2012 admissions cycle included 15,581applicants who undertook SJT as part of the United Kingdom Clinical Aptitude Test (UKCAT) pilot. A further 15,454 were involved in the 2013 admissions cycle, where SJT were an integral part of the UKCAT assessment. The potential limitations of retrospective studies are inaccurate record-keeping, selection bias and the misidentification of classifications (Sedgwick 2014). Data for this study was collected via the UKCAT consortium, a computer-based standardised examination administered in a fully proctored environment at test centres worldwide, which is a significant strength of the study. The authors reported a significant effect on SJT performance for the socio-economic factors of ethnicity and gender, in both the 2012 and 2013 cohorts. The study concluded that SJT, in conjunction with other selection methodologies, could potentially place candidates from low socio-economic backgrounds at less of a disadvantage, thus diversifying intakes.

Husbands et al. (2015) explored the psychometric properties of SJT as a measure for integrity. The sample included 198 medical school candidates, who volunteered to participate in the study during the 2012/13 admissions cycle. The study included 87 male and 111 female participants, with no reported statistical differences between their age or gender. The participants took a written SJT, a personal inventory questionnaire and an acceptability questionnaire after completing their recruitment MMIs. The authors also included the participants' UKCAT and prior academic achievement data within the analysis. It is acknowledged that whilst the participants were medical school candidates and their results could therefore potentially be considered not generalisable to nursing candidates, some interesting findings emerged. Female participants scored significantly higher than males, which is consistent with previous research into SJT and MMIs. The authors also reported statistically significant correlations between SJT scores and personal dimensions. By order of significance, these relationships concerned the honesty-humility (integrity), conscientiousness, extraversion and agreeableness dimensions. Significant statistical correlations were also identified between the SJT and MMI scores, which was apportioned to the fact that MMIs and SJT were designed to measure the same domains.

3.6.3 Theme three: Multiple mini interviews and face-to-face interviews

Arguably, since the seminal work by Eva et al. (2004), MMIs have become one of the most popular methods of undergraduate selection for many universities and across many health professions. As part of the review, five articles were found that explored MMIs and face-to-face interviews as part of VBR candidate selection in the UK. These were as follows: Callwood et al. (2018b) conducted a cross-disciplinary evaluation study to explore the reliability and predictive validity of MMIs for undergraduate nursing, midwifery and paramedic students; Callwood et al. (2020) explored the predictive validity of MMIs across nursing and midwifery cohorts; Mirghani et al. (2019) investigated the reliability and validity of MMIs for dental schools; Traynor et al. (2018) undertook a qualitative study to ascertain male nurse candidates' perceptions of MMIs; Taylor et al. (2014) reviewed selection methods for nursing and midwifery in Scotland, focusing on face-to-face interviewing.

Callwood et al. (2018b) undertook a cross-disciplinary evaluation study that explored the reliability and predictive validity of MMIs for undergraduate nursing (in the adult, child and mental health branches), midwifery and paramedic students. The study examined correlations between students' end of year one practice outcomes and their MMI scores recorded on admission. The data was collected in two streams. Stream a) participants included 101 midwifery students across two cohorts: forty-seven students from the 2014 cohort and 54 students from the 2015 cohort. Stream b) included 281 participants who were

nursing students: 180 were in the adult branch, 33 were in the child branch and 34 were in the mental health branch; 34 were paramedic practice students. Nursing and paramedic candidates completed six four-minute MMI stations. The values/attributes assessed at each station were communication skills, kindness, compassion and empathy, with the final station being respect for privacy and dignity as well as difference and diversity. Midwifery candidates completed seven four-minute MMI stations, with the values/attributes assessed being motivation, intellectual curiosity and reflective nature, initiative, problem solving and teamwork, honesty and integrity, advocacy, respect for privacy and dignity, as well as respect for difference and diversity. The values/attributes assessed as part of the MMI stations were derived from previous studies (Callwood et al. 2014; Callwood 2015) and were congruent with the NHS constitutional values. All stations were scored on a seven-point Likert scale for ten criteria. The six-station MMI had a maximum score of 420, with the seven-station MMI offering a maximum score of 490. The findings highlighted significant correlations between MMI scores and midwifery students' end of year one clinical performance outcomes (OSCE and mentor grading), when age and academic level were controlled. However, this was not repeated with the nursing and paramedic students. It was concluded that a seven-station MMI model improves the predictive validity of academic outcomes.

Most recently, Callwood et al. (2020) reported their final findings from a longitudinal cross-sectional cohort study (see Callwood et al. 2017 and Callwood et al. 2019 for year one and year two findings, respectively). In this study, the authors extended their findings to report on the predictive validity of MMIs across nursing and midwifery cohorts. Their sample included 225 nursing and midwifery students from the September 2015 cohort who had all experienced MMIs as part of their selection, completed their study programme and agreed to participate (there were 120 adult branch, 32 children's nursing and 30 mental health nursing students and 43 midwifery students). The study analysis included an aggregate mark for overall clinical performance, academic performance measured by dissertation mark and MMI scores. Nurses undertook a six-station MMI model, with midwifery candidates undertaking a seven-station MMI model (see Callwood 2018b). The findings suggested that students with high admission MMI scores performed better in practice, irrespective of the use of the six- or seven-station MMI model. However, this was not reflected in academic attainment.

Mirghani et al. (2019) undertook a retrospective analysis of how traits identified during MMIs mapped against the requirements for dental practice. Data was retrieved retrospectively from 239 Leeds University Dental School undergraduate applicants who had attended MMIs. The data included the scores for 87 successful and 152 unsuccessful candidates. This can

be considered a significant strength of the study, as it reduced the potential for selection bias. All candidates undertook ten MMI stations, which assessed observation, ethics, communication skills (through a presentation), manual dexterity (an origami task), insight, communication and empathy, communication of complex instructions, analysis and interpretation skills. The final two stations assessed manual dexterity and were interactive digital stations using the clinical Kinematic assessment tool (CKAT) and Simdont, both of which are virtual simulators. Each station took between seven and eight minutes, with one minute given for candidates to move between stations, except for the manual dexterity stations, which took 20 minutes each: ten minutes for instructions and ten for the task. The stations were determined by academics, admissions staff and professional staff at the school. All the assessors were trained before the MMI, which included assessing simulated candidates to practise scoring and a briefing on the interview day. Each station required the assessor to rate whether they would accept a candidate, according to a five-point Likert scale of 'not happy at all' to 'very happy indeed'. This suggests the ratings were subjective and not criterion-based. The authors conducted factor analysis on the MMI stations and reported two factors, soft skills and sensorimotor skills. The former were reflected in six stations: presentation, memory, ethics, interpretation and insight. These items were related to the ability to communicate, show empathy, analyse and interpret data, describe things, show ethical awareness and reasoning, as well as give personal insights on issues.

Taylor et al. (2014) used a multiple case study method to elicit stakeholder views on the strengths and limitations of the selection process used in Scottish HEIs. The study utilised a questionnaire and focus groups for data collection. The strengths of this study were piloting the questionnaire with eight admissions tutors and holding scoping interviews with three key stakeholders (defined as experts in recruitment, selection and retention). In phase one of the study, 97 participants (lecturers, clinical staff and student nurses) completed the questionnaire. In phase two, six admission tutors participated in individual interviews, with a further 107 participants (lecturers, clinical staff, student nurses and experts in recruitment, selection and retention) taking part in focus groups. Some reported findings were that a high standard of literacy was perceived as an essential entry criterion, as judgements could then be made on candidates' preparedness. However, some concerns were raised concerning literacy testing for applicants with dyslexia, the consistency of marking and informing candidates they had failed. Students thought literacy assessments enabled them to show interest, aptitude and understanding of the profession, whilst some found the process stressful. Numeracy tests were also viewed by participants as valid and reliable, though the need for them was questioned given students' prior achievements; for instance, the need for a maths qualification as a university entry requirement was unclear. Students, despite

seeing the relevance of numeracy testing, viewed this as stressful because this was held under exam conditions.

Traynor et al. (2018) undertook a qualitative study to ascertain male nurse candidates' perceptions of the MMI process. Their sample included eight student nurses who participated in four focus groups. During the focus group, respondents answered questions about past experiences. As some memories would be more readily recalled than others, recall bias could be a weakness of this study. However, a major strength of their study was the coding process, which was iterative and clear. The authors reported on three key categories: the process, the candidates and being male as a candidate. Participants viewed MMIs as stressful, with some stations creating more stress than others. The findings also suggested that male candidates were aware of their gender as an influential factor during the MMI when seeking entry to a female-dominated profession. Consequently, being interviewed by male staff was viewed as comforting. Interestingly though, the authors perceived this to be because of assumptions of shared experience and perceptions. However, the participants identified age and experience as being of greater significance during MMIs. The study concluded by acknowledging that MMIs were imperfect and female-dominated; however, this did not seem to disadvantage male candidates.

3.6.4 Theme Four: Service users as assessors nurse recruitment

The role of the assessor as part of undergraduate values selection has gained some attention in VBR, which has its origins in mental health nursing recruitment. Two papers (Rouse and Tourney 2014; Heaslip et al. 2018) identified during the review explored service user involvement in the VBR process.

Rouse and Tourney (2014) undertook a process evaluation exploring the efficacy of service users as part of the selection process for an undergraduate nurse programme. Eight service users and carers were recruited to the study to participate in candidate selection via a local group (the Impact team) of NHS service users and carers. All volunteers received training on the recruitment, equality and diversity admissions policies; an introduction to the undergraduate programme; and the standards for pre-registration training for selection before the selection day. The selection day included a group activity, during which teams of six to eight candidates delivered a presentation based on an article sent to them before the day. The presentations were observed by the assessors and each candidate was graded for their performance based on seven factors, which accounted for 35% of their marks. However, it was not stated what these factors were, thus reducing the transparency and validity of the study. The candidates' remaining scores were based on written work and an

interview with a lecturer and a practitioner. Survey data was collected via an unvalidated, self-reported online questionnaire. A total of 56 (29.63%) responses were received from the 189 participants invited to take part in the survey (four service users, five practitioners, 13 lecturers and 34 enrolled students). Some of the authors reported that the findings (see Table 4) suggested service users and carers were viewed as appropriate and beneficial to candidate nurse selection. However, candidates' views were split in this regard, as it made some of them apprehensive. Concerns were also raised about how and when service users should be involved in the selection process.

Heaslip et al. (2018) undertook an evaluative case study to explore the inclusion of service users in value-based recruitment for preregistration adult nurse candidates, utilising a mixed-methods approach to data collection. Two hundred and seventy-four nurse candidates (a 42% response rate) responded to an online questionnaire about their recruitment experience. Nine service users who contributed to the candidates' interviews participated in focus groups, with a further two taking telephone interviews. Thirty-five surveys were also completed by 20 academic and 15 clinical nurses (a 35% response rate). Service users reported looking beyond candidates' academic ability to focus on what they (the users) wanted from nurses, whereas the perception was that university staff and academics focused on professional aspects. Academics and practitioners saw service users as focused on the caring and compassionate aspects of nursing. Candidates saw service user involvement as adding "a human dimension" (p.109). Service users considered that cooperation was essential, giving them their voice as advocates for vulnerable patients and contributing to care services. Academics and practitioners felt service users provided a more rounded approach to the interview process, whilst candidates thought that service users offered alternative perspectives at the interview. Service users were seen as active partners and integral to the process, rather than passive recipients of care, while candidates considered user involvement in VBR to be indicative of a true partnership. By contrast, academic staff and practitioners, although mostly supportive, questioned service user involvement in the VBR process. The authors also favoured restrictions on the inclusion of service users as they were considered to lack the knowledge required to make the final decision.

3.7 Stage 5 – Conclusion and implications of the findings.

The literature consistently identified as important values such as honesty, communication, compassion, empathy, competence and courage. Commonalities in the values identified were reflective of the Constitution (NHS 2015a), 'The Code' (NMC 2018b), NIPEC (2014) and the 6Cs (DoH 2012). Consequently, the literature demonstrates a national picture of

VBR as having a broader uptake than is outlined in the VBRF (HEE 2016a). As such, the validity of the Constitution (NHS 2015a) as a pivotal value framework is questionable. This suggests a mismatch in the core values and behaviours that underpin VBR and a failure to establish a common language. This adds weight to the call for a UK-wide blueprint of values against which nurse candidates can be measured nationally (Patterson et al. 2016a; Groothuizen et al. 2017). However, the values considered essential by service users, academics, practitioners, students and candidates differed. Contradictory findings centred on the organisational pressures, burnout and the courage needed to raise concerns when care was missing or compromised. By contrast, witnessing poor care values also led to values dissonance (Kneafsey et al. 2015; Callwood et al. 2017; Callwood et al. 2019).

As earlier identified, MMIs have gained significant popularity as a measure of values in HEI VBR practices since their introduction (Callwood et al. 2018a). However, researchers generally agree that they are subjective, with recruitment decisions based on assessors' personal beliefs (McNeil 2018; Mirghani et al. 2019). Nevertheless, authors reporting on the validity and distal outcomes of MMIs have described correlations between MMI scores as predictors of academic ability and clinical performance (Husbands et al. 2015; Callwood et al. 2018b; Callwood et al. 2020). Traynor et al. (2018), however, added caution, as their findings suggest that male candidates believed gender was an influential factor during the MMI when seeking entry to a female-dominated profession. Studies highlighted within this review also suggest a lack of consensus in assessors' values ratings and a divergence between what assessors and candidates consider essential values (Taylor et al. 2014; Waugh et al. 2014). This suggests the potentially inconsistent scoring of candidates, casting doubt on the objectivity of the weighting of attributes during MMI. There is an implication that assessors are seeking the 'final product', whilst candidates are viewing themselves as a 'professional in the making'. These findings reiterate the need for appropriate time for assessment decisions to be made, robust scoring systems, ongoing training with calibration and the benchmarking of scores between assessors. These processes would ensure consistent objectivity and transparency, as opposed to a subjective and intuitive decision process.

The findings of this review suggest that SJT, as part of MMIs, could improve the psychometric properties in the measurement of values (Husbands et al. 2015; Mirghani et al. 2019). However, it must be acknowledged that SJT and psychometric testing are reported as being gender-biased, with female candidates outperforming their male counterparts (Husbands et al. 2015; Lievens et al. 2016; Snowden et al. 2018). HEIs also require good standards of literacy and numeracy, indicating a sufficient level of academic achievement is

needed to ensure student preparedness and successful outcomes. Nevertheless, over-reliance on these factors has been found to negate important non-academic factors, such as widening access initiatives (Rouse and Tourney 2014; Waugh et al. 2014; Callwood et al. 2018b). Lievens et al. (2016) and Husbands et al. (2015) additionally showed the effects of socio-economic status during SJT can be diminished when cognitive ability is controlled. This consequently balances out the effects of academic attainment. However, researchers have reached a consensus that coaching and the more favourable presentation of values during psychometric tests continue to be areas of common concern (Taylor et al. 2014; McNeill et al. 2018).

The review revealed an absence of literature that explores nurse candidates' meaning-making of caring and professional values and how these values are reflected in aptitude testing. Moreover, minimal research has explored candidates' experiences of aptitude testing in comparison to MMIs as part of HEI VBR practices. Thus, this study aims to enhance the body of literature relating to this subject, making a contribution that will benefit HEIs, nurse candidates and the profession. The ultimate intention is to improve patient care by enhancing the caring and professional values used at the bedside.

3.8 The research question for this study is:

'How do student nurses perceive value-based recruitment in the context of their personal constructs of caring values and professional values?'

3.8.1 The research aim of this study is:

'To identify how student nurses perceive value-based recruitment in the context of their personal constructs of caring values and professional values'

3.8.2 The research objectives of this study were to:

1. Provide a critique of the current body of literature pertaining to HEI VBR practices.
2. Determine the participants' caring values, professional values and identity constructs through aptitude testing.
3. Explore, through interviews, the participants' meaning-making of care and professional values.
4. Explore, through interviews, the participants' experiences of MMIs and aptitude testing for values within the context of VBR.
5. Critically analyse and synthesise findings from the literature, the qualitative interviews and idiographic data from the aptitude test through a social constructionist lens.
6. Disseminate the results to provide recommendations for HEIs and clinical practice environments.

Chapter 4 - Theoretical context

> *"The matter with human beans is that they is absolutely refusing to believe in anything unless they is actually seeing it right in front of their own schnozzles"*
>
> *The BFG, by Roald Dahl*

*4.1 **Theoretical considerations***

This chapter outlines the theoretical underpinnings for this study. Section 4.1 presents my epistemological, ontological and axiological stance. Section 4.2 discusses social constructionism and its relation to Interpretive Phenomenological Analysis (IPA). Section 4.3 explores social constructionism as a theoretical lens. Finally, section 4.4 draws together the ontological, theoretical and methodological fit.

4.2 Epistemological, ontological and axiological stance.

The relationship between ontological, epistemological and axiological positions is referred to by Durant-Law (2005, p.2) as the *"philosophical trinity".* Ontology is the science of beliefs and the fundamental nature of reality (Creswell and Poth 2018, p.21) or, put more simply, *"what is"* (Crotty and Crotty 1998, p.10). Epistemology is defined as *"how we know what we know"* (Creswell and Poth 2018, p.21); in this field, all knowledge is experiential, subjective and bound to the context in which people live their lives (Hiller 2016). Epistemology is the validity of knowledge and beliefs produced about a phenomenon (Hiller 2016, p.99). Hence, humans apply values to people and to the meanings of situations, not just to behaviours (Pascale 2011). Axiology, or value theory in its narrowest sense, is primarily concerned with classifying what is good (Given 2008). Hence, axiology questions what is valuable to human life and therefore which knowledge is intrinsically valuable (Heron and Reason 1997, p.277).

My personal ontological belief is that multiple realities exist. Consequently, as highlighted by Denzin and Lincoln (2013, p.22) and Rees et al (2020. p.847), there is no ultimate truth. Thus, in line with Rees et al. (2020, p.847), objective measures cannot represent or measure truthfulness. My epistemology takes a constructivist position, as I believe that all humans construct knowledge as they interpret the world, which is experiential and subjective. My axiological stance as an individual, ODP and educationalist is that I believe that people are free to make choices. However, I believe choice comes with ethical responsibility. Thus, in line with existentialist thought, as illustrated by Given (2008) and Schroeder (2021), values become a constraint when considering the morality of values and the relationship between what is good or bad. Hence, I align my personal definition of values with Tschudin (1992, p.2):

Values are closely related to meaning - the meaning of life. The inner meaning of an action, an experience or an attitude gives us our values.

4.3 Social constructionism and Interpretive Phenomenological Analysis

Social constructionism has emerged over several decades from combined influences and is said to be rooted in philosophical development (Burr 2015). Recent contributions to social constructionism focus on the works of Berger and Luckmann (1966), who suggested that people construct their identities through the social interactions with others; Gergen (1973) and Tajfel and Turner (1979), for whom all knowledge is socially and culturally specific; and Shotter (1995a; 1995b), for whom conversation becomes the dynamic process of construction. Burr (2015, p.2) and Rees et al. (2020) emphasise that no single clear definition of social constructionism exists; rather, it is a set of commonalities or *"familial resemblances"* that accept several assumptions. These are:

- A critical stance is taken towards taken-for-granted knowledge
- Understanding is shaped by time and culture-specific
- Knowledge is socially constructed through interaction and language
- Different constructions elucidate different actions

Language is important to understanding, as what we say and how we say it does not speak of one reality, as multiple worlds exist and no one reality is truer than another (Eatough and Smith 2008; Smith et al. 2009a; Burr 2015). Social constructionism involves a postmodernist stance, rejecting the modernist belief that objective measurement and scientific evidence of what reality is provide moral rules for humans to live by (Burr 2015). Therefore, a social constructionist position assumes that truth cannot be made beyond human descriptions of it (Burr 2015). In social constructionism, the analysis of socially and culturally constructed discourse shares common interests and concerns with IPA (Smith et al. 2009a, p.195). IPA is described as being located at the *"light end"* of the social constructivist scale, emphasising the importance of the empirical realities of people's lived experiences and their sense of self (Eatough and Smith 2008, p.184). Ontologically, IPA involves a social constructivist stance, which views all knowledge as *"constructed"* (Ashworth 2003, p.15). Additionally, IPA involves an interpretive/hermeneutic epistemology, which refers to a person's relatedness to their world (Larkin and Thompson 2012). Lyon (2016, p.243) emphasises the contextual constructivist approach to IPA's epistemological underpinnings, whereby language underpins the meaning of events and social situations. Thus, with IPA, a chain of connection is assumed between thought, emotion and speech, in which the expression of these connections is considered complex (Smith and Eatough 2016, p.51). Therefore, the use of IPA requires an interpretation of participants' linguistic comments as the inquirer moves between participants' *"rich experiential descriptions"* whilst being critical and interrogative of what was said (Smith and Eatough 2016, p.51). IPA was chosen for this

study as it focuses on nursing students' meaning-making of caring and professional values and the interpretation of meaning through the language of aptitude testing. It is also acknowledged whilst the students had experienced MMIs as part of their selection, aptitude testing would potentially be a novel VBR experience for the students. Therefore, I was also interested in the students' lived experiences of aptitude testing when compared to their MMI. Thus, I felt a more detailed picture of each student's experiences was needed, rather than the more typical normative measurement of values. Accordingly, an idiographic and qualitative approach was adopted to align with the research question. As a researcher, I also accept that this study's idiographic findings are co-created rather than simply represented. As a researcher, I bring my own world beliefs and experiences to the interpretive process, whilst ensuring that the knowledge produced is representative of the participants' reality (Denzin and Lincoln 2013, p.211; Hiller 2016).

4.4 Social constructionism as a theoretical lens

Two prominent forms of social constructionism exist: micro- and macro-constructionism. Micro-constructionism privileges the individual through language and social interaction (Burr 2015; Rees et al. 2020). In this study, micro-constructionism focuses on the students' individual meaning-making of their own personal caring and professional values. Macro-constructionism is founded on the power of language through social structures and practices (Burr 2015; Rees et al. 2020). Therefore, macro-constructionism is addressed in this study through two levels: on a meso-level, which focuses on the social structures of nursing stereotypical norms illustrated within the value frameworks in Table 1; and on a macro-level, which involves how nursing stereotypical norms encased within value frameworks (see Table 1) are interpreted through HEI VBR practice, centring on aptitude testing and MMIs. Consequently, values are explored on three different levels: values on a micro-level within the context of the students' individual personal caring and professional values; values on a meso-level within the context of the professional and cultural identity of the nurse; and finally, on a macro-level, with the context of HEI VBR practices of aptitude testing and MMIs. These concepts are presented in the framework of understanding, as described below.

4.4.1 Micro – personal identity

Personal identity is shaped through interactions with the social world. It can vary by time and place and is based on knowledge, culture and meaning (Burr 2015). Consequently, identity is not static but is a constantly evolving and dynamic process. Social constructivists argue that identity exists in relation to the 'generalised other', i.e., the attitudes, beliefs and values of a community (O'Neil 2010). Pattison (2020, p.29) describes this as societal 'rules' which make claims of truth about the world. Therefore, personal identity is a constellation of

identities based on who we are and the roles we want to play — which are established on experiences, context, norms, interaction and the perspectives held of others — as people begin to make sense of who they are (O'Neil 2010). In this study, Gergen's seminal work of social constructionism, an approach to explaining how people come to describe and account for themselves and the world in which they live (Gergen 1985), was used as a lens for exploring students' perspectives of their personal nursing values within the context of socially and culturally specific nursing values (illustrated in the value framework presented in Table 1).

4.4.2 Meso – professional identity

Values and identity tend to be focused on the experiences and interactions between groups. Thus, values are a key aspect of professional identity as they orientate and differentiate between occupations (Pill et al. 2020). Consequently, knowledge is important in gaining a shared understanding and how people respond to it. Shared knowledge creates norms, i.e., shared practices about behaviour for a given identity, which can be conformed to or not and viewed as good or bad, but which nevertheless provide a guide for appropriate social behaviour (Burr 2015; Pattison and Pill 2020). Consequently, professional values become institutionalised from the individual to the collective (Armstrong 2020). Hence, normative values are legitimised as they imply order, validity and knowledge (Berger and Luckmann 1966, p.111). Thus, as illustrated in section 2.4, professional values, or regulatory norms, are the rules and standards describing how a given identity should act within the professional context; they describe the rules of *"the game"* (O'Neil 2010, p.740). Social identity and self-categorisation theory, through the works of Hogg and Terry (2000), are employed in this study as a framework for exploring students' values and how they identified their values with those of the nurse in the organisational context. Here, 'in groups' reflect established cultures and 'out groups' reflect others with different values, attitudes, behaviours or beliefs (Hogg and Terry 2000; Samuriwo 2021). Festinger's (1957) cognitive dissonance theory was also employed to frame the values conflict between what the student considered the *'gold standard'* of professional values espoused by the university and the perceived deficient values observed in practice.

4.4.3 Macro - Institutional values

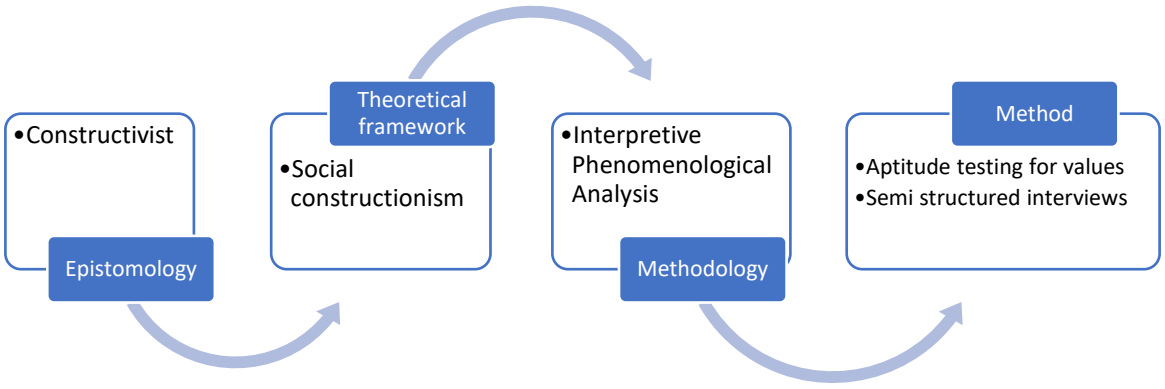
As illustrated above, macro-constructionism focuses on the broader discourses reproduced through social structures (Rees et al. 2020). Thus, in the context of this study, professional values do not exist in isolation from institutions (Pill et al. 2020). As illustrated in section 2.2, HEIs are responsible for the provision of newly qualified nurses through their retention of control over entry to the profession and awards of professional qualifications, thus licensing

the nurses to practise according to professional standards. Hence, VBR is viewed as a method of restricting access to the nursing profession to candidates who embody the "right" values, skills and aptitudes (HEE 2016a, p.4). As illustrated by Samuriwo (2021), pedagogy reflects the dominant professional culture which influences how people understand, perceive and learn from experiences. Thus, in the context of VBR, the students in this study learn, construct and reconstruct their personal nursing values in line with the social and cultural representation of the nurse, with whom they were being compared. Therefore, Goffman's (1956) dramatological approach to how people manage and construct their identities as a performance during social interactions was utilised as a lens with which to frame the students' representations of their values through the HEI VBR practices of aptitude testing and MMIs. Foucault's concepts of power (Foucault 1977, Foucault 2000, Foucault 2006) were also adopted to frame the students' perceptions of their values within the social context of the MMI when compared to their experiences of aptitude testing. Additionally, Goffman's concept of how society classifies people based on characteristics and behaviour was used to illustrate the students' perceptions of their values when mediated through their test reports (Goffman 1963).

4.5 Conclusion

In conclusion, this study took a broad view to interpreting and debating the phenomena of VBR grounded in a social constructionism approach. Values and identities are socially constructed by collective meaning, interpretations and assumptions about the world, so social constructionism is ideally situated to this study. As explained by Rees et al. (2020), social constructionist researchers can situate themselves anywhere on the relativist realist continuum. Thus, in the context of this study, the constructionist approach moves between the micro-individual value, the meso-social practices of professional values and the macro-organisational structures of VBR. Finally, as illustrated in Diagram 2 below, this study aligns my philosophical position with the study's theoretical framework, method and methodology.

Diagram 2 Philosophical position, theoretical framework, method and methodology.



Chapter 5 – Method

5.1 Chapter overview

In this chapter, the methodological approach and the research methods used are discussed. IPA was selected for use in this study, the theoretical underpinnings of which include existential phenomenology, hermeneutics and idiography. Each is discussed and the rationale for using IPA is provided. Sampling and recruitment are then addressed. This is followed by a discussion of the data collection and analysis methods, which comprised three discrete phases:

Phase one: An overview of Identity Structure Analysis (ISA) (the methodological underpinnings for the psychometric tests utilised in this study); the data collection using two psychometric tests, the Nurse Match Instrument screening tool (NMIST) and the Nurse Match Instrument (NMI); and the analysis.

Phase two: The data collection using semi-structured interviews, transcription and IPA analysis.

Phase three: The triangulation of the NMIST, NMI and IPA findings in each participant's case.

The chapter concludes by outlining the study's ethical considerations.

5.1.1 Interpretive Phenomenological Analysis

The major phenomenological philosophies of IPA are influenced by the existential perspectives of Husserl, Heidegger, Merleau-Ponty and Sartre (Smith et al. 2009a). IPA is also influenced by hermeneutics and idiography, which stem from the work of Schleiermacher and Gadamer (Smith et al. 2009a). These concepts concern the human experience and its interconnectedness and involvement in the lived world (Smith et al. 2009a). Thereby, whilst experience is personal, it is also collective and not experienced in isolation. Edmund Husserl, considered the father of phenomenology, conducted in-depth explorations of human experience (Smith et al. 2009a, p.12). Heidegger, whose work is deemed the foundation of IPA, developed Husserl's work and was broadly concerned with perception, awareness, consciousness and being-in-the-world (Laverty 2003; Sembera 2007; Giorgi and Giorgi 2008; Heidegger 2010). Unlike Husserl, Heidegger advocated a hermeneutic, interpretative lens, in which human meaning-making of the world is "*always in relation to something*" (Smith et al. 2009a, p.18) and which is characterised as *Dasein* (Smith et al. 2009a, p.18; Heidegger 2010). *Dasein* means the interconnectedness of human experience; thus, phenomenology investigates and interprets experiences, whereby human experience comes into existence through things, people, language and culture (Tuffour 2017). IPA has been described as a method and a philosophy which centres on the study of experience (Moran 2002; Smith et al. 2009a, p.11). IPA, as a methodological approach, is considered particularly useful to "*professional practitioners*" and novice doctoral researchers, since Smith et al. (2009a) provided a guided manual for undertaking an IPA

study (van Manen 2014, p.15; van Manen 2018, p.1966). By comparison, a key criticism of IPA has been its non-prescriptive and unscientific nature, which Giorgi (2011) argued considerably affects the confirmation and validity of findings. However, Smith (2010) rebuts this, emphasising that through the methodical steps of the IPA process, students' interpretations are supported, demonstrated and checked by supervisors. This is demonstrated in chapters 5 and 6 of this study. IPA assumes a chain of connection between thought, emotion and speech, whereby the expression of these connections is considered complex (Smith and Eatough 2016, p.51). Therefore, IPA requires interpretation of participants' linguistic comments as the inquirer moves between *"rich experiential descriptions heavily grounded in the participant's own words"* whilst being critical and interrogative of what was said (Smith and Eatough 2016, p.51). However, Tuffour (2017, p.4) presents a second criticism of IPA as *"unsatisfactory recognition to the integral role of language".* Smith et al. (2009a) subscribed to a different view, stating that meaning-making within IPA occurs in the context of narratives, discourse, metaphors; thus, language is entwined with experience. IPA seeks to illuminate the subjective lived experience through all aspects of "*desires, feelings, motivations and belief systems*" and how these are evident in behaviour and action (Eatough and Smith 2008, p.181). IPA, therefore, explores how people comprehend major life experiences, engaging with the meaning of lived experience and participants' reflections on experience as they negotiate meaning (Smith et al. 2009a, p.3).

Whilst experience is personal, it is also collective and not experienced in isolation. Consequently, IPA researchers are grounded in the lived experiences of people, relationships and language (Tuffour 2017). For example, in this study, the students' relatedness of their personal nursing and aspirational values to nursing stereotypical norms illustrated in Table 1, could be aligned with Heidegger's use of the term 'care' (*sorge*) to describe concern of the self in-the-world (Bradshaw 2009). Heidegger was also concerned with how we engage with people through his discussion of *"fürsorge"*, translated as 'concern', in which *"nursing of the sick body"* was deemed concern (Heidegger 2010, p.118). Hence, *sorge* and *fürsorge*, like *Dasein*, relate to a person being meaningfully engaged with the world (Tompkins and Eatough 2013). Heidegger defined a difference between authentic and inauthentic *fürsorge,* whereby inauthentic concern focuses on objects rather than people (Peters 2019, p.453). In this study, I consider the notion of *fürsorge* central to VBR, as VBR is an institutional mechanism for ensuring the authenticity of candidates' caring and professional values, thus displaying their potential to meaningfully engage with caring for patients.

5.1.2 Hermeneutics

Heidegger's phenomenology comprised two elements: phenomenon, the new object as it is brought forth; and logos, how the new object is interpreted (Heidegger 2010, pp.29-39). Therefore, as each phenomenon appears and is perceived, every individual's perception through their lived experience is different (Eatough and Smith 2017, p.4); consequently, multiple perspectives or realities exist. For Heidegger (2010, pp.150-152), the inquirer brings with them to a phenomenon "*fore-conception*", or what Giorgi and Giorgi (2013, p. 167) describe as *"fore-knowledge"*, that is, experiences, assumptions and preconceptions. These experiences typically colour the inquirer's view. Hence, IPA assumes a phenomenological attitude, meaning the inquirer brackets or suspends judgement of the outer world, then strips away preconceptions and biases, to identify the phenomena under investigation by going beyond the contextual and personal (Laverty 2003; Gearing 2004; Smith et al. 2009a; Eatough and Smith 2017). Here, existential bracketing becomes a dynamic, reflective and cyclical process of engaging with the text and fore-conception whilst giving priority to the lived experience (Gearing 2004; Smith et al. 2009a; Heidegger 2010). Thus, IPA seeks to illuminate the subjective lived experience through all aspects of "*desires, feelings, motivations and belief systems*" and how they are evident in behaviour and action (Eatough and Smith 2008, p.181). IPA, in this context, enables an understanding of the participant's being-in-the-world whilst acknowledging the inquirer's preconceptions and biases and how they shape the study. This process is referred to as double hermeneutics, or *"the participants trying to make sense of their world; the researcher trying to make sense of the participant trying to make sense of their world"*, which defines the dual role of the inquirer (Smith and Osborn 2015, p.53). Double hermeneutics facilitates the inquirer's identification with the participant whilst being sufficiently removed to ask critical questions (Smith and Eatough 2016, p.51). Hence, whilst the participant is encouraged to reflect on, describe, interpret and comprehend their experience, the researcher is trying to make sense of the participants' experience. IPA is therefore considered dynamic and complex. Interpretation of data becomes dependent on, and complicated by, the inquirer's conceptions (Smith and Eatough 2016, p.51). Determining the hermeneutic process in the context of this study was achieved by incorporating reflexive accounts, thereby acknowledging the inquirer's preconceptions and biases whilst drawing on shared experiences with the participants.

5.1.3 Idiography

Idiography is a major influence on IPA as it is concerned with "*the particular*", that is, the individual experience (Smith et al. 2009a, p.29), which seeks variations within individual meaning, described as within-person patterns (Tomkins and Eatough 2013, p.7). The

alternative nomothetic analysis identifies patterns of behaviour across a population, described as between-person patterns (Conner et al. 2009). Thus, the study of personality, i.e., values, need not be exclusively nomothetic (Ashworth 2017, p. 14). As illustrated in chapter 4, this study sought to explore the students' meaning-making of caring and professional values; how these values were mediated through the language of aptitude testing; and the students' experiences of the subjective assessment of their personal nursing values through the MMI compared to the objective measurement through aptitude testing. To accomplish this, the study used complementary data collection methods of aptitude testing, as an objective measurement of values in line with Francis' (2013) recommendations, and interviews in a synthesis (Danziger 1997. p,410), rather than erecting epistemological barriers (Coffey and Atkinson 1996, p.12). This combination of methods facilitated an in-depth understanding of the students' meaning-making of their personal nursing caring and professional values and how these values were mediated through the language of an aptitude test. However, an idiographic (emic) 'within person' approach was maintained to the test data analysis, preserving a commitment to understanding VBR from the perspectives of the individual in context. Hence, generalisation was not avoided but established in a different way by exploring the convergence and divergence of participants' experiences (Smith et al. 2009a, p.29). Thus, through *Dasein*, the meanings of values, as given by the students, were understood through their experiences of aptitude testing and MMIs in relation to the phenomenon of VBR. Meanwhile, employing a constructionist lens to analyse the students' experiences of aptitude testing and MMIs facilitated a critical approach to the causal effects generated by the actual nature of VBR. A multi-method approach to IPA is not novel and reflects research that utilises complementary methods. For example, and most notably, Smith (1999) utilised IPA with repertory grid analysis; Spiers and Riley (2019) also mixed IPA with thematic analysis; additionally, Madill et al. (2018) used IPA with multiple methods, including psychosocial narrative analysis, dialogical analysis and critical discursive psychology. Meanwhile, the multi-dimensional approach of ISA incorporated within discourse analysis (Stapleton and Wilson 2003) and nurse education (Parry 2011) is evident in the literature. In this vein, some have accused IPA of promiscuous epistemologies as it integrates different methods (Dennison 2019). Giorgi (2011, p.212) argued the lack of fidelity means *"anything goes",* while credibility and trustworthiness are diminished. Counterclaims emphasise that a one-size-fits-all approach does not produce high-quality research and stifles creativity (Smith 2010; Dennison 2019). Thus, adopting multiple methods is a strength of this study, as the intermingling of analytical approaches illustrates the contrasting perspectives of the subjective and objective assessment of values through VBR, considerably strengthening this study's impact (Madill et al. 2018).

5.2 Sample and recruitment

This study used a purposive sampling strategy, which is considered appropriate for IPA (Smith et al. 2009a, p.48). The original sample population was nursing students (n=94) in the adult and mental health branches in the March 2017 Cohort, School of Healthcare Sciences, Cardiff University. This population was considered appropriate as it represented student nurse perspectives on the phenomena of caring and professional values in the context of VBR. All participants had experienced MMIs based on professional values (NMC 2018a; NMC 2018b) and those values embedded within the 6Cs (DoH 2012) as part of their recruitment and, to this extent, were homogeneous.

Students were informed of the study through a face-to-face, 15-minute PowerPoint presentation during their induction week. Each cohort member was provided with a copy of the participant information sheet (Appendix 6) after the presentation. The cohort was given time to read the sheet whilst a register was circulated to collect names of volunteers. From a potential sample of 94, 49 students volunteered to participate, from which 22 were randomly selected using Excel, as described by Hutchison and Styles (2010, pp.1-20). The sample was representative across age and gender. Thus the sample was deemed appropriate as current literature suggests that male nurses' voices lack representation in the care and compassion debate (Lindsey 2008; Bradshaw 2009; Bradshaw 2011; Fielden and Burke 2014), while age is linked to values (Conard 2006; Kulasegaram et al. 2010). Consequently, an exploration of the phenomena of care and compassion from the age and gender perspectives was considered appropriate. However it is acknowledged that despite the sample representing a traditional student nurse cohort within Wales, in the light of national demographics and diversity of the student nurse body across the UK, the sample could be considered as not fully representing the black, Asian and minority ethnic (BAME) communities.

Selected students were emailed (Appendix 4) with an attached electronic copy of an invitation letter (Appendix 5) and participant information sheet (Appendix 6). This gave participants time to re-read the sheet, contact the inquirer should they require further information or withdraw should they wish. Written consent was taken on the data collection day. Twenty-two participants were deemed appropriate for this study, as this would allow for dropouts at the three stages of the data collection process, Test 1 (NMIST), Test 2 (NMI) and the interviews. Small sample sizes are congruent with IPA methodology, with a final sample of between four and ten participants considered appropriate for a doctoral thesis (Reid et al. 2005; Smith et al. 2009a, p.52; Smith and Eatough 2016, p.54). Ten participants

completed all three stages; the participant demographics are presented in Table 5 (below) and their data is presented in chapter 6.

Table 5 Participant demographics

Participant	Programme of study	Children	Age	Ethnicity	Education	Application data
Paul	Adult	-	25	White	-	none
Lisa	Mental Health	4+	45	White	Bachelor's Degree	none
Nicky	Adult	3	45	White	O level/GCSE	none
Claire	Mental Health	0	37	White	Bachelor's Degree	none
Pauline	Mental Health	0	28	Other	Bachelor's Degree	Dyslexia
John	Adult	0	23	White	A level	none
David	Adult	3	34	Black	A level	none
Anna	Adult	0	24	White	A level	none
Fiona	Mental Health	0	28	Other	Bachelor's Degree	Dyslexia
Mary	Adult	0	28	White	Bachelor's Degree	none

5.3 Phase 1 - Identity structure analysis (ISA), NMIST and NMI instruments, data collection and analysis.

This section provides an overview of Identity Structure Analysis (ISA), the methodological underpinnings of the psychometric instruments used in this study, the Nurse Match Instrument screening tool (NMIST) and the Nurse Match Instrument (NMI). Attention is also drawn to the congruence of ISA with IPA.

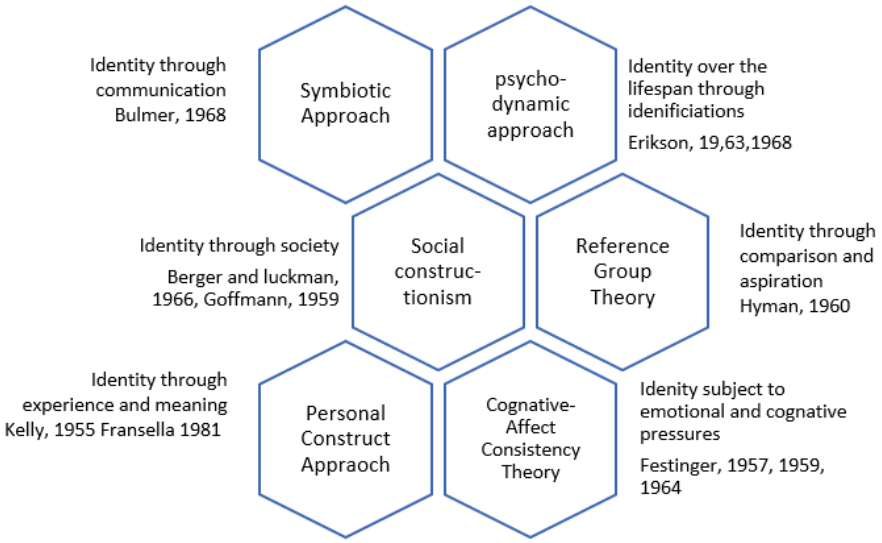
5.3.1 Identity Structure Analysis (ISA)

Two psychometric aptitude tests were used in this study to measure the students' personal nursing values, the NMIST and NMI. The NMI instrument was designed to measure and explore the identities of nurses, nursing students and applicants to nursing programmes (Ellis et al. 2015). The development of the NMI by Professor Roger Ellis and his team was followed by the creation of the NMIST from Identity Exploration Ltd. The NMI originated as a direct result of the VBR agenda, driven by the Staffordshire Inquiry and the perceived lack of instruments measuring professional identity and values in nursing (Ellis et al. 2015, p.1). The NMIST and NMI were chosen for this study as the NMI is offered as a VBR selection tool by HEE (2016a, p.16). Permission was sought and granted by Identity Exploration Ltd to use both instruments in this thesis (Appendix 1). Both instruments are based on the theoretical underpinnings of Identity Structure Analysis (ISA), described as a meta-theoretical framework of key perspectives on the nature of identity and self. Each instrument has linked software, Ipseus, which presents the instrument as an online tool (Ellis et al. 2015; Mazhindu et al. 2016). Ipseus also provides a report detailing both idiographic (emic) 'within person' and nomothetic (etic) 'within group' analysis (Mazhindu et al. 2016). In this research, for practical reasons related to the aim, the report was limited to an appraisal of

what the students understood to be their personal nursing values at work (work self) and those they believed were those of the 'model' i.e., good nurse, as outlined in section 5.4.6.

ISA utilises several theoretical perspectives and concepts (Weinreich and Saunderson (2003, p.7). Some major elements of ISA are a psychodynamic approach to the formation of identity through developmental processes, a social constructionist approach, the use of language in the social construction of the material and social world, as well as self-concept and social identity (Figure 1).

Figure 1 The Identity Structural Analysis (ISA) meta-theoretical framework



Adapted from Mazhindu et al. (2016, p.38)

Weinreich integrates these approaches by borrowing a feature of Personal Construct Theory (PCT), namely the repertory grid (Kelly 1955). Repertory grids were presented by Kelly as a diagnostic instrument for PCT (Kelly 1955, pp.219-220) and are used as a framework for the ISA instruments. Harré (2003, p.xxii) describes ISA as a *"sibling"* to the well-established methods of repertory grid analysis. The ISA instrument, like repertory grids, consists of a phenomenon or event under review and bipolar constructs to which entities can be designated, all of which lie within a range of convenience, i.e., understanding (Kelly 1955; Weinreich and Saunderson 2003; Fransella et al. 2004, p.9). Bipolar constructs, entities and convenience are illustrated in Appendix 9. ISA, therefore, explores the "*individual's experience and relationships between self and others over time and how these relationships change due to new experiences"* (Weinreich and Saunderson 2003, p.1). The epistemological position adopted with ISA is essentially constructionist and phenomenological; it is thus in harmony with the existential phenomenological perspectives of IPA.

The NMIST and the NMI, through the ISA framework, were tailored to reflect the topic areas of professional identity and values in the nursing community. Emergent themes were developed from the literature of the past 15 years and include values such as those emphasised in the 6Cs (DoH 2012) and the NHS constitution (NHS 2015a), in addition to those indicated by the nursing community through interviews and subject expert groups (Ellis et al. 2015). During this process, a list of 102 value constructs was reduced to twenty through content analysis and consolidated into six value themes related to the attribute themes used in the NHS. This final set was then piloted. The professionals who completed the pilot instruments provided feedback, which generally confirmed that the values used in the study had face and content validity (Ellis et al. 2015). The nurse match project was presented by Health Education England (HEE 2016a, p.16) as a case study of a VBR selection tool. As such, the instruments were inclusive of the value frameworks evident with VBR practices throughout the four nations and endorsed by HEE (HEE 2016a); they were thus deemed appropriate for this study.

It is acknowledged that the study's participants' only previous experience of MMIs was as part of VBR. Therefore, the additional experience of the NMIST and NMI tests provided two specific functions for this study that could not be achieved through semi-structured interviews alone. NMIST and NMI were used to (a) characterise the participants' perceptions and beliefs about their personal nursing values, as well as provide participant profiles based on the six value themes and their perceptions of their 'work-self' compared to the 'model' nurse and (b) allow participants to explore their interpretation of the NMIST and NMI test results and lived experience of the tests.

The NMIST and NMI (Appendix 9) require participants to make 260 ratings per instrument (13 entities x 20 constructs) that elicit the participants' emotional significance, or strength of feeling, about the construct under review (Ellis et al. 2015). Here, the entities under review were their real work-self and the 'model' nurse. The real work-self pertains to the participant *understanding* when appraising their own personal nursing values at work. The 'model' nurse describes what the participant *believes* to be the attributes and values of the good/ideal nurse, as defined by the profession. However, it must be noted that, occasionally, the participants' ratings for constructs as their ideal-self, that is, the participants' *aspirational* and *preferred* personal nursing values, exposed opposing views, as discussed in the test analysis (section 5.3.4).

The NMIST differs slightly from the NMI, as it considers life experience at the point of recruitment and does not assume experience of the nursing world. Therefore, the construct

language is more generic as it accounts for applicants from a non-healthcare background with no previous experience of carework. As such, the NMIST uses words generic to the concept of work, like people, work, help and job (Table 4, Appendix 9, highlighted in blue text). Meanwhile, the NMI uses wording specific to nursing, like nurse, patient and medical care (Table 5, Appendix 9, highlighted in red text). This was considered at the outset of the study and documented in an email to Identity Exploration Ltd. (Appendix 3).

5.3.3 NMIST and NMI data collection

Participants undertook the NMIST and NMI within their initial academic block, with a four-week gap between tests. This gap was considered appropriate for limiting test to retest memory (Kline 2015, p.2). Both the NMIST and NMI were undertaken in a proctored classroom setting with computer access to ensure procedural fairness and test integrity. The added benefit was that all the data was collected at one time while providing assurance that only the participant had completed the test. Login instructions were provided and technical support was available during both tests. The NMIST and NMI data collection, analysis and reports are further discussed in this section.

5.3.4 NMIST data collection

The NMIST was scheduled for April, early in the first academic block, thus minimising the curriculum input on nursing values, which might have influenced student responses. The majority of teaching content until then included an introduction to safe practice and public health. Therefore, the NMIST appraised, as pragmatically as possible, insights into the students' personal nursing and professional values on entry to the profession. Fifteen of the twenty-two invited students completed the NMIST. Four students withdrew, one did not respond to the invite and two failed to attend. A brief presentation was given before the students undertook the NMIST. The presentation was based on information given to the cohort during the original Belfast study, supplied by Identity Exploration Ltd. The presentation included guidelines on how questions would be presented and how to log responses when completing the NMIST (Hogart and Ellis 2016, p.56). All 15 students consented to continue (Appendix 8) and completed a demographic questionnaire (Appendix 7). The NMIST was not timed; the students completed the test within an approximate range of 25 to 60 minutes. All participants were verbally invited to undertake the NMI on completion of the NMIST, which was followed up with an emailed invitation. Approximately four weeks passed between participants receiving this email and undertaking the NMI, during which time they could contact the inquirer if they had further questions and/or wanted to withdraw.

5.3.5 NMI data collection

The NMI was completed by participants in May, towards the end of their first academic block, when the majority of teaching on caring and professional values had taken place. Therefore, it was possible to ascertain changes in the students' personal caring and professional values over that time and explore which, if any, experiences during that time had influenced their responses, compared to the NMIST. Of the fifteen participants invited, thirteen completed the NMI; two failed to attend and were withdrawn. Before commencing the NMI, all participants signed a consent form (Appendix 8) and were reminded of their login instructions. All participants completed the test within an hour.

Appendix 10 presents reflections on the NMIST and NMI data collection.

5.3.6 NMIST and NMI analysis

A modified descriptive approach to analysing data from the ISA identities of real work-self and 'model' nurse was taken to understand students' meaning-making around caring and professional values, as derived from the NMIST and NMI data. This framework was adapted from Smith (1995) and Smith (1999). Despite each student sitting the same test, each set of construct choices was unique to them, which defined the caring and professional values of each participant. Each participant's NMIST and NMI ratings, along with their value theme scores, were examined side-by-side in grid form, as Figures 2 and 3 illustrate. Therefore, the comparison of students' ratings for their real work-self and the 'model' nurse indicated how they *understood* their personal caring and professional values at work, compared to what they *believed* were the values of the 'model' nurse. Exploring how students rated the constructs enabled an understanding of how they applied meaning to caring and professional values. Hence, grids were analysed for evolving patterns on a construct and structural level. Some key patterns explored were:

- Responses where the real work-self and 'model' nurse showed similarities and differences in responses over time,
- Differences in responses across both tests and therefore across context and time,
- Extremes of responses on both preferred and non-preferred poles.

As discussed in section 5.3.2, students' ratings for ideal-self are not presented within their grids. Occasionally, however, the students' ratings for constructs as ideal-self, that is, the participants' *aspirational* and *preferred* values, exposed opposing views. Consequently, the constructs highlighted in bold text in the NMIST and NMI grids in chapter 6 will draw the reader's attention to the students' *aspirational* and *preferred* values on the bipolar scale (see example in Figure 2). The students' views of their ideal-self are discussed throughout the analysis when patterns emerge in the same way as described for the real work-self and the 'model' nurse, thus forming part of the analysis. To ensure transparency and validity, each

student's NMIST, NMI value theme scores, construct ratings for real work-self and 'model' nurse, as well as descriptive analysis, are presented for each case in chapter 6 (see exemplars in Figures 2 and 3).

Figure 2 Exemplar constructs and entities grid

N°	Test 1 - NMIST				Test 2 - NMI			
	Constructs		Ratings		Ratings		Constructs	
			self	nurse	self	nurse		
	Column (C) 1	C2	C3	C4	C5	C6	C7	C8
01	**People's dignity comes first**	need for help comes first	**2**	**3**	**2**	**4**	**Patient's dignity comes first**	need for help comes first
02	**Safety at work comes first**	resource limits may reduce it	**3**	**3**	**4**	**4**	**Safety at work comes first**	resource limits may reduce it
03	**Unpleasant tasks done by all**	done by less well paid	**- 4**	**4**	**3**	**4**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**1**	**3**	**-3**	**1**	**Nurses work best in a team**	work best on own
05	Can get people to follow instructions	**finds it hard to**	**4**	**-3**	**4**	**4**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**4**	**4**	**4**	**4**	**Learning competence is lifelong**	is for new workers only
07	**Listens carefully**	listening a distraction - get on	**-3**	**-4**	**4**	**4**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**2**	**3**	**3**	**4**	**Better be open and honest**	wiser to manage truth
09	**No excuse for lack of kindness**	pressures can be excuse	**4**	**-4**	**4**	**4**	**No excuse for lack of kindness**	pressures can be excuse
10	**Challenge authority if in best interests of work**	do not	**3**	**4**	**3**	**4**	**Challenge authority in best interests of patient**	do not challenge
11	**Enjoys decisions when competent**	prefers others do it	**4**	**2**	**4**	**4**	**Enjoys decisions when competent**	prefers others do it
12	**Takes responsibility for own actions**	sticks to guidelines	**2**	**4**	**3**	**4**	**Takes responsibility for own actions**	sticks to guidelines
13	**Take time needed for tasks**	do best in time one has	**4**	**4**	**3**	**4**	**Take time needed for tasks**	do best in time one has
14	**Good communicator**	not a good communicator	**4**	**4**	**4**	**4**	**Good communicator**	not a good communicator
15	**Relates well to others**	has problems relating to others	**-1**	**4**	**-4**	**4**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**4**	**4**	**3**	**4**	**Can be relied on**	real world can affect reliability
17	**Works with little supervision**	works better if managed	**3**	**4**	**3**	**4**	**Works with little supervision**	works better if managed
18	**Generally, understands situations**	sometimes does not	**3**	**4**	**3**	**4**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**-1**	**3**	**1**	**4**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**4**	**4**	**3**	**4**	**Always thinks about others**	focusses on own needs

Figure 3 Exemplar value theme grid

Value theme	Personal Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	37.74	62.82	59.1	65.05	68.06	50.18	57.16
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	68.19	62.69	61.26	55.51	57.29	46.08	58.5
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

5.3.7 NMIST and NMI participant reports

Central to the investigation were the students' viewpoints in relation to the content and complexity of the meaning of caring and professional values, in addition to their experiences and meaning-making around VBR. To facilitate the study aims, students were provided with their NMI test results through a simplified report (Appendix 13), thus encouraging them to reflect on their results and their VBR experiences before the interview. Reports were sent securely to and from a university-hosted account which only the student could access. The report was produced in collaboration with Mr Colin McNeill, a research psychologist employed by Identity Exploration Ltd, who provided advice and guidance on the test data analysis. Each report included an overarching explanation of how to interpret results; students' value theme scores and the group mean value theme scores; 20 construct responses to their real work-self, ideal-self and 'model' nurse identities; and an overarching explanation of individual responses. The NMI report was considered an appropriate basis

for the interview as this test is contextualised to nursing (Ellis et al. 2015) and offered a perspective on the NMIST results. The students' NMI and NMIST reports were available throughout the interviews so they could reflect and use their reports to explore caring and professional values, their experiences of taking the tests and the meaning of their results. The NMIST reports were sent to the students after their interview, completing the reporting process.

5.4 Phase 2 – Semi-structured interview method, interview schedule, data collection and IPA analysis

This section provides an overview of the semi-structured interview method, followed by the development of the interview schedule, data collection, interview process, transcription and, finally, the IPA analysis process.

5.4.1 Semi-structured interviews

The aim of the semi-structured interviews was to facilitate an understanding of:

- The caring values and professional values endorsed by the students.
- The students' points of view of the content and complexity of the meaning of caring and professional values.
- The students' meaning-making around caring and professional values in the context of the lived experience of VBR.

Smith et al. (2009a, p. 56) recommended semi-structured interviews as a data collection methodology well suited to IPA, as they offer rich, detailed first-person accounts of the experiences and phenomena under exploration. In the context of this study, interviews were regarded as a tool to enable participants to speak with their own voice and express their own thoughts, feelings and beliefs (Alshenqeeti 2014). Semi-structured interviews used in IPA are considered a co-produced, co-constructed dialogue, so they are a collaborative, meaning-making approach (Patti and Ellis 2017). As Hydén (2008) described, the intention was that the interview would become a mutual exchange, where the thoughts, beliefs and experiences of the students were valued, encouraging them to become more engaged in the conversation. Silverman (2013) and Kvale (1996) emphasised the challenges of collecting data through interviews; while conversation is a natural social encounter of everyday life, the professional research interview requires the inquirer to retain a methodical awareness and focus on the interview dynamics.

5.4.2 The semi-structured interview schedule

The interview schedule (Table 6 and Appendix 2) consisted of several key questions developed from the literature on caring and professional values and recruitment practices, as illustrated in chapter 3 (Rouse. 2014; Taylor et al. 2014; Waugh et al. 2014; Husbands et al.

2015; Kneafsey et al. 2015; Lievens et al. 2016; Callwood et al. 2017; Callwood et al. 2018a, Callwood et al. 2018b; Heaslip et al. 2018; McNeil et al. 2018; Snowden et al. 2018; Traynor et al. 2018; Mirghani et al. 2019; Callwood et al. 2020). The interview questions were additionally driven by the constructs explicit within the NMIST and NMI, students' responses to those measures and their lived experience of VBR practices. In semi-structured interviews, the schedule becomes a guide for conversation, making possible discreet comparisons in participant responses across data sets during analysis. Smith and Eatough (2016, p.58) describe this process *"as a dance of moving seamlessly between questions predicted and prepared in advance and unanticipated avenues which come up spontaneously".* Each participant's caring and professional values are unique, as are their VBR experiences. Consequently, the schedule became a guide, whereby questions might be asked in a different order or new questions asked, but all the students were asked explicit questions, as indicated in Table 6. Additional prompt questions were used on a case-by-case basis when required (Appendix 2).

Table 6 Research objectives and corresponding interview questions

Objectives	Questions
Explore, through interviews, the participants' meaning-making of care and professional values. (objective 3)	1. What does caring mean to you? 2. What do professional values mean to you?
To investigate the participants views on the caring values, professional values and identity constructs identified through their aptitude tests (objective 2)	3. What were your thoughts about your ratings? 4. What were your thoughts when you rated the model nurse? 5. What do you think accounted for the differences between your responses to test 1 in comparison to test 2?
Explore the participants experience of undertaking aptitude testing (objective 4)	6. Reflecting on your experience of undertaking aptitude testing for nursing values. Can you tell me a little bit about your perceptions?
Explore the participants experience of MMI (objective 4)	7. Reflecting back on your recruitment experience of undertaking MMIs. Can you tell me a little bit about your views?

5.4.3 The semi-structured interview data collection

Thirteen students completed both tests and were invited to interview, which ten students attended. Two students withdrew, while one did not respond to invitations. The interviews were conducted between July 7th and July 30th, 2017. They were completed whilst students were in their first academic block to ensure they could recollect their VBR experience and also remain safeguarded from the influence of clinical practice. The average interview time was 43 minutes. The longest was 55 minutes and the shortest was 25 minutes. All interviews were audio-recorded. Audio-recording is considered essential to enable

transcription and allow the inquirers to focus on the interview (Smith et al. 2009a, p.58). Additionally, I was aware that the interview environment was crucial to a successful interview and had to be considered. Therefore, I respected students' travel details, teaching times and availability. The interviews were arranged by email via university accounts at each student's convenience. They were conducted on campus in a convenient, dedicated interviewing facility, which was a quiet, private space which facilitated high-quality audio recording. All interviews proceeded without interruption. There were no time constraints; the duration of each interview was dictated by the interview schedule and the student. All interviews were conducted as intended.

5.4.4 The semi-structured interview process

The researcher is often perceived as having a position of power in an interview and is considered to be *"in charge"* of questioning (Kvale 1996, p. 20; Kvale 2006). Thus, I was aware of the additional potential power connotations between the student and me, which might have led them to provide responses deemed socially acceptable and potentially introducing bias. Kuzmanić (2009) defined the social psychology of the interview, emphasising the actor/observer, speaker/listener roles of self and other, in which the interviewee is the object under investigation. Thus, the interviews were initiated with neutral conversation like travel, the weather and their plans for the day. I dressed casually and emphasised my student status to establish a rapport. I initiated the interview with a brief explanation of the study and the questions. I stressed there were no expected right or wrong answers. Before the interviews, the students' anonymity and confidentiality were explained, while informed consent was discussed and given.

Trust in the accuracy, honesty and objectivity of the participants' meaning was achieved through several means:

- In-situ questioning and reaffirming key points during the interview.
- Follow-up emails to the students with an overview of the key themes from the interview process and inviting responses should they wish.
- Verbatim transcripts of the interviews, providing a robust audit trail according to the requirements of IPA (Smith et al. 2009a, p.183).
- Confirmation of the emerging themes through independent audit during supervision.
- Inquirer reflexive accounts were evident throughout the study.

Please see Appendix 11 for reflections on the semi-structured interview process.

5.4.5 Transcription

Each interview was transcribed verbatim from the audio transcription, as discussed by Bryman (2012, p. 484). Utterances from the inquirer such as *"umm"* were removed as these were irrelevant, distracted attention from the student's voice and made reading the transcripts easier. Observational field notes, taken post-interview, added detail to explore thoughts and ideas about the interview data as it unfolded. These notes considered the inquirer's world view and its effects, the research process and reflexivity (Smith 1999; Creswell 2014, p.197). Transcripts were read and re-read while listening to the audio recordings to immerse the inquirer in the students' accounts, so they were the focus of the analysis. Each transcription was organised in a lined table with three columns, with each line and page numbered. Transcripts were presented in the middle column, the right-hand column was used for initial notes and the left-hand column for themes, as shown in Figure 4.

5.4.6 Interpretive Phenomenological Analysis – the process

IPA takes an idiographic approach, leading to an in-depth and detailed analysis of the phenomena under investigation. Therefore, each student's world-view of caring and professional values in relation to the phenomenon of VBR was explored from their unique perspective (Smith et al. 2009a, p.29). Analysis aims for not only description of, but also engagement with, double hermeneutics, in which a participant's meaning-making around the phenomena takes primacy and the inquirer's sense-making becoming second-order (Smith et al. 2009a, p.36). Analysis moves from each participant's view of the phenomena to the shared view, or from the descriptive to the interpretive through inductive and iterative procedures. IPA provides a balance between the insider position and outsider stance (Reid et al. 2005, p. 22). To ensure quality analysis, the steps outlined by Smith et al. (2009a) for IPA were adhered to and are described in this section.

Maintaining the methodological approach to IPA outlined by Smith et al. (2009a), thematising was not undertaken by qualitative data analytic software (QDAS). Whilst there is extensive debate over using QDAS with IPA (Sohn 2017), some consider that QDAS does not achieve the insights required for phenomenological research (van Manen 2014, p. 390), nor is it advised for novice IPA researchers (Smith et al. 2009a, p.99). Conducting analysis by hand leaves a *"decision trail"* as a guide to the inquirer's approach, adding rigour to the study (Pringle et al. 2011, p, 16). Therefore, as Smith et al. (2009a, p.100) advocated, analysis was presented in a typed table for each student, as shown in Figure 4.

Figure 4 Example of the process of analysis

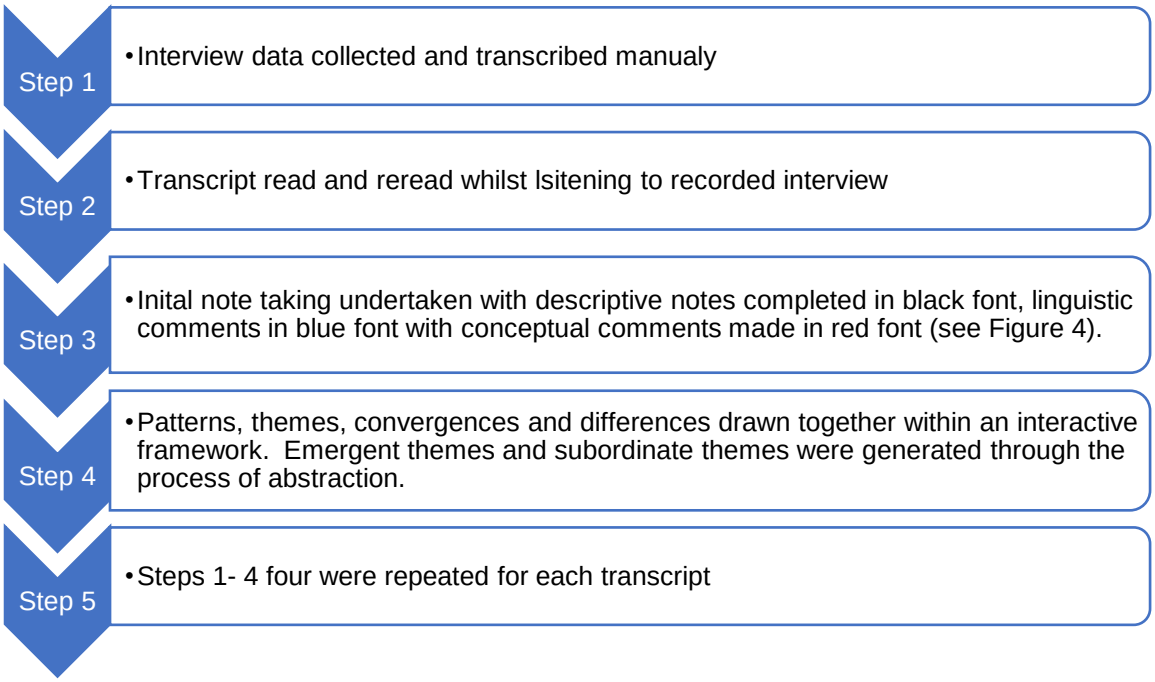
Managing identity	62.	self) caring, compassion, Competence, courage, communication. I'm	6c's as professional values
	63.	Missing one but yeah (laugh) that's the 6c's.	
	64.	S. (laugh) you can rattle of a few more than me.	
Previous experience	65.	Paul. umm yeah ummm it's hard to say because I have worked as a	Previous experience **care is well established within their working practices.**
	66.	HCA for so long it's just ingrained in my work isn't it you know.	
	67.	S. so do you see a difference between care and professional values	
Professional values are powerful	68.	Paul. umm. (long pause) professional values encompass so much	
	69.	More I suppose. Because care is just a part of what you do,	Care is just part **professional values are different seen as supervisory and powerful** *again the use of you here suggests ownership* **transitional self, nurse in the making**
Transitional self -nurse in the making	70.	Professional values also encompass you working with your	
	71.	Colleagues. You're working under supervision, your supervising	
	72.	Others you know. (long pause)	
	73.	S. So how you see yourself in terms of these umm care values.	
Care as doing	74.	Paul. Care values? I believe I'm OK with. I've been doing care for a	
	75.	Little while, and that sort of thing. Professional values. I'm working	Care as doing **sees professional values as transitional aspiring to be but not quite there yet** *use of I is possessive Use of from and to transitioning of values*
Aspiring to be but not quite there yet	76.	Towards that now. I'm going from being a HCA to being (deep intake	
	77.	of breath) a nurse now, So, it's getting more professional isn't it	
Transitional self	78.	S. yeah so, its umm yeah so its almost putting a different hat on	
	79.	Isn't it ?	
	80.	Paul. yeah definitely (long pause)	
	81.	S. so how do you think that other people see you in relation to	
	82.	These values care, both care and professional?	
Past self	83.	Paul. (long pause) umm I honestly don't know it hard to say. I think	
	84.	They think I'm alright, because I would not have a job and I wouldn't	excessive thinking - Reflective past image of self. *The use of "I" use as positive* **reaffirming for their place on the course and** *positive reinforcement with I* **used with care and professional values.** Subliminal I am caring I am professional other people think so - **manging identity of self**
	85.	Be here, I would not have got through the interview, so I must have	
Test is affirmational	86.	Some level of confidence in my ability to care for people and my	
	87.	Ability to be professional. I must have, or I would not be here.	
Managing identity of self	88.	S. (laugh) yeah so you sort have rattled off the 6cs and you kind of	
	89.	You (stuttering) the profession sort of the nursing profession say's	
	90.	That umm as a nurse you should be caring and compassionate. So	
	91.	What do you think about that? How do you feel about that?	

As illustrated in Figure 4, in the right-hand column, the initial level of analysis was undertaken. This included descriptive comments (black font). These comments were concerned with key phenomenological focuses which had meaning for the student, describing the context and content of the transcription. Linguistic comments were then completed in blue font; the specific language used by the student, as well as any repetition, pauses, laughter and other aspects of the students' language and iterations such as 'umm', were noted. Finally, conceptual comments were completed in red font and considered interpretive and abstract aspects, meaning the inquirer drew on experience, knowledge or fore-conceptions. Meanwhile, any comments in the transcript (middle column) considered potentially significant were underlined. Therefore, the analysis moved between my own understanding and the emerging understanding of the student's world (Smith et al. 2009a, pp.88-89). Once the initial analysis was complete, the larger data set was developed into the emerging themes and noted in the left-hand column, as illustrated in Figure 4.

Smith (2004, p.45) emphasised the levels of interpretation during analysis whilst staying grounded and close to the text. Engaging with the double hermeneutic enables the inquirer to transcend the participants' horizon of understanding; meanwhile, the inquirer remains centred and empathic to the meaning of the text, engaging with the hermeneutics of suspicion and critical questioning (Smith 2004). These different levels of interpretation, illustrated through the descriptive, linguistic and contextual analysis of the text, provide a depth of analysis and a comprehensive view of the participants' lived experiences (Smith

2004; Smith et al. 2009a). Performing the cyclical hermeneutic process with transcripts and across cases characterises the synergistic process of description and interpretation, which represents participants' words and thoughts and the inquirer's interpretation. Smith et al. (2009a, p.109) emphasised the inquirer's critical role within hermeneutic dialogue, whereby the inquirer moves from their position of knowing to the naive position of making sense of the participant's experiences. This process is cyclical, complex and dynamic, requiring the inquirer to be attentive and focus on the participant's sense-making around their life-world. When exploring transcripts, the inquirer attempts to bracket fore-conceptions, enabling the participant's voice to take primacy and bridging the gap between inquirer and participant so they share a *"mutual understanding"* (Smith 2007, p.5). Emergent themes and subordinate themes were generated through the process of abstraction, as described by Smith et al. (2009a, p.96). This involved the clustering of emergent subordinate themes into themes. Each case presents patterns, themes, convergences and differences integrated into an interactive framework, as described by Smith (1995) and Smith (1999). Each case is searched for a meaningful account of the findings until *Gestalt* has been achieved, at which point the inquirer moves to the next transcript (Smith 2004), as illustrated in Diagram 3. Thus, ten unique case studies are presented and discussed in chapter 6.

Diagram 3 Data analysis process



See Appendix 12 for reflections of the analysis process.

*5.5 **Phase 3 – Triangulation***

Triangulation of the descriptive test data (NMIST and NMI) and the participants' IPA narratives facilitated a multidimensional approach to the phenomena under investigation (Mason 2006). Hence, the focus was on within-person and individual meaning-making of the students' understanding of their caring and professional values, their understanding of the values of the 'model' nurse in comparison and their experiences of aptitude testing and MMIs (Smith et al. 2009a, p.29). The amalgamation of the NMIST, NMI and IPA data is discussed next.

5.5.1 Bringing together the data sets

Triangulating the students' NMIST and NMI descriptive analysis with the interview narratives enabled the mapping of the students' meaning-making of caring and professional values and how these values were mediated through the aptitude test language. Thus, whilst aligning with constructionism by exploring meaning-making of caring and professional values through interviews, the study also explores the interpretation and variability of meaning through the different positioning of the aptitude test. Thus, triangulation is valuable as it enriches understanding, allowing the phenomena to be observed from different perspectives rather than from a singular account (Yardley 2015, p.261). Emerging themes generated through IPA were triangulated with the NMIST and NMI data and are presented in each student's case in chapter 6. This contextualist method of triangulation provides a clear picture, looking for completeness, not convergence (Madill et al. 2000, p.10). This study's approach to triangulation provides a *"multi-layered understanding"* of the students' privately and publicly held beliefs and attitudes concerning caring and professional values (Yardley 2000, p.22). Despite ongoing debate about the use of triangulation and its place in mixed methods research (Morgan 2019), triangulation is considered a strength of this study as it seeks to provide transparency and clarity (Yardley 2000).

5.6 Ethics

Ethics was granted by Cardiff University's School of Healthcare Science Research and Ethics Committee in April 2017 (Appendix 14). As the NMIST was developed after ethical approval was granted, additional approval was sought from the Ethics Committee and granted in July 2017 (Appendix 14). The approved proposal was adhered to throughout. All data collated through the NMIST and NMI, in addition to the interview transcripts and recordings, were stored in the researcher's password-protected personal server space made available by the university. This ensured secure storage and protected anonymity and confidentiality, in accordance with Cardiff University managing research data policies (Cardiff University 2019). Autonomy was protected as the invitations explicitly stated the voluntary

nature of the research (Appendix 4), with consent forms signed by each participant at every stage of the data collection process (Appendix 8). Feedback from the NMIST and NMI was provided directly to participants via their university email accounts, therefore ensuring security as only the students had access to the information. The invitation letter (Appendix 5) and a participant information sheet (Appendix 6) emphasised the students could withdraw at any time during data collection and up to publication (Smith et al. 2009a, p.54). As direct quotes will be utilised in subsequent publications, the research participants' anonymity was protected using pseudonyms (Silverman 2013).

It is acknowledged that the potential adverse consequences for participants during the interview phase included distress, although predicting such consequences was complex. Support was provided as, discussed by Smith et al. (2009a, p.32) and as outlined in the University's Research Integrity and Governance: Code of Practice guidelines (Cardiff University 2019). In practice, whilst the majority of participants chose to divulge personal insights in their meaning-making of care and caring, no students indicated distress at any point during or after the interviews. However, one participant shared information of a deeply personal nature, as described in Appendix 11. To ensure this student did not require further support after their disclosure, I contacted them via email to offer support through student services (Cardiff University 2019), which they declined.

Chapter 6 – Findings

6.1 ***Chapter overview***

This chapter will present ten unique student cases. Each case comprised two interrelated parts, the tests and IPA interview. The first part presents an overview of the findings from Test 1 (NMIST) and Test 2 (NMI). Test 1 was taken by participants within two weeks of commencing the undergraduate nurse programme, with Test 2 completed by participants during their second month on the programme. The resulting construct ratings and value theme scores are presented in table format, along with a descriptive analysis of the test data. As explained in section 5.3.6 of the methods chapter, the descriptive element of the test data explains participants' ratings in terms of their value themes (please see Appendix 9 for NIPEC value themes) and the values and attributes related to both the real work-self and the 'model' nurse. Consequently, these findings reveal the participants' responses in terms of their *understanding* of their attributes and values at work, in comparison to those they *believed* should be exhibited by the 'model' nurse. As previously stated in section 5.3.6, the participants' ratings for the entity of the ideal-self, that is, the participants' *aspirational* and *preferred* personal nursing values, are not presented numerically within the participant tables. They are, however, highlighted in bold text within the tables on the bipolar scale.

The second part of each student's case is the findings from the IPA analysis of the interview, in which associations with the test data are highlighted. For clarity, the emerging themes and subordinate themes from the IPA analysis are presented in table format and an audit trail of quotes from each participant IPA is recorded within the appendix.

The final stages of the IPA cross-group analysis and the emergence of the final themes are presented in section 6.2 of this chapter.

6.1.1 Paul's case

Table 7 Paul's NMIST and NMI ratings

№	*Test 1 - NMIST*				*Test 2 - NMI*			
	Constructs		*Ratings*		*Ratings*		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	**People's dignity comes first**	need for help comes first	**4**	**3**	**3**	**4**	**People's dignity comes first**	need for help comes first
02	Safety at work comes first	**resource limits may reduce it**	**-2**	**-4**	**4**	**4**	**Safety at work comes first**	resource limits may reduce it
03	**Unpleasant tasks done by all**	done by less well paid	**-4**	**4**	**4**	**4**	**Unpleasant tasks done by all**	done by less well paid
04	People work best in a team	**work best on own**	**-2**	**-2**	**-1**	**-2**	People work best in a team	**work best on own**
05	Can get people to follow instructions	**finds it hard to**	**2**	**-3**	**0**	**2**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**1**	**1**	**2**	**4**	**Learning competence is lifelong**	is for new workers only
07	Listens carefully	**listening a distraction - get on**	**-2**	**-4**	**2**	**4**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**2**	**4**	**1**	**1**	**Better be open and honest**	wiser to manage truth
09	**No excuse for lack of kindness**	pressures can be excuse	**4**	**-4**	**4**	**4**	**No excuse for lack of kindness**	pressures can be excuse
10	Challenge authority if in best interests of work	**do not challenge**	**-1**	**-4**	**1**	**4**	**Challenge authority if in best interests of work**	do not Challenge
11	**Enjoys decisions when competent**	prefers others do it	**-1**	**1**	**2**	**4**	**Enjoys decisions when competent**	prefers others do it
12	**Takes responsibility for own actions**	sticks to guidelines	**2**	**3**	**-1**	**3**	**Takes responsibility for own actions**	sticks to guidelines
13	**Take time needed for tasks**	do best in time one has	**2**	**1**	**2**	**4**	**Take time needed for tasks**	do best in time one has
14	**Good communicator**	not a good communicator	**3**	**4**	**2**	**4**	**Good communicator**	not a good communicator
15	**Relates well to others**	has problems relating to others	**3**	**4**	**2**	**4**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**2**	**4**	**2**	**4**	**Can be relied on**	real world can affect reliability
17	**Works with little supervision**	works better if managed	**2**	**2**	**1**	**4**	**Works with little supervision**	works better if managed
18	**Generally, understands situations**	sometimes does not	**2**	**4**	**0**	**4**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**2**	**3**	**1**	**2**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**2**	**4**	**2**	**4**	**Always thinks about others**	focusses on own needs

Paul's construct ratings (Table 7)

In Test 1, there were 6 constructs (NMIST, 2, 3, 4, 7,10 and 11 Table 7, column 1-4) in which Paul favoured the opposing view to the professionally preferred pole, which reduced to only 2 (constructs 4 and 12) in Test 2 (NMIST, Table 7, column 5-8). Paul also rated the model nurse on the preferred pole on 13 occasions in Test 1 (see Table 7 column 4) in contrast to 19 times in Test 2 (see column 6, Table 7). This suggested that his understanding of the values of the model nurse changed significantly over time. Interestingly Paul also rated his personal nursing values the same as the model nurse on one occasion in Test 1 (see columns 3-4 Table 7) and 4 occasions in Test 2 (see columns 5- 8 in Table 7). This indicated that Paul viewed a degree of difference between his own personal nursing values at work and those of the model nurse. When Paul considered his ideal nursing values there were 5 constructs on the non-preferred pole in Test 1; these were constructs 2 (safety), 4 (teamwork), 5 (following instructions), 7 (listening) and 10 (challenging authority) (NMIST, Table 7, bold text, columns 1-2). This reduced significantly to only 1 construct – construct 4 (teamwork) in Test 2 (NMI, Table 7, bold text, columns 7-8).

In summary - Construct 2 (safety at work) was rated as -2. This indicated that Paul was of the view that safety at work would suffer as a result of pressures on staff and work resources. In construct 3 (Table 7, columns 1-4), Paul identified that he considered that unpleasant tasks were done by those paid less, rated -4. Construct 4 (teamwork) rated as -2 suggested that on the whole he preferred to work on his own. Paul rated construct 7 (Listens carefully) as -3. i.e. Paul preferred to get on with the job as opposed to listening carefully to others. His ratings for construct 10 indicated that he recognised that he would be unprepared to challenge somebody more senior (rated -1). For construct 11 (decision making) Paul ratings i.e. -1 on the non-professional preferred pole, identified that at work he preferred others to make decisions.

When Paul rated the model nurse in Test 1 (NMIST, Table 7, columns 1-4) there were a further 6 constructs rated on the non-preferred pole, these were constructs 2, 4, 5, 7, 9 and 10. His ratings for construct 2 indicated that that Paul believed that for the model nurse the pressures at work can leave less room for kindness and sympathy – rated -4. Paul also rated construct 4 as -2 for the model nurse, this suggested that like him the model nurse generally worked best on their own. When rating construct 5 (following instructions) Paul identified that he understood the model nurse found it hard to influence and get people to follow instructions (rated -3). He also rated construct 7 as -4 for the model nurse. This suggested that he thought they would prefer to get on with the job and found listening a distraction. His ratings for construct 9 (kindness) indicated that Paul understood the pressures of work left less room for kindness and sympathy for the

model nurse; whereas his ratings for construct 10 suggest that Paul recognised that the model nurse would be unprepared to challenge somebody more senior (rated -4). Which indicated a strong response on the non-preferred pole.

Paul's ratings for Test 2 (NMI, Table 7, columns 5-8) indicated a significant change of opinion when he measured his own personal nursing values and those of the model nurse with only 2 constructs - 4 (teamwork) and 12 (guidelines) – rated on the non-preferred pole when he considered his values in work and only one for the model nurse – construct 4 (teamwork) suggesting these value statements were in some way significant for Paul. In Test 2 Paul's responses suggested that he continued to believe that both he (rated -1) and the model nurse (rated -2) would work best on their own as opposed to being part of a team. Whilst his ratings to construct 12 denoted that, on the whole, he would adhere to guidelines and instructions whilst at work, rated -1, as opposed to taking responsibility for his actions.

Table 8 *Paul's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	40.34	41.34	43.74	27.54	33.08	38.29	37.39
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	57.75	49.06	51.49	40.29	43.92	41.34	47.31
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

Paul's value theme scores (Table 8)

Paul's value themes in Test 1 were mainly clustered just below the group average (Table 8). Scores for value themes, Integrity (27.54 in Test 1 and 40.29 in Test 2) and Commitment to personal development (33.08 in Test 1 and 43.92 in Test 2) however, were well below the group average. Paul's scores improved in Test 2 with Accountability (49.6), Trust (51.49) and Person-centredness (57.75) scores being high and in line with the group average.

Paul's interview

Paul was a 25-year-old male with no children. He had enrolled in the BSc adult nurse pathway and worked as a healthcare assistant (HCA) before starting his nurse training. Analysis of Paul's interview identified three themes, 'Caring values', 'The ideal nurse' and 'The experience of value-based recruitment' (Table 9). These themes, along with their relevant subordinate themes, are described below.

An audit trail of quotations is provided in Appendix 15.

Table 9 Themes and subordinate themes from Paul's interview

Themes	Subordinate themes
Theme 1: Caring values	Care and experience Professional values
Theme 2: The ideal nurse	Nurse in the making
Theme 3: The experience of VBR	The MMI Getting the whole picture

Caring Values

This theme summarises how Paul viewed honesty, duty and empathy as intrinsic components of care, whereby his previous experiences of carework had informed his ideals and what he believed to be the values of the nurse.

Care and experience

Paul described himself as caring, as evidenced through his work, which he believed had *"got [him] through"* his selection. Paul believed there was an intrinsic relationship between the nature of empathy and life experience. He regarded his previous carework as valuable *"life experience"* as he could *"empathise"* and be "*pragmatic"*, compared to those without care-work experience. Paul regarded caring as a *"natural"* aptitude for a nurse which could not be taught but *"could be built on".*

> *[It's] your ingrain[ed] values isn't it, like your honesty, your sense of empathy and that sort of thing … If you haven't got that sense of duty then you're not going to help the patients when you're busy or when you're stressed and that's not fair. That sense of responsibility and empathy. That's really important and that's something that you can't really teach.*

The extract above suggested that honesty and empathy were firmly established caring values for Paul, which centred on the task and act of care, characterised as *"help".* Consequently, care incorporated the moral components of responsibility and fairness. Paul's transcript also highlighted dissonance involving missed opportunities to provide care. He considered carework as pressured, time-limited and *"busy"* work, where he was conscious that *"you haven't got that two minutes"* to spend with patients. Work pressures were also

linked to his novice status: *"As time goes on, your responsibilities get a bit larger and time gets a bit shorter and then you get into that rushing mode"*; he described this as stressful. This was reflected in Paul's ratings for his first test, which indicated he believed that safety, kindness, sympathy and time for listening to patients were affected by the pressures and pace of practice (Constructs 2, 7 and 9, NMIST, Table 7, columns 1-4). Paul's previous experience was also a source of tension, characterised as *"bad habits": "I have got preconceptions [and] I have got prejudgements and that sort of thing, which isn't good, that's an advantage some people that have not done care before have got; they are coming in fresh".* This suggested his expectations of care in practice were more practical and realistic than they were for students without carework experience, which was a disadvantage to his aspirational values. Tension between aspirations and realities of care in practice continued. Paul described how care taught in the classroom, depicted as the *'gold standard',* might not be *"the best way out there",* i.e., in practice:

> *[What] we are taught now is everything it's gold standard, isn't it, it's what you really should be doing, isn't it, you shouldn't be cutting corners, you shouldn't be, you know; and then of course, being away from the ward has made you more idealistic in your viewpoint.*

For Paul, the values portrayed by the university were the benchmark to be emulated. However, his repeated use of *"should"* and *"isn't it"* indicated that his view of the realities of carework (as long, tiring and busy) conflicted with classroom teaching. Nevertheless, an absence from carework had enabled him to distance himself from his earlier preconceptions and to align his values with those taught by the university.

Professional values

Paul found it difficult to distinguish between caring and professional values because they were so deeply rooted, which he characterised as *"ingrained"*.

> *Professional values encompass so much more because care is just a part of what you do. Professional values is working with your colleagues. You're working under supervision [and] you're supervising others you know.*

Paul's account suggested that he viewed professional values as subsumed within caring values; therefore, professional values were more meaningful and collegiate. Nevertheless, he identified the 6Cs (DoH 2012), i.e., caring, compassion competence, courage, commitment and communication as professional values, ticking them off on his fingers as if presenting a list. Throughout the transcript, Paul stated these were the values the nurse *"should"* have, implying the 6Cs embodied the professional norms handed down by the nursing profession. Paul considered care and compassion as essential values, which he was *"working towards"* rather than *"going from"*, being an HCA. This suggested that

professional values - illustrated in value frameworks (see Table 1) - were transformational and aspirational values that embodied the stereotypical nurse.

The ideal nurse

Within this theme, Paul described how his previous preconceptions and patterns of behaviour as an HCA had shaped his personal nursing values and how he viewed the nurse in comparison. This influenced how he rated test constructs.

Nurse in the making

Paul defined a firm idea of the values of the 'model' nurse, which he considered *"an ideal".* This contrasted with his own values in work, described as "*this is how I am at the moment with the fact [that] I've worked"*. This implied that not only had his values been influenced by his practice experiences but also his understanding of his existing values, rather than his future values. This suggested he considered himself inexperienced compared to the nurse and this had influenced his test responses. Thus, rating constructs for the 'model' nurse was easy, compared to rating his own values, which was complex. Consequently, he scored his values differently: *"I can view the model nurse and the ideal way down there, and I can view myself here and see what I'm working towards"*. As Paul spoke, he indicated ahead of himself. This suggested he was describing future values, which implied these values were aspirational and goals he was working towards. Paul confirmed this analysis: "*That's me saying I'm four or five and as good as I'm going to be"*; therefore, *"there would be no room for improvement"*. Paul considered his view as a positive aspect, as he viewed his progression in a *"timeline"* and had *"a bit of modesty"* about his values. Again, he appeared to emphasise that his student status affected how he rated his personal nursing values during the tests. He also described construct values statements as *"things you do",* which suggested constructs measured competencies rather than values. As I probed further, he drew on his experience of completing the NMI (Test 2) and focused on construct 10 (Table 7) in his report:

> *Challenge authority. I remember that question vividly and I know that a model nurse should [challenge authority]. I put that way down there in the timeline for me … as I am further down here.*

Paul acknowledged that challenging authority was something he would not do. His use of *"vividly"* emphasised his strength of feeling. This indicated that challenging authority would be difficult for him, although he understood this was something he should do and something he would do in the future. This suggested his student status influenced his opinion and construct ratings. Conversely, his emphasis on *"should"* also implied that challenging authority, even in the patient's best interests, did not always happen in practice. Thus, the nurse lacked courage on the occasions when they did not speak up. Reflecting his ratings in both tests over time (Construct 10, Table 7, columns 1-8). Paul added that his low trust and

integrity value theme scores were surprising as he considered himself a *"trusting person" and "trustworthy",* questioning the validity of the scores compared to his beliefs. Paul also acknowledged that curriculum input between tests had affected his responses to the second test:

> *I think it's because I've been learning the theory of nursing these past few months, I suppose the practical nature of what I was doing before, so maybe a little bit more idealistic because I've been off the ward for a bit, I've been not working 12-hour shifts four days a week and getting tired and busy and not being able to do anything.*

Paul considered had become more *"idealistic"*, whereby notions of care promoted by the university had taken precedence when completing the tests. This was evident in Paul's ratings of the 'model' nurse, which was on the preferred pole 13 times in Test 1 (NMIST, Table 7, column 1-4) and 19 times in Test 2 (Table 7 column 5-8). Consequently, this improved his Test 2 scores (Table 8).

The experience of VBR

This theme reflects Paul's multiple mini interview (MMI) experience and how he could prepare and manage his performance. Paul viewed the tests as stressful because of an absence of communication, which, for him, made the tests' validity questionable.

The MMI

Paul described positive MMI experiences at several universities but because of his broad MMI experiences, he failed to remember clearly the MMIs at Cardiff University. Therefore, his reflections were limited. However, he described MMIs as *"looking for certain characteristics in people"* that were *"beneficial to the profession"*, as *"you have got to have a certain set of values"*. This suggested an inventory of values against which candidates were assessed. Paul recollected two activity stations which apparently had particular resonance, "*the video of the elderly gentleman",* which explored dignity, and *"origami"* (folding a napkin under instruction), which explored communication. Paul also admitted knowledge of the MMI stations' content before the interview, which he described as "*the heads up"*: *"The student nurses on the ward had done it the year before [at] Swansea, [so] I knew what to expect. At Swansea, Cardiff and UWI, they are all similar".* Paul's words indicate that candidates are aware of the MMI stations' content before the interview; therefore, they come prepared to present their values in line with those expected at MMI. This information seems to be readily passed between students and candidates working in practice. Paul did not articulate any hesitancy or dilemma in accepting information to enhance his performance and gain a potential advantage over other candidates through the MMI. This implied a desire to present his values more favourably.

Getting the whole picture

Paul described psychometric tests for the recruitment process as *"extremely stressful"*, stating *"I was much more comfortable with the MMI".*

> *I think you can learn more by conversation in the MMIs we done than you can from that, you know. It's nice [and] it's interesting but I wouldn't rely on it. I wouldn't, I, it's not my call [and] I wouldn't like it if you were relying on that.*

Paul repeatedly seemed dismissive of the tests, referring to his report as *"that",* in comparison to his more positive MMI experience. Paul's account implied that communication was desirable during the recruitment process and afforded a sense of legitimacy absent in the tests. It could be surmised that his anxiety was rooted in his interpretation of his report, which Paul maintained was not truly accurate:

> *… partially, almost most certainly, it does reflect partial. But whether you get the whole picture, I don't believe so because, the questions are open to interpretation as well, aren't they, even though they are chosen words and stuff. If I interpreted the questions slightly different to what it should have been interpreted as, then my results can be way, way off.*

His transcript also indicated a belief that right and wrong responses to the constructs existed. Thus, if his understanding were deemed incorrect, this would undermine his results. This suggested the values statements within the construct were occasionally complex for Paul.

6.1.2 Lisa's case

Table 10 Lisa's NMIST and NMI ratings

№	*Test 1 - NMIST*				*Test 2 - NMI*			
	Constructs		*Ratings*		*Ratings*		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	**People's dignity comes first**	need for help comes first	**2**	**0**	**1**	**2**	**Patient's dignity comes first**	need for help comes first
02	**Safety at work comes first**	resource limits may reduce it	**1**	**0**	**2**	**2**	**Safety at work comes first**	resource limits may reduce it
03	**Unpleasant tasks done by all**	done by less well paid	**-3**	**4**	**2**	**3**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**2**	**2**	**-1**	**3**	**Nurses work best in a team**	work best on own
05	Can get people to follow instructions	**finds it hard to**	**1**	**- 2**	**1**	**1**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**4**	**3**	**2**	**2**	**Learning competence is lifelong**	is for new workers only
07	**Listens carefully**	listening a distraction - get on	**2**	**2**	**1**	**3**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**2**	**2**	**0**	**-3**	Better be open and honest	**wiser to manage truth**
09	**No excuse for lack of kindness**	pressures can be excuse	**3**	**-4**	**3**	**4**	**No excuse for lack of kindness**	pressures can be excuse
10	**Challenge authority if in best interests of work**	do not challenge	**1**	**3**	**1**	**3**	**Challenge authority in best interests of work**	do not challenge
11	**Enjoys decisions when competent**	prefers others do it	**2**	**2**	**2**	**3**	**Enjoys decisions when competent**	prefers others do it
12	Takes responsibility for own actions	**sticks to guidelines**	**0**	**3**	**0**	**0**	Takes responsibility for own actions	**sticks to guidelines**
13	**Take time needed for tasks**	do best in time one has	**1**	**1**	**0**	**1**	**Take time needed for tasks**	do best in time one has
14	**Good communicator**	not a good communicator	**3**	**4**	**-1**	**-2**	Good communicator	**not a good communicator**
15	Relates well to others	**has problems relating to others**	**-3**	**-1**	**1**	**3**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**-1**	**-1**	**0**	**0**	Can be relied on	**real world can affect reliability**
17	**Works with little supervision**	works better if managed	**2**	**2**	**0**	**2**	**Works with little supervision**	works better if managed
18	**Generally, understands situations**	sometimes does not	**1**	**-1**	**-2**	**-2**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**2**	**2**	**2**	**4**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**3**	**2**	**3**	**4**	**Always thinks about others**	focusses on own needs

Lisa's construct ratings (Table 10)

The majority of Lisa's ratings for both tests were between 2 and -2 (Table 10, columns 3-6) which focused on the difficulties and challenges of being the model nurse as opposed to being the best. Lisa declined to rate constructs on three occasions in Test 1 (NMIST, Table 10, constructs 1, 2, and 12, columns 1-4) and seven in Test 2 (NMI, Table 10, constructs 8, 12, 13, 15 and 16, columns 5-6). Her ideal self, thus her aspirational values, were on the preferred pole on all but three occasions in Test 1 (NMIST, Table 10, bold text, column 1-2, constructs 5, 12 and 15) and four occasions in Test 2 (NMI, Table 10, NMI, bold text, column 7-8 constructs 8, 12, 14 and 16).

Lisa's ratings to the constructs in Test 1 (Table 10, columns 1-4) identified that she believed that unpleasant tasks were the responsibility of those less paid (construct 3, rated -3). At work she understood that she often misunderstood others and had a problem relating to others (Table 10, construct 15, rated -3). She rated construct 16 - reliability - as -1, this indicated that she considered that the real word could affect reliability. In Test 1 (NMIST, Table 10 columns 1-4) Lisa viewed that the model nurse found it hard to get people to follow instructions (construct 5, rated -2) and that work for them was pressured, which could mean there was less time for kindness and sympathy (construct 9, rated -4). Lisa's ratings to construct 15 (relating to others), denoted that she believed that the model nurse did not relate well with others (rated -1). Lisa also indicated that the model nurse did not always understand the situation at work (construct 18, rated -1) and that the real word could affect reliability for the model nurse (construct 16, rated -1).

In Test 2 (Table 10, columns 5-8) Lisa's ratings identified that at work she denoted she worked best on her own as opposed to in a team (construct 4, rated -1). She also considered that, on occasions, she misunderstood things (construct 14, rated -1) and that she did not always understand the situation in work (construct 18, rated -2). In Test 2 (NMIST, Table 10, columns 5-8), when Lisa gauged the values of the model nurse, she rated construct 8 -3. i.e., the model nurse would manage the truth in the best interests of work. She also believed that on the whole, the model nurse was not a good communicator (construct 14, rated -2) and sometimes did not understand the situation (construct 18, rated -2).

Table 11 *Lisa's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	25.95	23.78	12.83	18.63	20.12	16.72	19.67
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	35.96	32.08	14.48	21.88	32.34	33.37	28.37
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

Lisa's value theme scores (Table 11)

All of Lisa's value theme scores were considerably lower than the group average for both tests. Her mean value theme score for Test 1 (NMIST) was 19.67 compared to the group mean of 42.23. In Test 2 (NMI) whilst her mean value score improved (28.37), she continued to be below the group mean of 52.69. Trust (NMIST 12.83, NMI 14.48), Integrity (NMIST 18.63, NMI 21.88), and teamworking (NMIST 16.72, NMI 33.37) were also consistently low value theme scores in both tests for Lisa.

Lisa's Interview

Lisa, a 45-year-old female with five children, was taking the Mental Health Nursing pathway. Lisa had a degree but no previous paid carework experience. Analysis of Lisa's interview identified two themes, 'The caring position' and 'Judging the good nurse' (Table 12). These themes and relevant subordinate themes are described below.

An audit trail of quotations is provided in Appendix 16.

Table 12 Themes and subordinate themes from Lisa's interview

Themes	Subordinate themes
Theme 1: The caring position	The caring aptitude The professional manner Real V the ideal
Theme 2: Judging the good nurse	It's not clear cut Different and clever

The caring position

Lisa considered her personal nursing values embodied empathy, trust, dignity and respect. However, significant tensions emerged from her transcript when she compared the values taught by the university to her perceived realities of nursing practice.

The caring attitude

Lisa began the interview describing empathy as a cornerstone of her caring values and core to her *"caring position"*:

> *Empathy to me is a key issue of caring as I don't think that you can really truly be in a caring position if you haven't got empathy, that you could see things through other people's eyes.*

Lisa's word choice emphasised her strength of feeling, whereby empathy was an intrinsic caring value and those without empathy would not have the values required to become a good nurse. Lisa identified herself as compassionate, trustworthy, respectful, friendly and approachable. This suggested integrity and communication were essential values for her. Lisa described herself as an "*absolute stickler for trust; if somebody tells you something then you should respect that"*, emphasising trust had a particular resonance. Therefore, Lisa questioned the validity of her trust value score, which was below the group average (Table 11). She viewed the 'model' nurse as "*easy to approach; she's, she's friendly, she might come in with a smile, she might like have you know, just be easily, easy to talk to"*; thus, she was aligning her values with what she believed to be the stereotypical norms of the nurse i.e., those embedded within value frameworks (see Table 1). Consequently, she questioned the validity ratings for construct 14 (communication): *"I don't know why it's like that … I think I'm a good communicator".* Interestingly though, despite questioning the validity of her

ratings, she had also rated the 'model' nurse as a poor communicator, again aligning her values with those of the 'model' nurse. Lisa referred to the nurse as *"she"* throughout her transcript, which highlighted nursing values as embodying feminine perspectives of care. Lisa described herself as *"bit too soft".* Consequently, her *"caring attitude"* was sometimes disadvantageous as she could be taken advantage of, so being caring could be overwhelming. Lisa characterised nurses who "*don't give a damn about people"* as unsuitable, in comparison to others who go into nursing *"because you want to do it … [and] want to be a nurse".* Thus, for Lisa, nursing was desirable, aspirational and vocational, i.e., it was more than a *"paid job".*

The professional manner

Lisa stressed professional values as *"important"*, since professional values protected patients' dignity, autonomy and respect. She added, *"I think, wouldn't it be nice if all nurses who went into this profession were behaving or acting in their roles as we are being taught"*. Lisa's response indicated she believed nurses should portray themselves in a certain way. Thus, professional values were the demeanour and attitude of the nurse which embodied the professional image. This implied Lisa believed professional values, illustrated as respect, dignity and autonomy, provided the characteristics and patterns of behaviour that made the nurse look professional and were reinforced by the university. She described nursing as holistic, since nurses *"had to cover all areas"*, emphasising nurses had to be competent and committed to the work they did. Lisa used "*we"* during her description of professional values, which suggested an alignment with the values, stereotypical images and norms of the nurse (see Table 1). Lisa described a conversation with a neighbour who was a nurse: *"She said 'I've got a job in one of the local nut houses over there' and I was like, I was appalled … I was absolutely gobsmacked … knowing that there are people who work in the profession who really are the opposite and can really make people feel quite uncomfortable".* Lisa's words denoted a strong sense of concern and frustration, rejecting inappropriate behaviours not reflective of nursing professional standards, which included subscribing to *"the NMC code even in your life outside".* This implied that certain behaviours are overlooked in practice and professional values are retained outside of work.

Real v the ideal

Lisa stated, *"I don't know"* on 19 occasions when answering questions related to nursing values. Lisa's understanding was also reflected in her construct ratings for both tests, the majority of which clustered between 2 and -2, which focused on the difficulties and challenges of nursing rather than the aspirations. Analysis of Lisa's transcript also highlighted a dissonance between the integrity of her aspirational values, i.e., the *"ideal"* values taught in university, and the reality of nursing values in practice as she believed it to be. She described a *"real confliction"* that the values taught *"in the classroom" and*

characterised as the "*ideal eventuality"* did not reflect the reality *"in the hospital settings or community settings".* Lisa described her struggle between the differences in care values as *"inside"*, implying these feelings were hidden. Lisa described herself as being *"like a member of the public".* Consequently, as a novice who had not worked in practice, her perceptions were naïve. In this respect, Lisa drew on her own and her family members' experience of care to illustrate concerns. She described perceptions of care in practice as *"absolutely shocking"* and *"appalling"*, which illustrated her strength of feeling. Drawing on Francis (2013), she reiterated that nursing values are *"what we should be doing"* and these values were *"pumped into [the student] day after day after day"* in university, which challenged her perceptions of the good nurse. Although not explicit within Lisa's words, they indicate the worrying potential for diminished values when faced with pressures of clinical practice:

> *…It's like being told when you go out into placement you can see things and hear things and you really shouldn't let [yourself] be dragged into just going down [the route of] it's okay to talk about these people like this and we all do it you know and it's, you know, so you're supposed to like, make a stand.*

Whilst Lisa acknowledged that poor care practices were not tolerated by the university, her words indicate a lack of courage to challenge those who did not reflect nursing professional standards and behaviours. This was reflected in her ratings for construct 10 (challenging authority). She rated herself weakly at 1, with the 'model' nurse 3 in comparison (Table 10). As the conversation continued, Lisa considered pressures of carework and the impact on vulnerable patients:

> *Maybe, maybe it's easier to respond to the ones that are shouting loud yeah to run to the ones that are shouting loud than to the ones quietly sitting there and aren't really able to complain and it's quite awful really because they sometimes are the ones who really need to be fed … They can't get a drink themselves with thirsty [and] they can't go to the toilet themselves … maybe it's easy to leave those ones to last because they're not so demanding [and] not so loud then, making a fuss, they are not disturbing everyone.*

Lisa described a chaotic image of her perceptions of the reality of practice, while analysis of the extract above indicated that Lisa considered the pressures of carework justified poor care practice, in which care became task-driven and devoid of empathy. Her thoughts seemed to reflect her construct ratings, which focused on the challenges of carework, whereas the real world was pressured and limited a nurse's reliability, leaving less time for kindness and sympathy (Constructs 9 and 16, Table 10, columns 1-4).

Judging the good nurse

In this theme, Lisa described being disadvantaged in the test environment because of her lack of care experience. Her test results caused disappointment in comparison to her MMI, which, despite initial misgivings, was a positive experience.

It's not clear-cut

Lisa described being disadvantaged in comparison to other students when taking testing as she had not worked in care, stating that if she had, she *"would have approached [it] differently"*. She described finding it difficult to *"place"* herself, i.e., rate constructs, because she understood values statements as *"being directed as if you worked as a nurse".* Therefore, she found herself unable to answer, resulting in a *"need to go in the middle".* This suggested her inexperience affected how she responded to the tests. Lisa believed *"I can't really judge [the nurse]"* as she *"had not completed her training"*; therefore, she was not in a *"position"* to pass judgement on nursing values. Emphasising her student position had influenced her ratings. This uncertainty appeared in her construct ratings for both tests (Table 10), which mirrored her preconceptions and biases, rather than the values of the 'model' nurse. Lisa rated her values in 29 out of 40 constructs between 1 and -1. She described rating constructs as complex, presenting a view that the values of the 'model' nurse were aspirational and goals to be achieved in the future, rather than values she possessed now. This indicated Lisa considered the nurse as knowledgeable and competent by comparison. Lisa drew on her previous experience of when *"patients are not really happy"*, returning to her earlier portrayal of carework as being busy, pressured and stressful. Consequently, she rated constructs based on *"how I feel sometimes is in reality"*. Therefore, her perception of poor care in practice was reflected in her ratings. As a result, her report reflected her understanding of the real-world challenges for the nurse, rather than the aspirational values of being a nurse, which resulted in low value scores for both tests (Table 11). Lisa considered her reluctance to *"judge"* people was partly due to her values as a mental health nurse, as she considered it was not *"fair"* to judge others. This suggested that different branches of nursing display a unique approach to the values statement under review. Lisa acknowledged that during the tests, she wondered if she should *"tick at each end"*, emphasising how her inexperience made it difficult to differentiate and 'grade' the constructs; she characterised the process as not *"clear-cut".* Lisa alluded to outside pressures influencing her ratings, such as feeling tired, rushed and worried about her children, which she equated with the pressured and rushed world of the nurse. She recalled her initial views when reading her results: *"I don't really know if you'd like those results really or not … It didn't really make me feel very good about myself to be honest".* Lisa's transcript intermittently hinted at disappointment with her test results, stating that she thought there

were a *"lot of minuses"*, which suggested she viewed her results as a failure that affected her self-esteem.

Different and clever

Lisa described her MMI experience as "*a bit self-conscious at first thinking 'ohh bugger I don't really know what to expect now'*". Her words implied performance anxiety before the MMI, as she considered herself unprepared for the unknown. However, her non-verbal communication, a smile, indicated a pleasant experience despite feeling nervous. Thus, when probed further, she stated the MMI was not *"nearly as bad"* and it had been "*a clever way to interview people".* This suggested Lisa considered the MMI as a relaxed and astute way of gaining information about candidates. Lisa perceived there was a right choice when responding to the MMI scenarios:

> *You know these things they tell you there is no right or wrong answer, but you know you go home and you keep thinking … 'Did I make the right choice?'*

Lisa clearly displayed apprehension about her performance and decision making during the MMI. Lisa also used *"different"* on several occasions, although this may have been in two contexts. For example, she described "*different scenarios"* or *"talking to [different] people"*, highlighting that her experience of the MMI was unlike anything she had experienced previously, while each station and assessor were also different. Thus, for Lisa, it appeared that negotiating the MMI was complex.

6.1.3 Nicky's Case

Table 13 Nicky's NMIST and NMI ratings

№	*Test 1 - NMIST*				*Test 2 - NMI*			
	Constructs		*Ratings*		*Ratings*		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	People's dignity comes first	**need for help comes first**	**4**	**4**	**1**	**1**	**Patient's dignity comes first**	need for help comes first
02	Safety at work comes first	**resource limits may reduce it**	**2**	**2**	**1**	**1**	**Safety at work comes first**	resource limits may reduce it
03	**Unpleasant tasks done by all**	done by less well paid	**2**	**2**	**1**	**1**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**2**	**2**	**2**	**2**	**Nurses work best in a team**	work best on own
05	Can get people to follow instructions	**finds it hard to**	**2**	**4**	**1**	**1**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**2**	**1**	**1**	**1**	**Learning competence is lifelong**	is for new workers only
07	Listens carefully	**listening a distraction - get on**	**4**	**4**	**1**	**1**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**1**	**1**	**1**	**1**	**Better be open and honest**	wiser to manage truth
09	No excuse for lack of kindness	**pressures can be excuse**	**1**	**1**	**1**	**1**	**No excuse for lack of kindness**	pressures can be excuse
10	**Challenge authority if in best interests of work**	do not challenge	**2**	**2**	**1**	**1**	**Challenge authority in best interests of work**	do not challenge
11	Enjoys decisions when competent	**prefers others do it**	**2**	**4**	**1**	**1**	**Enjoys decisions when competent**	prefers others do it
12	Takes responsibility for own actions	**sticks to guidelines**	**1**	**1**	**1**	**1**	**Takes responsibility for own actions**	sticks to guidelines
13	**Take time needed for tasks**	do best in time one has	**3**	**2**	**1**	**1**	**Take time needed for tasks**	do best in time one has
14	Good communicator	**not a good communicator**	**4**	**4**	**1**	**1**	**Good communicator**	not a good communicator
15	Relates well to others	**has problems relating to others**	**4**	**3**	**1**	**1**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**2**	**2**	**1**	**1**	**Can be relied on**	real world can affect reliability
17	**Works with little supervision**	works better if managed	**2**	**1**	**2**	**1**	**Works with little supervision**	works better if managed
18	Generally, understands situations	**sometimes does not**	**3**	**3**	**1**	**1**	**Generally, understands situations**	sometimes does not
19	Often pauses to reflect	**rarely does so**	**3**	**2**	**1**	**1**	**Often pauses to reflect**	rarely does so
20	Always thinks about others	**focusses on own needs**	**4**	**4**	**1**	**1**	**Always thinks about others**	focusses on own needs

Nicky's construct ratings (Table 13)

In summary - Despite Nicky scoring negatively for the majority of her value themes in Test 1 (NMIST, Table 13) (please note value scores are a combined score of the participants ratings for all 13 entities – see Appendix 9), her ratings for work-self and the model nurse in both Tests were all on the preferred pole (NMIST, Table 13, column 1-8). There were however some noticeable differences when Nicky considered her ideal nursing values in Test 1 (NMIST, Table 13, bold text, columns 1-4) with some 12 constructs on the non-preferred pole. This indicated that Nicky had focused on the difficulties of achieving a high standard as opposed to aspiring to be the best in Test 1 (NMIST, Table 13, columns 1-4). Nicky only rated 5 constructs as 4 at the extreme of the preferred pole for her personal nursing values; these were constructs 1 (dignity) construct 7 (listening), construct 15 (communication) and 20 (always thinking of others) (NMIST, Table 13, column 1-4) implying these were significant for her (NMIST, Table 13, column 1-4). Nicky's ratings for Test 2 were starkly different, with all constructs rated as 1 on the preferred pole, except for construct 4 - teamwork - which was rated as 2 (NMI, Table 13, columns 5-8). Additionally, all of Nicky's ratings for ideal-self were all on the preferred pole (NMI, Table 13, bold text, 5-8).

Table 14 *Nicky's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	-43.57	-14.25	-8.41	38.95	-39.83	-17.62	-14.12
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	40.99	43.93	40.37	46.59	45.15	37.06	42.35
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

Nicky's value theme scores (Table 14)

Nicky was the only participant with negative value theme scores in Test 1 (Table 14). Her individual mean value score of -14.12 was significantly lower when compared with the groups mean of 42.35 (NMIST, Table 14). Nicky's lowest ranked value theme score in Test 1 (NMIST) was Person-centredness at -43.57 compared to the group average of 42.82 (Table 14). Integrity was Nicky's highest value theme score at 38.95, which was her only positive score, just below the group average of 45.17 (NMIST, Table 14). In Test 2 (NMI, Table 14) Nicky's value theme scores clustered around the 40's with her highest being Integrity at 46.59 which was just below the group mean of 47.42 – with her lowest being Teamwork at 37.06 when compared to the group mean of 55.15.

Nicky's interview

Nicky was a 45-year-old married female with three children. She was taking the Adult Nurse pathway and had previously worked as a civilian with the military, coaching young recruits in life skills. More recently, she had worked as an HCA at a GP surgery. Analysis of Nicky's interview identified two themes, 'The good and bad nurse' and 'Measuring values' (Table 15). These themes, along with the relevant subordinate themes, are described below.

An audit trail of quotations is provided in Appendix 17.

Table 15 Themes and subordinate themes from Nicky's interview

Themes	Subordinate themes
Theme 1: The good and bad nurse	Dignity and safety The code Maturity
Theme 2: Measuring values	Light and dark numbers The good MMI The gatekeepers

The good and bad nurse

Within this theme, Nicky described herself as an empathetic person who had the values required to be a nurse. Dignity, safety, diligence and competence she considered core nursing values. Meanwhile, professional values required integrity when making moral judgements while being in high demand. Nicky's transcript suggested dissonance between the values espoused by the university and those observed in practice.

Dignity and safety

Nicky considered herself an *"empathetic, nice person"*, as she was *"calm", "reassuring"* and a *"good listener"*, which she believed was not reflected in her report. She illustrated her empathetic nature by recounting when she *"cried with"* a patient. For her, a patient's dignity and their need for *"help"* came first. Nicky described patient dignity as a "*no-brainer",* emphasising its importance to her as a value. *"Safety at work"* was a *"given",* which implied these values were accepted nursing professional norms and stereotypical behaviours i.e., those illustrated within the value frameworks illustrated in Table 1. These values also seemed to be subsumed by competence, communication and conscientiousness as the nurse needed to *"understand what they are meant to be doing"*, following *"instructions … as written"* and listening *"carefully"* to avoid *"mistakes".* This indicated Nicky considered a nurse to be skilled and diligent. However, Nicky's emphasis on *"meant"* indicated this was not always the case. Nicky described a *"light bulb moment"* when she realised she wanted to work in care. However, influenced by her experience of having children, her first choice was midwifery. For Nicky, the midwife epitomised her understanding of good care values and

displayed "*patience, time, care, compassion and empathy",* described as essential and *"natural",* that is, innate characteristics.

> *You have got to have that in you … The one thing that stood out for me were the midwives I thought they are amazing … I mean I get this whole Florence Nightingale thing … They are amazing and I was really in awe of the profession.*

Her description of the midwife, as depicted through the archetypal image of Florence Nightingale, implied they exceeded their professional obligations. Thus, the midwife's values embodied compassion and the moral ideal. However, her view of the nurse seemed contrary to this, drawing on her experiences as a mother with her son in hospital:

> *The girl who I was allocated gave me a telling off and said 'you shouldn't have left the ward'.*
>
> *… It was a procedure for her, she just wanted to get his cannula out, out of the room, clean up the bed, next person in and that was really obvious.*

Nicky revealed a real shift in views as she moved from the amazing midwife to the pressured nurse. Nicky described how poor care was distant, authoritative and task-driven, which suggested values dissonance. However, some nurses were described as *"lovely", "amazing people";* thus, they were aspirational and ideal. Consequently, deficient values were identified in an undesirable few, described as "*the minority".* Despite not wanting to emulate these values, her word choice indicated justification for impersonal and detached care because of pressures of carework when faced with the realities of practice:

> *[Caring is] critical, isn't it? Because I have seen lots of nurses and I really … wonder why they are doing the job. Were they like that when they started? Have they changed due to the pressures of the job? Has it made them like that or are they always like that?*

Nicky questioned the motivation of the caring nurse, implying an assumption that the pressures of carework caused a shift in values. Thus, good values were not only salient but also part of the nurse identity.

The code

Nicky's perceptions of professional values, characterised as "*consistency and competency"*, were not always reflected in the realities of practice, which she considered did not *"sync well"* - i.e., connect - when she reflected on the professional values advocated by the university. Nicky thought her negative experiences with the ward nurse reflected high levels of activity being prioritised over values; she questioned whether the nurse was having *"a bad day"* or *"maybe she had a telling off".* In comparison, she believed the professional nurse *"left your stuff outside the door",* emphasising that the professional nurse did not let domestic and work pressures influence behaviour and patient care. Thus, professional values

required the nurse to have integrity when facing pressured work but also making moral judgements. Nicky continued by describing how the test values statements had been *"thought-provoking"*, while some statements had been *"really important":*

> *… especially if you are in a situation where it is difficult, and you just have to keep going through your head 'NMC code, patient's dignity'. Patients [are] being really horrible and abusive and violent. Ok, just switch off from that; their dignity comes first and I've got to be professional … I've got to treat them with care [and] make sure they get what they need. It's like that putting on a façade, isn't it?*

Nicky's professional values were represented by the *"NMC code"*, i.e., the professional nursing standards of practice and behaviours (NMC 2018b). It would appear for Nicky that the *"code"* was a mantra, providing protection against uncaring practices when it was difficult to uphold values when faced with challenging patients. Consequently, professional values were an outward display of the nurse's public image, based on ideals rather than authentic values.

Maturity

Nicky described maturity as advantageous as it facilitated empathy, which she characterised as being in *"someone else's shoes"*. Therefore, it *"all slots into place".* Thus, her maturity enabled her to *"see the organisational stuff, being able to talk to people and tell people or ask people to do things".* This indicated Nicky's view of maturity was task-driven and authoritative. However, this was possibly due to her life experiences as a mother and working with the military. Maturity also had its disadvantages:

> *You obviously question why you're here and [I] think we all do all the time. Especially at this stage, because it's hard for a mature student with family and you're just adding something else into the mix, aren't you? And so, every day it is a question mark. Am I doing the right thing? I'm leaving my children at 7 in the morning to drive to [the city] in the traffic to sit in a lecture to then have to do my assignment.*

The competing priorities of family and studying indicate an awareness of times when she was absent as a mother. Consequently, Nicky questioned her commitment to the course. Hence, there was considerable tension for Nicky as a mature student when balancing her family and work life.

Measuring values

Within this theme, Nicky initially considered psychometric tests useful for assessing values, despite making an error when completing her second test. Nicky similarly believed MMIs exposed candidates' values as assessors could identify candidates' socially desirable responses.

Light and dark numbers

Nicky described feeling panic when taking the first test (NMIST), which she attributed to a new experience and the test environment. She likened her experience to taking a numeracy exam when her mind went *"blank".* She believed if she answered in the *"wrong way, it's going to make me out to be some kind of monster".* This suggested anxieties that the tests could expose poor values that were not reflective of the nurse. Nicky found the second test particularly confusing, describing herself as a *"muppet".* This implied she felt foolish because of her misinterpretation of construct ratings, reported it as follows: "[Is the] *lighter colour a bigger number than the darker number?"* In fact, the opposite was true. Nicky's tensions related to maths surfaced in her transcript on several occasions and circulated around perceptions of not being academic or good at maths. Therefore, Nicky voiced concern: *"You couldn't base those results on taking people on".* This highlighted two points of analysis: applicants could misinterpret the test instructions, increasing the chance of error, and candidates with dyscalculia could be disadvantaged by aptitude testing that utilised Likert scales. Nicky added: *"You would have to interview as well wouldn't you … I suppose I'm trying to justify my existence here; in my case, I don't think that's always a true reflection of who I am".* Nicky's response implied that universities could only assess candidates' personal nursing values accurately through interviews. However, this was apparently because Nicky considered her test results as a failure; consequently, she defended her position at university, having previously been interviewed and assessed as having the desirable values needed to be a nurse by the university. Consequently, the test was not a *"true"* account of her values. On first seeing her report, Nicky seemed to construe her results as exposing poor values stating: "*When I saw my results, I thought 'oh my God I should not be doing nursing. I'm going to be a horrendous nurse'"*. Therefore, her report coloured her view on her suitability to be a nurse and her positive social identification with the nurse. Thus, she questioned whether she had the values required to enter the profession, which also affected her self-esteem.

The good MMI

Nicky described her MMI experience as enjoyable, stating *"I loved mine"*. She added: "*I like a challenge"*, which suggested she viewed the stations as difficult, since they required effort and determination to succeed. She said she had applied to several universities and described disparities between university recruitment practices:

> *So we were in bigger groups in [name withdrawn] [and] we had to, you had to get your voice out there basically, where[as] this one [Cardiff University] was more specific to you as a person.*

MMIs in larger groups seemed to have made Nicky anxious as she found it difficult to stand out. Meanwhile, a more positive MMI experience identified her as an individual, giving value

to her contribution. Nicky spoke about memorable MMI stations, describing *"the cubicles where you had to fold the napkin, watch the film … And then choose items where you had to take things with you from your plane crash".* Interesting, all these stations were activity stations, which reflected the core care values Nicky had earlier described, i.e., communication, dignity and decision making, indicating an understanding of the care values being assessed during MMIs. Nicky particularly focused on her experience of the video:

> *I think it's a man or a woman sat on a toilet with their pants around their ankles in a lift. And my initial response was horror. Oh my god, that's like your worst nightmare … I could feel myself welling up.*

Nicky's description of her emotional response to the video supported her initial reports of empathy and dignity as important care values although she also described feeling embarrassed as she grew overcome by her experience. This suggests candidates' performances could be affected by station content.

The gatekeepers

Nicky believed that although candidates could *"put on an act"* in the interview, the assessor would be able to identify socially desirable responses:

> *You must know who's going to actually be suited to the role and who isn't. Because you have got to be good judges of character to do what you do. And you have worked in the profession long enough to know who you could work with and who you couldn't work with.*

Thus, interviewers were knowledgeable because of their professional experience. Nicky perceived like-mindedness, compatibility and good values as the deciding factors of a successful interview. Consequently, assessors were perceived as gatekeepers of the profession as they judged applicants' characteristics and values.

6.1.4 John's case

Table 16 John's NMIST and NMI ratings

№	*Test 1 - NMIST*				*Test 2 - NMI*			
	Constructs		*Ratings*		*Ratings*		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	**People's dignity comes first**	need for help comes first	**2**	**3**	**2**	**4**	**Patient's dignity comes first**	need for help comes first
02	**Safety at work comes first**	resource limits may reduce it	**3**	**3**	**4**	**4**	**Safety at work comes first**	resource limits may reduce it
03	**Unpleasant tasks done by all**	done by less well paid	**- 4**	**4**	**3**	**4**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**1**	**3**	**-3**	**1**	**Nurses work best in a team**	work best on own
05	Can get people to follow instructions	**finds it hard to**	**4**	**-3**	**4**	**4**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**4**	**4**	**4**	**4**	**Learning competence is lifelong**	is for new workers only
07	**Listens carefully**	listening a distraction - get on	**-3**	**-4**	**4**	**4**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**2**	**3**	**3**	**4**	**Better be open and honest**	wiser to manage truth
09	**No excuse for lack of kindness**	pressures can be excuse	**4**	**-4**	**4**	**4**	**No excuse for lack of kindness**	pressures can be excuse
10	**Challenge authority in best interests of work**	do not challenge	**3**	**4**	**3**	**4**	**Challenge authority in best interests of work**	do not challenge
11	**Enjoys decisions when competent**	prefers others do it	**4**	**2**	**4**	**4**	**Enjoys decisions when competent**	prefers others do it
12	**Takes responsibility for own actions**	sticks to guidelines	**2**	**4**	**3**	**4**	**Takes responsibility for own actions**	sticks to guidelines
13	**Take time needed for tasks**	do best in time one has	**4**	**4**	**3**	**4**	**Take time needed for tasks**	do best in time one has
14	**Good communicator**	not a good communicator	**4**	**4**	**4**	**4**	**Good communicator**	not a good communicator
15	**Relates well to others**	has problems relating to others	**-1**	**4**	**-4**	**4**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**4**	**4**	**3**	**4**	**Can be relied on**	real world can affect reliability
17	**Works with little supervision**	works better if managed	**3**	**4**	**3**	**4**	**Works with little supervision**	works better if managed
18	**Generally, understands situations**	sometimes does not	**3**	**4**	**3**	**4**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**-1**	**3**	**1**	**4**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**4**	**4**	**3**	**4**	**Always thinks about others**	focusses on own needs

John's construct ratings (Table 16)

When John considered his personal nursing values at work in Test 1 (NMIST, Table 16, columns 1-4) 4 constructs were rated on the non-preferred pole reducing to 2 constructs in Test 2 (NMI, Table 16, columns 5-8). In Test 1 (NMIST, Table 16, columns 1-4) John rated 3 constructs on the non-preferred pole for the model nurse with an additional 11 constructs rated as +4 on the extreme end of the preferred pole (NMIST, Table 16, columns 1-4). John did not rate any of the constructs for the model nurse on the non-preferred pole in Test 2 (NMI, Table 16, columns 5-8) rating the model nurse at the extreme end of the preferred pole (+4) on 19 occasions (NMI, Table 16, columns 5-8). When John considered his ideal personal nursing values all constructs - except for construct 5 (following instructions) - were on the preferred pole in Test 1 (NMIST, Table 16, bold text, columns 1-4). Whereas for Test 2 (NMI, Table 16, bold text, columns 5-8) all the constructs for his ideal self were rated on the preferred pole, this suggested that he identified his ideal values closely with those of the model nurse.

In summary – John's ratings to the constructs in Test 1 (NMIST, Table 16, columns 1-4) clearly identified that at work, he believed unpleasant tasks were done by those less well paid (construct 3, rated -4). He preferred to get on with the job as opposed to listening carefully to others (construct 7, rated -3). His ratings to construct 15 (-1), indicated that at work he believed that generally he did not relate well to others. Construct 19 was also rated as -1, denoting that John understood that he rarely paused to reflect on how things had gone. When John considered the model nurse in Test 1 (NMIST, Table 16, columns 1-4) there were 3 constructs - 5 (following instructions), 7 (listening) and 9 (kindness) - rated on the non-preferred pole. These ratings indicated that on the whole John thought that the model nurse found it hard to get people to follow instructions (construct 5 rated -3). He also strongly believed that the model nurse found listening a distraction and would prefer to get on with the job (construct 7, rated -4) and that the pressures of work often left less room for kindness and sympathy for the model nurse (construct 9, rated -4).

For Test 2 John rated only 2 constructs - constructs 4 (teamwork) and construct 15 (relating to others) - on the non-preferred pole when he considered his personal nursing values at work. Johns ratings to these constructs indicated that on the whole he preferred to work on his own as opposed to with a team (construct 4, -3). Interestingly his ratings to construct 15 (-4) suggested that he continued to believe he did not relate well with others, though this was now even more so in Test 2 (NMI, Table 16, columns 5-8). This suggested that this value statement was in some way significant for John. When John considered the values of the model nurse in Test 2 (NMI, Table 16, columns 5-8) all of John's ratings were now all on the extreme of the preferred pole (rated 4) except for construct 4 (teamwork), which was rated 1.

Table 17 *John's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	37.74	62.82	59.1	65.05	68.06	50.18	57.16
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	68.19	62.69	61.26	55.51	57.29	46.08	58.5
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

John's value theme scores (Table 17)

John's value themes (Table 17) were between 37.4 and 68.19 for Test 1 and 48.0 and 68.19 for Test 2. When compared with group scores, John's value theme score for Personal development was above the group average i.e., 68.06 for Test 1 and 57.29 for Test 2 (Table 17). His Personal development value theme score was supported by a cluster of very good scores for Integrity (NMIST 65.05, NMI 55.51), Accountability (NMIST 62.82, NMI 62.69) and Trust (NMIST 59.1, NMI 61.26, Table 17). John's lowest score for Test 1 was his Person centredness scores (37.74). This was below the group average of 42.82. His lowest value theme score in Test 2 was Teamwork (Test 2 NMI 46.08, see Table 17); again this was below the group average of 55.15.

John's interview

John was a single male in his twenties, in a long-term relationship and with no children. John had taken A levels, worked as a community healthcare assistant and then enrolled on the BSc Adult Nurse pathway. John was articulate and spoke with little hesitation during the interview. Analysis of John's interview identified four themes: 'Care and caring', 'The nurse', 'Getting on with the job' and 'Measuring nursing values' (Table 18). These, along with associated subordinate themes, are described below.

An audit trail of quotations is presented in Appendix 18.

Table 18. Themes and subordinate themes from John's interview

Themes	Subordinate themes
Theme 1: Care and caring	Empathy The code
Theme 2: The nurse	The ideal nurse
Theme 3: Getting on with the job	Communication
Theme 4: Measuring nursing values	The terrible truth and the miserable nurse The lock in

Care and caring

This theme encapsulates John's sense of care and professional values. John considered empathy as an unimportant value and a driver of inequalities in care practices. Meanwhile, the *"NMC code"*, i.e., the professional nursing standards of practice and behaviour, defined idealistic care behaviours.

Empathy

John began the interview describing care as holistic in nature, which encompassed practical acts and tasks of care, characterised as *"help"* and *"support"*, for patients going "*through medical, emotional or social changes in their life".* John separated the act of care from the emotional context of caring, later described as *"interpersonal beliefs".* He believed care was "*not so much being able to empathise or sympathise"*. Consequently, he did not *"put a lot of tact on to empathy really".* John's words indicated that empathy was less important compared with more practical care practices. He described empathy as individualised, so empathy, as a feeling, was personal and unique: "*I don't know [if] you can truly understand what somebody is going through because everyone approaches situations differently".* John acknowledged that his view might differ from those of other nursing students as he put comparatively less "*weighing"* on empathy. John perceived empathy as an emotional connection, which could affect care practices negatively and overcome the nurse. Thus, nurses had to guard against empathy, pulling "*themselves back from having too much care"* and creating emotional distance between themselves and the patient, as distance facilitated protection against negative influences and distress caused by empathy. Therefore, for John,

protecting emotional well-being was important. John believed empathy meant inequitable care:

> *[The nurse] might relate to them [the patient], like they remind them of someone and so if you put too much empathy and too much feeling on to one patient, you're possibly ignoring the others or not giving them equal care.*

Thus, for John, lacking an emotional connection with the patient did not diminish his perceptions of being a caring nurse.

The code

John illustrated his view of professional values through *"the code"*, i.e., the professional standards of practice and behaviour for nurses (NMC 2018b), described as the *"legal side"*, which focused on confidentiality and anonymity and promoted autonomy. Professionalism *"encompassed care"* for John and defined what was *"acceptable"* care in addition to how *"you should go about caring"*. This suggested that John viewed *"the NMC code"* as a set of characteristics and behaviours that embodied the stereotypical norms of the nurse, i.e., the professional image illustrated in value framework outlined in Table 1. John's use of *"should"* in this context intimated a dissonance between how care *"should"* be done and the realities of care in practice as he perceived them.

The nurse

Within this theme, John described the ideal nurse as intelligent, knowledgeable and skilled, rather than compassionate and caring.

The ideal nurse

John described himself as caring, which he framed within his experiences of caring for an elderly relative. He described a sense of moral duty, putting his relative first and going part-time to college. Johns' words, however, resonate with a dissonance which involved money, which suggested that care practices could be financially driven. John utilised examples of receiving care in the NHS and the private sector. He described private sector care as more efficient than that of the NHS. However, John believed that NHS staff *"compensate"* for perceived process deficiencies by being more *"friendly"* than nurses in the private sector, where carework was a *"paid job"*. Therefore, private care was task-led and emotionally detached, as nurses were in the position for financial reasons. John's ideals seemed firmly rooted in social justice, which he described as *"helping each other… regardless of who we are"*. Thus, care was part of a human commitment to help and support others universally, irrespective of their ability to pay. John described his view of the nurse as someone who is altruistic and "*someone that's willing to help no matter what the case".* This suggested that the nurse would put patients foremost, which was significant for John. John described having the same aptitudes and values as the nurse, aligning himself with his ideal of the intelligent nurse. However, he described a difference between his values and those of the

'model' nurse, which he illustrated as a *"bit of the idea",* as these values were aspirational and thus represented a future achievement. John's test rating reflected his view, as he rated his values level with the 'model' nurse on only six occasions. By comparison, the 'model' nurse was consistently rated at the extreme end of the preferred pole (Table 16 columns 5 - 8). John emphasised that everybody's ideal nurse would be unique: either *"they need to be extremely intelligent"* or *"they need to be extremely compassionate".* John explained the nurse needed "*to know what they're doing",* which reiterated that the ideal nurse was knowledgeable, competent and "*pushing feelings aside"* to continue the *"job"* of nursing. Again, he alluded to the strategies that maintained his values, whilst developing mechanisms to cope with the emotional labour of carework. This suggested John saw care as balanced between being directional and authoritative when working *"with"* patients, highlighting a form of relationship. John additionally mooted informal conversation, described as *"chit-chat",* as a hindrance to *"getting on"* with the job, reflecting his earlier tensions around communication and teamworking. Interestingly, John's views were also reflected in his NMIST ratings, in which he marked 'listening' as a distraction from 'getting on with the job' (Table 16, construct 7, columns 1-4).

Getting on with the job

This theme focuses on John's understanding of his communication and teamworking skills at work and how this translated into his test scores.

Communication

John maintained a negative view of his communication abilities throughout the interview, which emphasised a significant tension. He described *"struggling to make friends"* and *"relat[ing] to other people"* during the time of the NMIST. However, this was not reflected in his test ratings (construct 14, Table 16, columns 1-8). This indicated that, to some degree, John had potentially provided socially desirable responses. John reported that at the time of the NMI, he had completed a *"communication course"*, which they had a *"chat"* about at university. Since then, he had "*relate[d] to people a bit better and had actually gone through different ways of communicating".* Consequently, since the university's input on communication skills, he had *"perked up a little"* and now considered himself *"quite good at communicating".* This indicated the course content had influenced John's understanding of his values and his NMI response. As John reflected on his report, he considered his teamwork value theme score to be low, which he was not *"surprised"* by. He stated this was because of how *"questions were formed".* He explained this was because the values statements questioned how well he would *"relate"* to others and, as John believed he would be *"terrible"* at relating to other team members, this affected his ratings. John reiterated that when working in a team, "*I have to I put away all of that and I get on with it"*. This implied that despite John's discomfort when working in a team, he understood it was a requirement

for effective care practices to occur. Thus, he would focus on the task at hand. This intimated an emotional disconnect which enabled him to protect his emotional well-being, maintain values and "*get on with"* the job of being a nurse. John's belief that he worked best alone and did not relate well to others was reflected in his construct ratings (constructs 4 and 15, Table 16, columns 1-8) and his low team working value theme score (Table 17).

Measuring nursing values

This theme encapsulates how John perceived the tests, which he believed he had answered truthfully. Consequently, he perceived his report as more accurately reflecting his nursing values than the MMI did.

The terrible truth and the miserable nurse

As the conversation turned to John's experience of taking the tests, he expressed considerable unease that centred on social experiences, which he feared had influenced the outcomes. John drew a distinction between his values and those of the stereotypical characteristics of the nurse (see Table 1) which, for John, focused on the importance of communication. John described a worry that he would *"fail"* the test *"miserably"* because he did not *"like"* working with people, though he would *"if I have to".*

> *I wince every time and it would be like 'oh you know how would you react to this situation' and I know that's not the best, that's not the thing a good nurse would do. And it is what I would sort of… There were certainly times that I thought 'this is a terrible answer but it's the truth'.*

John was convinced he had answered truthfully and emphasised his honesty and integrity when completing the tests. This had caused considerable unease on occasions where he believed his responses did not emulate the characteristics and stereotypical norms of the *"good nurse*" i.e., those illustrated in value frameworks (see Table 1); consequently, he would be labelled a *"miserable nurse".* This offers two points of analysis. Firstly, he believed the test had a preferred response and thus a favoured aptitude; secondly, his words, i.e., his use of "*should*" compared to *"would",* suggested a dissonance between his aspirational values and those he thought truly reflected practice. However, John considered his report reflected his values accurately. Consequently, he viewed his report positively: *"I would be alright with [it] being used [for recruitment]".* John's belief, however, could also be reflective of earlier tensions around communication, i.e., the test removed the need to communicate, so John was more comfortable during testing. He believed the NMI could form the basis for an interview during which candidates could reflect on their performance and show a *"willingness"* to *"improve", "change", "adapt"* and *"learn";* this would develop their values. He also viewed his report as something to *"take away and look"* at, so it was a beneficial reflective tool and could be used to improve his values.

The lock-in

John initially thought the MMI was one of several intense interviews: *"In my head it was it was an idea [that] I'm going to be locked in an office with one person … they'll interview me for half an hour [and] then I'll be locked in a room with another person".* Consequently, John intimated significant anxiety, illustrated as feeling *"panicky"* and *"terrified"*, as he lacked clarity about the nature of the MMI. However, the MMI became less daunting when he realised he was part of a group. Interestingly, this seems to contradict his earlier tensions related to communication and anxiety in social situations, as he *"relaxed"* as part of the group and the group was a source of comfort to him. Ultimately, he perceived the MMI as quite *"enjoyable",* describing it as *"little almost games".* This indicated John viewed the MMIs as competitive, requiring skill and strategy. However, John thought candidates could *"perform really well"* during the MMIs; only later would it be discovered that they were *"actually not very good"*. Thus, MMIs were not an accurate measure of values as candidates could provide a more complimentary reflection of their values. John regarded MMIs as predominantly assessing communication skills and the standards required at university, which he appeared not to associate with the values of the nurse in practice. Consequently, he thought the MMI measured skills, not values. The exception seemed to be the *"video"* (which explored dignity), which John associated with feelings. This suggested that the values assessed, and therefore the relevance of the station, were not always initially clear to John. He also alluded to dwelling on his performance between stations: *"When you walked away and you're thinking, 'did I do that right?'"* This implies that the content and order of the MMI stations influenced his performance.

6.1.5 Claire's case

Table 19 *Claire's NMIST and NMI ratings*

Nº	*Test 1 - NMIST*				*Test 2 - NMI*			
	Constructs		*Ratings*		*Ratings*		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	**People's dignity comes first**	need for help comes first	**4**	**4**	**3**	**3**	**Patient's dignity comes first**	need for help comes first
02	**Safety at work comes first**	resource limits may reduce it	**2**	**3**	**3**	**3**	**Safety at work comes first**	resource limits may reduce it
03	Unpleasant tasks done by all	**done by less well paid**	**- 2**	**-2**	**4**	**2**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**3**	**2**	**3**	**4**	**Nurses work best in a team**	work best on own
05	Can get people to follow instructions	**finds it hard to**	**3**	**-4**	**3**	**4**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**3**	**3**	**4**	**4**	**Learning competence is lifelong**	is for new workers only
07	Listens carefully	**listening a distraction - get on**	**4**	**4**	**3**	**4**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**-2**	**-2**	**-2**	**-2**	**Better be open and honest**	wiser to manage truth
09	No excuse for lack of kindness	**pressures can be excuse**	**2**	**0**	**2**	**3**	**No excuse for lack of kindness**	pressures can be excuse
10	**Challenge authority if in best interests of work**	do not challenge	**4**	**4**	**4**	**4**	**Challenge authority in best interests of work**	do not challenge
11	**Enjoys decisions when competent**	prefers others do it	**2**	**1**	**2**	**4**	**Enjoys decisions when competent**	prefers others do it
12	**Takes responsibility for own actions**	sticks to guidelines	**2**	**4**	**3**	**4**	**Takes responsibility for own actions**	sticks to guidelines
13	**Take time needed for tasks**	do best in time one has	**3**	**0**	**3**	**4**	**Take time needed for tasks**	do best in time one has
14	Good communicator	**not a good communicator**	**-2**	**- 4**	**2**	**4**	**Good communicator**	not a good communicator
15	**Relates well to others**	has problems relating to others	**4**	**4**	**4**	**4**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**2**	**2**	**3**	**4**	**Can be relied on**	real world can affect reliability
17	**Works with little supervision**	works better if managed	**4**	**4**	**3**	**4**	**Works with little supervision**	works better if managed
18	**Generally, understands situations**	sometimes does not	**3**	**4**	**2**	**4**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**3**	**3**	**2**	**2**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**3**	**4**	**3**	**4**	**Always thinks about others**	focusses on own needs

Claire's construct ratings (Table 19)

Claire rated the majority of the constructs in Test 1 (NMIST, Table 19, columns 1-4) as either 3 or 4 on the preferred pole. This indicated that she had a good concept of the values of the model nurse. Claire rated her ideal-self on the preferred pole on all but 5 occasions in Test 1 (NMIST, Table 19, bold text, columns 1-2), with only 3 constructs rated on the non-preferred pole when she considered her personal nursing values and those of the model nurse (Table 19, columns 1-4). There were also 3 constructs where the ratings remained the same for both tests - these were honesty (constructs 8, rated -2), challenging authority (constructs 10, rated 4) and relates well to others (constructs 15, rated 4) (Table 19) – This suggested that these values were significant for Claire.

In summary – Claire identified in Test 1 (NMIST, Table 19, colums 1-4*)* that on the whole unplesant tasks were done by those less paid as oposed to being done by all (constuct 3, rated -2). Claire also rated construct 8 (honesty) as -2 i.e., she believed it was best to manage the truth at work as opposed to being open and honest in all things. Claire also thought that she was not a good communicator and was often misunderstood at work (construct 14, rated -2). Claire rated the model nurse similarly for these constructs in Test 1 (NMIST, Table 19, columns 1-4). This suggested that she viewed her values to be the same as the model nurse. i.e. Claire also thought that the model nurse reguarded unplesant tasks were done by those less paid (constuct 3, rated -2) and would manage the truth at work (construct 8, rated -2). However, whilst Claire understood that like her the model nurse was not a good communicator and was sometimes misunderstood (construct 14), this was to a greater extent rated -4. There were also two occasions were Claire failed to rate the construct value statements for the model nurse in Test 1 (NMIST, Table 19, Columns 1-4) - these were constructs 9, kindness and construct 13, time for tasks. However, when Claire considered her own personal nursing values for these constructs they were rated on the preferred pole. Her ratings indicated that Claire believed pressures at work were not an excuse for a lack of kindness (construct 9, rated 2) and you should take the time necessary to do a job properly (construct 13, rated 3). Finally, Claire's response to construct 5 - following instructions (NMIST, Table 19, columns 1-4) - indicated a different view of her values at work compared to those of the model nurse. Claire understood at work she could on the whole get people to follow instructions, rated 3; though privately - like the model nurse rated as -4 - she believed it was hard to get people to follow instructions (NMIST, Table 19, bold text, column 1-4). Thus her ideal values continued to be aligned with those of the model nurse. There was a stark difference to Claire's rating for Test 2, which were all on the professional preferred pole except for construct 8 - honesty - (NMI, Table 19, columns 5-8). Claire's ratings for this construct interestingly remained the same as Test 1 for herself at work and the model nurse, both rated at -2 (Table 19). That is to say, Claire considered that on the whole, both she and the model nurse understood it was best to manage the truth in the best interest of all concerned as opposed to being open and honest in all that you do.

Table 20 *Claire's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	57.11	43.71	52.14	42.16	51.98	57.75	50.81
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	59.75	56.53	68.45	55.34	67.05	64.06	61.86
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

Claire's value theme scores (Table 20)

Claire's value themes in Test 1 were mainly clustered above the group average (Table 20) except for her Integrity value theme score of 42.16, was ranked the lowest in Test 1 (NMIST) and was below the group mean of 45.17 (NMIST, Table 20). Claire's highest ranking value theme score in Test 1 was Teamwork at 57.75, which was above the group mean of 44.57 (NMIST, Table 20). In Test 2 (NMI) Trust was Claire's highest value theme score at 68.45 with a group mean of 50.49 (NMI, Table 20). Integrity was Claire's lowest value theme score in Test 2 (NMI) at 55.34, though this was still above the group mean of 47.42 (NMI, Table 20). Therefore Claire's lowest value theme in both tests was Integrity.

Claire's interview

Claire, a single, mature student with no children, was studying Mental Health Nursing. She had previously worked in the NHS as a healthcare assistant and an information technology manager. Claire's transcript identified three themes: 'Caring values', 'Recruitment integrity' and the 'MMI experience' (Table 21). These themes and their relevant subordinate themes are described below.

An audit trail of quotations is provided in Appendix 19.

Table 21 Themes and subordinate themes from Claire's interview

Themes	Subordinate themes
Theme 1: Caring values	Care and caring Professional values
Theme 2: Recruitment integrity	Language of the test Paper faces
Theme 3: The MMI experience	MMI stations

Caring values

This theme identified how Claire viewed caring as an active process, which required knowledge, understanding, empathy and aptitude. Meanwhile, professional values formed a public image rather than true personal values.

Care and caring

As the interview commenced, Claire described care and caring as *"two different meanings for the same thing".* Caring was an emotion, i.e., *"being concerned"* made *"things better"*, which was a driving force for care, which she characterised as *"taking action"*. Claire also suggested an alternative view, that *"taking action"* also meant "*being aware"*, implying the act and task of care incorporated knowledge and understanding. Caring, exemplified as "*ease their suffering",* denoted empathy as a component of caring. Claire believed caring was an intuitive natural aptitude, but it was not identical for everyone. She described herself as empathetic, though apparently caused emotional distress:

> *I feel for people, you know. I was sitting at home in tears yesterday watching the news and so I have that instinct...*
>
> *… I think through my life I realised you have got to care for yourself as well … You can't make everything about other people because you burn out, so you have got to keep that balance as well. And you can't control people, you can't go around trying to fix people and change people … The respectful thing to do is let people be who they want to be and make their own choices.*

Claire's use of the terms "*burn out"* and "*balance"* suggested that caring required effort and was stressful. Care-of-self also appeared to play an active role in her view of caring behaviours. The extracts above emphasised a tension around Claire's sense-making of care values, in which the act and task of care, characterised as "*control"*, "*fix*" and "*change"*, was juxtaposed with feelings of caring, illustrated as "*respect*" and "*choice"*. Thus, caring occasionally meant *"not doing anything".* This indicated that respecting the patient's choice and autonomy was sometimes difficult. Claire considered compassion as a *"blindingly obvious"* caring value. However, her transcript implied a tension: if nurses who did *"not feel"* for the patient *"ended up"* in nursing, it was *"horrible".* For Claire, empathy was an essential nursing caring value, as nursing was vocational, extending beyond the job itself. Her words hinted at a dissonance between intrinsically and altruistically motivated care as she viewed it compared to care practices that were emotionally detached, which she characterised as the nurse being *"in it for financial reasons"*.

Professional values

Claire ruminated often as she described her professional values, stating: *"there are so many, so many different things"*. This indicated how these values encompassed many values for the nurse and that a tension existed around qualities she considered good professional values. However, she also admitted she had not thought about professional values before the interview. This suggested that for her, professional values were not as valuable.

> *I don't like this idea of [a] professional having really judgemental and critical thoughts but not saying them and putting a nice face on.*
>
> *…I think it's more about being a professional person than having some values that you put on for the day.*

Claire's description of professional values appears synonymous with an accepted moral code, which she viewed as equal to her personal values. Despite this, professional values were viewed as a façade. It would seem that for Claire, professional values epitomised the nurse's public image which, at times, was an *"act"* and thus inauthentic.

Recruitment integrity

Within this theme, Claire indicated that one's mood, experience of carework and branch of nursing could influence how values statements in the test constructs were rated. Meanwhile, MMIs were consequential for the university and the candidate in decision making.

Language of the tests

Claire described her frustration when taking the tests, which she apportioned to the Likert scale. She perceived the wording as extreme, saying it was *"always … very black and white"* and some constructs described routine work and unpleasant tasks. Drawing on her previous managerial roles, routine work would be given to less-qualified staff. Additionally, whilst toileting could also be described as *"unpleasant"*, there was a sense of reward when

caring for patients. Consequently, she interpreted these words differently and would either *"completely disagree"* or respond to the construct in the strictest sense, that is, *"very literally"*. Claire claimed her experience of the second test accounted for the difference in scores: *"I just wasn't in such a rebellious mood that day, I think"*. Claire considered some values statements assessed skills, which referred to *"trying"* and *"achieving"*, which *"skewed"* her responses. Claire also discussed communication on five separate occasions throughout her transcript, which seemed to refer to communication skills rather than values. Her comments suggested that the test language had affected her ratings, implying that changes in mood, attitude and approach can alter test responses. Claire added that she *"behaved differently in different types of work"*, so a *"bad attitude as an information analyst isn't necessarily what you would think is a bad attitude for a nurse".* This implies that candidates' work experiences could mean values statements would be perceived differently. Claire described her concern about *"misrepresenting"* her values *"or not giving me [i.e., the interviewer] the answers I was looking for".* This emphasised tension between being honest and presenting her values in a positive light. Claire acknowledged that her student status had affected her responses as *"there is more to learn [and] there is more to practise"*, whereas experience of carework would mean that constructs could be interpreted differently:

> *In some situations, that's asking you to weigh two values and again somebody who's been in more situations that are difficult, where things are [a] little more grey and [a] little less black and white, is going to answer differently than somebody who is just kind of coming into [nursing].*
>
> *I'm thinking about mental health nursing, you know, [if] people want to leave, you can't let them. That what I'm thinking about, they have got a right to liberty but you're not going to let them out the door. So I think an adult nurse might have answered that differently.*

Claire's words indicate that nurse candidates with little experience of carework would have different views on caring and professional values than those with care experience. This suggested these candidates would potentially not perform as well. Meanwhile, candidates with extensive care experience would view the constructs as complex but would be advantaged. Claire implied different branches of nursing would have differing perspectives for some values, confirming the earlier analysis of Claire's view on autonomy. She highlighted that some values in the test would supersede others, for example, mental health nurse candidates might view human rights differently. Claire's test rating seemed to reflect her view, as she only rated herself on the extreme end of the preferred pole on a minority of occasions in both tests (Table 19). Her test ratings also reflected her meaning-making of care, whereby the patient's dignity and human rights took priority (construct 1, Table 19, columns 1-8).

Paper faces

Claire clearly stated that her report held little meaning. On several occasions, she referred to the report as a *"piece of paper".* Claire's transcript, however, presented several contradictions. Claire asserted she was truthful when completing the test as she trusted *"the piece of paper that said 'I'm not going to get kicked out of university if I tell you the truth'"*. Yet she was concerned the report did not represent her values. Her words reflected further contradictions. Claire emphasised a belief that values could not be measured through testing alone; therefore, she seemed distanced from the implications of the report: "*I'm gonna get emotional about because it has no impact on me whatsoever".* Claire's previous experience as a computer analyst played an active role in how she perceived her report, which was "*not something that I would attach a lot of personal meaning or importance to, really".* Measuring values was insignificant, compared with what was considered more meaningful information, and she characterised her report as *"a drop in the ocean of numbers".* However, she stated she would *"be fuming, I'd be absolutely fuming"* if she did not get a place as a result. She described interviewing people as preferential to getting an assessor to *"tick some stuff"* since she could *"go and be herself".* Meanwhile, she would *"trust*" the interview, which more accurately represented her values. Thus, she wondered, should she be unsuccessful in gaining a university place, how much would be due to her values or the fact that "*15 million people have applied for this and there was only 50 places"*. This suggested Claire felt less in control of outcomes when taking the aptitude test. Claire pointed to a perceived lack of transparency in the recruitment decision-making process: *"I don't know if I scraped through and I did terribly on one of the things or if I, you know, got 100% … I've literally got no idea".* She believed that the ability to communicate face-to-face during the interview gave a *"more accurate representation of myself in less time, less of my time, face-to-face"*. This suggested she perceived the test as time-consuming by comparison. Indeed, Claire was the last to leave the testing environment on both occasions. Claire stated she would *"respect the university more for taking the time to judge people in person"*. Her views offered several significant points of analysis. The university's reputation is affected by its choice of recruitment strategies, whereby a face-to-face assessment of values has integrity, unlike aptitude testing. Claire again referred to time, though in this context it was reciprocal: universities were taking time and making an effort to appraise applicants' values, while candidates additionally had time to *"judge"* the university: "*Interviews are two-way, [as] you get an idea of what you're getting into and it's nice to have the opportunity to do that [and] to come and talk to the people".* Therefore, a good recruitment experience involved *"choice".* Claire also referred to "*the personalities you meet on the day make a difference as well",* implying that compatibility with assessors (hence, the teaching staff) and other candidates was also important to her decision-making process

when choosing where to study. Claire believed the MMI provided these opportunities, whereas the tests failed to instil *"confidence"* in her decision making, as the university would not have *"seen"* her in person and would thus have been unable to understand and judge her values.

The MMI experience

Within this theme, Claire depicted her experience of the MMI.

MMI stations

Claire had experienced MMIs at two universities: *"When I got to it my first one, it completely freaked me"*. This suggested that not only was her first MMI experience anxiety-provoking, but also the information given by the university had not prepared her sufficiently. Activity stations remained memorable for Claire, which she described as *"gone fully"*, adding: *"I think it would have affected, like, which order you get [the stations] in might have affected the result quite a lot".* Thus, immersion in some stations affected her performance in subsequent stations. Therefore, the order and content of the MMI stations appeared significant. Claire viewed the tests as a form of self-assessment and thus not reliable when compared with an assessor's independent judgement of her values. Consequently, she perceived MMIs as an accurate measure of her values, as values were acted out and observed. Despite this, Claire questioned the integrity of the MMI due to the subjectivity of the assessor. The MMI might be reliable "*providing the person that was assessing it was fair and, you know, equally peaceful throughout the morning".* This indicated a belief that the assessor's mood and experiences of successive candidates could affect the ratings given during the day.

6.1.6 Fiona's case

Table 22 Fiona's NMIST and NMI ratings

№	*Test 1 - NMIST*				*Test 2 - NMI*			
	Constructs		*Ratings*		*Ratings*		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	**People's dignity comes first**	need for help comes first	**4**	**3**	**4**	**4**	**People's dignity comes first**	need for help comes first
02	**Safety at work comes first**	resource limits may reduce it	**3**	**4**	**4**	**4**	**Safety at work comes first**	resource limits may reduce it
03	**Unpleasant tasks done by all**	done by less well paid	**- 4**	**4**	**4**	**4**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**4**	**4**	**3**	**3**	**People work best in a team**	work best on own
05	Can get people to follow instructions	**finds it hard to**	**3**	**-4**	**2**	**4**	**Can get people to follow instructions**	finds it hard to
06	Learning competence is lifelong	**is for new workers only**	**3**	**-4**	**4**	**4**	**Learning competence is lifelong**	is for new workers only
07	Listens carefully	**listening a distraction - get on**	**4**	**4**	**4**	**4**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**4**	**4**	**0**	**0**	**Better be open and honest**	wiser to manage truth
09	**No excuse for lack of kindness**	pressures can be excuse	**4**	**-4**	**4**	**4**	**No excuse for lack of kindness**	pressures can be excuse
10	**Challenge authority if in best interests of work**	do not	**-3**	**4**	**2**	**4**	**Challenge authority if in best interests of work**	do not
11	Enjoys decisions when competent	**prefers others do it**	**-3**	**-3**	**-4**	**-4**	Enjoys decisions when competent	**prefers others do it**
12	Takes responsibility for own actions	**sticks to guidelines**	**3**	**-3**	**-2**	**0**	**Takes responsibility for own actions**	sticks to guidelines
13	**Take time needed for tasks**	do best in time one has	**2**	**4**	**3**	**4**	**Take time needed for tasks**	do best in time one has
14	**Good communicator**	not a good communicator	**3**	**4**	**3**	**4**	**Good communicator**	not a good communicator
15	**Relates well to others**	has problems relating to others	**3**	**3**	**3**	**3**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**4**	**4**	**-4**	**-4**	Can be relied on	**real world can affect reliability**
17	Works with little supervision	**works better if managed**	**-3**	**0**	**-4**	**4**	**Works with little supervision**	works better if managed
18	**Generally, understands situations**	sometimes does not	**-1**	**-4**	**-2**	**-3**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**4**	**4**	**3**	**4**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**4**	**4**	**4**	**4**	**Always thinks about others**	focusses on own needs

Fiona's construct ratings (Table 22)

Fiona rated the majority of the constructs within Test 1 (NMIST) on the extreme of the poles at either +4, +3 or -3, -4 signifying a strong belief of her personal nursing values and those of the model nurse. Fiona rated 5 constructs (3, 10, 11, 17 and 18, NMIST, Table 22, columns 1-4) on the non-preferred pole with regards to personal nursing values at work; with a further 6 for the model nurse (5, 6, 9, 11, 12, and 18, NMIST, Table 22, columns 1-4). She failed to rate one construct for the model nurse - construct 17, (NMIST, Table 22, columns 1-4).

In Test 2 (NMI) Fiona rated an additional 5 constructs on the non-preferred pole with regards to her personal nursing values at work - these were 11, 12, 16, 17 and 18 (NMI, Table 22, columns 5-8), with a further 3 for the module nurse (11, 16, and 18, NMI, Table 22, columns 5-8). She failed to rate construct 8 (better to be open and honest) in Test 2 (NMI) for her own personal nursing values and those of the model nurse, and construct 12 (responsibility for own actions) for the model nurse (NMI, Table 22, columns 5-8). Interestingly constructs 11 (decision making) and 18 (understanding) remained on the non-preferred pole in both tests (Table 22, columns 1-8). This suggested that the values statements within these constructs were significant for Fiona.

When exploring Fiona's perception of her ideal-self (Table 22, Bold Text, columns 1-2 and 7-8) there were 6 constructs in Test 1 (5, 7, 11, 12 and 17, NMIST, Table 22, bold text, columns 1-2) and two in Test 2 (11 and 16, NMI, Table 22, bold text, columns 7-8), where she did not consider that her ideal personal nursing values mirrored those of the model nurse.

In summary - Test 1 (NMIST, Table 22, columns 1-4) identified that Fiona believed that unpleasant tasks were undertaken by those less paid (construct 3, rated -4); she worked best when managed as opposed to minimal supervision (construct 17, rated -3) and would not challenge someone senior in any circumstances (construct 10, rated -3). In Test 2 (NMIST, Table 22, columns 1-4), where Fiona thought about the values of the model nurse, she considered the nurse found it hard to follow instructions (construct 5, rated -4) and believed learning and development was for new workers only (construct 6, rated -4). Fiona's ratings also identified an understanding that work pressures left less room for kindness and sympathy for the model nurse (construct 9, rated -4), who would adhere strictly to guidelines and instructions (construct 12, rated -3).

In Test 2 (NMI, Table 22, columns 5-8) Fiona's response to construct 12 (Responsibility for actions at work), rated -2, suggested that at work she would stick to guidelines as opposed to taking responsibility for her judgments and actions. Fiona's view of supervision in her ratings to construct 17 in Test 2 (NMI, columns 5-8) indicated she continued to believe she would work best if managed (rated -4). Interestingly, Fiona aligned her personal nursing values with those of the model nurse on the non-preferred pole on three occasions in Test 2 (NMI, Table 22, columns 5-8): these were constructs -11 (decision making), 16 (reliability) and 18 (understanding situations). This meant that Fiona's ratings (-4) for construct 11 identified, that at work, she preferred others to make decisions, as did the model nurse who she also rated -4. She additionally rated construct 16 as -4, that is, she believed that sometimes the real world could affect reliability, which was similarly rated at -4 for the model nurse. Fiona's score indicated that sometimes she did not understand the situation (construct 18, rated -2); though this was even more so for the model nurse rated as -3.

Table 23 *Fiona's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	50.56	41.9	43.01	41.45	19.1	38.2	39.04
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	51.03	37.44	35.07	32.2	32.07	34.49	37.05
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

Fiona's value theme scores (Table 23)

Fiona's value theme scores in Test 1 (NMIST) were clustered around 40, with a mean of 39.04; this was just below the group mean of 42.23 (NMIST, Table 23). Her lowest value theme for Test 1 was Personal development at 19.1 when compared with the group mean of 39.7 (NMIST, Table 23). Her Integrity (41.45) and Teamwork (38.2) value themes were also below the group averages (NMIST, Table 23 Integrity: 44.17 and Teamwork: 44.57). Fiona's highest ranking value theme was Person-centredness at 50.56, which was above the group average of 42.82 for Test 1 (NMIST, Table 23).

In Test 2 (NMI) the majority of Fiona's value themes clustered around 30, with a mean score of 37.05; this again was below the group average of 52.69 (NMI, Table 23). In Test 2 her Personal development value theme remained her lowest at 38.2 compared to a group average of 55.15 (NMI, Table 23); with her highest continuing to be Person-centredness at 51.03 (NMI, Table 23). However, again, this was below the group average of 59.2. Interestingly Fiona was one of only two participants whose mean value theme score decreased in Test 2. This suggested that Fiona had focused on the difficulties of being a nurse as opposed to aspiring to be the best.

Fiona's interview

Fiona, a 28-year-old single female with no children, was studying Mental Health Nursing. Fiona had previously taken a degree and was working as a bank Healthcare Assistant. Fiona's transcript identified two themes, 'Values' and 'Complexity and desirability' (Table 24). These themes and their relevant subordinate themes are described below.

An audit trail of quotations is provided in Appendix 20.

Table 24 Themes and subordinate themes from Fiona's interview

Themes	Subordinate themes
Theme 1: Values	Fluffy hats Going the extra mile Butterflies and guns
Theme 2: Complexity and desirability	This isn't black and white People and computers

Values

Fiona described a complex picture of values, characterised as *"hats",* whereby caring was an emotional connection of empathy and care with the actions and tasks of care.

Fluffy hats

Fiona initiated the interview by describing care as *"automatically"* being *"healthcare"* and thus it was a *"professional"* view which was *"non-judgemental".* This implied that professional care required moral judgements by the nurse. Fiona described *"delivering"* professional care, a task-orientated word choice which she said sounded *"mean"*. By comparison, Fiona described caring as *"fluffier"*; hence, it was subtle and indistinct, which suggested an emotional context. However, her care behaviours at work, described as her *"professional hat",* required competence (aptitude and ability) and the emotional aspects of caring. Thus, Fiona seemed to make-meaning of care and caring as two different values, which were dependent. Fiona said her concept of care encouraged patients to be self-reliant, reporting *"the absolute satisfaction that they have once they have done something for themselves".* This suggested values of dignity, respect and empathy, i.e., a patient centred-centred approach to care. By comparison, her nurse colleagues encouraged dependence, described as traditional *"institutionalised"* nursing. Conversely, Fiona also believed patients saw nurses *"doing stuff for them as care"*. This suggested she believed patients might not necessarily make distinctions between care and caring, which implied similarities and differences in the perceived importance of care behaviours. Consequently, she perceived that patients prized technical proficiency over caring behaviours. Fiona described a complex picture of the self, in which her values and attributes, characterised as *"hats",* changed depending on whether her environment was her university, work or home. Her use of *"my*

hat" in the context of her home implied real-self, in contrast to the other *"hats",* depicted as *"those characters".* Consequently, *"uni hat"* and *"work hat"* were performances constructed on experiences and socially accepted values for those environments. Therefore, Fiona presented herself in accordance with those values:

> *I am like snappy with my partner and I swear and I'm a bit lazy … Those aren't like great characteristics to have as a student nurse or as a, a support worker within healthcare. And I know that but I can't be, I have to have that kind of that separation. I think it's resilience; I think you know you have to let off some steam and you have to kind of give it a good old swear. The fact that I know that those characteristics do not translate well into the professional world … That's a good thing.*

Thus, it would appear that Fiona's *"hats"* facilitated a separation of the academic, professional, social and interpersonal aspects of her life, which implied she saw these three selves as a form of resilience, helping her cope and affording protection from the pressures of carework.

Going the extra mile

Fiona repeatedly referred to the nurse *"going the extra mile",* which meant exceeding the expectations of the typical nurse in the best interests of the patient. She drew on her carework experiences, emphasising that when she tried *"to do the best",* she felt pleasure. This suggested providing a high standard of care afforded her satisfaction. Fiona made meaning of care values through sensitivity. She described a perspective from which sensitivity required closeness: *"I'm quite sensitive to people's, like, body language and that flash of uncomfort"*, as well as distance, "*but I try not to push in, I try to take a step back".* She understood sensitivity as a *"caring skill"* which required her to try her best. This indicated that good care required aptitude, ability and desire. She described herself as *"cheeky"* when she was not trying her best, implying she had high expectations of herself at work. Whilst she agreed that such characteristics are not good for a nurse, the language implied mischievousness rather than malevolent behaviour. Whenever her behaviours did not embody nursing stereotypical norms i.e., those illustrated within value frameworks (see Table 1), she would *"try to make up"* for it, which implied conscientiousness.

Butterflies and guns

Fiona considered the pressures of carework as a rationalisation of poor caring values. Good care was "*put under pressure for X, Y and Z",* so "*it could be quite easy to lose that compassion or lose that caring side"*. Her language indicated an emerging awareness that, when unchallenged, values could be influenced by poor workplace management and culture. This developed into poor care practices and institutional norms. Her views also seem to be reflected in both tests, since she considered kindness and reliability were affected by

pressures of work (Constructs 9 and 16, Table 22, Columns 1-8). By comparison, Fiona described her aspirational values as embodying those of the good nurse: *"They are absolutely like butterflies when it comes to communication and people skills and that is like the nurse I aspire to be".* Fiona's characterisation of the good nurse implied someone who is transformative and influential, and for whom communication was key. She added, *"They just stick to their guns and they are very kind of factual [in a] positive way and you kind of end up taking it on board and you feel empowered by it".* Fiona's use of *"guns"* in this context became a metaphor for the nurse's moral values and beliefs. It appeared that Fiona perceived the nurse as resolute, and thus courageous, when maintaining professional values; this behaviour was founded on knowledge.

The conversation moved to professional values, which Fiona considered as *"evolving"* values based on experience. Fiona characterised professional values as an *"opinion".* She believed maintaining a *"good opinion"* required *"integrity"*, which she exemplified as *"sticking to it".* Hence, you had to be "*a real strong person"* not to have *[*"*your values] swayed"* in the face of knowing *"the right thing to do".* Fiona's words indicated that maintaining good professional values required knowledge, strength, integrity, courage and confidence. Whilst not explicit within Fiona's text, her words implied that not being swayed, i.e., being courageous, would be difficult for a student nurse working with a more experienced and knowledgeable practitioner. This was reflected in her ratings for construct 10 in Test 1, which indicated that, unlike the 'model' nurse, she would not challenge authority (NMIST, Table 22, columns 1-4). Fiona confirmed this analysis later in the transcript: *"I can't kind of construct my argument as well as they can and I find it too awkward. When I have been assertive or delegated duties, I find it awkward".* She alluded to her nurse colleagues' comments and gestures: *"[they said 'the patient is] going to have you running rings'"* and *"they all just sort of rolled their eyes".* This suggested that her perceived lack of knowledge and confidence meant she had sometimes lacked courage and integrity; consequently, she had been *"intimidated"*. This had caused Fiona frustration, which she characterised as *"double standards".* Her views were reflected in her construct ratings, which indicated that, at work, Fiona found making decisions and understanding situations difficult (constructs 11 and 18, Table 22, columns 1-8). Interestingly, double standards emerged from Fiona's transcript on several other occasions, involving her test ratings. Fiona regarded the differences in ratings as *"double standards"* and the difference in perspectives had *"blew her head"* and caused her to reflect. This was characterised as having to *"raise a dialogue"* and work on her values. Consequently, the report was useful as a reflective tool to help improve values.

Complexity and desirability

Within this theme, Fiona described how her aspirations, age and experience had influenced her ratings of the constructs in the tests.

This isn't back and white

Fiona described her test experience through several disjointed descriptions, which suggested she found the situations complex. Examples include:

> *I mean, when you become a bit older, you become quite fearful of things and you understand [the] complexities of things.*
>
> *I was constantly thinking 'this is a kind of straightforward answer' but I can't compare it to a straightforward situation because healthcare and individuals are so complex … This isn't black and white.*
>
> *I've only really met, like, one ward manager and she was, like, horrible and I think I can't really use that to taint my whole vision of ward managers but then I've only go that to compare it to.*

Analysis indicated that Fiona viewed the test values statements as complex, as her perceptions built on concepts of age and experience and had influenced her ratings for the constructs. Fiona believed candidates without experience *"are only gonna have their imagination or here [their university experience] to answer that question. I don't think it would be fair".* Thus, she seemed to be a candidate who thought carework experience would be an advantage within the testing environment. Fiona also believed there were right or wrong answers, which indicates three significant issues. Firstly, it appeared Fiona recognised a preferred response to the values statement, described as "*the obvious"*. Secondly, truthful answers did not always reflect the realities of practice, which she illustrated as "*or I could go with, like, my honesty".* This suggested values dissonance between the perceived realities of practice values and values that embody stereotypical nursing norms i.e., those illustrated within value frameworks (see Table 1). Thirdly, giving truthful answers, rather than providing socially desirable responses, was described as the *"constant battle"*. Interestingly, Fiona emphasised her honesty was for my benefit. This could account for Fiona's test ratings and her low value theme scores (Table 23), which seemed to reflect the challenges of practice rather than her aspiring to be the best. However, her honest responses seemed to have caused anxiety: *"Even though you have been, like, we are not going to tell anybody the results [and] it's between you and me, part of me is like 'what if I am like really bad at this and she has to'?"* This implied she feared she was exposing poor personal nursing values that were unreflective of the 'model' nurse. Consequently, Fiona emphasised the potential to have done *"the obvious"* and rated constructs on the professionally preferred pole, thus conforming to traditional nursing values.

Fiona generally focused on differences in her responses between tests. She considered values statements as complex, with no *"black and white"* answers. Consequently, she marked herself *"low"* because, as a student, there was *"no guarantee"* she could do *"everything 100%".* This was because she *"was new to the course", "[didn't] like to be cocky",* had *"confidence issues"* and questioned if *"I can do what it said on the tin"*. These affected her construct ratings. Therefore, the ratings were based on perceptions of knowledge and competence. Fiona considered that, by the second test, she *"felt more comfortable as well and I felt I was able to justify it better that I was being truer to myself".* This indicated that the curriculum had somewhat affected Fiona's confidence in her decision making during testing. Fiona described this as *"work[ing] toward"* her goal, saying *"I aspire to be"* the 'model' nurse. This rationalised her increased score and ratings on the preferred pole for test 2 (Table 22).

People and computers

Fiona experienced MMIs in two universities, which she described as *"completely different",* due to the station content. Fiona considered the absence of group assessment within MMIs as *"peculiar"* due to the nature of nursing: *"You're constantly with groups of people".* This suggested communication and teamworking were significant for Fiona. Fiona believed she had prepared extensively for her MMI: *"I had looked into the MMI and wanted to know everything about it, like where it came from, the point of it and everything",* which she apportioned to interview-related nerves and anxiety about the unknown nature of MMIs. Fiona expressed feelings of confidence after her MMI: *"I was like fine. I kind of walked away and I was kind of like if they don't give me a place I don't know what's wrong with them".* This implies a belief she had reflected good nursing values. By comparison, the test she defined as *"the computer"* was lacking in communication and interaction. Consequently, Fiona viewed the tests as measuring knowledge and facts, exemplified by her saying *"very much 'right you're a nurse, you're on the shop floor, what do you think?'"* Fiona believed this gave candidates an opportunity to provide socially desirable responses: *"You could do everything by the book".* Subsequently, Fiona thought the tests could not assess care values due to the lack of human interaction, which she described as *"not getting a feel for them".* Meanwhile, the MMI was *"more about how you worked as a person, how yeah, how your brain worked and how you perceived stuff".* Thus, the assessors, through the medium of the MMI, could evaluate understanding through human interaction and distinguish between good care values and socially desirable responses.

6.1.7 Mary's case

Table 25 Mary's NMIST and NMI ratings

№	Test 1 - NMIST				Test 2 - NMI			
	Constructs		Ratings		Ratings		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	**People's dignity comes first**	need for help comes first	**4**	**4**	**4**	**4**	**People's dignity comes first**	need for help comes first
02	**Safety at work comes first**	resource limits may reduce it	**4**	**4**	**4**	**4**	**Safety at work comes first**	resource limits may reduce it
03	**Unpleasant tasks done by all**	done by less well paid	**-3**	**4**	**4**	**4**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**-1**	**4**	**2**	**3**	**People work best in a team**	work best on own
05	Can get people to follow instructions	**finds it hard to**	**3**	**- 4**	**4**	**4**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**3**	**4**	**4**	**4**	**Learning competence is lifelong**	is for new workers only
07	Listens carefully	**listening a distraction - get on**	**3**	**4**	**4**	**4**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**3**	**4**	**4**	**4**	**Better be open and honest**	wiser to manage truth
09	**No excuse for lack of kindness**	pressures can be excuse	**4**	**- 4**	**4**	**4**	**No excuse for lack of kindness**	pressures can be excuse
10	**Challenge authority if in best interests of work**	do not	**3**	**4**	**3**	**4**	**Challenge authority if in best interests of work**	do not
11	**Enjoys decisions when competent**	prefers others do it	**4**	**4**	**3**	**4**	**Enjoys decisions when competent**	prefers others do it
12	**Takes responsibility for own actions**	sticks to guidelines	**3**	**4**	**4**	**4**	**Takes responsibility for own actions**	sticks to guidelines
13	**Take time needed for tasks**	do best in time one has	**3**	**3**	**3**	**4**	**Take time needed for tasks**	do best in time one has
14	Good communicator	**not a good communicator**	**-3**	**- 4**	**4**	**4**	**Good communicator**	not a good communicator
15	**Relates well to others**	has problems relating to others	**4**	**4**	**4**	**4**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**1**	**3**	**3**	**4**	**Can be relied on**	real world can affect reliability
17	**Works with little supervision**	works better if managed	**2**	**4**	**4**	**4**	**Works with little supervision**	works better if managed
18	**Generally, understands situations**	sometimes does not	**4**	**4**	**4**	**4**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**2**	**4**	**3**	**4**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**3**	**4**	**4**	**4**	**Always thinks about others**	focusses on own needs

Mary's construct ratings (Table 25)

Some 34 out of 40 of Mary's rating for Test 1 were on the preferred pole (NMIST, Table 25, Columns 1-4). This suggested that she had a clear understanding of her personal nursing values and those of the model nurse. There were also only three occasions were Mary considered her ideal nursing values did not reflect those of the model nurse; these were constructs 5, 7 and 14 (NMIST, Table 25, bold text, Columns 1-4). This suggested that Mary privately believed that she found it hard to get people to follow instructions (construct 5), she found listening a distraction preferring to get on with the job (construct 7) and considered she was not a good communicator (construct 14).

Mary's Test 1 (NMIST, Table 25, columns 1-4) ratings indicated that - at work - she believed unpleasant tasks were done by those on lesser pay (construct 3, rated -3) and on the whole she worked best on her own (construct 4, rated -1). In terms of the model nurse values in Test 1 (NMIST, Table 25, Columns 1-4), Mary's responses identified that she strongly believed that the model nurse found it hard to get people to follow instructions (construct 5, rated -4) and they accepted that work pressures left less room for kindness and sympathy (construct 9, rated -4). Interestingly when Mary rated construct 14 this was on the non-preferred pole for both herself and the model nurse. i.e., Mary strongly believed that she was not a good communicator, rated -3, and this was even more so for the model nurse, rated -4 (construct 14, rated -3, Table 25, Columns 1-4).

Mary's Test 2 ratings were in stark comparison to Test 1, with some of the 33 out of the 40 constructs rated 4 at the extreme end of the preferred pole. This suggested that Mary had a very clear view of what she considered were good care values (NMI, Table 25, columns 5-8). All of Mary's ratings - including those for her ideal self (bold text, Table 25, columns 7-8) - were on the preferred pole at either 3 or 4 (Table 25, columns 5-8) with the exception of construct 4 (teamwork) which was rated as 2. This suggested that teamwork was significant in some way (Table 25, columns 5-8).

Table 26 *Mary's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	77.52	70.82	70.84	55.46	78.67	65.78	69.85
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	90.28	81.51	84.01	69.47	84.14	76.84	81.04
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

Mary's value theme scores (Table 26)

Mary's value theme scores were the highest in the group. Her mean Test 1 value theme scores were 69.85 compared to the groups mean of 42.23 (NMIST, Table 26), with her Test 2 value theme score being 81.04 in comparison with a group mean of 52.69 (NMI, Table 26). Integrity was her lowest ranked theme in both tests (55.46 in Test 1, 69.47 in Test 2, Table 26) though these were still above the group mean (45.17 in Test 1, 47.42 in Test 2, Table 26). Personal development was her highest ranked in value theme Test 1 at 78.67 when compared with the group at 38.7 (NMIST, Table 26). Finally, Person-centredness was her highest score in Test 2 at 90.28 (group mean of 59.2, Table 26).

Mary's interview

Mary, a 28-year-old single woman with no children, was studying Adult Nursing. She had previously completed a degree and worked in social services. Mary's transcript identified three themes: 'Values', 'The Test' and 'The MMI' (Table 27). These themes, along with relevant subordinate themes, are described below.

An audit trail of quotations is provided in Appendix 21.

Table 27 Themes and subordinate themes from Mary's interview

Themes	Subordinate themes
Theme 1: Values	Unspoken things Selflessness Burnout and mindfulness
Theme 2: The test	Confidence The model nurse and me Pinch of salt
Theme 3: The MMI	Demonstrating understanding

Values

Within this theme, Mary identified caring, compassion and empathy as important values. She viewed the 'model' nurse as selfless, altruistic and patient-centred and as someone who went above and beyond for the patient. However, Mary intimated that the conditions and pressures of carework could result in burnout due to its moral demands.

Unspoken things

Mary began the interview by discussing what caring meant to her. She stated: *"I guess it's something that's inside, but I feel like it's always like a doing verb as well, if you know what I mean, like caring"*. Thus, the task and action of care were entwined with the emotional context of caring. Mary believed caring was innate, saying "*you're either that kind of person or you're not*". Likewise care, compassion and empathy were *"obvious"* values for the nurse, although these would be *"hard to pinpoint"*. She also believed care as a value could not be taught: *"You either have it or you don't"*. She added, *"It is kind of a bit of an unspoken thing that you have got to have those qualities".* This suggested that for Mary, the nurse had implicit and tacit tendencies towards caring, compassion and empathy. For Mary, care values were "*a massive part of*" professional values. Professional values required the actions and tasks of care to be of *"higher standards"*. Thus, they were *"done … properly"* and subsequently undertaken with principles and moral judgements. Thus, professional values were explicit rules and societal norms for the nurse; they shaped care. However, a tension appeared when professional standards were not *"thought through".* This indicated a dissonance between her aspirational values, which were of a *"higher standard"*, and the realities of professional values in practice.

Selflessness

Mary's tensions continued as she focused on her report and the entities of *disliked person and bad nurse*. This prompted her to consider her relationships with other nurses at work. She noted positive relationships with most nurses, except for "*a few people that I find a bit more difficult to work with and they are people that don't kind of go above and beyond for other people"*. Mary's words again indicated a dissonance when she compared her high standards with those of other nurses, whom she believed did not embody good nursing values. She repeatedly emphasised annoyance when colleagues were not *"going out of their way [to help patients]".* Mary's insistence that the client/service user was put first emphasised a perception that care values were selfless, altruistic and patient-centred. Consequently, for Mary, there was an expectation that the good nurse would exceed the required standards.

Burnout and mindfulness

Mary described her experiences of burnout in her previous social care role. Mary depicted burnout as *"horrible"* and as taking a significant emotional and physical toll, which caused substantial anxiety. Mary thought her experiences had influenced her ratings for construct 20 in Test 1 (thinking about others), which she only rated as 3 (NMIST, Table 25, columns 1-4): *"Maybe I do not need to always think about others and sometimes I do need to think about myself".* Therefore, care-of-self played an active role in Mary's meaning-making of care. Mary believed burnout was a consequence of the work conditions and demands: *"I guess maybe that would, like, impact if someone has been in the job for too long maybe".* This implied that continued long-term pressure could compromise the nurse's capacity to deal with patients. Consequently, the nurse could become emotionally exhausted and disengaged, ultimately leading to poor care standards. Mary voiced that being mindful could help maintain an awareness of becoming uncaring. She noted: *"There is only so much of you to go round isn't there, you've just got to be really careful of that kind of thing".* This appeared to consolidate her belief that the demands of nursing work could exceed a nurse's emotional and physical capacity. Mary's ratings for construct 9 in Test 1 reflected her opinion that work pressures would leave less scope for kindness (NMIST, Table 25, columns 1-4).

The test

Mary believed her report had given her the confidence that she possessed the values needed to be a good nurse. She acknowledged that lectures and her previous experience had also actively influenced her decision making when rating constructs. She thought the tests provided an opportunity for candidates to present themselves favourably; therefore, the report could not be relied upon.

Confidence

Reflecting on her responses to the test values statements and focusing on subtle differences between ratings, Mary reported she did not necessarily fully understand them, though she acknowledged her value theme scores were *"above average"*. Throughout her interview, Mary conveyed a lack of confidence in her ability to be a good nurse, which was a major influence when she was rating construct values statements in the first test. Mary repeatedly referred to her report as *"nice*"; hence, the report apparently validated Mary's attributes and consequently improved her confidence in her abilities to be a nurse. Mary believed that the lecture content had also *"influenced"* and *"shaped my ideal of the model nurse",* giving her more confidence in her aspirations to be a good nurse. Interestingly, this was also evident in Mary's ratings, as she aligned her aspirational values more closely with those of the 'model' nurse in Test 2, thus obtaining higher mean scores (Table 26). Mary suggested confidence came with experience: *"That's more of a confidence thing, feeling like I'm not, because I'm not, like, that experienced in healthcare and stuff".* Thus, confidence mediated by experience played an active role in Mary's decision making when rating values statements, which she believed would also influence candidates' test responses, "*Cause again, I guess confidence comes into it as well … You might have somebody who doesn't answer as well as maybe they would work and that would be kind of a shame".* This suggested that candidates with more care experience could outperform those with no experience of carework, potentially eliminating candidates who could be good nurses.

The model nurse and me

Mary described nurses as a "*special kind of people*" whom she had "*always looked up to"*. Her best friend was a nurse who *"inspired me to come into nursing".* Thus, when rating 'best friend' and 'model' nurse within the test, she thought *"she's very like me, so it was like… and obviously we value that in each other"*, which indicated that shared values had influenced her ratings. As Mary reflected on her report, she focused on the ratings for her work-self in comparison to the 'model' nurse, as several constructs were not aligned (Table 25, columns 5-8). These were constructs 4 (teamworking), 10 (challenging authority), 13 (time for tasks) and 16 (reliability). Mary used her previous carework experience to frame her understanding and justify her ratings. Within this context, when focusing on construct 4 (team working, construct 4, Table 25, columns 5-8), Mary understood that nurses had *"got to be able to work on [their] own as well"* because of making *"decisions and things".* Therefore, the 'model' nurse was viewed as knowledgeable and competent. Mary reflected on decision making and, whilst she stated she enjoyed it, her dialogue suggested competence, as a component of decision making, would be attained in the future, once qualified; hence, she felt "*a million miles away".* Consequently, Mary acknowledged a degree of difference between herself and the nurse because of her perceived lack of experience. Mary

considered her student status, described as *"because of where I am",* had also affected her response to construct 10 (challenging authority, NMI, Table 25, Columns 5-8): *"I feel like that is going to be [a] challenge, like, especially on placement and stuff, like if I see something that's not right".* Thus, she believed that as a student, it was difficult to be courageous and speak up when challenging poor care practices when working with a knowledgeable nurse. Mary continued and paused on construct 13 (time for tasks, rated 3, Table 25, columns 5-8): *"I was really considering time pressures and worrying cause I am really worried about that … Am I actually going to have the time to do a proper job*?" This reflection seemed to identify a real fear that limited time and resources were constraints to providing good care. Despite believing she was reliable, Mary also considered that this had affected her response to construct 16 (reliability) (Table 25, columns 5-8). Overall, analysis of the extracts indicated values dissonance as Mary perceived the realities of practice were not always reflected within the values statements.

Pinch of salt

Mary described VBR as *"making sure that it's the right types of person for the job",* while caring and compassionate values were *"innate"* for the nurse. Whilst Mary understood the principle of VBR, she questioned the legitimacy of testing for caring and professional values: "*I don't know how easy it is to test for it".* Consequently, Mary believed that if aptitude testing were used for recruitment, applicants would *"obviously"* present themselves more favourably, aligning their values to those embodying the nurse: *"You put yourself close to that wouldn't you… good communicator, good teamwork, good listener … all the skills you need. Cause as a nurse you're like 'yep yep yep' to all of those things"*. Consequently, despite commenting that aptitude testing would be *"useful"*, she would take the report "*with a pinch of salt"* and *"not rely"* on the results. Mary considered her responses were honest and she did not "*have to worry about being a certain way*" as the tests were not part of the recruitment process. Therefore, she viewed the tests as a true reflection of her values. Mary's purported honesty emerged earlier in the transcript: *"I just answered honestly then like hopefully I'm not going to get something back that I'm not a complete psychopath".* Thus, despite her honesty and not worrying she must be *"a certain way",* there remained underlying anxieties that the tests could expose poor values that were not reflective of the nurse.

The MMI

Within this theme, Mary described the MMI as an intense experience in which values and attributes needed to be demonstrated. By comparison, values were explicit in the test and her opinion was sought. However, the MMI was viewed as preferential as it gave her the opportunity to establish common values and an understanding with the assessor.

Demonstrating understanding

Mary described her preparation for MMI as *"intense",* as she needed *"to make sure I say this and demonstrate this and make sure that I understand this. So you know, it is almost like they're going to have a list of things they're looking for, aren't they?"* Mary was the only student to refer to stations which asked about the understanding of nursing values and motivation to become a nurse. She likened this to a job interview: "*Do you understand the role, do you understand why you're there, why you want to be on the course?"* In this respect, Mary described MMIs as a performance of a *"list"* of values, in which she presented her values favourably and in line with those embodying the nurse. Consequently, the assessor was an observer of the values *"list"* who identified *"demonstrated"* values and understanding of values. In contrast, during testing, values were given and opinions were sought, which Mary illustrated by saying, "[it] *gives you those things and you score".* Mary believed the test had *"a lot more depth"* and was *"robust"*; subsequently, it was more challenging to present her values in line with those of the nurse. By comparison, during MMI she could "*see what they were getting at in certain, different stations"*, in which it was "*up to you to say the right things".* Consequently, Mary said she would have liked a *"longer interview with someone"*, although her choice of words emphasised this as informal. She characterised it as a *"chat"*, indicating a need to make a personal connection or take the opportunity to interact personally.

6.1.8 Pauline's case

Table 28 Pauline's NMIST and NMI ratings

№	*Test 1 - NMIST*				*Test 2 - NMI*			
	Constructs		*Ratings*		*Ratings*		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	**People's dignity comes first**	need for help comes first	**1**	**2**	**3**	**3**	**Patient's dignity comes first**	need for help comes first
02	Safety at work comes first	**resource limits may reduce it**	**-3**	**-2**	**2**	**3**	**Safety at work comes first**	resource limits may reduce it
03	**Unpleasant tasks done by all**	done by less well paid	**4**	**4**	**4**	**4**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**3**	**2**	**1**	**3**	**Nurses work best in a team**	work best on own
05	Can get people to follow instructions	**finds it hard to**	**1**	**2**	**3**	**4**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**4**	**2**	**4**	**4**	**Learning competence is lifelong**	is for new workers only
07	Listens carefully	**listening a distraction - get on**	**3**	**4**	**2**	**4**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**2**	**3**	**2**	**3**	**Better be open and honest**	wiser to manage truth
09	**No excuse for lack of kindness**	pressures can be excuse	**1**	**-3**	**3**	**4**	**No excuse for lack of kindness**	pressures can be excuse
10	**Challenge authority if in best interests of work**	does not challenge	**2**	**4**	**3**	**4**	**Challenge authority in best interests of patient**	does not challenge
11	**Enjoys decisions when competent**	prefers others do it	**3**	**2**	**3**	**4**	**Enjoys decisions when competent**	prefers others do it
12	**Takes responsibility for own actions**	sticks to guidelines	**1**	**0**	**1**	**1**	**Takes responsibility for own actions**	sticks to guidelines
13	**Take time needed for tasks**	do best in time one has	**3**	**3**	**3**	**3**	**Take time needed for tasks**	do best in time one has
14	Good communicator	**not a good communicator**	**-2**	**-4**	**2**	**4**	**Good communicator**	not a good communicator
15	**Relates well to others**	has problems relating to others	**4**	**4**	**4**	**4**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**4**	**3**	**3**	**3**	**Can be relied on**	real world can affect reliability
17	**Works with little supervision**	works better if managed	**4**	**4**	**3**	**3**	**Works with little supervision**	works better if managed
18	**Generally, understands situations**	sometimes does not	**3**	**3**	**2**	**3**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**3**	**3**	**4**	**4**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**4**	**4**	**2**	**3**	**Always thinks about others**	focusses on own needs
Pauline's construct ratings (Table 28)								

Pauline rated 2 constructs on the non-preferred pole when she considered her personal nursing values at work in Test 1, these were construct 2 (safety) and 14 (communication) (NMIST, Table 28, columbs1-4). With an additional 3 constructs – 2 (safety), 9 (kindness) and 14 (communication) - rated on the non-preferred pole for the model nurse (NMIST, Table 28, columbs1-4). Pauline did not rate construct 12 for the model nurse. By comparison she rated all the construct on the preferred pole in Test 2, for both her personal nursing values at work and those of the model nurse (NMI, Table 28, columns 5-8). She rated her values the same as the model nurse on only 8 occasions in both Tests. This suggested she understood there to be a degree of difference between her personal nursing values and those of the model nurse (Table 28).

When Pauline rated her ideal nursing values in Test 1 (NMIST, Table 28, bold text columns 1-2) there were 4 constructs that did not reflect the preferred pole. These were, construct 2 (dignity), construct 5 (following instructions), construct 7 (listening) and construct 14 (communication). As compared to test 1, Pauline rated all her ideal values on the preferred pole in Test 2 (NMI, Table 28, bold text columns 7-8). This suggested she had a clear understanding of the values of the model nurse.

In summary – Pauline's ratings for Test 1 (NMIST, Table 28, columns 1-4) indicated that at work she believed that safety at work suffered as a result of pressures on staff and resources (construct 2, rated -3); however, this was less so for the model nurse which was rated -2. She also considered that pressures of work would leave less room for kindness and sympathy for the model nurse (construct 9, rated-2). Pauline also thought that generally she was not a good communicator (construct 14, rated -2) but this was even more so for the model nurse, rated -4, which was a strong response.
Pauline's ratings for Test 2 were markedly different, with all constructs rated on the preferred pole (NMI, Table 28, columns 5-8).

Table 29 *Pauline's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	52.8	53.95	50.39	70.3	62.4	70.4	60.04
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	86.37	66.84	60.71	67.88	69.86	70.7	67.36
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

Pauline's value theme scores (Table 29)

Pauline's mean value theme scores were higher than the group mean for both Test 1 (60.04:42.23) and Test 2 (67.36:52.69) (Table 29). Her value theme scores ranged between 50 - 70 in Test 1, increasing to 60 - 80 in Test 2. Her highest value theme score in Test 1 was Teamwork at 70.04 when compared with a group mean of 44.57, with her lowest value them score being Trust (50.39). This compared to the group mean of 39.91 (NMIST, Table 29). For Test 2 (NMI, Table 29), Pauline's highest values theme score was Person-centredness at 86.37. This compared to the group mean of 59.2. Her lowest value theme in test 2 was also Trust at 60.71 with a group mean of 50.49.

Pauline's Interview

Pauline was in her twenties, had no children and was studying on the Adult Nursing pathway. She had worked as a healthcare assistant in the community and in residential homes before beginning her nurse training. Pauline presented as a mature, confident and articulate young woman who appeared at ease. Pauline's transcript identified two themes, 'Being the nurse' and 'Assessing values' (see Table 30). These themes, along with relevant subordinate themes, are described below.

An audit trail of quotations is provided in Appendix 22.

Table 30 *Themes and subordinate themes from Pauline's interview*

Themes	Subordinate themes
Theme 1: Being the nurse	Emotions and relationships Guidelines
Theme 2: Assessing values	The test The report The MMI

Being the nurse

Pauline described care and caring as a balance between action and emotion. Caring was a core value for Pauline and typified a way of behaving, whereas poor care values were described as repetitive, basic learnt tasks, devoid of emotion. Pauline understood professional values as guidelines for care that were instructional and provided consistency. However, professional values also had boundaries which were punitive if not adhered to.

Emotions and relationships

Pauline started the interview by defining care as *"something personal"* and how she would want care *"done"* for herself, *"sort of putting myself in their shoes".* Pauline's description indicated that care involved the task and action of care. However, it also seemed person-centred, whereby dignity and respect were central, which required empathy. She continued to describe care as how *"I want to be looked after",* implying that care also required moral judgements. Care required "*a good emotional relationship"* in which the nurse created *"a symbiotic relationship".* This indicated that caring required a common connection between nurse and patient, suggesting a mutually beneficial closeness. Nevertheless, caring was *"created*", a view which emphasised that the nurse/patient relationship required engagement and investment to flourish. Pauline further illustrated her point: *"So it's [caring], like, looking after them emotionally as well as, like, making sure that yourself that you are emotionally capable".* Thus, whilst care and caring seemed interconnected, Pauline was aware of how the emotional effort carework affected the nurse, so care-of-self appeared important. Interestingly, there was an emerging recognition of missed opportunities for care in Pauline's

transcript when she considered the compassionate nurse. In this context, poor care was seen as something *"missed"*, which she illustrated through *"incident reports"* and *"reviews"*. This suggested the nurse needed to be knowledgeable, conscientious and vigilant. Pauline believed caring behaviours must be *"monitored",* suggesting that nursing values changed if exposed to poor practices. Pauline also expressed caring as "*something that you do in your everyday life",* typifying caring as a way of behaving. Pauline returned to this point later in the transcript by illustrating caring as "*how you have been brought up to act … something you want to do instinctively".* Pauline described her mother (also a nurse) as *"compassionate"* and *"brilliant"*, implying she had fashioned her nursing values on her mother. Whilst Pauline's words indicated that, for her, caring was intuitive and innate, it also seemed to be a learnt behaviour. She described poor care practices as nurses with the *"fundamentals"* but for whom the emotional side *"is not quite there".* Such nurses performed their tasks *"robotically"* as opposed to *"responding to the patient".* This implied poor care values were a repetition of basic learnt tasks and devoid of emotional response, whereas the emotional attachment of caring provided the driver for good care. Pauline considered she had the *"fundamentals"* to be a nurse, as she *"knew how it was done".* Therefore, she had learnt the tasks and actions of care and viewed herself as knowledgeable. In this respect, she did not "*mimic anything that [the nurse]"* did, as she was aware that *"they [i.e., the nurses] are not quite up to standard".* Pauline's discourse intimated that observing poor values had influenced her practice, but this was not a debasing of values, rather a 'casting off' of values that Pauline felt did not correspond with the societal norms for the nurse.

Guidelines

Pauline made meaning of her professional values as "*guidelines"* on how to care.

> *You know what you are meant to be doing and if you're not doing them then it's your own fault, because you are meant to know them.*

The extract above suggested dissonance between what Pauline believed were *"taught"* professional values and those evident in practice, which she characterised as *"meant"* and *"fault".* However, on these occasions, the nurse was accountable for their actions and ignorance of the guidelines was not an excuse for poor care. Pauline stated that guidelines were *"important"* because "*if you don't have them then you don't have a set rule for everyone to follow [and] that way you get, like, different, methods of doing a certain task".* Guidelines seemed to provide boundaries for professional behaviour, which were instructional on *"how to"* look after patients. Guidelines enabled a patient to *"feel secure"*, and Pauline intimated that professional values encompassed the nurse's public persona. In the absence of guidelines, care was seen as inconsistent. Pauline seemed to suggest professional values encompass care values. Pauline described herself as having *"instinct",* which she had earlier described as the *"personality to become a nurse"*, whereas now she referred to it as *"getting*

the procedures down to back it up". This implied that the nurse required the aptitude of caring before they could learn the professional values of care. Thus, professional values were aspirational, based on knowledge and experience, as well as being something attainable in the future. Interestingly, Pauline consistently used *"you"* when describing her professional values, which suggested an alignment of values with those advocated by the profession.

Assessing values

Within this theme, Pauline described how her previous work experience, her mother and the curriculum had influenced her construct test ratings, also saying the report had given her confidence. Pauline described the MMI as an activity she had prepared for; it had been aligned with the 6Cs and tested candidates' *"knowledge"* of values.

The test

Pauline described her initial feeling when taking the first test. She felt it was *"nerve-racking",* which she apportioned to *"not knowing what I was doing"* and the test being *"something completely new".* This indicated an element of performance anxiety. However, Pauline's anxieties were not related to the test environment but to her perceived lack of knowledge and experience, which she characterised as *"I don't know anything".* This implied her student status had influenced her behaviour during testing. Pauline also used her mother as a guide to her responses when identifying the 'model' nurse as she *"imagined"* how she herself *"wanted to be"* as a nurse. This created a *"glow"*, making her mother *"perfect"*. Therefore, she rated the 'model' nurse higher because of *"positive emotions"* and the bad nurse lower as she did not want to *"mimic"* those behaviours. This suggested that her strong emotional bond with her mother, her idealisation of the nursing image and her aspirations to become a nurse had influenced her responses to the test. Pauline's previous experience had also influenced her decision making. She thought she was not *"exactly like a nurse",* so she saw a degree of difference between her values and those of the 'model' nurse and *"sort of moved it down a bit".* This indicated that her perceived lack of knowledge and experience, which related to her previous HCA role (i.e., a carer, not a nurse), had also influenced her ratings in the test. Pauline also reiterated that she had attended *"a few more lectures"* between the tests, which had *"coloured her opinion"* and *"impression"* of the nurse, particularly her views on accountability and trust. Consequently, the values endorsed by the university had also influenced the changes in her ratings between the tests. Pauline perceived her scores as *"pretty good"*, which influenced her belief that aptitude testing was a valid recruitment tool. She questioned whether, had her scores been lower, they would have been *"good enough"* to let her *"slide through".* If unsuccessful, Pauline questioned whether she could *"improve"* on her scores and maybe *"try again next year",* emphasising great anxiety about perceived failure.

The report

Pauline viewed her report as *"pretty good"* so she would be *"happy"* for it to be used for recruitment purposes. This could, however, have been influenced by her understanding that she had a *"good"* score. Pauline indicated that the positive report had given her more *"confidence" and a* "boost" and that she had the *"personality"* to be a nurse. Therefore, she was *"proud"* of her "marks". Thus, the report *"affirms"* both her care values and her *"choice"* to become a nurse, endorsing her place on the course and confirming that she had the values needed to become a nurse. With regard to *"marks"*, she stated, "*I suppose I see it as like a test, like an exam*", a view she considered was influenced by her perspective as a student. This suggested she viewed the tests as pass or fail. Hence, the report would help her to *"build"* on *"how I see a model nurse … [It will] colour my opinion … It will make me work harder to be that nurse".* Consequently, the report was viewed as a reflective tool to help improve values.

The MMI

Pauline seemed undecided about whether the MMI or the report best reflected her values. She thought the report reflected her values as she was *"reading a lot"*. This implied she had aligned her values more closely with those embodying the stereotypical values (see Table 1) of the nurse in the second test. This suggested her responses to the values statements in the second test were based on learnt behaviours. However, her experience of the MMIs required her to *"look up on the internet"* what it *"means"* to be a nurse, which she illustrated as *"making notes, that kind of thing".* Seemingly, the public image that purported to exemplify the nursing profession had influenced her behaviours during the MMI and she presented her values in line with this image. As she stated, *"I had something in my head of how, what the answers they were looking for"* in the test, but she believed that the test represented her better as an *"individual".* By comparison, she had *"practised what I felt needed to be said"* during the MMI. This indicated that the MMI facilitated an opportunity for Pauline to present her values more favourably. Pauline described *"repeating"* herself initially through the MMIs due to *"nerves".* However, over time, she *"calm[ed] down a bit"* and was able to give more complex responses, illustrated as being *"more than one answer".* This suggested that anxiety affected Pauline's performance in the initial stations of the MMI. Pauline also stated she could identify the values assessed in some stations. She further stated: "*I can see now why each booth was chosen and why, like, each task like was chosen for you to do"*. This further indicated an understanding of the values assessed through the MMI, which made sense to Pauline. She considered that MMIs assessed *"knowledge",* were good for *"assessing people"* and identified if candidates had the right *"personality".* This indicated Pauline considered MMIs to be a measure of candidates' knowledge of values, not personal attributes that were comparable with those deemed essential to the nursing

profession. Despite this, Pauline considered MMIs *"less daunting"* compared to a traditional interview. Yet she said she felt it necessary to "*throw [knowledge] out",* hoping she would pass. In this context, knowledge had to be demonstrated to the assessor, suggesting that, for her, knowledge took precedence as it had to be demonstrated urgently and hastily within the time allotted for each station.

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6.1.9 David's case

Table 31 *David's NMIST and NMI ratings*

№	*Test 1 - NMIST*				*Test 2 - NMI*			
	Constructs		*Ratings*		*Ratings*		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	**People's dignity comes first**	need for help comes first	**4**	**4**	**4**	**4**	**People's dignity comes first**	need for help comes first
02	**Safety at work comes first**	resource limits may reduce it	**-4**	**4**	**4**	**4**	Safety at work comes first	**resource limits may reduce it**
03	Unpleasant tasks done by all	**done by less well paid**	**4**	**-4**	**-4**	**4**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**4**	**4**	**-4**	**-4**	People work best in a team	**work best on own**
05	Can get people to follow instructions	**finds it hard to**	**-4**	**-4**	**4**	**4**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**3**	**4**	**-4**	**4**	**Learning competence is lifelong**	is for new workers only
07	Listens carefully	**listening a distraction - get on**	**4**	**4**	**4**	**4**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**-4**	**4**	**-4**	**4**	**Better be open and honest**	wiser to manage truth
09	**No excuse for lack of kindness**	pressures can be excuse	**-2**	**-2**	**4**	**4**	No excuse for lack of kindness	**pressures can be excuse**
10	Challenge authority if in best interests of work	**do not challenge**	**4**	**-4**	**4**	**4**	**Challenge authority if in best interests of work**	do not challenge
11	Enjoys decisions when competent	**prefers others do it**	**4**	**-2**	**-4**	**4**	**Enjoys decisions when competent**	prefers others do it
12	Takes responsibility for own actions	**sticks to guidelines**	**4**	**4**	**-4**	**-4**	Takes responsibility for own actions	**sticks to guidelines**
13	**Take time needed for tasks**	do best in time one has	**4**	**4**	**4**	**4**	**Take time needed for tasks**	do best in time one has
14	Good communicator	**not a good communicator**	**1**	**-1**	**4**	**4**	**Good communicator**	not a good communicator
15	Relates well to others	**has problems relating to others**	**-3**	**3**	**4**	**4**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**-3**	**0**	**4**	**-4**	Can be relied on	**real world can affect reliability**
17	**Works with little supervision**	works better if managed	**-2**	**4**	**4**	**-4**	**Works with little supervision**	works better if managed
18	Generally, understands situations	**sometimes does not**	**0**	**-4**	**-4**	**4**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**4**	**-4**	**4**	**4**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**-4**	**4**	**4**	**4**	**Always thinks about others**	focusses on own needs

David's construct ratings (Table 31)

David's ratings for constructs in Test 1 identified that the values and attributes of the model nurse were endorsed in 11 out of the 20 constructs. Eight (constructs 2, 5, 8, 9, 15, 16, 17 and 20) were rated on the non-preferred pole when David considered his personal nursing values at work (construct 18 was rated as 0) (see Table 31). A further 8 constructs (3, 5, 9, 10, 11, 14, 18 and 19) were aligned with the non-professional preferred pole for the model nurse (Table 31, columns 1-4). For Test 2 (NMI, Table 31, columns 5-8). David's ratings for all constructs were on the extreme end of the poles at either +4 or -4. His ratings also indicated that he believed that he had many of the attributes and values of the good nurse – some 13 out of 20 (Table 31, columns 5-8). He rated seven constructs (3, 4, 6, 8, 11, 12 and 18) at the extreme end (-4) of the non-professionally preferred pole when he considered his personal nursing values at work, with an additional four constructs (4, 12, 16 and 17) at -4 for the model nurse. There were also only two constructs which remained on the preferred pole (rated 4) for both tests: construct 1, dignity comes first and 13, takes time needed for tasks (Table 31, columns 1-8). Markedly when exploring David's perception of his ideal-self there were only 6 constructs out of 40 - three in Test 1 (7, 9 and 19, Table 31, columns 1-2) and three in Test 2 (2, 9 and 17, Table 31, columns 5-6), when David did not denote that his ideal personal nursing values mirrored those of the model nurse. This indicated a marked difference between what he considered were his aspirational personal nursing values and his values at work.

In summary - Test 1 (NMIST, Table 31, columns 1-4) identified that David believed the real world of work had limited resources which affected safety (construct 2 rated -4), was pressured, which could mean there was less time for kindness and sympathy (construct 9 rated -2), and effect reliability (construct 16 (reliability) - rated -3). David's responses also suggested he believed it was best to manage the truth at work (construct 8 rated -4) and that he found it hard to follow instructions (construct 5 rated -4) and relate to others (construct 15 rated -3). He also identified that on the whole he worked best when managed as opposed to working with minimal supervision (construct 17 rated -2), and predominantly focused on his own needs when at work (construct 20 rated -4). In Test 1 (NMIST, Table 31 columns 1-4), David's view of the values of the model nurse was starkly different to those values identified within the preferred poles of the test constructs. He responses indicated that the model nurse thought that unpleasant tasks were done by those less paid (construct 3 rated -4). His responses suggested that he believed the model nurse found it hard to get people to follow instructions (construct 5 rated -4) and generally preferred others to make decisions (construct 11 rated -2). His ratings to construct 14 (communication) indicated that he believed that the model nurse sometimes misunderstood things in work (rated -1) and did not relate well with others (construct 15 rated -4). David's ratings to construct 9 (kindness) indicated that the pressures of work could leave less room for kindness

and sympathy from the model nurse (rated -2), who further would not challenge someone senior (construct 10 rated - 4), and rarely paused to reflect on how things have gone (construct 19 rated -4).

In comparison a differing picture emerged in Test 2 (NMI, Table 31 columns 5-8). David's ratings for his personal nursing values at work indicated that unpleasant work was done by those less paid (construct 3, rated -4) and learning was for new workers only (construct 6, rated -4). He continued to believe it was better to manage the truth in the best interests of work (construct 8, rated -4). David's ratings further suggested that he did not always understand the situation (construct 18, rated -4) and preferred to stick to guidelines as opposed to taking responsibility for his actions whilst at work (construct 12, rated -4). His responses also indicated that he thought he worked best on his own (construct 4, rated -4), though would prefer others to make decisions (construct 11, rated -4). When he considered the values of the model nurse in Test 2 (NMI, Table 31 columns 5-8) his ratings identified that he believed that they worked best on their own (Construct 4, rated -4) and would prefer to adhere strictly to guidelines and instructions (construct, 12 rated -4). David also understood that the real world of work affected reliability for the model nurse (construct 16 rated -4) and they worked better if managed as opposed to working with minimal supervision (construct 17 rated -4).

Table 32 *David's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	35.29	18.28	21.51	20.67	11.7	20.78	21.37
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	50	39.01	16.67	41.54	46.15	42.74	38.35
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

David's value theme scores (Table 32)

Several of David's attributes at work, contrasted quite sharply with those of the model nurse, and as a result, all of his value theme scores were significantly lower than those of the group mean (Table 32). David's Personal development value theme was lowest in Test 1 (NMIST, 11.7) with Trust being his lowest in Test 2 (NMI 16.67). Person-centredness - his view of what attributes a truly person centred nurse, was his highest value themes for both tests (NMIST, 35.29 - NMI, 50), however, these were below the group average (NMIST 42.82, NMI 59.2).

David's interview

David was a married man in his thirties with three children, educated to A level standard and studying on the Adult Nurse pathway. David had previously worked for a few months as an HCA for a private company within the community. David's first language was not English, so I often repeated David's responses to seek clarification.

Analysis of David's interview identified two themes 'Being the nurse' and 'The values experience' (Table 33). These themes, along with associated subordinate themes, are described below.

An audit trail of quotations is provided in Appendix 23.

Table 33 Themes and subordinate themes from David's interview

Themes	Subordinate themes
Theme 1: Being the nurse	Caring and competence The novice nurse
Theme 2: The values experience	Something positive, something negative The manual Making connections

Being the nurse

Within this theme, David described caring as a behaviour which required aptitude, skill, ethics and morals. Caring and professional values for David were synonymous with competence, so training and supervision seemed essential for him as a student.

Caring and competence

At the outset, David defined caring as "*being there for someone"*, which was synonymous with compassionate behaviours like *"treating [the patient] well".* Care also required the nurse to do *"as much"* as they could, implying care had limitations. Care was also given to the best of the nurse's *"ability",* which, for David, was tantamount to *"help".* This indicated David understood care as both the act and task of care. Whilst David did not differentiate between professional values and caring values, he denoted professional care as *"learn[ing] something",* whereby you were *"trained"* then you *"apply"* training. Thus, professional care required aptitude, knowledge and ability. Interestingly, analysis of his transcript identified 'help' defined in two contexts: the nurse being *"willing"* and *"wanting"* to help *and* the nurse *"going"* to *"help"* others. Meanwhile, if the patient *"need[ed] some help",* the nurse required aptitude to provide 'help'. David's transcript alluded to a difference between caring for family and providing professional care. However, he was hesitant and unclear when he tried to rationalise the differences. In spite of this, he stated that family care meant a parent not wanting their children *"harmed", "sick"* or *"ill".* This was viewed in contrast to professional

care, which required the nurse to have *"competence"* and provide *"help",* which seemed devoid of emotional connection. David suggested that nursing values meant giving *"dignity"* and *"respect"* to the person you were caring for. David's view centred on his previous role in community care, where patients were *"isolated*", *"sick"* and unable to *"look after themselves".* This indicated his view of patient care was one of dependence, not promoting independence. For David, care was also synonymous with physical competence to undertake the tasks and actions of care, which connected with his perceptions of care as 'help'. Interestingly, David additionally described giving good care as being rewarding, which appeared in two contexts. Rewarding meant making a difference to the lives of others; rewarding also meant he was given the rest of the day off for doing a *"good job",* implying his motivation to provide care was both intrinsic and extrinsic. David described the nurse as having *"to be compassionate and caring"*, which he described as a *"pre-sequel of the Department of Health",* whereby the nurse had to be compassionate "*to do your job".* Interestingly, here, David reiterated that the nurse *"should"* be a *"caring person"* and *"should have compassion and caring and courage …those things, the 6Cs".* David's use of *"should"* in this context suggested values dissonance between the stereotypical values of the nurse, illustrated in the value frameworks in Table 1, as he perceived them (having an aptitude for care and compassion), and those evident in practice. This may also be interpreted to mean that for caring values to become effective, they do not stand in isolation. Thus, the *"6Cs"* (DoH 2012) were identified by David as stringent guidance for everyday practice.

The novice nurse

As David reflected on his report, he focused on construct 17 (works with little supervision). He expressed reservations about supervision, which appeared to cause him concern. Whilst he initially failed to define what supervision *"should be"*, later in the interview, he stated there should be *"a lot"* of supervision and he should be *"supervised properly"*. This indicated he thought supervision could sometimes be lacking, though he failed to define why. David's view was reflected in his test rating for construct 17 in Test 1, saying he believed he worked more effectively when managed (Table 31, Columbus 1-4). However, this was not reflected in his second test, in which he considered that, unlike the 'model' nurse, he worked best alone (Table 31, Columbus 5-8). Nevertheless, when comparing himself to the 'model' nurse, he described himself as a *"little bit, you know, on the way down",* which implied he saw a difference in values. His belief involved knowledge and competence, which had affected his ratings of the values statements in the test. When trying to comprehend his knowledge and competence, he described himself as a *"beginner".* When interpreting

David's meaning of competence, it seemed synonymous with knowledge and the craft of nursing, which was complex.

The values experience

Within this theme, David reflected on his experiences of taking aptitude testing and indicated his confusion when rating constructs. Nevertheless, David viewed his report as instructional as it helped him *"learn"* to be a nurse. In comparison, his MMI experience was viewed as a more accurate measure of his values.

Something negative, something positive

When David reflected on his experience of taking the tests, he reported that despite finding them *"straightforward",* he was *"confused"* when rating constructs, hinting at their ambiguity. However, he did not feel *"stressed"* when taking the tests because they were not *"valuable"* as he was a *"volunteer"*. Despite this, he had tried his *"best".* David also described his experience of responding to constructs as *"freaky"* which, in this context, implied uncertainty about how the constructs were worded and presented in the Likert scale, which he expressed as "*how they are put together".* This may be interpreted to mean David struggled with the construct wording as English was not his first language. David's expressions, however, suggested he could differentiate between good values and poor values, as he perceived them, within the values statements. For instance, he described bipolar constructs as *"something negative"* and *"something positive".* Consequently, if he thought it was *"the right answer, I just tick[ed] it on that side"*. Therefore, he concentrated on what good or poor nursing values were, not the extent to which he agreed or disagreed with the values statement. This was evident in David's responses to both tests, but more so in Test 2, as he only responded at the extreme end of the poles (Table 31). Interestingly, David added, "*I don't know how it works for me"*. This may be interpreted to mean that David sometimes thought his responses would not necessarily be judged as good nursing values. This indicated a potential disconnect between what David perceived as good nursing values evident in the tests and an honest reflection of his personal nursing values. David reported he recognised similarities between the tests which had helped him *"do the next one, you know, good"*. When interpreting this excerpt, David appeared to describe test-to-retest memory, which helped him improve his score for Test 2 (NMI, Table 31, columns 5-8). He seemed to confirm this by recalling constructs in the tests as *"similar or a lot alike"*. Consequently, test-to-retest memory meant David had potentially unwittingly provided socially desirable responses for Test 2, reflected in his improved values theme scores (Table 32).

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David admitted he had not read his report before the interview. Consequently, we took time to examine his report, after which David stated he was *"amazed"* as he was not *"expecting"* a favourable report. He added he did not always respond *"positively"* to the values statements, suggesting values dissonance when compared to his perceptions of the realities of care in practice. Despite this, David considered his results indicative of *"passing"* the test because of *"hard work".* Thus, David apparently viewed his results as an expression of his desire to learn, rather than values. David recognised his teamwork values scores were low in comparison to the group mean. Therefore, he stated he would "*work on it"* and *"try to develop"* himself, again expressing his perception that the report was a way to learn and improve. David viewed his results as *"ideas"* that would provide him with "*extra information"* about nursing values, which he referred to as a "*guide or a manual".* This implied the report became instructional, providing David with information about how to be a 'model' nurse, which he seemed to think gave him an advantage over others who had not participated in the study. However, for David, the usefulness of the report as a reflective tool was potentially short-lived, which he demonstrated by saying "*I will use this for some time";* thereafter, the course learning would take primacy. David's views also seemed evident in his test ratings. In Test 2 (NMI, Table 31, columns 5-8), he believed that learning was only for new workers (construct 6, rated -4), potentially reflecting his learning needs as a student nurse. Interestingly, when David reviewed his teamwork values score, he perceived the group mean in a unique way compared to the other study participants. David considered the group score as evidence that teamwork, which he described as *"being a team player"*, meant better outcomes than *"doing [work] by yourself"*. Thus, he saw his scores as helping to improve those of the group.

Making connections

David described being *"nervous"* about his MMI because he did not know what to *"expect"*; however, he stated once there, *"it gets good".* Despite initial misgivings, David indicated he had generally found the MMI a *"good experience".* He stated, *"I find relevance to the course, the questions".* This indicated that he understood the values being assessed during the stations and their relevance to nursing values. David continued to describe a starkly different view of the tests compared to his experience of the MMI:

> *It's totally different … This is a test, this is you're going to sit down at the computer … in front of the computer and then the test. That one is, you know, communication skills … That's different that you know you are speaking … to the person face-to-face.*

For David, the test was an automated process, characterised as *"sit down", "[sit] in front … [and] "then [take] the test".* Alternatively, the MMI facilitated an opportunity to communicate with the assessors, that is, people who could identify values which he characterised as *"confidence"*, *"worth"*, *"fit or not"* and *"background"*. Consequently, assessors would be *"judging"* if the candidates were "*good enough"* to become nurses. This may be interpreted to mean that only assessors, and therefore MMIs, could evaluate complex senses like feelings and understanding through human interaction, which he described as a *"person-to-person connection".* His use of the word *"connection"* seemed to denote a like-mindedness and common ground with the assessors. Consequently, through the MMIs, a relationship with the assessor developed which was absent when responding to the computer-based tests. It could be surmised that removing the person from the recruitment process was significant for David. David concluded by stating the test did not represent his values: *"This is someone with experience, this is someone who is a model nurse and the bad nurse. How are you going to be weighted [by] someone relating to this?"* David's words suggested that, unlike the MMI, the test was only relevant to those nurses with experience who could decide between what were good or deficient care practices. Thus, it was a measure of knowledge, not values, which reflected his earlier thoughts about his report. David questioned how a candidate could be *"weighed",* that is, measured and assessed, against values depicted in the tests. This differed to his view of MMIs, when he had been *"judged"* by *"about 12 persons"*, which gave validity to the assessment of his values and his place on the course.

6.1.10 Anna's case

Table 34 Anna's NMIST and NMI ratings

№	*Test 1 - NMIST*				*Test 2 - NMI*			
	Constructs		*Ratings*		*Ratings*		**Constructs**	
			self	nurse	self	nurse		
	Column (C) 1	**C2**	**C3**	**C4**	**C5**	**C6**	**C7**	**C8**
01	**People's dignity comes first**	need for help comes first	**3**	**2**	**3**	**3**	**Patient's dignity comes first**	need for help comes first
02	**Safety at work comes first**	resource limits may reduce it	**2**	**4**	**2**	**3**	**Safety at work comes first**	resource limits may reduce it
03	**Unpleasant tasks done by all**	done by less well paid	**-4**	**4**	**3**	**4**	**Unpleasant tasks done by all**	done by less well paid
04	**People work best in a team**	work best on own	**3**	**3**	**3**	**3**	**Nurses work best in a team**	work best on own
05	Can get people to follow instructions	**finds it hard to**	**3**	**-4**	**2**	**4**	**Can get people to follow instructions**	finds it hard to
06	**Learning competence is lifelong**	is for new workers only	**3**	**1**	**2**	**4**	**Learning competence is lifelong**	is for new workers only
07	Listens carefully	**listening a distraction - get on**	**3**	**4**	**2**	**4**	**Listens carefully**	listening a distraction - get on
08	**Better be open and honest**	wiser to manage truth	**3**	**4**	**2**	**2**	**Better be open and honest**	wiser to manage truth
09	**No excuse for lack of kindness**	pressures can be excuse	**2**	**-4**	**2**	**4**	**No excuse for lack of kindness**	pressures can be excuse
10	**Challenge authority if in best interests of work**	do not challenge	**-1**	**3**	**-1**	**4**	**Challenge authority in best interests of patient**	do not challenge
11	**Enjoys decisions when competent**	prefers others do it	**1**	**0**	**2**	**4**	**Enjoys decisions when competent**	prefers others do it
12	Takes responsibility for own actions	**sticks to guidelines**	**1**	**2**	**2**	**4**	Takes responsibility for own actions	**sticks to guidelines**
13	**Take time needed for tasks**	do best in time one has	**-1**	**3**	**2**	**4**	**Take time needed for tasks**	do best in time one has
14	Good communicator	**not a good communicator**	**-3**	**-4**	**3**	**4**	**Good communicator**	not a good communicator
15	**Relates well to others**	has problems relating to others	**3**	**4**	**4**	**4**	**Relates well to others**	has problems relating to others
16	**Can be relied on**	real world can affect reliability	**2**	**4**	**2**	**3**	**Can be relied on**	real world can affect reliability
17	**Works with little supervision**	works better if managed	**3**	**2**	**2**	**4**	**Works with little supervision**	works better if managed
18	**Generally, understands situations**	sometimes does not	**3**	**4**	**3**	**4**	**Generally, understands situations**	sometimes does not
19	**Often pauses to reflect**	rarely does so	**1**	**3**	**3**	**4**	**Often pauses to reflect**	rarely does so
20	**Always thinks about others**	focusses on own needs	**3**	**4**	**2**	**4**	**Always thinks about others**	focusses on own needs

Anna's construct ratings (Table 34)

When exploring Anna's construct rating in both tests it was interesting to note that she only ranked herself as 4, the extreme of the preferred pole, on one occasion in Test 2 (construct 15, relates well to others, NMI, columns 5-8, Table 34). In comparison she rated the model nurse as 4 eight times in Test 1, increasing to fifteen in Test 2 (Table 34, columns 3-6). There was also four instances were Anna rated her values at work the same as those of the model nurse - one in Test 1 (construct 4 - teamwork - rated 3, NMIST, Columns 1-4, Table 34) and three in Test 2 (constructs 4 - teamwork - rated 3, construct 8 - honesty - rated 2, and 15 - communication - rated 4, NMI, columns 5-8, Table 34). Anna additionally failed to rate construct 11 (decision making) in Test 1 for the model nurse (NMIST, Table 34, column 1-4). All other ratings indicated a degree of difference between Anna's perceived values at work when she compared them to those of the model nurse. Anna had rated three of her ideal personal nursing values on the non-preferred pole in Test 1 (NMIST, bold text, columns 1-2, Table 34). These were constructs 5 (following instructions), construct 7 (listening), 12 (guidelines), and 14 (communication). With only one by comparison for Test 2 which was construct 12 (guidelines) (NMI, bold text, columns 7-8, Table 34).

In summary - Anna's Test 1 (NMIST, columns 1-4, Table 34) ratings indicated that at work Anna understood that unpleasant tasks were done by those less paid (construct 3, rated -4) and that she had to be quick to do the best she could in the time available (construct 13, rated -1). Anna also recognised that she would not challenge authority (construct 10, rated -1) and she was not a good communicator (construct 14, rated -3). When she thought about the values of the model nurse in Test 1 (NMIST, columns 1-4, Table 34), she strongly believed that they found it hard to get people to follow instructions (construct 5, rated -4) and pressures of work was an excuse for a lack of kindness and sympathy (construct 9, rated -4). Also like her, the model nurse was not a good communicator (construct 14), though this was to a greater extent, rated -4. In Test 2 (NMI, columns 5-8, Table 34) all of Anna's rating were on the preferred pole except for construct 10 challenging authority which remained as -1. i.e., Anna believed on the whole that she would not challenge someone senior, this suggested that the construct is in some way significant

Table 35 *Anna's value theme scores*

Value theme	Person Centredness	Accountability	Trust	Integrity	Personal Development	Teamwork	Mean
Value theme scores Test 1 - NMIST	61.14	47.81	29.84	47.9	25.09	68.15	46.65
Group mean Test 1 - NMIST	42.82	41.18	39.91	45.17	39.7	44.57	42.23
Value theme scores Test 2 -NMI	66.33	44.94	31.74	38.62	26.07	60.76	44.74
Group Mean Test 2 -NMI	59.2	52.58	50.49	47.42	51.27	55.15	52.69

Anna's value theme scores (Table 35)

Anna's mean value theme score for Test 1 was 46.65, which was comparable with the group mean of 42.23 (NMIST, Table 35). Alternatively, her mean score of 44.74 for Test 2 was lower than the group mean of 52.69 (NMI, Table 35). In this regard Anna was also one of only two participants who's value theme scores decreased in the second test. Personal development was Anna's lowest value theme score in Test 1 at 25.09 compared to the groups mean of 39.7 Her highest was Teamwork at 68.15 comparing to a group mean of 44.57. In Test 2 Anna's Personal development value theme continued to be her lowest score at 26.07 in comparison to the group mean of 51.27, with her highest value theme score being Person-centredness at 66.33 compared to a group mean of 59.02.

Anna's interview

Anna was a newly married woman in her twenties with no children. She had taken A Levels and was studying on the Adult Nursing pathway. Anna had previously attended university to study teaching; however, she had not completed her degree. Anna had worked as a healthcare assistant before her nurse training.

Analysis of Anna's interview identified two themes, 'Care and closeness' and 'The values experience' (Table 36). These themes, along with relevant subordinate themes, are described below.

An audit trail of quotations is provided in Appendix 24.

Table 36 *Themes and subordinate themes from Anna's interview*

Themes	Subordinate themes
Theme 1: Care and closeness	Caring and compassion Close yet distant
Theme 2: The values experience	The test The report The model nurse and me Being observed

Care and Closeness

In this theme, Anna described care as an innate value which encompassed compassion, sympathy and empathy. Nursing professional values were hard to define for Anna but she considered they meant a closeness which required emotional boundaries.

Caring and compassion

Anna believed care meant *"looking after all the people's needs"*, which aligned with her experiences as an HCA, when care meant *"doing the things that [the patient] can't do on their own*" or *"aren't able to do for themselves".* Thus, Anna defined care as the act/task of care which facilitated independence. In contrast, she illustrated caring in *"the family sense"* in which a person *"cared about people"*, looked *"after"* them and did *"nice things"*. This suggested that, unlike work care, family care had emotional commitments. Anna considered herself caring, describing herself as a *"mother hen"* looking after the needs of others. She exemplified this as *"feeding"* people*, "making them happy", "relieving"* discomfort and making the *"situation better"*. This indicated that caring for another person entailed responsibility. She viewed her care values as innate, which she described as *"natural",* and not able to be taught. Anna also identified the nurse as compassionate *"because if you're not caring and compassionate then you're cold".* This implied that if compassion were absent, care could be task-orientated. Anna also identified empathy as an essential nursing value: "*If you can't almost put yourself in someone's shoes, how can you make the situation better for them?"*

This suggested empathy was a driver for good care practices. Anna perceived herself as caring as she could not *"hurt someone's feelings",* so she would only be truthful if it was *"really important"* as she did not *"like to be in the middle of a drama".* This suggested a lack of confidence and courage when expected consequences would be damaging to a relationship. Her hesitancy was reflected in her ratings for construct 8 (better to be open and honest in all that you do) (Table 34, Columbus 1-8). Regardless, Anna believed honesty was important, referring to this over 40 times in the interview.

Close yet distant

Anna found thinking about professional values taxing: "*I don't know, I'm a bit tired when I think about professional values".* She stated several times she could not "*explain it [i.e., professional values]*". Despite this, she understood professional values as aligning with her personal view, characterised as "*my value[s]"*, but stated, *"I'm trying to think what they say in uni".* This suggested that professional values were constructed as she engaged with the world of the nurse. Anna also perceived a difference between care and professional values, saying, *"it's not like when your … if [your] mum's ill, you give her a hug and a kiss",* whereas professional values meant *"you have to sort have [to] take a step back rather than be too involved".* Thus, professional values required closeness, yet also a distance. Anna's transcript suggested discomfort in emotional situations, though this implied emotional boundaries rather than avoidance, for example, when she stated: *"to protect yourself, I suppose. I think you have to in a way you have to put some sort of barrier".* She described building a *"therapeutic relationship"* with the patient and their family, instead of an emotional attachment when she was aware of her feelings and actions. Thus, care-of-self seemed important to Anna in managing emotional boundaries.

The values experience

Anna believed a lack of experience and knowledge were significant challenges when rating values statements in the test. Despite this, she considered her report an accurate reflection of her values. Anna described a positive MMI experience, which she believed could represent her values more accurately than the tests.

The test

Anna described nervousness when responding to the values statements in the test. She thought some responses, whilst a true reflection of her perceptions of practice, could *"reflect badly"* on her as she was not emulating values characterised by the *"NMC"* as *"high value"*. Thus, they were not reflective of her aspirational values of the 'model' nurse. Anna appeared cognisant of what she believed to be the preferred pole and the values she would be expected to align with when rating constructs. For example, she stated, *"you know what you should be clicking to give you the best chance to get into uni"*. She denoted the tests

could be *"fake[d] … easily"* but she *"could have just scored myself higher on everything".* Thus, she questioned the validity of the tests as a recruitment tool. This also indicated that her honesty would be circumvented in obtaining her perceived *"dream career",* for example, when she stated, "*if I'm brutally honest, if I was doing that as an admissions test I would, probably wouldn't have had the same results".* Therefore, it would appear that for Anna, the desire to become a nurse, described as a path she wanted *"desperately"*, took precedence over being honest. Thus, she would have presented her values in line with the stereotypical norm, illustrated in value frameworks (see Table 1), e.g. when she stated, *"yep I'm really, really good at everything".*

The report

Anna described answering values statements in the test *"really carefully"* and being *"really, really honest"* to give *"a true reflection",* adding, *"it's voluntary so why would you lie?"* Due to her honesty, Anna considered her report a true reflection of her personal nursing values. Consequently, the personal benefit of being honest during the test was the report. Anna admitted to being *"disappointed"* when she initially received her report. This circulated around self-doubt as she had *"dropped out"* of a previous degree. She claimed she did *"not want it to happen again"*; she had a *"crisis of confidence*" which made her worry about her *"lack of commitment to [academic] work"*. However, she viewed the report as beneficial: *"I can see it on paper; that's a weakness, I know where to work on it",* so it was *"good to have that reflection".* Hence, that despite causing initial anxiety for Anna due to her previous missed opportunities, the report had apparently been a reflective tool with which she could improve her nursing values. However, her tensions remained, as she believed that "*you have got to get the higher score possible; otherwise, it's not good".* This suggested Anna viewed the tests as exams which candidates would either pass or fail. Thus, she believed her scores indicated a fail because she *"scored too low"*, suggesting disappointment.

The model nurse and me

When Anna reflected on her report, she focused on her personal development theme, which she perceived as a low score. She admitted to not being surprised. She described herself as *"lazy"* and not always proactive about her studies. She imagined a situation when, once qualified, she would have family commitments. Consequently, she would not be *"sitting down to do a load of research".* She thought she would not have time to study, as home life and work was difficult to *"balance".* Anna did not prioritise personal development for the nurse, perceiving that *"it isn't what it should be",* as the nurse did the *"bare minimum".* Anna believed this was because nurses had *"busy lives"* and *"work long shift[s]"* because *"wards are understaffed".* This suggested a dissonance between her aspirational values, as she considered them, and her perceived reality of practice, which had influenced her behaviour during the tests. Anna added that *"development happened organically … you meet new*

people and they teach you things, especially as a student", intimating that mentors were important in shaping values. Despite this, she thought she would *"only do it [i.e., professional development] to keep my job"* as it was an activity *"I know you have to do",* implying she viewed professional development as punitive.

Anna stated she considered some values statements, such as accountability, *"hard to work … out unless you've been in that situation".* She returned to this point later in the transcript: *"I have to be realistic … I'm not perfect, I'm, I've only just started … I think if you score on the same plane as what you consider a model nurse for everything, then how can you develop cause you already think you're there, don't you?"* This implied she had rated her values lower than those of the 'model' nurse because she lacked knowledge, experience and competence. A further point of analysis suggested her ratings were lower because she saw her values as developing; thus, she was learning the values needed to become a nurse, having highlighted that these values were aspirational. Anna only rated her values as being the same as those of the 'model' nurse on a few occasions in both tests. However, only one of Anna's aspirational values remained on the non-preferred pole in her second test (Table 34), which seemed to reflect her view. Anna indicated candidates' previous employment could also influence ratings for values statements. Anna turned to construct 8 (better to be open and honest) (Table 34, column 5-8): *"If it's about somebody's health then yes, but if it's something that doesn't need to be said, I'd rather not say it".* She returned to this point several times within the transcript, saying, *"all things, it's that all things … maybe not in all things"*, implying the wording of the construct had influenced her ratings in this regard. She later questioned herself, saying, *"or that I'm just so scared of confrontation",* which suggested that her integrity and courage was challenged in the face of confrontation. She confirmed this analysis when she turned to construct 10, which elicited a strong response: "*Oh no, challenging someone more senior … This is definitely something that I am not able to do … definitely, there is no way".* She gave the impression that her student status and lack of knowledge would prevent her from challenging someone she considered more senior and knowledgeable. Further analysis suggested her views were linked to her earlier discomfort in emotional situations, when she would avoid conflict as she would *"struggle to challenge people"*, which she characterised as *"naughtiness".* This indicated she regarded challenging authority as deviant behaviour. Interestingly, this was Anna's only remaining negative rating in her second test, implying this was an ongoing tension (Table 34, columns 1-8).

Being observed

Anna described her MMI experience as *"rushed"* compared to a *"normal interview",* as she preferred to *"talk"* with *"someone".* She related this to her experience of one of the activity

stations, *"that origami thing"* (i.e., the communication station). She described being able to complete the task but found it difficult to explain to the assessor that *"my brain doesn't work like that"*, which she found *"stressful"* because *"five minutes isn't enough".* This indicated she did not think she had sufficient time at each station to fully explain her values, which caused anxiety. Anna also took her MMIs two days before her wedding, which also added to her nervousness, which she characterises as *"collywobbles".* Thus, it could be considered that life events also impacted her performance during MMIs. She added that *"they don't really explain [the MMI] to you beforehand"*, emphasising that she thought the university did not prepare their applicants for MMIs. This suggested a lack of information also affected her performance. Consequently, she questioned the validity of MMIs as she did not *"understand what they were looking for"* as only *"some"* of the values were measured in *"some"* stations. This suggested the values assessed during MMIs were not always evident to candidates. Anna compared this to her test experience, which she described as *"fake"* on several occasions throughout the transcript *"because it was behind a screen"* and she *"did not get to speak to someone"*; thus, she felt detached from values. By comparison, the MMI was viewed as a more reliable reflection of her values as she had to "*say something more, do something"*. Thus, it was a performance of values, which made it difficult to provide socially desirable responses as candidates were observed and therefore more likely to be honest. Consequently, the assessor was viewed as a powerful influence on character during the MMI. Anna added that *"you don't know how good somebody actually is at caring or doing the job until they actually do it".* This implied that, regardless of the recruitment tool, candidates would present their values in line with those advocated as stereotypical norms embedded within value framework (see Table 1) for the nurse in order to be successful and gain a place at university.

6.2 Analysis at group level

This chapter examined the students' accounts at a descriptive level to develop the themes representing their meaning of caring and professional values and their experiences of both the MMIs and psychometric testing. Student conversations revealed that all were cognisant of the care values deemed essential to a career in nursing and described themselves as caring. Caring was defined as the emotional component of the act and task of giving care. Caring was also considered an authentic part of an individual's personality, so nursing was more than just a 'job'. Empathy, however, was identified as being a primary care value by the majority of participants.

Professional values were perceived as rules that governed care practices. These values were often referenced in the context of standards, guidelines, professional codes of practice and the 6Cs. Perspectives of professional values were also considered boundaries that protect nurses against emotional attachment. Within this context, Fiona and Mary also described burnout and a need for resilience, given the pressures of carework. In students' conversations, there was significant dissonance between the *'gold standard'* of care, i.e., the values taught by the university, and what they often described as deficient care observed in practice. The students, however, acknowledged that pressures of time and limited resources often affected care practices in the busy carework environment. The students viewed the 'model' nurse as technically competent, good at communication and as someone who went the extra mile. By comparison, the students viewed their own care values as aspirational values that would be developed over time.

The students initially described the MMIs as stressful as they were an unfamiliar experience. They thought the nurse's knowledge and attributes had to be demonstrated and performed during the MMI. Thus, the assessor was considered essential when gauging candidates' authentic attributes. MMIs were viewed as *"games"* but the duration and content of stations were deemed important, with activity stations more memorable than stations that explored concepts like understanding and the motivation to become a nurse.

As the students described their test experience, they drew attention to the language in the tests. Language use led to conflicting views which guided how students thought, felt and behaved during the test. Nicky stood out in this respect as she was the only candidate to score negatively. The students also acknowledged their test responses were an honest reflection of what they believed to be their values and attributes, in comparison to those of the 'model' nurse.

Responses that did not reflect the attributes endorsed by the profession caused concern amongst students. As a consequence, and despite stressing the integrity of their responses, students acknowledged the potential to 'fake good' should the tests be used for recruitment purposes, due to their desire to obtain their *"dream career"*. Test reports were viewed as insignificant and lacking relevance. Participants who received favourable results viewed the report as confirming their career aspirations, whereas those who performed badly (e.g., Lisa) thought the tests had affected their self-esteem. The report, however, was also viewed as a tool students could use to reflect and learn.

Once each student's case analysis was complete, 55 subordinate themes were evident across the ten individual cases. To facilitate the process of group thematic analysis, the four discrete steps described by Smith et al (2009a, pp.92-102) were taken, as described below:

Step 1. Contextualisation: During this step, patterns and connections across the 55 themes were explored and similar themes were brought together.
Step 2. Abstraction: This step comprised the grouping together of subordinate themes. It resulted in ten emergent superordinate themes: 'Personal nursing values',' Professional values', 'Knowledge and competence', 'Values dissonance: university and practice', 'The ideal nurse', 'The report', 'People and computers', 'The games that people play', 'Language of the test' and 'Faking good'.
Step 3. Subsumption: This step combined the emergent superordinate themes. During this process, three overarching key themes emerged, including: 'The candidate's identity in value-based recruitment', 'The nurse: Aspirations and realities' and 'I think [I am a nurse]; therefore, I am [a nurse]'. These three steps are illustrated in Table 37.
Step 4. Numeration: In this step, the three overarching key themes were explored to determine their frequency and thus their importance across the group. This is presented in Table 38.

Table 37 *Relationships between themes*

Subordinate themes			Subordinate themes		Subordinate themes				
Care and experience Empathy Care and caring Care and competence Fluffy Hats Unspoken things Burnout and mindfulness Selflessness Emotions and relationships Caring and compassion Dignity and safety Maturity The caring attitude	The code The code Guidelines Professional values Professional values Close yet distant The professional manner	The ideal nurse Going the extra mile Butterflies and guns	Real v the ideal Communication The test	Nurse in the making Model nurse and me The novice nurse The model nurse and me	The MMI Different and clever The good MMI The lock in MMI stations The MMI	The gatekeepers People and computers Demonstrating understanding Making connections Being observed Getting the whole picture Paper faces	Pinch of salt The report The manual Confidence The report	The terrible truth and the miserable nurse This isn't black and white It's not clear cut The test	Light and dark numbers Language of the test Something negative something positive
⇩	⇩	⇩	⇩	⇩	⇩	⇩	⇩	⇩	⇩
Superordinate themes			Superordinate themes		Superordinate themes				
Personal nursing values	**Professional value**	**The ideal nurse**	**Value dissonance: university and practice**	**Knowledge and Experience**	**The games that people play**	**People and computers**	**The report**	**Faking good**	**Language of the test**
⇩	⇩	⇩	⇩	⇩	⇩	⇩	⇩	⇩	⇩
Key theme			Key theme		Key theme				
⇩			⇩		⇩				
The candidate's identity in value based recruitment			**The nurse: Aspirations and realities**		**I think [I am a nurse], therefore I am [a nurse]**				

Table 38 *Frequency of Superordinate theme emerging across the group.*

Key themes	Superordinate themes	Paul	Lisa	Nicky	Claire	Pauline	John	David	Anna	Fiona	Mary	Total
The candidates identity in value-based recruitment	Personal nursing values	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10
	Professional values	✓	✓	✓	✓	✓	✓		✓			7
	The ideal nurse		✓				✓			✓		3
The nurse: Aspirations and realities	Knowledge and competence	✓						✓	✓		✓	4
	Value dissonance: university and practice		✓			✓	✓					3
I think [I am a nurse], therefore I am [a nurse]	People and computers	✓		✓	✓			✓	✓	✓	✓	7
	The games that people play	✓	✓	✓	✓	✓	✓					6
	Language of the test			✓	✓			✓				3
	Faking good		✓				✓		✓	✓		4
	The report					✓		✓	✓		✓	5

6.3 Summary

This chapter explored the students' narratives and developed themes that represented their meaning of nursing care and professional values, as well as their experiences of MMIs and psychometric testing for caring and professional values. During the analysis, it seemed the students constructed their caring and professional values based on their social experience as either receivers or providers of care. The students also aligned their values with the nursing stereotypical norms evident in value frameworks such as the 6Cs, illustrated in Table 1. Whilst professional values were viewed as encompassing caring values, they also required emotional distance to facilitate resilience and protect emotional well-being. Values dissonance was also evident in the students' transcripts when they made meaning of the values taught in the classroom compared to their experience of the realities of caring in practice. Age, gender, experience and pedagogy seemed to influence meaning-making of caring values, which influenced attitudes and behaviours during testing.

Students generally regarded their MMI experience favourably. Nevertheless, assessors were seen as powerful gatekeepers who *"assessed"* and *"observed"* those candidates *"demonstrating"* values. However, there were counterclaims when students compared the validity of the mechanistic psychometric test to the 'face-to-face communicating' of values in the MMI. The language used in the test also led to conflicting views which guided students thoughts and behaviours during the test. Students emphasised their honesty when completing the test. Thus, whenever their responses did not reflect the social norms of the nurse, this caused conflict and a motivation to 'fake good', due to their desire to obtain what Anna described as the *"dream career"*. In this respect, the test report affected self-esteem based on salience and the cohesion of identity the 'model' nurse has.

Chapter 7 – Discussion

7.1 *Chapter overview*

"The Calling"

Do you sometimes wonder?
Why you do the job you do?
Did you choose your career?
Or did your job choose you?

By: Edwin C. Hofert

In this chapter, the three overarching key themes and their associated superordinate themes, evident across the ten participant cases outlined in chapter 6, are discussed. The first two key themes, 'The candidate's identity in value-based recruitment' and 'The nurse: Aspirations and realities', address Objectives 2 and 3 (Objective 2 was to determine participants' caring and professional values and identity constructs through aptitude testing and Objective 3 was to explore, through interviews, participants' meaning-making of caring and professional values). The third key theme, 'I think [I am a nurse]; therefore, I am [a nurse]', focuses on Objective 4: To explore, through interviews, the participants' experiences of MMIs and aptitude testing for values within the context of VBR. All the themes address Objective 5: To critically analyse and synthesise the findings from the literature, qualitative interviews and idiographic data from aptitude tests through a social constructionism lens.

The three key themes and their associated subordinate themes are discussed below.

7.2 *The candidate's identity in value-based recruitment.*

The students' understanding of caring and professional values was central to interpreting the findings of this study. Six subordinate themes were identified within this key theme, which included: 'Personal nursing values', 'Values as fuzzy lists', 'Empathy', 'Social cognition and pedagogy', 'Professional values: Boundaries, façades and resilience', 'Professional identity and gender: Implications for VBR' and 'Widening participation: Impacts of VBR'. These are discussed in the section below.

7.2.1 *Personal nursing values*

As outlined in chapter 6, this study found that students identified themselves as caring, in line with the values required to be a nurse. Although most students found it difficult to define caring values, each used terms which focused on patient-centred relationships, like altruism, empathy, sympathy, compassion, honesty and dignity. This aligns with the findings of

Kneafsey et al. (2015) and Waugh et al. (2014), whose research demonstrated how student nurses regarded compassionate relations as essential core attributes in the nurse/patient relationship. However, unlike their female counterparts, the male students in this study predominantly defined caring as practical elements of care (i.e., the act and task of caring), such as duty, advocacy, competence and teamwork. These findings align with work by Schmidt (2016), who emphasised that male nursing students viewed caring as a core nursing value, demonstrated as *"help".* Interestingly though, as illustrated in chapter 6, on several occasions, male students described the nurse as 'she'. Whilst this initially suggested that male students aligned their perception of nursing characteristics as feminine, it also seemed to suggest they considered that their nursing values stood apart from those of the female nurse. By comparison, the students characterised the values that embodied the 'model' nurse as caring, intelligent, competent and compassionate, *"approachable"* and *"easy to talk to".* Therefore, nurses should be proficient in communication, teamwork and organisational skills while remaining committed to the work they do. Thus, the nurse would exceed the professional requirements. These findings align with those of Callwood et al. (2019), Kneafsey et al. (2015) and Waugh et al. (2014), who also identified these as values embodying core nursing attributes. All values were described by the students as important and as the accepted values and stereotypical norms i.e., those embedded within value frameworks (see Table 1) for the nurse's *"caring position"*. Paul, in particular, recited the 6C's (DoH 2012) as stereotypical nursing values, ticking them off on his fingers as if recalling a list. However, the students generally differentiated between professional values on the one hand, which they regarded as the standards, guidelines and rules firmly established by the nursing 'code' (NMC 2018b), and the '6Cs' on the other, i.e., care, compassion, commitment, communication, competence and courage (DoH 2012). Professional values were viewed as ensuring dignified care, providing protection against errors and raising care standards, all of which encompassed caring values and reflected the nursing literature (Schmidt and McArthur 2018). Professional values were deemed by students as part of the nurse's *"manner"*, which Mary described as *"obvious values"* and *"an unspoken thing that you have got to have those qualities".* Whilst distinct differences existed between what the students believed were caring values rather than professional values, the concepts also overlapped, with professional values ultimately subsuming caring values. Most students differentiated between physical care and patient-centred care, with all students using caring and professional value terms interchangeably. Consequently, the students depicted caring and professional values as inventories of values that embodied nursing attitudes and stereotypical behaviours rooted within value frameworks (see Table 1). This aligns with theories of social constructionism and self-categorisation, as students constructed their caring and professional values in line with *"fuzzy sets"* of values (Hogg and Terry 2000, p.

123) that were context-dependent, based on their perception of the nurse (O'Neil 2010). Hogg and Terry (2000, p.123) defined *"fuzzy sets"* as central to social identity theory, whereby people cognitively stereotype the attributes and characteristics that represent exemplary or ideal members of their group; this enables people to distinguish their group (in-group) from others (out-group). In this context, it refers to how the students aligned their values with those attributed to the 'model' nurse, i.e., the entity within the test that depicted good nursing values.

7.2.2 Values as fuzzy lists

Values deemed essential for a career in nursing are represented by value frameworks, as illustrated in Table 1. Therefore, value frameworks are considered 'institutional facts', which describe and prescribe the collectively desirable values and behaviours (Gergen 1973, p.311) representing the nursing profession. In this study, the students' identification of the 6Cs (DoH 2012) (i.e., caring, competent, compassionate, courageous, good at communication and committed to the work they do) and 'The Code' (NMC 2018b) as values that embodied the 'model' nurse allied with the value frameworks to which they were exposed during recruitment. Consequently, as candidates, they were cognisant of appropriate (and expected), desirable behaviours and nursing values, which were to be demonstrated during recruitment. Aligning with constructionism theory, these findings suggest that students constructed and presented their values in line with these frameworks as a set of "*intrinsic qualities or characteristics"* (Gergen 2015, p 53) that defined the nurse.

Researchers have previously described how healthcare has become incentivised, mechanised and 'McDonaldised', resulting in 'cookie cutter' professionals imposing an appearance of care and compassion on the nursing profession (Bradshaw 2009; Smajdor 2013). In this respect, VBR could be described as a meritocratic model, as candidates are required to demonstrate caring and compassionate behaviours which can be measured, audited and data-gathered. However, the findings of this study do not wholly support these views, i.e., students viewed caring as an essential characteristic of the nurse, which was equally identified in their own personal nursing values. Indeed, Anna, despite struggling to articulate what professional values were, described a belief that professional values aligned with her own nursing values, which she characterised as *"my values".* Consequently, the boundaries between constructed and real values were obscured, as students perceived themselves as nurses, interpreted through value frameworks. The subjective position of the students suggests that candidates would adopt the discourse, concepts and images of the nurse as they presented their values during what Callwood et al. (2017) defined as their 'recruitment journey'. These findings align with the work of Goffman (1956, p.69) and his

dramatological theory for social interaction. Central to Goffman's theory is the idea that as people interact, they manage their identities. This transforms any social interaction into a negotiation of situational meaning and the roles people play within it, shaping how we are perceived and how we perceive others. Thus, as the students played the part of the nurse, they became convinced by their own *"act"* (Goffman 1956, p.10). Consequently, the students were persuaded of the realness of their performance and believe the part they were playing (Goffman 1956, p.10). Thus, as outlined in social constructionism theory, the students presented their values in line with what they considered were the 'right' nursing values. Researchers have previously suggested the advantage of recruiting candidates who recognise their own values, rather than those dictated by value lists (Groothuizen et al. 2017, Rankin 2013). However, as established in chapter 2, value frameworks (Table 1) such as the 6Cs (DoH 2012) and the Constitution (NHS 2015a) are inherent to nurse education and training (Wills 2015, p.14); therefore, they could be considered permanent fixtures of healthcare recruitment. Hence, candidates would be expected to defer to value frameworks during selection and harmonise their values with those of the nurse during recruitment. These findings indicate candidates' professional identification with nursing values potentially occurs during recruitment through exposure to value frameworks as a component of VBR. This aligns with Jackson's (2016, p.2) definition of students' pre-professional identity as *"an understanding of and connection with the skills, qualities, conduct, culture and ideology of a student's intended profession"*. Consequently, value frameworks, as a component of VBR, could be considered foundations for pre-professional socialisation, which influence candidates' behaviours during recruitment. This adds to the evidence base and understanding of VBR by implying that since candidates are exposed to stereotypical nursing behaviours that are defined through value frameworks (see Table 1) during recruitment, they construct and present their values in line with these frameworks, thus conforming to the accepted social identity of the nurse (Hogg and Terry 2000; O'Neil 2010; Gergen 2015, p.7). These findings broaden the concept of VBR, as there is an absence of literature exploring the influences of value frameworks, such as the 6Cs (DoH 2012), in pre-empting professional socialisation.

7.2.3 Empathy, social cognition and pedagogy

This study found that empathy resonated as the term most often used by students to describe caring. Despite a lack of consensus in VBR nursing literature on which aptitudes demonstrate and describe the caring characteristics associated with compassionate care, empathy has recently gained significant academic attention (Patterson et al. 2016a; Groothuizen et al. 2017). Empathy as a caring aptitude within nursing literature arose from the seminal works of Carl Rogers (Rogers 1959). Rogers (1959, pp.210-211) described

empathy from a therapist's stance, *"as if one were the other person, but without ever losing the "as if" condition*". This emphasised the subjectivity of empathy, which cannot truly be known other than through *"empathetic reference".* Morse et al. (1992, p.273) however, questioned the usefulness of empathy as a care value, emphasising its *"uncritical adoption"* from psychology and poor 'fit' to the clinical realities of nursing practice. The varying perspectives, concepts and discourse used to describe empathy over the last two decades have led to a complex picture (Sulzer et al. 2016; Hall and Schwartz 2019). Researchers describe concepts of empathy as 'knowing' how others feel, caring about someone, adopting the other's posture (mirroring), feeling like the other, projection, perspective taking, imagined-self and vicarious feelings of distress, or as some combination of all of these characteristics (Batson 2011, p.20; Coplan 2011; Kneafsey et al. 2015; Zahavi 2017, p.33). Despite this complexity, empathy as a characteristic is considered to employ high levels of emotional skill, intellect and behaviour, clarifying that insight and meaning exist within the nurse/patient relationship (Adams 2018). In this study, students often described empathy as putting themselves in the *"shoes"* of another. This view of cognitive empathy is consistent with those of Rogers (1959), Morse et al. (1992) and Lishner et al. (2020). Cognitive empathy is characterised as the ability to adopt the other's perspective, predict thoughts, understand feelings (such as pain or suffering) and communicate understanding, which ultimately drives care practices (Reynolds and Presley 1988; Morse et al. 1992; Yu and Kirk 2009; Cunico et al. 2012; Williams et al. 2015; Hojat et al. 2018). Cognitive empathy, a recent focus of values literature, has been described as a skill due to its *"concrete nature"*. It can be learned, taught and developed; thus, it is a measurable aptitude (Jeffery 2016; Adams 2018). Within the VBR literature, Callwood et al. (2020, p. 2), Kneafsey et al. (2015), Mirghani et al. (2019, p.419) and Waugh et al. (2014) acknowledged empathy as an underlying characteristic, attribute or value and a component of compassionate care in their studies. Recent international studies also suggest a link between empathy and mindfulness, as well as emotional intelligence and resilience (Valentín et al. 2019; Fuentes et al. 2020), which is associated with candidates' beliefs that empathy was an important professional value and characteristic of nursing (Karayiannis et al. 2020). This suggests that assessing candidates for empathetic behaviours (more specifically, cognitive empathy) through dispositional measures designed to measure perspective taking has validity as a measurable care characteristic within a VBR framework.

It is widely accepted that values depend on cognitive ability since people adapt their values and behaviours through cognition (e.g., memory, perception, information processing and stereotyping), (Pam 2013; HEE 2016a; Hogg and Terry 2000; Reschly and Robinson-Zañartu 2000). Researchers generally regard empathy (e.g., perspective taking, mind

reading or mimicking) as a significant component of social cognition, construction and development as people predict, judge, make sense of and interact with the social world (Rogers 1959; Hogg and Terry 2000; Marchant and Frith 2009; O'Neil 2010; Turner and Reynolds 2012; Hodges et al. 2015; Szanto and Krueger 2019). As discussed in chapter 5 and illustrated in Appendix 9, the tests utilised in this study are based on two founding principles of identification outcomes, the *'aspirational'* and *'empathetic'* (Weinreich 2003, p. 58). Thus, students rated construct values statements either in line with those they wish to emulate or by disassociating themselves from values they rejected, which Weinreich (2003, p.60) described as *"empathetic identification"*. As described earlier, the values measured in the test were incorporated into six value themes (Appendix 9). Empathy, as a values dimension, was incorporated within the Person-centredness (PC) value theme. This study found that students who associated empathy or empathetic behaviours with an accepted value, aptitude and professional norm for the nurse during their interview also scored either in line with, or above, the group mean for their PC value theme; they also generally scored highly compared with the group mean for both tests.

The students additionally described caring as an innate and authentic characteristic, which was part of the nurse's natural personality and developed through experience of carework, since the 'model' nurse went *"above and beyond"* to help their patients, *"no matter what"*. These findings align partially with those of Kneafsey et al. (2015, p. 73), who reported that students considered compassion as an innate emotion linked to feelings of empathy and altruism, which became a force for action. The students also believed that due to the innate nature of caring, it could not be taught. Despite this, eight out of ten students' mean scores increased between testing after they had been taught about professional values (Appendix 25). Asked what they thought accounted for the differences in their scores, students claimed the curriculum and teaching had influenced their responses to Test 2 (NMI). This was particularly noticeable with John's perception on communication. To recap, John perceived the nurse as authoritative and as someone who got "*on with [the job], rather than all the chitchat that tends to go on".* As described in chapter 6, this was associated with John's negative views on social interaction. However, as his studies progressed, John's confidence increased, as did his interpersonal skills and test scores, which he apportioned to having been taught good communication skills. These findings suggest that how respondents think, feel and behave during testing is potentially influenced by pedagogy, i.e., the process of acquiring the skills and knowledge valued within professional roles and considered professional norms. Researchers have previously noted a link between personality testing and increased scores through professional training (Lievens et al. 2009; Eley et al. 2012; Andrade and George 2013). Likewise, Callwood et al. (2020) highlighted the link between

personality testing and in-training performance, reporting that students with high MMI admission scores performed better in practice. Philosophers have long debated whether values like care, compassion and courage are taught or innate, intimating that human nature and innate goodness could be cultivated through education (Pence 1983, p.189; Richey 2015). Researchers have also previously stated: *"It is the curriculum that transforms the candidate and that … transformation is faster and easier if the candidate possesses an aptitude"* (Andrade and George 2013, p.3). Consequently, students' work-related attitudes and identities are considered a less mature form of professional identity (Jackson 2016). This aligns with social constructionism thought, so it should be unsurprising that the students presented their personal nursing values in solidarity with those of the stereotypical nurse, illustrated in Table 1, as they are exposed to the social and cultural perspective of the nurse through the medium of the curriculum (O'Neil 2010).

The students' perspectives on empathy and their test scores suggest a dichotomy, as empathy was not only an established caring behaviour and a component of compassionate care but also a component of social cognition. Together, these findings and the research literature indicate a link between cognitive empathy as a component of social cognition and empathy as a dispositional measure in VBR and as an established caring behaviour for the nurse. Therefore, this study's findings indicate that candidates testing highly for empathy as a dispositional measure do so by adopting the perspective and projected images of the nurse, i.e., the stereotypical values and behaviours purported through value frameworks, like those illustrated in Table 1. Their scores were further enhanced by the curriculum. These findings bridge a gap in the knowledge base as there is an absence of VBR literature that explores the measurement of empathy as a dispositional measure and a component of social construction.

7.2.4 Professional values: Boundaries, façades and resilience

As outlined in chapter 6, some students offered a divergent view of empathy which was somewhat insightful to the debate over whether empathy is a 'useful' aptitude in nursing practice. The data demonstrated that whilst some students recognised empathy as a valuable attribute, empathy could also cause emotional distress and inequitable care practices. This is termed affective (emotional) empathy and characterised as *"feeling with"* the person (Sinclair et al. 2017, p.438), which goes beyond the notion of intersubjectivity (Morse 1992) in response to patients' suffering (Sinclair et al. 2017; Lishner et al. 2020). Students described this as *"feeling"* for the patient, which was a catalyst for "*taking action to make things better"* and thus an *"altruistic force that motivates practice"* (Morse et al. 1992, p.274). Batson (2011, p.11) further defined empathy as a *"constellation"* of emotions

(e.g., sympathy, compassion, concern, sorrow and tenderness) that includes *"feeling for the other"*, which drives motivation for change when seeing another in need. This was reflected in the students' descriptions of *"duty"* as a component of empathy, which would ensure ethical judgements of *"fairness"* and *"responsibility"* when confronted with the busyness of nurse work. This aligns with the perspectives of Adams (2018, p.186) and Gullick et al. (2020), who reported that affective empathy supported decision making and ethical judgements in the interrelated worlds of nurse and patient. Due to the effort involved when people manage their own and others' emotions when responding to the suffering of others, affective empathy can illicit feelings of distress, resulting in compassion fatigue (Batson 2011; Duarte et al. 2016). This suggests cultivating an empathetic workforce by recruiting candidates who display an aptitude for affective empathy could be detrimental, as it might raise the instances of compassion fatigue amongst healthcare professionals if a balance is not achieved. Yet only a few students drew attention to burnout arising from the stresses of carework, whereas most viewed nursing professional values, i.e., the nurse's *"manner",* as providing protection against the emotional labour of carework.

In this study, the students perceived nursing professional values as facilitating a closeness with *and* emotional distance from the patient, described as *"boundaries"* which protected against emotional attachment. As highlighted in chapter 6, Nicky particularly viewed professional values as protection from "*horrible and abusive and violent"* patients. Hence, the nurse utilised professionalism as a *"façade",* hence, it was a mechanism to protect patients' dignity. This aligned with the feminine ethic of care, whereby professional values provided a moral basis for helping the hostile and unsympathetic stranger (Bradshaw 2009, p.466). Benner (2001, p.xxv) also characterised the nurse/patient relationship as a kaleidoscope of intimacy and distance, which Fiona exemplified in chapter 6 as trying *"not to push in"* and taking *"a step back".* These findings resemble those of Agosta (2014, p.3), who offered an alternative view: the empathetic experience between the nurse and patient creates a mutual understanding on an emotional and cognitive level. Here, the boundaries between patient and nurse can be maintained but become *"permeable"* (Agosta 2014, p.3). Consequently, the nurse takes the 'other' perspective, understanding the patient's experience without demonstrating emotional responses, false assumptions or distress, by *"stepping aside"* from emotional identification and retaining *"boundaries"* (Jeffery 2016, p.447). Nevertheless, the students considered nursing was more than just a *"job*", since care with a *"professional hat"* did not mean nurses did not care about their patients. Thus, cognitive and affective empathy are described as two sides of the same coin, i.e., cognitive empathy prevented burnout and compassion fatigue from becoming overwhelming, whereas affective empathy prevented caring from becoming detached. This is also evident in the

difference between students' views on caring for family and friends and how they regarded professional caring in their capacity as a nurse.

The students described the complexity of their values, often characterised as *"hats",* to illustrate roles they played at home or as a partner, nurse or student. However, there was an awareness that not all these characteristics translated well into nursing. The students described their professional *"hat"* as representing the role of the caring and compassionate nurse at work. Here, aspects of nursing considered highly valued, such as a caring and compassionate disposition, were accentuated. Meanwhile, certain attitudes and behaviours deemed acceptable at home, described by Fiona as being *"snappy", "lazy"* and *"having a good old swear"*, i.e., those which may represent the student's natural self, not reflective of the stereotypical nurse illustrated in value frameworks (see Table 1) were suppressed. This further aligns with Goffman (1956), who described social interaction as an 'audience' observing the 'performance' of the roles that people play. Goffman (1956) characterised this as 'back' and 'front' stage. 'Front stage' is where 'actors' are conscious of the roles they should play and conform to the expected behaviours within those roles. Meanwhile, 'backstage', people are relaxed and can be themselves. Therefore, students were aware of the 'rules of the game' for the nurse, i.e., the established norms and perspective taking required during social interaction between nurse and patient. They presented their values in line with these stereotypical attributes and behaviours depicted within value frameworks (see Table 1). Thus, it would seem that the students' perceptions of professional values were central to their presentation of major aspects of professional nursing etiquette and standards. Hence, the students created their professional identity in line with the public image of the nurse, whereby professional values were a performance for others (Gergen 2015, p.100). These findings also reflect the views of Roach (2002), regarded as the founder of the 6Cs (Baillie 2015). Roach (2002, p.48), in her version of the 6Cs (compassion, competence, confidence, conscience, commitment and comportment), described comportment as an attribute of caring, demonstrated in the patient/nurse relationship as *"true to myself and to the patient"*. Consequently, it was important for nurses *"to portray ourselves in a certain way".* For Roach (2002, p.48), comportment concerned both receiving and giving respect, which was part of the nurse's manner and actions and which required the nurse to have *"a clear sense of self-other differentiation"* (Coplan 2011, p.3). Similarly, Wainwright and Pattison et al. (2020, p.146) question whether maintaining values as principles, and thus defining a certain way in which the nurse has to *"act",* is an impossible dream. Thus, value frameworks offer no practical help as they represent *"problematic ideals"*: these values cannot be maintained in everyday life (Hussey 1996).

Nonetheless, as illustrated above, the students in this study displayed emotional intelligence (EI), though each student exhibited this to different depths. EI was defined by Salovey and Mayer (1990, p.189) in their seminal work as the *"ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions".* Rankin. (2013) reported significant relationships between EI, programme outcomes, practice and academic performance and retention, in the context of values-based compassionate nursing care. EI has also been reported to help nurses effectively manage their working environment and provide good care (Smith et al. 2009b). EI has similarly been found to improve student nurses' emotional competence, critical thinking, ethical behaviour and performance (Michelangelo 2015). Relationships have likewise been demonstrated between student nurses' EI and academic performance (Haavisto et al. 2019). Similarly, Snowden et al. (2018) reported that nurses who completed their programmes of study scored significantly higher for emotional intelligence and social connection than those who had not completed their studies. However, Salovey and Mayer (1990, p.186) also highlighted the link between empathy, social intelligence and social behaviour, adding: *"These skills enable individuals to gauge accurately the affective responses in others and to choose socially adaptive behaviours in response".* This further emphasises the compelling connectedness between empathy, social cognition and personal nursing values as components of VBR.

7.2.5 Professional identity and gender: Implications for value-based recruitment

In social constructionism, emphasis on identity is not *a priori*. Identity is formed through reflection, perspective taking and interaction with the social world; hence, values are generalised and influenced by communities which shape personal values and beliefs (O'Neil 2010). Moreover, identity is a combination of personal, societal and professional values (Cingel and Brouwer 2021). Therefore, it is commonly understood that professional identity, often described as a career, occupation or vocation, is augmented by the individual's position in society, interaction with others and interpretation of experiences (Holland et al. 1993; Sutherland et al. 2010; Skorikov and Vondracek 2011; Johnson et al. 2012). Thus, professional identity is influenced by public image, work environment, work values and education, as well as traditional, social and cultural values (Hoeve et al. 2013). Consequently, professional identity and self-identity are intertwined, as our sense of self is connected to the work we do. Cingel and Brouwer (2021, p.4) emphasised that, in general, nurses make career choices based on a need to put compassion into practice. This had motivated them to become a nurse and this motivation generally resonates with societal views. Hence, congruence exists between public perceptions, self-concept and self-esteem,

which makes a nurse's professional image relevant to nursing recruitment (Tajfel and Turner 1986; Reardon and Lenz 1999, p.109; Hogg and Turner 2000).

Motivation to become a nurse and a connection with societal views can be quite starkly identified in the contrast in recruitment outcomes between the time of Francis (2013) and the recent COVID-19 pandemic. During the Francis era, the professional identity of the nurse was reportedly at an all-time low: nursing was described as a *"profession in need"* (Cingel and Brouwer 2021, p.2) and a *"profession in crisis"* (Clayton-Hathway et al. 2020, p.12), while the nurse was seen as the *"troubled professional"* (Girvin et al. 2016, p.1001). This discourse led to a public outcry and extensive media coverage of the quality of care, resulting in a drop in trust and a corresponding reduction in nurse recruitment (Hoeve et al. 2013; Charles 2015; Girvin et al. 2016; Cingel and Brouwer 2021). However, during the recent COVID-19 pandemic, hospitals have been likened to war zones. At a time of extraordinarily societal need, nurses have been described as heroes and warriors, recognised for their courage *"in the face of incredible adversity"* (Mitchell 2020; Morin and Baptiste 2020, p.1; Stokes-Parish et al. 2020; Faulconbridge and Houlton 2021). The resulting improvement in the nurse's public image has also been associated with a resurgence in applications to nursing (Mitchell 2020; Stokes-Parish et al. 2020). The enhanced public image of the nurse also coincided with a 30% increase in male nursing students in 2020 (Ford 2020). It is acknowledged that motivations for choosing jobs are multifactorial and can be based on social and personal circumstances, job security and income (Arnold et al. 2003; Billsberry 2007; Hollup 2012; Patterson et al. 2016a). The greater interest in nursing among male candidates could also be a reflection of the nurse's professional identity being associated with labels such as 'hero' and 'warrior', thus taking on a more masculine character. Thus, as demonstrated in social constructionism theory, male nurse candidates can identify more readily with nursing characteristics through this revised image (Gergen 2015, p.53). This has further motivated men to become nurses, as nursing characteristics are no longer viewed as stereotypically female and reflective of the care philosophies and gender attributes that underpinned the post-war division of medical labour (Nodding 1984; Witz 1992; Chaney 2020).

When exploring concepts of caring more broadly, Bradshaw (2009, p.465) drew on Gilligan (1982) and Mayeroff (1971) to argue that care is not derived from individual virtue, but is *"relational, feminine and emotional".* Watson (1979) had previously described caring as an art and a science based in knowledge and humanistic behaviours. Whereas Roach (2002) considered caring as a high regard for the patient. The nurses caring repertoire is also regarded as both science and patterns of knowing, where holistic care means a deeper

richer understanding of the patient (Carper 1978, Adams 2016). Consequently knowledge of caring provides guidance, ethics, values and morals in the way that the nurse thinks, feels and acts in *her* practice (McIntyre, 1995). These views of care reflect the female students' meaning-making of caring in this study, and as a result, the discourse of care and compassion as the desired behavioural characteristics and virtue that have underpinned nursing practice for over 100 years (Cochrane 1930, Pearce 1937-71, Benner 1998). This further emphasises nursing care and compassionate behaviours as synonymous with women (Lindsey 2008, Fielden and Burke 2014). This highlights the discreet discourse of care and compassion within the gendered division of nursing care labour which is still used to describe values, attitudes, skills and behaviours central to nursing education and practice (Duffy 2013, Penprase et al 2015, Sedgwick et al 2015), which are evident in value frameworks central to VBR illustrated in Table 1.

Williams (1978) had also previously described the discourse between the ideologies of profession, vocation, and custodial activity in healthcare. Williams (1978) position is considered reflective of Foucault's description of power and hierarchal structure within which gender plays a part in power relations, division of labour and the hierarchy of tasks (Foucault 2000, pp. 338). Foucault's position emphasises the significant body of nursing literature that explores sexual stereotyping, sexual differences in expressions of care and intimate touch within nursing (Conner et al 2016, p. 31). Lindsey (2008), in as much, describes the care-tech link where the gendered nature of work shifts between technical (male) and care (female) roles within contemporary healthcare. Lindsey's (2008) position draws attention to the perceived negative connotations of the male nurse being labelled as caring and compassionate, but also a fear that care is no longer central to nursing which has become second to the contemporary technically dominated setting of healthcare today. For example, Ekstrom (1999) had previously discussed male nurses avoiding being described as caring and compassionate because of these stereotypically feminine characteristics. Twidwell et al (2022, p. 22) more recently also raises the assumptions that male nurses are *"more likely to identify as gay",* assumed to have lacked success to enter medicine, in addition to facing discrimination by being denied employment in areas such as obstetrics and gynaecology. In this way Kellett et al (2014, p. 80) highlight that the physical care of women is risky business for the male nurse, which casts a *"potential shadow over the care"* provided. This reflects Englund et al (2020) concerns that if the core concept of caring remains reflective of the *"Nightingale archetype"* it becomes problematic by feminising touch, connectedness and compassion *"as a means of demonstrating care".* However, interestingly Stott (2007) offers an opposing view in that male nurses found it difficult to navigate personal and intimate care, and as a result, felt more comfortable dealing with the technical aspects of the profession.

However, Kellett et al (2014, p. 82), Nerges et al (2022) and Twidwell et al (2022) draw attention to the perceived burden of the male nurse to be physically strong with superior physical strength, where the male nurse finds themselves in the role of *"lifter, enforcer, or protector".* Interestingly you will recall that his reflected David's meaning of care, which was synonymous with physical competence. In this way, gender continues to be a recruitment issue except for small pockets of specialties where men can express their masculinity such as the military, mental health, accident and emergency, theatre, and intensive care, where these roles are perhaps viewed as more technical and therefore masculine (Lindsey 2008, Fielden and Burke 2014, Conner et al. 2016). Kellett et al (2014, p. 79) also highlight a pervasion for male students to be *"evaluated according to feminine standards of communication, social interaction, and caring that is foreign to them as men".* This draws attention to Peplau who had previously cautioned that the continued view of caring as a female dominated trait would act as a barrier to men entering the profession (Adams 2016).

As illustrated in chapter 6, male students' meaning of caring leaned towards the practical elements of care, which focus on duty and the act and task of care. Hence, care was used as a neutral term to define what was important to them, but 'care' itself had no intrinsic moral component. Thus care for the male students emphasised the technical as a way of demonstrating care behaviours. As Bradshaw (2009, p.466) highlights, this aligns with the more masculine Kantian *"duty ethic"* rather than Nodding's view of feminine morality. This was further reflected within the findings of this study as the male students also generally performed less well than their female counterparts during testing, also recording lower scores in the PC value theme. These findings align with those of McNeil et al. (2018), who reported a statistically significant relationship between participant value themes and overall mean scores. However, John was an exception, as he performed considerably better than David and Paul during testing. During the interview, John also appeared focused and cohesive when aligning his values with those of the nurse, which implied his confidence in how he *ought* to behave and what was expected in the social environment of the nurse (Hogg and Terry 2000, p.124). McNeil et al. (2018), along with Ellis et al. (2015) and Mazhindu et al. (2016), reported on the development and validation of the Nurse Match Instrument, an aptitude test designed for the recruitment and selection of nurse candidates which was used in this study (see chapter 5). However, the authors did not report on gender, so it is difficult to make a direct comparison. Nevertheless, as demonstrated in chapter 5 and Appendix 9, the PC value theme is one of NIPEC's (2014) six value themes, which are defined as a list of the attributes deemed essential for a career in nursing. Whilst NIPEC (2014) failed to outline the meaning of person-centredness, this concept began with Carl Rogers (1951), who stated that individuals develop a view of self based on interactions

with others, described as *"empathetic referencing"* (Rogers 1959, pp.210-211). This aligns with Weinreich's (2003, p.60) notion of *"empathetic identification"*. Thus, person-centredness is underpinned by values like empathy (Irving and Dickson 2004, McCormack et al. 2011). The discourse of person-centredness has been embraced by nursing, the government and healthcare in efforts to improve patient outcomes (Capko 2014), so it is relevant to VBR. Seminal research has focused on the emotional aspects of care, with relationships viewed as distinct nursing work and compassionate care predominantly associated with nursing (Bradshaw 2011; Chaney 2020), findings which align with those of this study. However, as previously stated, in this study, patient-centred caring predominantly reflected the female students' meaning of caring. Therefore arguably, if care and compassion is synonymous with nursing and therefore women, utilising objective aptitude testing for care and compassion will ultimately disadvantage male candidates. In this way it is also widely acknowledged that psychometric testing for values generally favours female candidates (Husbands et al. 2015; Lievens et al. 2016; Karayiannis et al. 2020). Additionally, international researchers have recently found statistically significant gender differences in aptitude testing for empathy as part of nurse recruitment (Valentine et al. 2019; Karayiannis et al. 2020). Likewise, Snowden et al. (2018) highlighted a gender difference in psychometric testing, whereby female nursing students tested higher for social connection dimensions than their male counterparts. Furthermore, Traynor et al. (2018) reported that male candidates viewed gender as an influential factor during MMI. These findings suggest HEI VBR practices could be severely hampered by selection bias if testing includes social connectivity dimensions like empathy and person-centredness domains.

Consequently, the findings of this study suggest that the discourse within value frameworks such as the 6Cs (DoH 2012) lean towards more traditional feminist philosophies of caring and compassionate practice. This is not unexpected: value frameworks like the 6Cs (DoH 2012) and the nursing professional code (NMC 2018b) were written by nurses for nurses, the majority of whom, almost 90%, are female (RCN 2018a, RCN 2019a). The concept of a gendered division of care labour is shaped by its association with *"natural feminine attributes such as love, care and empathy"* (Clayton-Hathway et al. 2020, p.19), while the *"domestic practicality of nursing"* is considered innately feminine (Stokes-parish et al. 2020, p.3). Consequently, nursing is perceived as an occupation generally suitable for women (McDowell 2009). Therefore, a constructionism approach to values and the status of gender identity within nursing values are understood within the context of moral judgements which inherently feminise the workforce. Thus, VBR could be viewed as politicising gender identity within nursing, where perspectives of care are embedded in women's way of knowing. Therefore, the findings of this study question if value frameworks, such as the 6Cs (DoH

2012), are gender blind and whether they in fact fail to account for differences in value structures. This moves the debate towards a more feminine discourse of patient-centred caring involving domains like empathy and person-centredness. If so, the ramification of recruiting to value frameworks as part of VBR could be significant, as male nurse candidates could be outperformed by female nurse candidates. This could result in a reduction in the number of successful male candidates to university places and, ultimately, further reduce the male nurse workforce. Thus, whilst measuring durable dispositions such as those advocated in the 6Cs (DoH 2012) seems on the surface to be highly valuable, nursing values are also historically dependent on the feminised perspectives of nursing. Therefore, two significant findings of this study are the important distinctions between how caring values are viewed across genders and how gender is represented in values testing in the context of VBR.

7.2.6 Widening participation: Impacts of value-based recruitment.

A paradox emerges in VBR between the needs of the employer, i.e., the nursing profession, and the needs of the university in providing a caring practitioner with sufficient academic ability to pass a degree. As noted in the Cavendish review (Cavendish 2013), there is a drive to recruit talented healthcare support workers within a backdrop of high university dropout rates among young students with little experience of carework. In this study, it was the mature students who had less care experience (Nicky and Lisa) before starting their degree, and they consequently performed less well during testing than those with broader experiences of carework. To recap, Lisa stated: *"If I had worked in care then I would have approached [the test] differently*". However, Nicky also considered maturity, and thus life experience, advantageous as it facilitated empathy, communication and organisational skills. Fiona also highlighted that maturity and experience had challenged her values, which in turn had influenced her test responses. She also acknowledged that candidates without carework experience only had their university experience on which to base their perception thus, she questioned the fairness of using aptitude testing as a VBR tool. In this vein, the students indicated a belief that age and experience were important components of caring for the nurse, aligning with the position of the Cavendish review (Cavendish 2013). Whilst these findings align with constructionism, in which all knowledge is constructed and based on perceptions of age and experience (Phillips 1995), the test outcomes seem to suggest that experience of carework was a more significant factor in the aptitude testing outcomes. Whilst this questions the fairness of testing for values in those candidates with little or no care experience, aptitude testing in this context could potentially reduce attrition rates by eliminating those candidates more likely to drop out of university, i.e., young students with little carework experience (Cavendish 2013). This stance is not new: as illustrated in chapter

2, aptitude testing was utilised as early as the 1930s as a tool to enhance nurse retention (Habbe 1933) and in the 1950s to aid mass recruitment to the newly founded NHS (Petrie and Powel 1950). The Dennis Childs (DC) aptitude test was used in the 1990s as a mechanism to widen access for nurse candidates who had not achieved the required undergraduate entry qualifications (Elkan and Robinson 1995; Houltram 1996; Robinson et al. 2006). A criticism of the DC test was its availability on the 'black market', which led to familiarisation and desensitisation. This issue, the rise in student applications as a result of Project 2000 and the drive to professionalise nursing resulted in the DC test being withdrawn in the late 1990s (Rodgers et al. 1995, p. 48). Champions of the DC test, however, suggested more caring, committed, conscientious and mature practitioners with significant life experience were entering the profession as a result of the use of the DC test (Elkan and Robinson 1995; Houltram 1996; Robinson et al. 2006), reflecting the stance of the more recent Cavendish review (Cavendish 2013, p. 58). Therefore, aptitude testing within VBR could arguably enhance caring within the workforce if utilised in conjunction with academic achievement. These findings are supported by those of Lievens et al. (2016), who found that situational judgement tests (SJT) as part of VBR could balance out the effects of academic attainment. Thus, testing for caring values could herald a shift in university emphasis from academic achievement to personal attributes, thus educating critically thinking and caring practitioners.

Aptitude testing as a mechanism of VBR can be set against a backdrop of widening participation. Widening participation in higher education has been a pillar of educational reform in the UK since 1997 (Kennedy Report 1997). Widening participation is defined as addressing under-representation in higher education, i.e., recruiting candidates from under-privileged backgrounds who would not traditionally attend university. As illustrated in section 2.4, universities are required to ensure candidates can complete a programme, so they must have academic ability (QAA 2018). Concerns have been raised about a perceived need for additional academic support for students recruited due to widening participation, which may have subsequent negative impacts on high-achieving cohort members (Whiteford et al. 2013). Consequently, if care aptitudes are given primacy over academic ability, this could mean candidates entering university without having achieved the required entry qualification but having scored highly when tested for aptitudes. This suggests that due to widening participation, HEIs are potentially setting up these candidates to fail (Walker et al. 2004). Ultimately, this could run contrary to the view of Cavendish (2013) and translate into failing students and rising attrition rates. It has been suggested that widening access candidates should be targeted at the beginning of their studies to improve retention (Riddell et al. 2013, p.58). Therefore, if testing for care values increases widening access and translates into

individuals known to be poor academic achievers but who have high aptitude test scores becoming students, this could require universities to increase their academic staff numbers to provide additional support.

However, universities have also been criticised for institutional elitism, stifling diversity, encouraging inequality, reducing social mobility and raising barriers to progression (Burns 2014). It has long been acknowledged that a university's main aim is to recruit the *"brightest and best"* (Social Mobility and Child Poverty Commission (SMCPC). 2015, p.34). Thus, the VBR model may be viewed as reformist in this context, challenging the notion of universities offering places to suitable candidates based on academic ability, as VBR suggests that ability is incorporated into a candidate's aptitude for caring and compassion values. Thus, values should have an equal weighting with academic attainment during the selection process. However, places on healthcare undergraduate courses are highly competitive, so even if universities placed more emphasis on personal attributes, this would not necessarily mean lower academic standards for entry to university. Therefore, testing for care values arguably remains a test that candidates are required to pass to gain entry to university. Hence, from this perspective, VBR remains a meritocratic model of inclusion. The process is have ability, work hard and access university (Sheeran and Baker 2007).

Clearly, the move to higher education for nursing has not been without its challenges. It has been mooted for some time that the move to professional status and university education for nursing had the unintended consequence of placing more value on academic achievement than on care behaviours (Wilz 1992; Wills 2012). Thus, qualifications have been regarded more highly than clinical skills (Griffiths et al. 2011). However, it has been outlined that the nursing profession cannot accept *"nice but dim"* future healthcare professionals (Dingwell 2007, p.112). As illustrated by Waugh et al. (2014), educators and managers value student nurses for their knowledge and experience. Callwood et al. (2019) also reported a tension for students between being skilled versus caring practitioners. It has also been argued that nurse training should be vocational rather than academic. However, the more accepted view is that, for nursing, a move away from higher education would be a retrograde step (Oliver 2019), given the mounting evidence that degree-educated healthcare staff improve patient outcomes and reduce hospital mortality (Audet et al. 2018). Before Francis (2013), there was an emphasis on skill, competence and qualifications in nursing. Some consider this a possible cause of the perceived lack of care practices, as caring nurses have been excluded in favour of the clever (DoH 2000, p.83; Gillet 2011; Wills 2012). Over-education and professionalism have been criticised as having produced healthcare staff *"lacking in compassion and failing to deliver dignified care"* (Buchanan 2013). Nurses are a particular

focus for claims that they are, for instance, *"too posh to wash"* (Beer 2013). The media have also reinforced these claims, as illustrated by headlines such as *"Sorry Florence; no degree, no job'"* (Dalrymple 2009). Thus, a potential shift in focus from academic achievement to care characteristics as the primary entry requirement for nursing does not match the *raison d'être* of the universities, which seek to attract candidates based on academic achievement. Nevertheless, the addition of measuring care characteristics as a university selection method for nursing entails a potential need for university culture to change. The introduction of aptitude testing and MMIs, deemed credible measures for care characteristics within VBR, can be viewed as an attempt to redress the balance between academia and caring values.

However, universities are ultimately businesses, where income is based on 'bums on seats' (Jones 2020). Changes to HEI funding in England in 2015 removed directly subsidised NHS student places in favour of student loans to allow universities to increase the number of nurse training places (Her Majesty's Treasury 2015, p.31; Beech et al. 2019). Despite the recent replacement of the loan by a grant (Department of Health and Social Care (DHSC) 2019), national financial support is described as patchy at best, as the other three nations did not follow suit (Complete University Guide 2020). Conversely, as a result of removing bursaries, English universities experienced a decline in applications, which was not reflected in the other three nations, where undergraduate nurse admissions remained stable or increased (RCN 2019b). HEE (2020a) also highlighted the worrying trend of significant attrition rates in mature undergraduate nursing students, who cite financial issues pressure and increasing debt as key indicators for leaving training. However, Cavendish (2013, p.58) emphasised the dichotomy between university and practice, as employers raised concerns about the imposition of a *"glass ceiling"* with the move to an all-degree profession. The consequences of the new requirement to have a degree are perceived as curtailing career opportunities, reducing applications from talented healthcare assistants, wasting potential and undermining attempts to raise care standards (Cavendish 2013, p.58). Cavendish (2013) and Francis (2013) recommended that universities should prioritise caring experience more when considering nurse applicants. However, universities have a duty of care to ensure candidates can achieve academic outcomes (NMC 2018a; NMC 2018b; QAA 2018, p.3). As Snowden et al. (2018) also illustrated, there is also no guarantee that previous care experience will mean students complete their study programme. Nevertheless, due to the Cavendish recommendations, care experience has become a prerequisite to starting a nursing degree, alongside widening participation for non-traditional routes into nursing and apprenticeship pathways (Cavendish 2013, p.9; NHS 2021a, pp.79-82).

Universities have recently experienced a steep national rise in nursing students being accepted into universities, with England seeing a clear increase in the number of older applicants as a direct result of recruitment campaigns which reflect the Cavendish review recommendations (Cavendish 2013; HEE 2020b; UCAS 2021). Statistics from the RCN labour market reviews for 2018 and 2019 highlight that, on average, only 16% of registrants are under 30 (RCN 2018b; RCN 2019a). Further, it is acknowledged that HEE launched its widening participation strategy (HEE 2014a, p.17) at the same time as VBRF, and the government drive to increase nursing student numbers is continuing (Beech et al. 2019). This emphasises that the rise in student nurse numbers is multifactorial. However, the findings of this study extend the knowledge of VBR by suggesting that if aptitude testing for values is used at either the point of attraction or recruitment, there is the potential to maintain or increase the trend for mature applicants with care experience to outperform younger candidates with less care experience, when measuring values as part of VBR. Therefore, the unintended consequences of a combination of increased applications, the drive for applicants with care experience as a prerequisite to a nursing degree, widening participation for non-traditional routes into nursing and aptitude testing as part of VBR, could see a significant rise in the number of students with extensive care experience but low academic ability. Thus, an unintended outcome of VBR, given the rising numbers, could mean firstly, a need for additional provision and support for candidates who are recruited for their values but who have limited academic backgrounds and are amongst the most likely to drop out; second, increased pressure on academics to provide support for these students; and third, an increasingly mature nursing workforce, which could mean a future skills deficit (Buchan 2021).

7.3 The nurse: Aspirations and realities

The students' understanding of their personal nursing values was dependent on their perceived realities of practice in comparison to those endorsed by the university. Thus, comparisons of the students' beliefs and how these were represented within aptitude testing were central to interpreting the findings of this study. Three subordinate themes were evident within this key theme: 'Cognitive dissonance', 'Integrity and aspirational values' and 'Courage, knowledge and confidence'. Each subordinate theme is explored below.

7.3.1 Cognitive dissonance

As students had not yet attended a practice placement before testing, they drew on their previous experiences as either a receiver or a giver of care to make meaning of nursing caring and professional values during testing and the interviews. For example, Paul (chapter 6) referred to the values taught at university as *"the gold standard".* By comparison, the

students perceived the realities of carework as understaffed, pressured and time-limited, with nurses having little time for personal development because of their *"busy lives".* Consequently, the *"best way out there"*, i.e., in practice, required *"cutting corners"* and diverging from the situation presented at university. Therefore, the students' perceptions of ethical tensions, under-staffing and diminished care were based on prior experience. As a result, this study found that students who divulged incongruent or dissonant values during the interviews also reflected these tensions when rating values statements in the first test (NMIST). However, as illustrated in section 7.2.6, the students' perceptions of poor care diminished over time as they were exposed to the *'gold standard'* and the stereotypical nursing norms (see Table 1) endorsed by the university. However, some tensions evidently remained, as they reoccurred in the students' values statement ratings in Test 2 (NMI). This indicated a significant strength of feeling when students considered these values statements. This aligns with Weinreich's (2003, p.58) concept of 'contra-identification', whereby students disassociated from values they rejected, which ultimately had a bearing by lowering the test scores.

Analysis of the students' transcripts and aptitude test ratings highlighted a considerable tension within the nursing literature which revolves around the theory/practice gap (Greenway et al. 2019; Pill et al. 2020). Allmark's (1995, p.18) seminal work described the theory/practice gap as an expression of conflicting values when practice, i.e., the doing of nursing, fails to *"live up"* to nursing knowledge. Thus, a gap emerges between idealised nursing values and the actual behaviours and practices observed by the public and practitioners. This was particularly evident in Lisa's transcript, as she expressed a strong sense of conflict and frustration throughout her interview and described a chaotic image of practice that caused her real concern. Her transcript focused on her experiences and perceptions of deficient care, which directly conflicted with her aspirational values, i.e., those she believed to be good nursing values taught in the classroom. Lisa's ratings of values statements in the tests also reflected what she *believed* to be deficient values of the nurse; therefore, she performed poorly during both tests. Together, the students' understanding of poor care practices, given the pressures of carework noted in this study, suggested cognitive dissonance.

Cognitive dissonance is defined as situations which involve feelings of mental discomfort when a person holds conflicting beliefs, attitudes and behaviours (Festinger 1957). Cognitive dissonance has been defined as a major contributor to stress and burnout in healthcare professionals (see section 7.2.3), who control their emotions due to the demands and expectations of work (Zapf and Holz 2006). Thomas et al. (2014) and Sabo

(2011) also emphasised that uncomfortable tensions arise between conflicting values. These not only result in compassion fatigue but are also a driving force that changes beliefs and aptitudes in an attempt to reduce conflict, which can determine the nature of learning. Thus, caring aptitudes dissipate as knowledge and exposure to poor clinical practice increase (Groothuizen et al. 2017). Similarly, Coetzee and Klopper (2010) stated that the physical and emotional pressures of caring work can result in callousness, indifference to patients and poor judgements by nurses. As highlighted by Fiona and Pauline in chapter 6, a dark side to social cognition exists, in that students who are exposed to suboptimal care are at risk of adopting poor care practices (Paley 2014; Groothuizen 2017). This highlights a key criticism of social constructionism, whereby if all values are deemed socially constructed, *"there is no basis for moral behaviour"* (Gergen 2015, p. 226). Consequently, value frameworks could be considered an ethical code against which all nurses can be judged. However, this could be to the detriment of other values, since by *"legislating good for all",* initiative and creativeness could be threatened (Gergen 2015, p. 226). Hence, Gergen (1973) suggested that cognitive dissonance theory is predictive because of learned dispositions. This suggests that dissonance, reflected as low aptitude test scores, can reveal just as much about such candidates' values as those of candidates who test highly. Thus, aptitude testing has potential value as a gateway to further discussion with candidates about their perceptions of caring and professional values which rank behind aptitude test scores as part of VBR. This contrasts with relying solely on candidates' scores as the benchmark for entry to university, i.e., when high scores mean the offer of a university place but low scores mean rejection.

7.3.2 Integrity and aspirational values

It was evident that students aligned their values with those they considered accepted, stereotypical nursing aptitudes and professional norms rooted in value frameworks, exemplified in Table 1. However, significant tensions existed in students' transcripts, characterised by dissonance and congruence, because of their challenged aspirational values. This suggested the values endorsed by the university were viewed as faith systems, i.e., a coded belief in good nursing values. Meanwhile, good values were sometimes viewed as illusionary within the social and moral order of practice. Thus, it would seem that students' experiences of practice challenged their integrity as they adapted their aspirations to the realities of practice. These findings concur with those of Beauchamp and Childress (2019, p.41), who defined integrity as one of the five focal virtues for health professionals, which are important for the development and expression of caring and provide a moral compass. Callwood et al. (2019) also reported how student nurses thought the pressures of clinical practice could compromise values, particularly empathy. Integrity includes emotions,

aspirations and knowledge, each complementing one another. Dissonance occurs through a conflict of moral norms, a loss of autonomy and sacrifices to personal goals and commitments due to moral demands. Thus, as discrepancies occur between individual beliefs and aspirations, dissatisfaction occurs (Higgins 1987, p.319). This was illustrated when Mary referenced a real fear that a lack of time and resources would prevent her from doing *"a proper job",* which influenced her construct ratings for values statements that included integrity, her lowest-scoring value theme. This emphasised a resonance between challenged integrity and aspirational values in the face of the perceived demands of practice. As illustrated in chapter 6, dissonance occurred in the students' transcripts when care was viewed as task-orientated, impersonal and detached. Mazhindu (2003, p.256) similarly emphasised that aspirational values afford *"emotional armour"* whilst enabling the nurse to behave in a socially acceptable manner and in line with the ideals and societal norms of the nurse. This emphasises the learned and socially constructed nature of values (Ravlin and Meglino 1987, p.354; Meglino and Ravlin 1998; Parks and Guay 2009; Patterson et al. 2016a). More recently, researchers have reported that when student nurses witnessed a lack of caring aptitudes in practice, this led to conflicting values and resulted in a tempering of idealistic views, as care standards were not as envisaged (Callwood et al. 2017; Callwood et al. 2019). As in the research of Callwood et al. (2017), the students in the current study described deficient care as revolving around missed opportunities to provide physical care. They also perceived pressures of carework as a justification for poor care practices, whereby compassionate caring was lost and care became task-driven. These findings concur with those of Kneafsey et al. (2015), who reported that nurses lost compassionate behaviours when there was insufficient time.

Initial interpretations of the students' test results suggested that psychometric testing for integrity could potentially eliminate candidates who are at risk of adopting poor care practices. However, this initial analysis failed to address the potential for students to learn good caring values through exposure to both the nursing curriculum and the good values endorsed by the university (see section 7.2.6), as supported by Meglino and Ravlin (1998), Parks and Guay (2009), Patterson et al. (2016a) and Ravlin and Meglino (1987). A closer inspection of the students' Test 1 and Test 2 ratings also revealed that they aligned their aspirational values more closely to those of the 'model' nurse in Test 2. Thus, in line with social constructionism theory, students exposed to the values overtly prized by the profession through the curriculum adhered to the moral norms (Hogg and Terry 2000; O'Neil 2010; Beauchamp and Childress 2019; Pattison and Pill 2020). The 'model' nurse was seen as a knowledgeable doer (Maben et al. 2007) and a positive role model, with students aspiring to emulate these models when balancing their workload and ethical decision

making. Fiona likened the 'model' nurse to a *"butterfly"*, describing the models as *"empowering"* by instilling strength and confidence in the student's abilities. Thus, the values of the 'model' nurse were aspirational, drawing on idealistic perspectives of the values and archetypal images of the nurse as being compassionate towards others and the moral ideal. This was described by Nicky as the *"Florence Nightingale thing".* Despite Mary's earlier conversation about her fears, it was evident that she clearly identified with the 'model' nurse, as did Pauline, whose mother was a nurse. Mary described nurses as a "*special kind of people",* whom she *"always looked up to"*, describing the strong social bonds with nurses who had inspired her to choose a nursing career. Meanwhile, Pauline's mother had shaped her ideals of the nurse, which guided her responses about the 'model' nurse as she *"imagined"* how she *"wanted to be"* as a nurse and made the 'model' nurse *"perfect"*. Thus, their *"idealistic identification",* i.e., the similarities they identified between their personal nursing values and the 'model' nurse (Weinreich 2003, p. 58), were reflected in their strong ratings of values statements in both tests. Therefore, Mary and Pauline ranked highest in the group for both tests. Whilst it is acknowledged that determinants for occupational choice are mixed, it is widely recognised that occupational choice is highly dependent on parental background, gender, culture and parental ambitions for their offspring (Polavieja and Platt 2014; Palmer et al. 2020). Several studies have indicated that the reasons for choosing a career in nursing, other than the desire to help others, include having friends or relatives in healthcare professions (Mooney et al. 2007). Lievens et al. (2016) also reported that parental occupation, and thus candidates' socio-economic status, affected medical and dental school candidates' SJT performance. Thus, from a constructionist stance, the findings of this study suggest that the construction of nursing values for Mary and Pauline was founded in historic familial and social relationships (Gergen 2015, p.116). This indicates candidates who have strong social and/or family bonds with nurse/healthcare professionals would also perform well during aptitude testing for values. However, a paucity of literature explores the impact of these determinants on nursing candidates' performance when testing for values through HEI VBR practices. This suggests an area for further research.

7.3.3 Courage, knowledge and confidence

As illustrated in chapter 2, courage is one of the six values domains within the 6Cs and is defined as enabling *"us to do the right thing for the people we care for, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working"* (DoH 2012, p.13). It has been argued that courage is the prime human virtue as it supports others (Walston 2004; Peate 2015). Therefore, courage is denoted as a core nursing attribute, central to the integrity needed when delivering compassionate care and defending moral values (Beauchamp and Childress 2019, p.41). However, the findings

of this study indicate that, because of the students' novitiate status, challenging poor care practices was considered difficult to do, despite their understanding that this was something they *should* do, when faced with a more knowledgeable practitioner. Fiona's description of the 'model' nurse, that *"they just stick to their guns and they are very kind of factual [in a] positive way"* was as someone courageous because they speak up. In comparison, Anna gave her meaning of challenging authority as *"naughtiness",* suggesting that, for her, challenging poor practices reflected disobedience and was a form of aberrant behaviour. These findings align with those of Gallagher (2011) and Lachman (2010), who also asserted that nurses may choose not to speak out as they fear embarrassment or punishment. In this respect, the students considered challenging authority was something to be done "*way down there in the timeline".* This was because they believed they were not nurses *"yet"* and they needed to *"develop",* as these values were the *"ideal eventuality"*. This indicated that courage was linked to experience and knowledge. The students' concerns are also represented in the wider literature, where courage, identified as speaking up and acting as a patient's advocate against other healthcare professionals, was challenging, difficult and depended on knowledge and confidence (Barchard et al. 2017; Callwood et al. 2017). Thus, in the test environment in which the students compared their personal values to those of 'model' nurse, there was a degree of difference between the two. This was illustrated by Paul, who stated, "*that's me saying I'm 4 or 5 and as good as I'm going to be"*, while similar ratings indicated *"there would be no room for improvement"*, which Fiona likened to being *"cocky"*. Consequently, when the students appraised their values in comparison to those embodying the 'model' nurse, the latter values were viewed as aspirational, a future acquisition and goals they were *"working towards*", described by Mary as a *"million miles away".*

The link between the courage to defend professional and ethical principles and knowledge has been documented (Lindh et al. 2010; Barchard et al. 2017; Numminen et al. 2019). Moreover, it has been highlighted (see section 7.2.5) that courage, like compassion, can be cultivated through education and the curriculum (Pence 1983; Andrade and George 2013; Richey 2015). However, Barchard et al. (2017, p.29) asserted that, as a strategy of VBR, only candidates willing to challenge should be recruited into healthcare. The findings of this study contradict Barchard et al. (2017), as it was found that students' construct ratings in the tests increased and decreased in line with their experiences, discourse and perceptions of care practices, with courage firmly rooted in experience and knowledge. This indicates that candidates who recognised the importance of courage, but perceived they did not yet have the confidence or knowledge to speak up against more knowledgeable practitioners, would return poor ratings of dimensions measuring courage. These findings add to the VBR

evidence base, as they indicate that prioritising courage as a measurable characteristic means the potential loss of good candidate nurses who recognise the importance of courage but do not yet feel they have the knowledge or confidence to speak out. Thus, aptitude testing is potentially a poor indicator of the range and significance of some dispositional measures within the context of VBR as the prevalence and strength of values changes over time (Gergen 1973, p.318).

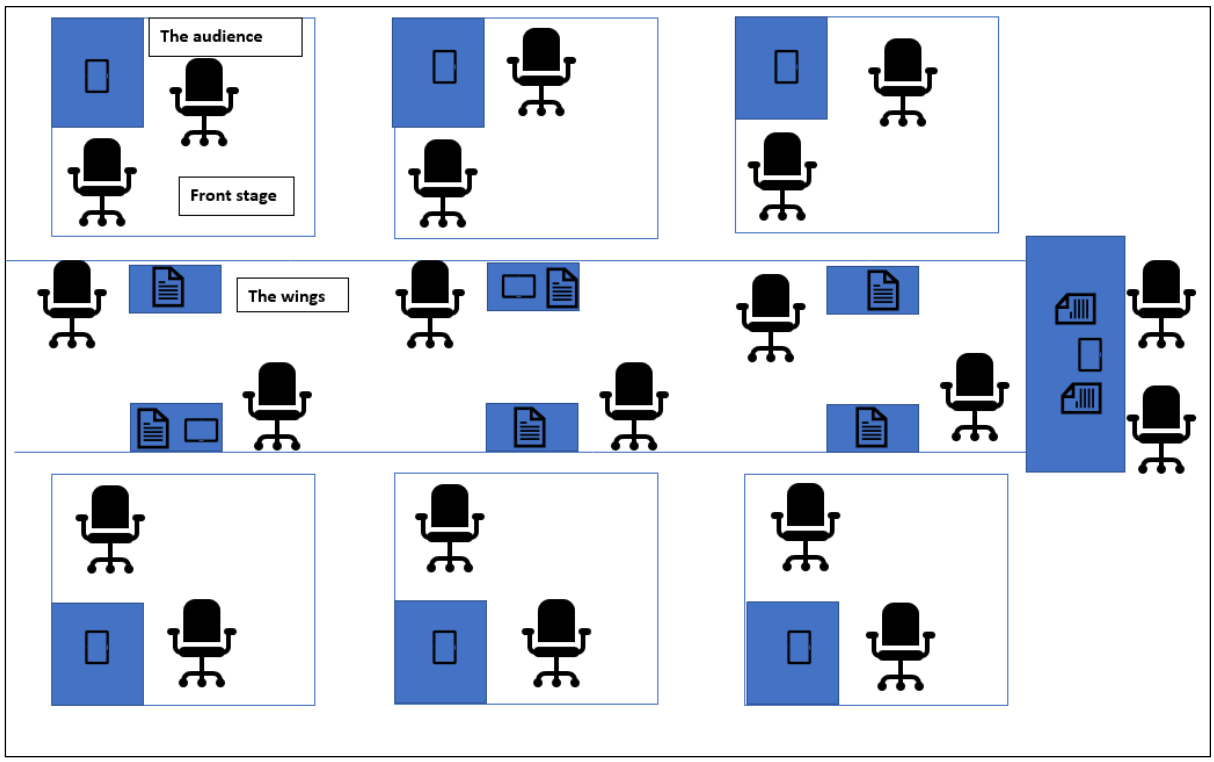
7.4 I think [I am a nurse]; therefore, I am [a nurse]

The students' personal experiences of their multiple mini interviews (MMIs) and aptitude testing formed an integral part of the study's findings. Student transcripts highlighted tensions when comparing MMI experiences to those of the aptitude test. These tensions revolved around human/computer relationships. Four subordinate themes were identified within this key theme: 'Performing values', 'Stepping out of character: when the examiner is a machine', 'Words and numbers' and 'The report'. These are discussed below.

7.4.1 Performing values

As described in section 2.7 and illustrated in Diagram 4, MMIs occur in a room divided into stations.

Diagram 4 Diagrammatic overview of a six-station multiple mini interview (MMI), in relation to Goffman's dramaturgical framework.



Each station is separated by a physical barrier, such as a screen or curtain. Hence, candidates are required to 'wait in the wings' on a chair outside the station as they prepare to enter 'front stage'. During this time, candidates must read the instructions and information about the station. Thus, they are preparing for their entrance 'front stage' and the task in the station ahead. Consequently, student experiences of MMIs can be framed using Goffman's (1956) dramatological metaphor, in which life is a series of performances and as people interact, they manage their identities as actors do on a stage. Goffman (1956) defined social interaction as a theatrical performance, when the 'act' depends on the setting, i.e., the stage, the audience and the cooperation of other players.

The students described the MMI as a positive experience, which was congruent with the VBR literature, where face validity is widely acknowledged (Eva et al. 2004; Pau et al. 2013; Patterson et al. 2016b). The students, however, also reported initially feeling anxious as they viewed the MMI as a daunting prospect, which they apportioned to a lack of information and resources about the MMI process. Consequently, students described having little or no understanding about VBR, leaving them feeling unprepared and resulting in performance anxiety. These findings align with previous research, which reports that candidates thought MMI pre-selection information was vague and provided little useful content. This resulted in cognitive anxiety and lower self-confidence, affecting their performance (Taylor et al. 2014; McConville 2016). This suggests that HEIs must adopt a more focused approach to giving candidates information about institutional VBR practices in an attempt to reduce candidates' anxiety and increase their confidence during recruitment. Students also perceived MMIs as looking for *"characteristics"* and *"set[s] of values"* which were *"beneficial to the profession"* and relevant to their programme of study. This suggests that students were aware of a culturally regulated moral code for the nurse, so they adapted their behaviour during MMIs. Thus, value frameworks, such as those illustrated in section 7.2.2, were identified as sources of information from which the candidates gleaned cues and indicators about 'the lines' they needed to learn for their MMI. Students who recounted preparing for their MMI described it as *"looking it up on the internet", "taking notes"* and *"practis[ing] what needed to be said".* Here, 'learning the lines' enabled them to *"perform really well"* in the role of the nurse during their MMI. As noted in the works of Goffman (1956, p.69), students' performances were *"schooled"*, *"fabricated"* and *"constructed"* so they could adopt the *"impression"* of the nurse for the benefit of the MMI. Thus, as Gormley et al. (2020) found medical students conformed to the role of the doctor within the OSCE scenario, the students in this study constructed roles and identities that conformed to the role of the nurse for their MMI. Thus, they prepared privately, thinking the values through and shaping their dialogue in line with the value framework in readiness for their public performance in the MMI. During the MMI, each

station is timed, with an audible prompt, such as a bell, marking the beginning and end of each station. Hence, the bell is a prop that sets the scene for the performance. The students' performance of nursing values cannot begin until the bell signals their entrance to the station. The bell also terminates their performance, when they must leave (Goffman 1956, p.23). Thus, as candidates step into the station, the performance begins and the candidate 'gets into the character' of the nurse. Each MMI station was denoted as an extended series of interactions, when first impressions about their future *"moral character"* were essential (Goffman 1956, p.161). Hence, as highlighted in chapter 6, students emphasised through their conversations that their performance was significantly affected by the time between and during stations, as well as the content and order of the stations. Such findings are widely acknowledged in the VBR literature, as researchers have previously highlighted that students need time to talk during the stations and time to recover from their previous performance (Pau et al. 2013; Knorr and Hissbach 2014; Callwood et al. 2018b). Interestingly, as illustrated in chapter 6, students' recollections tended to involve stations considered 'activity' stations, rather than stations that questioned their motivations to be a nurse. The students described the values assessed within stations as skills, e.g., dignity, communication and decision making, reflecting those embedded in the 6Cs (DoH 2012) and those to which they were exposed during recruitment. This reflects the view of Breil et al. (2020), who highlighted that candidates' social cognition, in relation to information and relationship-handling during MMIs, could lead to consistent performance across stations that assess social skills. This suggests if candidates are cognisant of the stereotypical behaviours of the nurse (see value frameworks exemplified in Table 1), as illustrated in section 7.2.3, they can identify task criteria during the MMI stations and are therefore more likely to perform well.

The student transcripts also emphasised an observational hierarchy during MMI stations, which expressed relationships between power and controlled behaviour. Hence, students described having to *"say something"* or *"do something"* so that *"certain traits would come out".* The students also regarded the assessor as someone who was *"knowing"* and a *"good judge of character".* Therefore, the students had to portray the right impression of their values, which they characterised as *"demonstrating values".* Hence, the assessor could identify their *"worth"* and *"fit"* for the profession. These findings align with those of Taylor et al. (2014, p.1158), who described interviews as an opportunity for candidates to *"sell themselves"*. Consequently, the assessor observed the performance as the *"audience"* (Goffman 1956, p.23) and was thus perceived as a powerful gatekeeper who identified candidates' values and rated their performance. This aligns with the view of Gormley et al. (2020, p.17), who also described assessors in the confines of the OSCE as conveying

"authority and power when determining candidates' success or failure". These findings further align with VBR literature, which suggests that assessors, and academics in particular, are viewed as being in positions of power when making final decisions on candidate recruitment outcomes (Taylor et al. 2014; Waugh et al. 2014; Heaslip et al. 2018, Yusoff 2019). However, as illustrated in chapter 3, there is a growing trend for service users to form part of the MMI assessment teams and such individuals are perceived as looking beyond candidates' academic ability and focusing on the caring, compassionate aspects of nursing (Heaslip et al. 2018). This suggests that adding service users to the assessment team offers a balance of views between caring and professional values. However, Rouse and Tourney (2014) offered an opposing view, whereby service users scored candidates less favourably than their academics counterparts; their study additionally reported tensions within the decision-making process.

Conversely, a paradox emerges from the VBR literature, as academics expect candidates to come prepared for selection with knowledge about the programme, the profession and university (Taylor et al. 2014). Indeed, as illustrated in section 7.2.2, universities direct candidates to high-profile value frameworks in preparation for recruitment. Thus, MMIs can be considered a mechanism of disciplinary power *"by means of observation"* (Foucault 1977, p.170). Contrariwise, being under observation during MMIs meant students presented their values in harmony with high-profile value frameworks. Thus, candidates' 'performance' of the role of the nurse during MMIs is objectively driven by their need for good 'ratings' and desire for an offer to study at the university of their choice. These findings further align with those of Gormley et al. (2020, p. 20), who suggested that the high-stakes nature of the OSCE, as with MMIs, assumes a significance that *"goes beyond performance"*. Interestingly, Callwood et al. (2018b) also drew attention to the correlation between nursing students' MMI scores and their end of year 1 clinical performance outcomes, assessed through OSCE. This finding calls into question whether the values presented by candidates during MMIs are real or constructed for the encounter. Thus, a social constructionism stance to MMIs questions the public performance of aptitudes compared to what people think *"inside"* (Burr 2015, p.147). That is, if what people say are social acts are governed by social interactions, the reality of attitudes is *"unknowable"* (Burr 2015, p.147). Thus, a critical stance to the consequences of VBR suggests that if the students' MMI performance is fabricated, this "*invites a scepticism and a distrust"* about the values being *"performed"* (Gergen 2015, p.100). Researchers have acknowledged the subjective nature of MMI, in that no one can truly know the candidates' values as they are expressed within the social context of MMIs (Eva et al. 2004, p.316; Pau et al. 2013; Sebok et al. 2013; Rees et al. 2016; Callwood et al. 2018a). Interestingly, the students in this study also acknowledged the

subjectivity of MMIs when describing the assessor's *"mood",* which they perceived was influenced by successive applicants during the course of the day. In this respect, Parad (2017) questions what MMIs are actually measuring, as first impressions during the MMI are based on non-cognitive abilities such as warmth, competence and performance, which correlate with self-assessments of extraversion (Pitt et al. 2014; Waugh et al. 2014; Callwood et al. 2018a; Zamanzadeh et al. 2020, p.11). This returns the discussion to Salovey and Mayer's (1990, p.194) summary of empathy as a component of EI, whereby individuals are perceived as *"genuine and warm".* Breil et al. (2020, p.15) also suggested that agreement between assessors during MMIs could be apportioned to a halo effect and their shared impressions of, for example, a candidate's attractiveness and professional appearance, which could overshadow judgements. In this respect, a UCAS blog (2019b) advised nurse candidates to dress smartly *"to give the right impression".* Hodges (2021) draws attention to the validity of human-rated performance-based scenario examinations, such as OSCE's and MMIs, as the candidates conform to stereotypical performances. Several troubling trends, such as the overuse of checklists, the production of pseudo-empathy and doubts about the appropriateness of some ethically based scenarios, have also added to the uncertainty over the use of MMIs for undergraduate healthcare selection (Hodges 2021, p.3). More worryingly, Razack et al. (2015) also found that candidates disguised their ethnicity to present themselves as the 'right kind of person' during the MMI interview for medical school. This raises concerns when giving candidates 'credit' for their performance during MMIs.

As illustrated in chapter 6, Paul drew attention to nursing students sharing information about station content to prospective nurse candidates. This suggests that the MMI station content is just as vulnerable to being compromised as aptitude testing, with candidates rehearsing responses. However, there seems to be little criticism of MMIs compared to aptitude testing in terms of the effects of the availability of station content on the 'black market', coaching and candidates performing values during MMIs. These findings suggest that security is an equally important consideration in preventing the sharing of MMI station content, which would compromise the MMIs. Nevertheless, HEE (2014b, p.29) noted that MMIs had "*good reliability and validity when designed appropriately".* However, they failed to identify criticisms of MMIs in their early evaluation of VBR literature (HEE 2014b). Nonetheless, it is acknowledged that significantly more evidence is now available as the pace of research within this area has been considerable, with key evidence from the Leeds review still outstanding (University of Leeds 2020). Nonetheless, as illustrated by the current evidence outlined in chapter 3, most VBR research focuses on the validity of measurement for selection and screening tools. These are described by Taylor (2014, p.1156) as *"distal*

outcomes", i.e., the success and retention of students, with the broader VBR literature failing to address the concerns about performance-driven assessment and dependence on the social encounter during the MMI. Consequently, the findings of this study allow the cautious suggestion that a combination of the candidates' performance and observation of values, in addition to the widespread availability of station contents, calls into question the legitimacy of using MMIs as an assessment tool for values.

7.4.2 Stepping out of character: When the examiner is a machine

The students' transcripts highlighted a dichotomy between the subjectiveness and surveillance of the human-rated candidate assessment in the MMI and the distancing of human judgement through the use of artificial intelligence (AI) during computerised aptitude testing. When considering computerised aptitude testing, several benefits have been reported: it is more accurate and less time-consuming for test-takers and administrators; therefore, it is cost-effective (Kaplan and Saccuzza 2017, p. 418). However, by comparison, concerns are often raised about identity verification (Mead et al. 2014, p.30) and standardisation, i.e., when test-takers are in different locations and using different technology with different distractions (Kaplan and Saccuzza 2017, p. 419). The COVID-19 pandemic has also brought into sharp focus digital exclusion, with the most vulnerable students experiencing challenges accessing digital devices (Organisation for Economic Co-operation and Development 2020, Smith and Cleland 2020): only 51% of low-income households had internet access (Office for National Statistics 2020). Whilst it is yet to be reported whether digital exclusion has impacted widening access recruitment in the UK due to COVID-19, it can be assumed that not all candidates have access to devices on which to take computerised aptitude testing. Without such access, candidates are arguably disadvantaged and potentially excluded from the application process. Consequently, widening access candidates who have limited or no internet access are particularly vulnerable. Smith and Cleland (2020) have voiced such concerns in relation to medical education, with MMIs having already moved successfully to digital platforms. Despite these concerns, the move to online testing might be deemed a viable option by HEIs, given the lockdowns and the need for social distancing, with aptitude testing given more weighting than in previous years.

Another considerable drawback of computerised aptitude testing is its inability to read subtle distortions of the truth which can be captured through human communication (Kaplan and Saccuzza 2017, p.418). Sophisticated AI technologies, such as 'intelligent classroom behaviour management systems' as part of 'the smart campus', can already log students' behaviour, facial expressions and mood within the classroom (Liang 2020). Advanced

computerised psychological tests are also available that can sense emotion and adjust accordingly (Lopatovska and Arapakis 2011). However, online VBR aptitude testing cannot currently identify subtle emotional clues about candidate truthfulness. Students in this study described aptitude testing as being *"quite easily fake, just score yourself the highest every time"* as the test was *"behind a screen"* and *"self-assessed"* and students just had to *"tick some stuff"*. Students also described understanding *"what you should be clicking to give you the best chance to get into uni"*. Therefore, in contrast to Foucault's (1977, p.200) perception of observation as power, the examiner during testing was perceived as anonymous and *"socially distanced"* (Goffman 1956, p.155) by the students. This was unlike the MMI environment, when students described being *"seen"* by the university, i.e., the assessor could *"judge"* the candidates' values.

As illustrated in chapter 6, students described honesty as a significant value, both personally and professionally, demonstrating an understanding of professional integrity and acting in accordance with professional codes of practice. Nevertheless, students stated their personal honesty and integrity in terms of telling the truth would be circumvented during aptitude testing in order to obtain their *"dream career"*, indicating that candidates' responses would be driven by the desire to obtain a university place. Consequently, students revealed the potential for nurse candidates to exhibit objective-driven behaviours and present their values more favourably during aptitude testing if it was used as a selection method; thus, they were 'faking good' (Griffin et al. 2004; Bradshaw 2009; Smajdor 2013; HEE 2016b; Patterson et al. 2016a; Groothuizen et al. 2017; McNeil et al. 2018).

Recent technological developments in psychological testing have also produced a surge of web-based tests, with unproctored testing becoming popular in personnel selection (Steger et al. 2020). Steger et al. (2020), in their recent meta-analysis, reported that unproctored ability assessments, i.e., aptitude testing, are biased due to cheating, which could be overcome by making assessments unavailable on the internet. As illustrated in chapter 2, the view of Stager et al. (2020) is reflective of the allegations made against the DC test, which was available on the 'black market' (Elkan and Robinson 1995; Rodgers et al. 1995; Houltram 1996; Robinson et al. 2006). Hojat et al. (2013) offered a solution, arguing that validity during aptitude testing can be maintained by reminding test respondents to be truthful. However, human surveillance is embedded within the test mechanism and *"intentionally false responses"* can be detected by an embedded scale, which would *"invalidate the test results"* (Hojat et al. 2013, p.1288). As evidenced in chapter 6, students expressed anxiety because of their honesty during testing, as this honesty when taking a test *"reflect[ed] badly"* on them. Consequently, students believed honest responses were

not always features which the profession, characterised as the *"NMC",* would consider *"high value"*. Hence, the students perceived the test as an *"exam",* whose goal was for them to present themselves as having the values of the nurse so they would pass the exam. Students believed they would not obtain a university place if they rated the values statements in the test in a way that reflected the realities of practice, rather than the way that reflected the *'gold standard'* (see section 7.3.2). Thus, a critical appraisal of VBR suggests that candidates' values are no more than products of good and desirable values, advertised through value frameworks as a mechanism of nursing culture (Gergen 1973, p.316; Burr 2015, p.139). Hence, Foucault (1977, p.18) described examinations as placing an individual in a *"field of surveillance",* where work-related aptitude tests are characterised as instruments of *"disciplinary power"* (Foucault 1977, p.191) that put everyone in their social place (Garrison and Burton 1995, p.75). Hence, nursing culture is defined through the institutional influences of VBR and of control and command individuals who use *"indulgences"* and *"sanctions"* (Goffman (1956, p, 152), which Gergen (1973, p.316) described as *"reward and punishment contingencies*". Consequently, candidates present their values in line with the 'institutional facts' propagated through value frameworks in order to gain a university place. However, students in this study also described a *"constant battle"* to provide honest answers rather than *"the obvious"*, i.e., those which conformed to values that reflected nursing stereotypical norms (see value frameworks in Table 1). In this regard, students indicated their honesty was for my benefit as the study was *"voluntary so why would you lie".* Whilst this adds validity to the aptitude test results reported in this study, it also emphasises the subjective position of the students. Hence, the students' views aligned with the micro-approach to identity formation which affords agency, as people's accounts are constructed in a way that best *"suits the occasion"* (Burr 2015, p.27). That is, students' *"faked"* responses were based on stereotypical norms embedded with value frameworks exemplified in Table 1, with *"honest"* responses arising from subjective experience and their perceptions of deficient care standards, as illustrated in section 7.3. Thus, candidates can critically analyse the institutional VBR discourse and either claim or reject values since they are driven by their goal of obtaining a university place. These findings in-and-of themselves open Pandora's box, as they question universities expectations of candidates during recruitment in terms of values, honesty or conformity. As discussed, it would seem that candidates conceal their honesty to obtain their object of desire, whether in MMIs or aptitude testing, as the students' perceptions are that honesty is not rewarded. Bradshaw (2009, p.466) emphasised how even Florence Nightingale argued that *"the art of care was not amenable to testing or certifiable by examination".* However, as Gergen (1973, p.316) highlighted, once reward and punishment have been inductively established, this in itself gains predictive value. Therefore, an alternative position to VBR would be to design

opportunities for candidates to express their understanding of nursing care and professional values and how these values underpin good standards of compassionate care, rather than attempting to demonstrate an ability to measure and know candidates' authentic values.

7.4.3 Words and numbers

As noted in chapter 6, the students perceived aptitude testing as broadly relevant to the concept of VBR for nursing. These findings align with the work of McNeil et al. (2018), who also reported the NMI as having face validity as test-takers were able to identify nursing values and found it easy to understand and complete the tests (McNeil et al. 2018). HEE (2016b) emphasised that face validity in aptitude testing can depend on the wording of test items, as rating scales can be influenced by the context and background against which the objects are rated (Kaplan and Saccuzza 2017, p.167). In this respect, the students described their responses to values statements as being context-driven. For example, Claire and Lisa both thought mental health nurse candidates might understand some dimensions differently to the ways other branches of nursing did. Their words highlighted that nursing candidates' chosen branch can also be influenced by their experiences and thus how they categorise and construct their nursing values. 'Expertise by experience', in other words, the worth of the lived experience, is widely acknowledged in mental health nursing (Oates et al. 2017). Hence, if aptitude testing were used as a recruitment tool, mental health nurse candidates could further differentiate between the beliefs, attributes, feelings and behaviours within the construct values statements based on their personal experiences. These findings align with the work of Hogg and Terry (2000, p.124), who defined the social construction and personal categorisation of attributes with organisations as context-dependent. This implies aptitude testing, as a recruitment tool for VBR, should be contextualised to different branches of nursing, rather than generic values statements, in an attempt to prevent candidates from being disadvantaged based on their chosen branch of nursing.

The use of phrases such as *"always"* in the tests also caused contention. Both Fiona and Claire highlighted the complexities of care, while the use of *"always"* in values statements was considered a *"black and white"* response. Lisa also considered *"tick[ing] at each end"* of the values statements, emphasising how she found it difficult to differentiate and *"grade"* the differences in value constructs because of her inexperience. In this respect, students gave lower ratings to values statements that they believed reflected skills rather than values, as there was *"no guarantee"* they could do *"everything 100%".* Consequently, ranking choices of the values statements in the test was also contingent on the students' earlier anxieties about their perceived lack of knowledge and experience (section 7.3.3). This somewhat

reflected the findings of Callwood et al. (2019), in which knowledge and skills were viewed by students as important in their first year of training. This suggests that the terminology in values statements denoting competence has underlying significance in aptitude testing for values and could influence test-takers' behaviour during testing. Tensions also emerged around judging the 'model' nurse during testing when students did not consider they had the experience to pass judgement on who was, or was not, a good nurse. Interestingly, this aligned students' perceptions of good care practices, i.e., being *"non-judgemental",* with those in the nursing 'Code' (NMC 2018a), which states that *"discriminatory attitudes and behaviours towards those receiving care"* should be challenged. These findings further emphasise the influence of value frameworks such as 'The Code' (NMC 2018a) in pre-empting professional socialisation (see section 7.2), whereby courage, knowledge and confidence were sources of dissonance for the students. The findings of Callwood et al. (2017, p.1145) also reflected this view, as they found first-year students exhibited an awareness that judgements about others could potentially affect values such as respect.

Both Nicky and David also had difficulty ranking values statements in the test. Nicky had issues with the test imagery, which related colour to the ranking of values statements. Nicky's transcript also highlighted an underlying anxiety around maths in general. Meanwhile, David gave the impression he found it difficult to grade values statements within the test because of how the values statements were worded and presented in Likert scales, which he described as *"freaky"*. Therefore, David responded on the extreme end of the poles, concentrating on what he considered 'good' or 'poor' personal nursing values, rather than differentiating between the degree of difference and consequently the strength of belief. This interpretation is supported by Kaplan and Saccuzza (2017, p.167), who acknowledged that Likert scales with nine or more responses can mean test-takers fail to clearly discriminate between finely grained choices. Collectively, however, these students' experiences suggest their test anxiety related to ranking the values statements, especially the numerical reasoning used. Mathematical learning difficulties, and dyscalculia specifically, is a controversial issue within nursing recruitment as it is linked to more complex competencies, such as drug dose calculations (RCN 2010 p.30; Sayadi et al. 2021). Lower mathematical skills have also been linked to higher instances of drug-related errors in practice (Sayadi et al. 2021), with serious incidents of harm through such errors being regularly reported via Never Event (NHS 2021b). In the VBR context, Waugh et al. (2014) reported that registrants and students regarded literacy and numeracy skills as less important for practice. By comparison, Taylor et al. (2014) stated that high standards of literacy, as part of the academic requirements for entry to nursing, were perceived as essential criteria for making judgements on candidates' preparedness for university. In this

respect, HEI entry selection criteria 'filter out', to some extent, candidates who could be considered as having 'true' dyscalculia, rather than those with poor maths skills (NHS 2021c). Even so, maths skills remain one of the four most common cognitive academic abilities on which nursing candidates are evaluated (Zamanzadeh et al. 2020, p.9). Researchers have reported that test anxiety in educational testing is more pronounced in mathematical reasoning and whilst this can be reduced through online testing (Barroso et al. 2021), numeracy testing is viewed as stressful when conducted under exam conditions (Taylor et al. 2014). Robert and Campbell (2017) also emphasised that test anxiety can be compounded, and confidence lowered, in nurse candidates with multiple HEI offers who fail their first mathematical test as part of the selection. In this respect, text anxiety, particularly high levels of maths anxiety, has also been linked to dyslexia in nursing students (Jordan et al. 2014). Consequently, people with dyslexia can often find aptitude testing harder (Kaplan and Saccuzza 2017). Generally, dyslexic test-takers may have problems reading instructions, though this can be overcome with good test management and giving them extra time (Kaplan and Saccuzza 2017). As illustrated in chapter 5, there was no time limit for the students to complete their tests, so this study complied with what can be considered best practice guidelines. Interestingly, and despite their anxiety during testing, neither Nicky nor David reported that dyslexia featured in their demographic data, whereas Pauline and Fiona identified as being dyslexic. Pauline performed well during testing, ranking second for both tests, whereas Fiona ranked sixth in Test 1 and ninth in Test 2. Neither addressed their dyslexia directly during the interview nor suggested that it had been an issue for them during testing. Though Pauline did report test anxiety, this was not related to the test environment but her perceived lack of knowledge and experience, which she characterised as not *"know[ing] anything".* This finding aligns with that of Jordan et al. (2014), who emphasised that test anxiety was not predicted by a dyslexia diagnosis but by general overall worrying by nursing students with few coping strategies. Additionally, Barroso et al. (2021, p.3) emphasised that when maths anxiety is experienced throughout development, this is associated with maths achievement later in life; this was reflected in Nicky's experiences. Barroso et al. (2021) also highlighted inequality in maths achievement, whereby male and ethnic test-takers perform less well than their female white counterparts, which could account for David's poor performance during testing. However, Gale et al. (2016) explored the predictability of MMIs in relation to literacy and numeracy, making the counterclaim that students from ethnic backgrounds who attended secondary school outside the UK outperformed UK-educated students in numeracy testing, irrespective of the origin of the latter. Nevertheless, this study's findings suggest that nurse candidates who tend to have lower mathematical achievement and higher anxiety when taking aptitude testing (which includes ranking tools such as Likert scales) may need targeted interventions to help reduce

their anxiety or improve their numerical reasoning. It is hoped this would minimise candidates being unfairly compromised if aptitude testing for values is used as an HEI selection method.

7.4.4 The report

The move for some HEIs to adopt computerised aptitude testing, for either self-selection or recruitment purposes, seems probable, given that VBRF (HEE 2016a, p.88) and Francis (2013) advocated the use of aptitude testing. Indeed, an example of this was when Queen's University Belfast (QUB) trialled the NMI for their nurse applicants (QUB 2018). The NMI and the Cambridge Personality Styles Questionnaire (CPSQ) (Cambridge Assessment Admissions Testing 2021) have been presented by HEE (2016a) as exemplar psychometric tests (HEE 2016b). Both the NMI and the CPSQ are computer-based programmes which provide automated reports tailored to a candidate's individual profile (HEE 2016a; HEE 2016b; Cambridge Assessment Admissions Testing 2021). However, psychometric instruments, such as aptitude tests and SJT, are notoriously expensive (HEE 2016b, p.5, Lievens et al. 2016). Therefore, the higher recruitment fees due to the introduction of aptitude testing would need to be absorbed by the university, which could place additional pressure on university finances (Council of Deans 2014a; Council of Deans 2019; HEIW 2021). This could lead to universities setting quotas, whereby only candidates who achieved the best academic and test results would be offered a university place. This could potentially reinforce the meritocratic, elitist view of the university and fail to address widening participation issues. However, it should be noted that universities receive monies through funding streams for achieving widening access targets (Office for Students 2018). This may, therefore, offset some of the associated costs. An alternative could be to transfer the fee onto the candidate. Notable examples of this practice would be the University Clinical Aptitude Test (UCAT), which currently has a fee of £75 (UCAT 2021). The additional fee to take the tests could be problematic for some candidates in lower socio-economic groups. This could also run counter to widening access initiatives and the result might be a reduction in the number of widening access applications. This might tempt HEIs to utilise tests that automatically generate reports, rather than trained individuals interpreting results, to provide candidate feedback. For example, the Nursing and Midwifery Board of Ireland (NMBI) (2021) have already developed a self-assessment questionnaire to help candidates decide if they are suited to a career in nursing or midwifery. This questionnaire generates an automated report on the applicants' suitability for the nursing role based on the test-takers' responses (NMBI 2021), which removes the need for an expert to interpret and score results. HEE (2016b), however, stressed the importance of providing feedback sensitively, i.e., reports should provide feedback on traits *"fundamental to an individual's character",*

while best practice would be to ensure a trained individual interprets the results and gives feedback (HEE 2016b, p.11).

Nonetheless, and despite adhering to best practices in this study (see section 5.3.7), tensions were still evident in the student transcripts and involved the participants' perceptions of their report. Those who perceived their reports as indicative of a fail displayed disappointment, which affected confidence in their suitability to be a nurse. Meanwhile, those who deemed their reports a pass, thus endorsing their values and suitability to be a nurse, regarded the report as a *"confidence boost"*. Hence, reports were perceived as a symbol of either prestige or stigma which laid claims to their values (Goffman 1963, p.59). Hence, the report made *"visible"* the students' values, which Goffman described as their *"known-about-ness"* (Goffman 1963, pp.64-65). This labelled students as either possessing or not possessing the values required to be the nurse. Consequently, students willingness to share their report was dependent on how they perceived the report: Those who perceived their reports as a pass were willing to share their information, whereas those who perceived failure, were not. Thus the students controlled the information about their identity within patterns of *"revealing"* and *"concealing"* based on perceptions of pass or failure (Goffman 1963, p.134). Meanwhile, on the surface, this study's findings suggest that nurse candidates who underperformed during aptitude testing for self-selection would not apply to take nurse training because of their poor values profiles. Therefore, self-selection would perform as intended by eliminating candidates who did not emulate the values of the nurse early in the recruitment process. This could by default result in better care standards. Conversely, it must also be acknowledged that HEE (2016a) does not restrict the number of occasions a candidate can undergo testing to self-select, nor must candidates provide proof of undergoing aptitude testing for self-selection. This suggests that nurse candidates who use aptitude tests to self-select, like the NMBI self-assessment questionnaire (NMBI 2021), could become 'test savvy' as they continue to take testing until they receive a favourable result. In this vein, the SMCPC (2015) highlighted that psychometric testing tends to improve with performance and feedback, with many test providers external to universities providing opportunities for coaching. However, candidates from less privileged backgrounds may not be able to afford these services, so they would be disadvantaged (SMCPC 2015, p.38). HEE (2016b, p.11) also stated that using personality testing at the attraction stage of VBR, as well as encouraging honest and open responses by clarifying to the test-taker that the results are not used in the selection process, would encourage potential applicants to reflect on their suitability for the role. Interestingly, students in this study also referred to the report as a reflective tool in the context of learning and improving values. These findings are initially encouraging, as they suggest that nursing candidates would use their profiles as

intended, i.e., as a reflective tool on which to base their understanding and suitability for a nursing role. This also highlights that aptitude testing for self-selection potentially means candidates can learn how to negotiate the test, again emphasising the potential for value frameworks (see Table 1) to aid with pre-professional socialisation. As a consequence, candidates would be additionally prepared to present their values in line with those that fit the stereotypical norm. This aligns with social constructionism, as it suggests that candidates who engage with testing for self-selection would be cognisant of what are considered 'good' nursing values and their moral behaviour, i.e., their dilemmas and choices would be determined by the social structures of VBR (Burr 2015, p.218). Hence, as illustrated in section 7.4.2, candidates' motivation is driven by their desire to gain a place in university. However, the implication of reporting on candidates' values using an automated reporting mechanism as a component of aptitude testing as part of VBR is not represented within the VBR literature. Whilst these findings illuminate the topic area, given that HEE (2016a) recommends candidates self-select based on values and the potential for HEIs to develop and utilise online aptitude tests with inbuilt reporting mechanisms, this remains an area worthy of further review.

7.5 Summary

In this study, the students truly believed they possessed the values required for entry into nursing. They depicted caring and professional values as inventories of values embodying the attitudes and stereotypical behaviours of the nurse. This indicated that their personal nursing values were constructed and shaped by their exposure to high-profile value frameworks such as those illustrated within Table 1. As a result, students presented their personal values in line with the established and positive stereotypical image of the nurse. This suggests that high-profile value frameworks (Table 1) are the foundation for pre-professional socialisation as they influence candidates' behaviours during recruitment. Empathy was the predominant value that resonated within the students' concept of caring values. Students who associated empathy or empathetic behaviours as a nursing professional norm scored either in line with, or above, the group mean for person-centredness values. This suggests cohesion between cognitive empathy as a component of social cognition and empathy as a care value. Students also described the complexity of their values, whereby their perception of professional values was central to their presentation of the major aspects of professional nursing etiquette and standards.

This study also found that male students' meaning of caring leaned towards practical elements of care, focusing on the act and task of caring. Thus, male students generally performed less well than their female counterparts during testing, with items in the aptitude

tests leaning more towards feminist philosophies of caring and compassionate practice, i.e., social connectivity dimensions that include empathy and person-centredness domains. This study also found that knowledge and experience of carework gained before their studies, in addition to the nursing curriculum, influenced students' behaviour during testing and aptitude scores. Therefore, students with minimal or no carework experience performed poorly during testing, compared to their more experienced counterparts. By comparison, students who identified strongly with the moral images of the nurse, particularly those founded on familial and social relationships, performed well during testing. Nevertheless, students' aspirational values remained stable over time.

The students' social and cultural experience of care also highlighted values congruence and dissonance. Students perceived the realities of nursing practice as understaffed, pressured and time-limited. Thus, values dissonance occurred when students compared the accepted nursing values, i.e., the '*gold standard'* taught at university, to their lived experiences of care practices. Integrity was viewed as an essential component of caring when faced with the moral demands of carework, whereas courage when challenging observed poor care practices was viewed as aspirational by students. Thus, values conflict would have implications when testing for dispositional measures such as integrity and courage. Students described learning nursing values before their MMI in an attempt to perform well. Thus, students prepared for their MMI as if it were a performance of nursing values from which they received credit, i.e., gained entry to university. The findings of this study suggest that a combination of candidates' performance and observation of values, in addition to the wide availability of station content, calls into question the legitimacy of MMIs as a values assessment tool. Therefore, MMIs should continue to be an area for further review. Students' descriptions of their test experience suggested assessors were perceived as distant. As a result, students displayed the potential for nurse candidates to exhibit objective-driven behaviours during aptitude testing, in which honesty was circumvented due to the desire to obtain a university place. This study's findings also emphasise how students categorise and construct their nurse values depending on their chosen branch of nursing. Therefore, they differentiated between the beliefs, attributes, feelings and behaviours in the construct values statements. Terminology such as 'always' in the test was sited within the students' perceptions of knowledge and competence, which also influenced their behaviour during testing. Similarly, test anxiety affected students' performance during testing, which seemed to focus on the mathematical reasoning associated with Likert scales. The aptitude test reports also influenced students' confidence in their suitability to be a nurse. Reports were perceived as laying claims to values and thus labelling students as either having or not having the values to become a nurse. Likewise, students viewed their reports as a reflective

learning tool that they could utilise to improve values. This suggests nurse candidates who use aptitude tests to self-select could learn to negotiate aptitude tests and present their values in line with those that fit the stereotypical norm exemplified with value frameworks (see Table 1).

Chapter 8 - Conclusion and recommendations

*8.1 **Chapter overview***

This chapter provides a summary of the research and details the original contribution to the field of study. The study's strengths and limitations are outlined and the chapter concludes with recommendations for practice and areas of future research.

8.2 Study summary

This study sought to explore students' meaning of caring and professional values and the representation of these values through HEI VBR practices. To do this, ten newly recruited undergraduate student nurses took aptitude testing and interviews in a university setting between April and June of 2017. An idiographic appraisal of aptitude testing data as a measurement of caring and professional values, as well as IPA as an autobiographical account, were utilised in combination through IPA to explore the students' meanings of caring and professional values, that is, how these values were mediated through the language of aptitude testing and how the students compared their experiences of aptitude testing and MMIs. A social constructionism lens was employed as a framework to critique students' personal nursing values, the significance of these as an expression of their identity within their world of the nurse and how their values guide their beliefs and behaviour through VBR practices of aptitude testing and MMIs. Students were homogeneous in that all had experienced MMIs during their recruitment to nursing, while all were in the same cohort and thus at the same point in their nursing programmes. However, their age, gender and previous care work experience varied.

The use of IPA as a method in this study highlighted how students' constructed and presented their caring and professional values in line with the nursing norms evident in value frameworks they were exposed to during recruitment. Therefore, value frameworks were central to student pre-professionalisation. The findings also revealed a gender difference in the students' meanings of caring values. For male students, caring was a neutral term which aligned with duty rather than more feminine perspectives of morality. Nevertheless, empathy was the foremost caring value endorsed by the students, who believed this value was central to the nurses' caring *position*. Cognitive empathy was linked to social cognition as students conformed to the accepted standards and behaviours of the nurse. By comparison, affective empathy was associated with professional values, which were viewed as central to nursing etiquette and standards and thus the nurse's *manner*. Therefore, in combination, the students believed that empathy facilitated a closeness, which enabled the nurse to understand the patients' needs, as well as a distance, which aided resilience and protected

the nurses' emotional well-being. This suggested that emotional intelligence further emphasised a connectedness between empathy and social cognition as components of VBR.

The students' social and cultural experience of care also highlighted values dissonance when students compared the accepted nursing values, i.e., the '*gold standard'* taught at university, to their perceived perceptions of the realities of nursing practice, which was understaffed, pressured and time-limited. Thus, integrity was viewed as an essential component of the nurse's care practices when faced with the moral demands of care work. However, integrity and courage were challenged when the students observed poor care practices and the more knowledgeable other. Students considered that their aptitude test results were similar to exam scores, so their report indicated either a pass or a fail. Therefore, and as a consequence of this understanding, the use of automated reports as a component of aptitude testing for self-selection had consequences for students' self-esteem, social cognition and pre-professional socialisation, based on a level of salience and cohesion of identity with the nurse.

A combination of IPA and aptitude testing revealed that students who aligned their caring values towards cognitive empathy performed well in aptitude testing. Meanwhile, aptitude testing based on a feminine discourse of patient-centred caring meant male students performed poorly compared to their female counterparts. Also, despite students' beliefs that caring was an innate and authentic value which could not be taught, test scores and aspirant values on care and professional values increased after they had received teaching. The student linked this increase to pedagogy. The test data also exposed how students with less care experience tended to focus on the perceived challenges of nursing practice during the interview, which was also reflected in their test ratings. Therefore, such students underperformed in comparison to their experienced counterparts. Knowledge and experience were also significant influences on dispositional measures of integrity and courage during aptitude testing. Meanwhile, students' empathetic identification with the stereotypical images of the nurse (see values frameworks illustrate in Table 1), particularly those founded on familial and social relationships, also meant these students performed well during testing. Mental health student nurses, as a subgroup, highlighted the potential for value formation to be sited in the candidates' branch of nursing. This was a significant finding, considering that the care and professional value discourse was mediated within the aptitude tests values statements. Terms like 'always' within the aptitude test values statements also led to conflicting views, a context which guided how the students thought

and behaved during testing. Students' test anxiety linked to mathematical skills was also highlighted as affecting testing performance.

A combination of IPA and aptitude testing, viewed through a constructionist lens, illustrated a dichotomy between students' understanding of aptitude testing and MMIs when both were used as measurements of care and professional values. Students described the MMI as a performance of values, which was schooled, fabricated and constructed, so they could adopt the image of the nurse to benefit during the MMI. By comparison, students displayed objective-driven behaviours during aptitude testing, whereby personal values like honesty and integrity were circumvented in order to obtain their *"dream career".*

8.3 Quality and validity

Smith et al. (2009a) recommended Yardley's (2000) framework for demonstrating quality within an IPA study. Yardley (2015, p.269), in a more recent publication, outlined four broad principles for evaluating validity in qualitative research. These are presented below:

8.3.1 Sensitivity to context

Sensitivity to context was adhered to by presenting the data as ten individual cases. Thus, individual meaning was observed when reporting convergence and divergence in the students' meanings and experiences, as outlined in the study's findings and illustrated in chapter 6. Language use was a particular focus of the study in specifically highlighting the students' expression of caring and professional values in the context of their social and cultural experiences of care. Hence, the social constructivism lens facilitated a critical approach to the relatedness and construction of the students' caring and professional values and the causal effects of the reality of VBR, as illustrated in chapter 7.

8.3.2 Commitment to rigour

As I am a novice researcher, a commitment to rigour was maintained throughout this study by adhering to IPA principles. Rigour is also demonstrated through the idiographic analysis of student data (described in chapter 5 and presented as ten unique cases in chapter 6), in addition to an audit trail of quotes for each case (available in the appendices). However, it is acknowledged that the interpretations made are mine, so should the study be repeated in a different context at a different time, different interpretations could occur. Nevertheless, adherence to double hermeneutics within the context of IPA and the commitment to reflexivity evident throughout the thesis — specifically within the reflective accounts provided in appendices 10, 11 and 12 — serve to reduce researcher bias whilst enabling me to discuss my position and the influences of my 'fore-perceptions' in the study. Triangulation of

the data for this study also produced an enriched understanding of the students' meaning of caring and professional values in the context of aptitude testing and their experience of aptitude testing compared to MMIs. This also enhanced the analysis and validity of the study's findings.

8.3.3 Coherence and transparency

Coherence is evident through the methodological rigour of adhering to IPA and ISA rules (as outlined by Smith et al. (2009a) and Weinreich and Saunderson et al. (2003), in addition to the interconnection between the theoretical framework, methodology and methods outlined in chapters 4 and 5. Thus, the research question, aims, objectives and study outcomes are in alignment. Transparency is equally demonstrated through the presentation of the data in each student's case and theme development, as well as the frequency and audit trails of student quotes presented in chapter 6.

8.3.4 Impact and importance.

As illustrated by Yardley (2015, p.268), the point of conducting research is to potentially make a difference and have a direct practical or theoretical impact. Ideally, the findings are useful to practitioners, policy makers and the community and make a practical real-world change. As illustrated in chapter 7, the value of the research presented in this thesis has been clearly demonstrated. Consequently, the contributions of this study to the phenomenon of VBR — outlined in section 8.4 — are envisaged as enabling a better understanding of the causal effects generated by the actual reality of VBR and thereby influencing HEI VBR practices.

8.4 Study contributions

As outlined in the scoping review in Chapter 3, most VBR studies are either qualitative or quantitative designs, with the majority focusing on distal outcomes, i.e., the predictive nature of MMIs or aptitude testing as a measurement of students' future values. The use of IPA in conjunction with idiographic analysis of aptitude testing could be considered distinctive in both an IPA and VBR context. Until now, triangulation to combine the complimentary perspectives of empiricists (aptitude testing) and constructionist (interviews), whist staying grounded to an idiographic approach to analysis of aptitude testing data has not been undertaken within the UK VBR context. Thus little was previously known about the social and cultural construction of nurse students values and how these were represented within the language of aptitude tests as an assessment of values within the VBR context. Therefore a combined approach facilitated a comparison of the students *understanding* of their own personal care, professional and aspirational values and, on the other hand, those

values they *believed* embodied the 'model' nurse. This approach also identified how these differing perspectives influenced students' decision making during aptitude testing. These different perspectives also enabled an exploration of the students' experiences of VBR through the medium of aptitude testing and MMIs. Thus, the study was methodologically aligned with Heidegger's (2010) characterisations of human meaning-making as *Dasein,* in which experience comes into existence through things, people, language and culture, *"which is always in relation to something"* (Smith et al. 2009a, p.18; Tuffour 2017). In this respect, a particular strength of this study was the integration of the data to present ten unique cases, facilitating an examination of individual patterns of meaning that combined aptitude test scores and interview data. Thus, this study extends the existing knowledge of measuring values as part of VBR by looking beyond the traditional normative approach to measuring values and by exploring the measurement of values from a different perspective. It adopted a critical approach to VBR from a constructionism stance, as suggested by Gergen and Dixon-Roman (2013), in highlighting that some viewed the measurement of values through aptitude testing as objective, while others regarded it as prejudicial.

Initially, the study's findings suggested empathy as a valid dispositional measure within the context of VBR. However, this study has also clearly evidenced a link between value frameworks as a factor of pre-professionalisation and empathy as a component of social cognition and emotional intelligence. Therefore, candidates were clear about the caring and professional values they needed to display during VBR in order to successfully achieve their desired outcome: gaining a university place. This was evident in the students' VBR experiences of MMIs and aptitude testing, as outlined in sections 7.4.1 and 7.4.2, in which MMIs were a performance of constructed values, and values were sidestepped in the objective-driven behaviours displayed during aptitude testing in order to obtain a *"dream career".* Thus, a cautious recommendation of this study would be a change in HEIs perceptions regarding what MMIs and aptitude testing can offer HEIs in the context of VBR. It is suggested that rather than HEIs adopting the position that MMIs and aptitude testing are authentic measurements of values, a pragmatic view would be for HEIs to select candidates on values congruence with nursing stereotypical norms embedded within value frameworks (exemplified in Table 1) that meet the needs of the profession, the public and employers. Therefore, HEIs would be adopting the stance that MMIs and aptitude testing can provide an *understanding* of what candidates *believe* are the values needed by the professional, rather than an authentic measurement. Consequently, HEIs could develop and enhance the candidates' values as they transition to become student nurses through the curriculum. Thus these VBR practices would explore the nurse candidates' understanding of the values required to function as a modern nurse, with all the pressures and moral challenges that this

environment brings. Therefore HEI would take the position of managing risks and providing support to students as opposed to pass/fail contingencies. Thus acknowledging the role of pedagogy and how it influences students understanding and perceptions of good nursing values.

Further significant findings of this study were the important distinction between students' caring values across genders and how gender is represented in values testing within the context of VBR. These findings suggest that HEI VBR practices, currently based on a historically feminist perspective of nursing, must be refocused to encompass contemporary perspectives of nursing in the contemporary practice contexts of gender, pressure and moral obligations. These findings may also have a potential impact on other professions in which groups are measured against the same standards.

The use of VBRFs (HEE 2016a), as a direct result of Francis (2013) and conflating policies such as the Cavendish (2013) review, suggest that during aptitude testing, more mature candidates with carework experience would outperform younger nurse candidates and those with little or no experience. Thus, these findings provisionally suggest that if HEIs adopt aptitude testing as a VBR practice, the number of students with extensive care experience but with low academic ability may rise significantly. This would put additional pressure on universities to provide academic support for these candidates or potentially face a growth in attrition rates among students who cannot achieve the entry requirements of a course.

The findings of this study also highlight that candidates' dispositional measures, such as courage and integrity, were affected by values dissonance due to the perspectives taken during aptitude testing, i.e., their social and cultural experiences of care practices. This indicates the complexity of rating construct values statements as part of aptitude testing for values. These findings cautiously suggest that using low scores as a screening mechanism is for aptitude testing is a blunt tool. Meanwhile, an idiographic approach to aptitude testing, as evidenced in chapters 6 and 7, has value as a gateway for further discussion on candidates values, as values dissonance (i.e., low scores) can reveal just as much about candidates' social and cultural meaning of the caring and professional values that sit behind their aptitude test scores.

8.5 Study limitations

Being a novice researcher is acknowledged to be one of the most significant limitations of this study. My inexperience might have meant that I occasionally missed subjects that surfaced during interviews which were worthy of further exploration. Furthermore, the

interviews took place over a short duration so whilst I did reflect on my interview technique (see Appendix 11), this might have been improved if there had been more time between interviews.

Whilst the sample size was appropriate for the study, it is acknowledged that this could be considered 'top end' in terms of size for a doctoral IPA study (Smith et al. 2009a). As such, adhering to the thesis word limit was a particular challenge. It is also acknowledged that the interpretive analysis of the testing data from such a small sample has its limitations. Therefore, there is scope for this study to be repeated with a larger sample to further delineate any potential issues for aptitude testing within subgroups.

It is also acknowledged that student paediatric nurses were not represented in the sample as the paediatric nurse programme only runs with the September intake. However, this cohort was considered appropriate for two key reasons. Francis' (2013) recommendation for aptitude testing to be used as a recruitment tool for student nurses to assess their caring and professional values was not apportioned to any specific branch of nursing. All data was collected before any specific branch training, ensuring there was no specific curriculum input relating to a particular patient group. However, a further recommendation would be to explore caring and professional values in the context of VBR from the perspective of the paediatric nurse subgroup.

As illustrated in Chapter 5 (section 5.2), it is also acknowledged that the sample, whilst representing what could be considered as a traditional student nurse cohort within a Welsh university setting, does not reflect the national demographics and diversity of the student nurse body across the UK. Therefore, the sample may not be considered as fully representing the Black, Asian and minority ethnic (BAME) student nurse communities and, a further recommendation from this study, would be to explore caring and professional values in the context of VBR from the student nurse perspective.

The sample was also not representative of lesbian, gay, bisexual, transgender or queer (LGBTQ) nursing students' cultural views of values. Interestingly though, the demographic data provided by the school only recorded students as either male or female. Therefore, this could not be accounted for in the random selection of participants for this study. However, students were given the opportunity to provide this information, should they wish to disclose it, when the demographic data was collected. Nonetheless, all participants identified as either male or female. Therefore, a recommendation of this study would be to explore the

phenomenon of VBR from the perspective of the LGBTQ student nurse community as a subgroup.

It is also acknowledged that all participants had been successfully recruited to their programme of study so the views of those who were unsuccessful are also unknown. Therefore, a further recommendation would be to explore the opinions of candidates not successfully recruited to the nurse programme.

8.6 Recommendations for further research

Whilst acknowledging the study's potential limitations, several recommendations have been highlighted by the study's outcomes. This study has established a link between value frameworks as a component of VBR and students' pre-professional identity, which influenced their performance during recruitment. However, little is known about value frameworks as a mechanism of pre-professional socialisation for nurse candidates during VBR recruitment, which suggests a noteworthy area for further review.

Further examination of how, for example, particular branches of nursing, ethnicity, testing anxiety, dyscalculia and socio-economic structures were influential as determinants of nurse candidates' performance during aptitude testing may provide further insights that contribute to HEI VBR practices.

Given HEE's (2016a) suggestion that aptitude testing is used for candidates' self-selection, the students' perceptions of their reports in this study were particularly enlightening. They serve to emphasise that using automatically generated reports as a component of aptitude tests has potentially wider ramifications, i.e., negative effects on self-esteem, with multiple attempts at testing suggesting applicants could become 'test savvy'. Thus, the development and utilisation of online aptitude testing with inbuilt reporting mechanisms as a method for nurse candidates to self-select on values remains an area that warrants further review.

8.7 Implications for HEIs VBR practices

As a result of this study's finding, there are several topics for HEIs to consider within their VBR policies and practices which are outlined below:

- HEIs need to recognise the duality of empathy as a) a dispositional measure for the resilient and caring, compassionate practitioner and b) the relationship of empathy to social cognition and emotional intelligence – i.e., the candidates ability to manage self

and others within the context of objective/goal driven behaviours for credit when undergoing VBR practices of AT and MMIs.

- HEIs should consider the potential for MMI station content to be vulnerable to compromise.

- HEIs should recognise the influence of gender as a key determinant during aptitude testing as a VBR method. It is suggested that HEIs look towards the value frameworks utilised within their recruitment practices to ensure the male nurse candidates way of demonstrating care is reflected within aptitude testing.

- HEIs need to be sensitive to the influence and impact of the candidates perceived knowledge, experience, confidence and context on the measurement of nursing care and professional values during aptitude testing for VBR.

- HEIs should be sensitive to the influence and impact of automated reporting of aptitude testing results when used for self-selection. i.e., this study's finding highlights the potential for poor profiles to affect candidates self-esteem.

- HEIs should consider restricting the number of attempts candidates can undertake aptitude testing when used for self-selection. It is also suggested that candidates provide proof of aptitude testing results when utilised for self-selection, in an attempt to a) prevent multiple test taking by candidates until they receive a favourable result and b) inform the interview process.

Chapter 9 - Epilogue

All the world's a stage
And all the men and women are merely players
They all have their exits and entrances
One man in his time plays many parts

As You Like It, by William Shakespeare

Since starting my doctoral journey, life has not stood back and waited patiently for me to finish my endeavours. My journey has been a tempestuous one, so writing these last few words has great personal significance. Nonetheless, it has always been a joke between my family and friends that the only reason I have completed my doctoral studies is to hear *"Dr Milton, can you please come and collect your handbag from reception?"* Whilst on the surface this might seem quite frivolous, I have come to understand the deeper meaning of my metaphorical 'handbag' within the context of my thesis.

In this vein, to finish, I will return to the beginning. To recap, the seeds of this thesis grew from wanting to understand the meaning of caring and professional values in the world of the nurse and the role of aptitude testing as a measure of values within VBR. Through my thesis, I have come to understand how inextricably linked caring and compassionate values are to the professional identity of the nurse and how the historical influence of gender has coloured the professional and public perception of what a good nurse *is*. Hence, the constructed nature of the students' values was abundantly clear throughout this study, based as they were on the students' social and cultural experiences of care practices before their training. This further influenced their behaviour during aptitude testing. Hence, I am drawn to the words of Shakespeare's monologue, commonly known as 'The Seven Ages of Man' because, like the students in my study, I can see how that too refers to the caring ODP and I constructed my values in tune with the social and culturally excepted view of the theatre practitioner. Thus, my values are presented in the way I have wanted to be viewed by my colleagues, patients and students. Consequently, taking my doctorate could also be viewed as another way to present myself as the archetypal image of the university lecturer, thus proving I have the aptitude to *be*.

In conclusion, I am again drawn to Shakespeare's words, as he ends his monologue by describing the ageing decline of man:

Sans teeth, sans eyes, sans taste, sans everything

Sans translated from the French means ‘without’. *Sans Everything: a Case to Answer*, written by Barbra Robb in 1967, was an exposé of the inadequate and inhumane treatment of elderly patients which prompted a nationwide scandal (Robb 1967). *Sans Everything* is considered the forerunner of many inquiries into patient safety since the establishment of the NHS, a process which has not ended with Francis (2013) (Sirrs 2021). Thus, Shakespeare’s monologue brings us full circle, as it questions whether candidates who play parts during recruitment are ‘without’ values. In this vein, I return to the words of Dahl and Hofert as, from a constructionism stance, if value frameworks establish the cultural and socially shared language of caring and professional values, they carry explicit and implicit values or desired goals (Gergen and Dixon-Roman 2013). This ultimately questions what we expect from our candidates during recruitment in terms of values, honesty or conformity. Thus, a question remains concerning which measure of values we can *believe* when recruiting nurse candidates, whose desire is inextricably linked to their motivation to achieve a university place and thus their *“dream career”*.

Sine metu neque gratiam

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Appendix 1 *Nurse Match Agreement Form*

26th November 2015

Sherran Milton
Lecturer
School of Healthcare Sciences
Cardiff University
Eastgate House, Rm 609, 6th Floor
Newport Road
Cardiff CF24 0AB

Dear Sherran,

Further to our discussions earlier this week, I am writing to confirm our agreement to provide you with access to our 'Nurse Match VBR tool' for the purposes of undertaking your PhD study.

In doing so, Identity Exploration Ltd asserts all rights to the 'Nurse Match VBR tool' and its content. This tool must be used solely for the purpose of your PhD studies and should not be used by Cardiff University or any other institution for recruitment or any other function.

We would also ask that you acknowledge Identity Exploration Ltd as the IPR holder of the tool in your PhD thesis and any other publications that emerge from your research. If considered useful or relevant from your end, some of our team may also be able to contribute to the development of publications from this work.

We are very pleased that you have selected this tool as part of your PhD research and we will provide all possible assistance to you to ensure that you can complete your research in good order. This will include providing online access to the tool, something that we usually make a charge for.

Please read and sign the attached as acknowledgement of the above.

Best regards,

Allen Erskine

Director

Agreement regarding the use of the 'Nurse Match VBR Tool' by Sherran Milton for PhD research

I, Sherran Milton, acknowledge the ownership by Identity Exploration Limited of the Intellectual Property of the 'Nurse Match VBR Tool'. I agree that I will use this tool solely for the purposes of my PhD research and that myself and Cardiff University will not use the tool for any other purpose.

I also agree to acknowledge Identity Exploration Limited as the owner of the tool in my PhD thesis and any associated publication with which I am involved.

Signature:

Print name: SHERRAN MILTON

Date: 09.12.15

Appendix 2 *Interview schedule*

Objectives	Questions	Corresponding NMI value theme
Explore, through interviews, the participants' meaning-making of care and professional values. (Objective 3).	**Caring professional values and perceived identity** 1. What does caring mean to you? 2. What do professional values mean to you?	**Person centredness** **Accountability**
Prompt question	*How do you see yourself in terms of being caring?* *How do you think other people see you?* *It's suggested that as a nurse you should be caring and compassionate. What do you think about that?*	
To investigate the participants views on the caring values, professional values and identity constructs identified through their aptitude tests. (Objective 2).	**Constructs and personal identity perceptions around the tests** 3. What were your thoughts about your ratings? 4. What were your thoughts when you rated the model nurse? 5. What do you think accounted for the differences between your responses to test 1 in comparison to test 2	**All value themes**
Prompt question	*How did the results make you feel?* *Do the results have any meaning for you?* *How do you see yourself in terms of the results?* *How do you consider yourself/group/profession in terms of the results?* *Will you share your results? If so who with?* *Do you think these results will have any impact on your future performance?*	
Explore the participants experience of undertaking aptitude testing. (Objective 4).	**Lived experience of the tests** 6. Reflecting on your experience of undertaking aptitude testing for nursing values. Can you tell me a little bit about your perceptions?	**Trust** **Integrity**
Prompt question	*How did you feel when you were completing the tests?* *What did you think/feel as you were responding to the tests?* *How do you feel about the test results being used as part of recruitment?*	
Explore the participants experience of MMI. (Objective 4).	**Subjective experience of MMIs** 7. Reflecting back on your recruitment experience of undertaking MMIs. Can you tell me a little bit about your views?	**Trust** **Integrity** **Person centredness** **Accountability**
Prompt question	*What do you understand about value-based recruitment?* *Reflecting on your experiences of the MMI and the tests, do you think they identified your caring values and professional values?*	

Appendix 3 Notes on contextualisation of the Nurse Match Instrument

From: Sherran Milton [redacted]
Sent: 27 November 2015 09:51
To: Allen Erskine <redacted>
Subject: Nurse Match Instrument

Hi Allen

I've completed the nurse match instrument so ready for the report when you are.

Here is a bit of feedback as requested.

Took me about 45 mins but that was with me making notes as I went along.

I felt it was missing a bit of an introduction/explanation of what to expect from the test e..g comprises of so many sections x amount of questions in each section, answer honestly, should take you about 30 mins to complete that kind of stuff.. Also it might be a good idea to let the user know that they can change their responses if they require...

You might need to consider if you are aiming this to the VBR market most healthcare applicants are in the 17-25 years old bracket and might not necessarily been exposed to the health care environment so a little explanation about how the test taker needs to respond in relation to questions about how a ward sister might think. i.e. if you have not worked in healthcare respond to the questions as what you feel an ideal senior practitioner would be.... this might be the same for medical teams and could just refer to teamwork.

Another thing about this age group best friends might not be nurses.. So again may be this needs to be defined or explained.. a close working colleague maybe??

And also you talk about parent, sorry PC head on now, how about those who come from care? Contextual admissions is a significant driver for universities I suggest this is something you might need to look at.

Thinking about longevity/durability/applicability.
Language that is used if you wanted to make the instrument applicable across all professions and again thinking about VBR from a university perspective..... Making it applicable to all applicant to healthcare programs and not just nursing.. Changing ward sister to team leader and nurse to practitioner.. or having a couple of versions were one is nurse specific and one could be allied health specific. Operating Department Practitioners (ODPs and you don't have them in Ireland) by the way are kind of insider outsiders when it comes to nursing as we work closely with our nursing colleagues in theatre/critical care even though we are allied health so that might also be a consideration....

Page 2 When you talk about kindness compassion and sympathy are these related to any of the key drivers i.e. the NHS constitution and how a practitioner should look, 6 C's from nursing ext... only I found this interesting especially as you were missing conscientiousness which has links to the big 5 and also has been linked to academic achievement so again the universities might be interested in this .. especially Russel Group
Page 4 - made me smile - polar – I'm risk adverse!
Page 5 - found interesting – again polar innate values..
Page 7 - for the miss understanding situations question... I found the words general and sometimes too much alike so had difficulty... were as frequent and often gives a wider margin.. hope this makes sense.
Page 15 - I would not say a patient enjoys making a decision about their care but I would say prefer to help make decisions..
Page 20 Q4 - this question stuck out to me... why would you challenge a senior person at home about a patients care? Especially as this questionnaire is aimed at nurses who are currently in the working environment I would suggest they wouldn't.. Because of patient dignity, data protection.. so this

question might not give you the answer your expecting.. I might have the wrong end of the stick here...

Anyway hope this helps as feedback from the questionnaire.

My sample group will be student nurses working in the clinical environment so I think the Nurse Match suits my purpose.

I know you said there might be an opportunity to adjust the instrument slightly. I would like to add a final page if I could invite my applicant to the next stage of the research. It would simply be a request to supply an email address if they would like to take part in the interview stage would this be possible??? and maybe reflect some of the points above??

I'm currently doing my background on the theories underpinning the Nurse Match and seeing how they map to the NHS constitution and the 6'c. I'm not fully versed in Kelly, Fransella etc as my reading has been more about Goffman and Becker.. but it all seems to tie in and I can see my "thread".

Look forward to the report.. I think? It makes me feel quite anxious ... which again reaffirms my research so happy days

Shez

Sherran Milton
Lecturer

Darlithydd

School of Healthcare Sciences
Eastgate House, Rm 609, 6th Floor
Newport Road
Cardiff
CF24 0AB

Ysgol y Gwyddorau Gofal Iechyd
Tŷ Eastgate, Rm 605, 6th eg Llawr
Ffordd Casnewydd
Caerdydd CF24 0AB

Email/Ebost: [redacted]

☎ xxxx xxxxx

Appendix 4 Email invitation to participate in study

Re: Invitation to take part in research - Sherran Milton

To Sherran Milton

You replied to this message on 30/03/2017 11:21.

Action Items

Thank you once again for taking your time to listen to my presentation today and volunteering to take part in my thesis research.

If you could once again read through the invitation letter and participant information sheet I have attached to the email to make sure you are still happy taking part in the research.

If you are willing to proceed could send me a quick email to confirm your attendance on the dates below to undertake the tests I would be most grateful.

I have checked your timetable and there should not be any clashes with your teaching and I will send you a quick reminder closer to the time...

- The 1st questionnaire will take place at **1.30 on the 12th of April 2017** in the small IT room at the Cochran (Health) Library on the Heath Park Campus.
- The second questionnaire will take place at either **1.30 or 3.30 on the 8th of May 2017** in Rm 1.23 Ty Dewi Sant.

Once again thanks in advance and I look forward to seeing you on the 12th.

Best wishes, Shez

Sherran Milton
Lecturer
School of Healthcare Sciences
Eastgate House, Rm 609, 6th Floor
Newport Road
Cardiff
CF24 0AB

Darlithydd
Ysgol y Gwyddorau Gofal Iechyd
Tŷ Eastgate, Rm 605, 6th eg Llawr
Ffordd Casnewydd
Caerdydd CF24 0AB

Email/Ebost:

<Invitation and information sheet 29 03 17.docx>

Appendix 5 Invitation letter

Sherran Milton
Lecturer
School of Healthcare Sciences
Eastgate House, Rm 609, 6th Floor
Newport Road
Cardiff
CF24 0AB

Date 29th March 2017

Dear Student

First let me congratulate you on starting your undergraduate degree programme. My name is Sherran Milton and I am a lecturer in the School of Healthcare Sciences. I am currently undertaking research exploring care and professional values in our undergraduate students and would like to extend an invitation for you to take part.

The research consists of two on-line questionnaires and an interview.

- The 1st questionnaire will take place at **1.30 on the 12th of April 2017** in the small IT room at the Cochran (Health) Library on the Heath Park Campus.
- The second questionnaire will take place at either **1.30 or 3.30 on the 8th of May 2017** in Rm 1.23 Ty Dew Sant.
- The interview will be arranged at a date and time that is convenient to you

The on-line questionnaires should take no more than 30 mins to complete. However there is plenty of time is available for you to undertake the questionnaires and there is no time limit, so you can take as long as you require.

Once the questionnaires have been undertaken the results will be sent to you in the form of two separate reports which will form the basis of your interview. The interviews will be in the interview rooms within the Caerleon Suit in Ty Dewi Sant at a date and time convenient to you after the questionnaires.

The results of your questionnaires **will not** be made known to anybody other than me and my supervisors and only be used for my research. In line with Cardiff University requirements, the completed questionnaires and interviews will be stored on the universities server and destroyed after five years.

If you are happy to take part in the research, please could you attend the small IT room in the Cochran (Health) Library on the Heath Park Campus at **1.30 on the 12th of April 2017.** Then Rm 1.23 (Computer lab) in Ty Dewi Sant at either **1.30 or 3.30 on the 8th of May 2017**.

Thank you for taking the time to read my invitation and I hope you agree to participate in this research.

Yours sincerely
Sherran Milton
Email: [redacted]
Tel no: xxxx xxxxx

Appendix 6 Participant information sheet

Participant information sheet

1. Study title

An interpretive phenomenological analysis exploring value-based recruitment through the students' personal meaning of care and professional values.

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part.

Thank you for taking the time to read the information leaflet.

3. What is the purpose of the study?

The study will last about two years and will have two parts: two online questionnaires and one interview.

The questionnaires are to determine what your care and professional values are. This is through two psychometric tests: the Nurse Match Instrument and the Nurse Match Instrument (selection). The results of the questionnaires will be used to explore which care and professional values you consider are needed to be a nurse, if you agree with your test results, how you felt about taking the test and what difference it made to you.

4. Why have I been chosen?

Twenty students will be randomly chosen who represent different qualities such as age and gender. If you are chosen you will be contacted by me via email and invited to undertake the two tests on the 12th of April and the 8th of May 2017

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part all you need to do is attend the small IT room at the Cochran (Health) Library on the Heath Park Campus at **1.30 on the 12th of April 2017** to undertake the first questionnaire and then Rm 1.23 Ty Dewi Sant at either **1.30 or 3.30 on the 8th of May 2017** for the second questionnaire.

A convenient date and time will be arranged with you after the test for your interview, which will take place within the Caerleon Suit in Ty Dewi Sant.

If you decide to take part, you are still free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part?

If you decide to take part, you will need to attend the small IT room at the Cochran (Health) Library on the Heath Park Campus at **1.30 on the 12th of April 2017** to undertake the first questionnaire and then Rm 1.23 Ty Dewi Sant at either **1.30 or 3.30 on the 8th of May 2017** for the second questionnaire.

Once you have completed both the questionnaires, I will send you your individual reports. Once you have received your reports and had time to read them I will contact you directly

with a convenient time and date for your interview. The interview will take place in Ty Dewi Sant, Caerleon Suit, interview rooms.

The interviews will be audio recorded and transcripts will be made by me.

If you decide not to take part, it will not affect your teaching.

7. What about confidentiality?

All questionnaire results, interview transcripts and recordings will be stored on my personal university server space, ensuring secure storage, protecting your anonymity and confidentiality in accordance with the Data Protection Act (1998). Data from the project will be stored for a period of five years or two years post-publication, with destruction of the records taking place under a supervisor's authorisation and in a confidential manner.

I will emphasise again that you can withdraw at any time during data collection and up to the time that publication takes place; all you need to do is contact me.

8. What do I have to do?
If you wish to take part in my research all you need to do is respond to the email invitation confirming that you will attend the small IT room at the Cochran (Health) Library on the Heath Park Campus at **1.30 on the 12th of April 2017** to undertake the first questionnaire and then Rm 1.23 Ty Dewi Sant at either **1.30 or 3.30 on the 8th of May 2017** for the second questionnaire.

A convenient date and time will be arranged with you after the test for your interview. The interviews will take part in the interview rooms within the Caerleon Suit in Ty Dewi Sant.

9. Are there any risks?
As the questionnaire results and interview materials are stored within a database that only I have access to, there is no risk that your results will be made available to anybody other than me and my supervisors.

10. What will happen to the results of the research study?
It is hoped that the results of the study will help to inform future admissions for the university and will be published within three years of the study ending. You will not be identified in any report/publication.

11. Who is organising and funding the research?

The research is organised by the university and is my final thesis for my Professional Doctorate studies. There is no funding allocated to the research.

12. Contact for Further Information

Sherran Milton

Email; [redacted]

Tel no: xxxxx xxxxxx

Appendix 7 Demographic questionnaire

Please place your unique identifyer code in the box below

Please tick or complete the appropriate box

1. Which nursing programme are you undertaking?

   Adult Nursing ☐
   Mental Health nursing ☐

2. What is your age?

3. What is your gender?

   Male ☐
   Female ☐
   Rather not say ☐
   Other ☐

4. What is your ethnicity? (Please state in the box below)
   White ☐
   Black ☐
   Asian ☐
   Mixed ☐
   Chinese ☐
   Other ☐

5. Did you tick any of the following on your application form?

   Contextual admissions* ☐

   Dyslexia ☐

   Dyscalculia ☐

* **Contextual admissions** is a term used to describe the use of additional information, including school performance data and socio-economic markers, to provide **context** for individual applicants' university applications and achievement.

6. What is the highest level of education you have completed?
   - CSE ☐
   - O Level ☐
   - GCSE ☐
   - A Level ☐
   - Bachelor's degree ☐
   - Master's degree ☐
   - Doctoral degree ☐

7. How many children do you have?

   - None ☐
   - One ☐
   - Two ☐
   - Three ☐
   - Four ☐
   - More than four ☐

8. What is your post code?

   ☐

Appendix 8 *Participant Consent Form*

Title of Study: An interpretive phenomenological analysis exploring value-based recruitment through the students' personal meaning of care and professional values.

Name of Researcher: Sherran Milton

Please initial box

I confirm I have read and understood the participant information sheet dated 29th of March 2017 for the above study and have had the opportunity to consider the information, to ask questions and to have these answered.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, this will not affect how I am treated in any way.	☐
I understand that all information about me will be kept in a confidential way and destroyed once the study is completed.	☐
I agree to take part in this study.	☐

Name of subject…….. ……..

Signature ……..……... Date ……..

Name of Witness (Researcher) ……

Signature ……..….. Date ……..

Appendix 9 NMIST and NMI instruments

The NMIST and NMI instruments are designed to measure and explore identities of nurses, nursing students and applicant to nursing programmes (Ellis et al. 2015) in particular they score applicants on their personal nursing values against professional values. Therefore, the elements under examination by the NMIST and NMI are personal nursing values and professional values deemed relevant to the nursing profession. The nursing values and attributes within the tests are called constructs. Both the NMIST and NMI have 20 constructs on a 9 point Likert scale + 4 - -4 with a 0 mid-point. Constructs are presented as a choice between two alternative interpretations of the nursing aptitude or value - described as poles as illustrated in Figure 1. One pole is the professionally preferred pole (4 to 1) and the other less so (-1 to -4). A score of 1 being a weak score - closest to 0 - with 4 being a strong score. As both tests have been developed the constructs have changed slightly over time as illustrated in Ellis et al. (2015), Hogart and Ellis (2016), Mazhindu et al (2016). The constructs under review within the tests at the time of the study is given in Tables 4 and 5.

Figure 1 Exemplar of Nurse Match Instrument Screening Tool and Nurse Match Instrument construct rating and pole

Constructs are also clustered together into six 'value themes' – person-centredness, accountability, trust, integrity, personal development and teamwork. The value themes can be described as superordinate themes with a clusters of subordinate constructs - specific values and attributes - embedded within each theme, illustrated in Table 1. The value themes are based on the Northern Ireland Practice and Education Council (NIPEC) attributes and value themes for a career in nursing (NIPEC 2014) and are reflective of the 6Cs (DoH 2012) (Table 2).

Table 1 Nurse Match Instrument Value themes

Value theme	Embedded construct by number
Personal centeredness	1, 2, 5, 7, 9, 14, 15, and 20
Accountability	1, 2, 3,5, 8, 9, 10, 11, 12, 13, 16, 17, 18 and 19
Trust	1, 2, 12, 13, 16, and 17
Integrity	8, 10, 13, 16, and 17
Commitment to personal development	6, 11, 12 and 19
Teamwork	3, 4, 14, 15, 16, 17, 18, 19, and 20

Table 2 Northern Ireland Practice and Education Council (NIPEC) attributes and value themes for a career in nursing

	Person-Centredness	Commitment to Personal Development	Accountability	Integrity	Trustworthy
Attributes	self-awareness understanding openness interpersonal communication skills including listening considerate collaborative concern for others emotional intelligence care and compassion empathy intuitive respectful awareness of perceptions of others	self-awareness commitment reflective willingness to learn and develop perseverance self-confidence desire for self-improvement	self-awareness responsibility taken for actions and decisions truthful self-confidence prioritise and manage time interpersonal communication skills situational awareness conscientious self-reliance	transparency honesty understanding sincere courage to challenge	self awareness respectfulness interpersonal communication skills including listening emotional intelligence reliability self-discipline

Participants who complete the instrument, take on the guise of a noted entity such as real work-self, ideal-self or, people from the workplace/home context (such as model nurse, bad nurse) (see Table 3) - and rate constructs on the bipolar scale.

Table 3 Nurse Match Instrument Screening Tool and Nurse Match Instrument entities

Entities	
Ideal self	Disliked person
Work self	Model nurse
Home self	Ward sister
Under pressure	Patient
Two years ago	Bad nurse
Five years' time	Best friend
	Parent

Table 4 Nurse Match Instrument Screening Tool (NMIST) constructs.

Construct	Preferred pole	Opposing pole
1	**Peoples** dignity and human rights always come first	Sometimes the need for help comes before **people's** dignity and human rights always come first
2	Safety of **people** in the **workplace** must come before anything else	Realistically safety at work may suffer as a result of pressures on staff and **work** resources
3	Routine and unpleasant tasks are part of everyday life at **work**	Routine and unpleasant tasks are the responsibility of those less well paid
4	**People** work best when working closely with others in a **team**	**People** work best when individual competence, character and decision making is encouraged
5	Can influence **people** and get them to follow instructions	Finds it hard to influence **people** and get them to follow instructions
6	Learning and developing competencies should be a lifelong process for **all staff**	Learning and developing competencies is mainly for new workers, **qualified people** deliver goods and services
7	Can listen carefully and tune into what people mean	Finds listening a distraction and prefers to get on with the job
8	Better to be open and honest in everything that you do	Sometimes its wiser to manage the truth in the best interest of all concerned
9	Resource constraints at work are no excuse for a lack of kindness and sympathy	Accept that work pressures can leave les room for kindness and sympathy
10	One should be prepared to challenge someone more senior if it is felt to be in the best interest of work	Should not challenge someone more senior under any circumstances
11	Enjoys making the decision within their area of competence	In a shared area of competence sometimes prefers other person to take decision
12	Owns their work and takes personal responsibility for their judgments and actions	Adhered strictly to guidelines and instructions which are at fault if things go wrong
13	One should take the time necessary to do a job properly	One must be quick and do the best one can in the time available
14	Is a good communicator and easily understood	Is not a good communicator, often misunderstood
15	Relates well to others	Often misunderstands others and has a problem relating to them
16	Can be relied upon	The real world can effect reliability
17	Works best with minimal supervision	Works best when managed by others
18	Generally understands the situation	Sometimes misunderstands the situation
19	Often pauses to reflect on how things have gone	Rarely takes time to reflect on how things have gone
20	Is always thinking about the other person	Focuses on their own needs and priorities

Table 5 Nurse Match Instrument (NMI) constructs

Construct	Preferred pole	Opposing pole
1	**Patients** dignity and human rights always come first	Sometimes **medical care** comes before **patients** dignity and human rights
2	Safety of **patients** must come before anything else	Realistically **patients** safety at work may suffer as a result of pressures on staff and **hospital** resources
3	Routine and unpleasant tasks are part of everyday role of all **nurses**	Routine and unpleasant tasks should normally be the responsibility of those **less skilled nurses**
4	**Nurses** work best when working closely with others in a **medical team**	**Nurses** work best when individual competence, character and decision making is encouraged
5	Can influence people and get them to follow instructions	Finds it hard to influence people and get them to follow instructions
6	Learning and developing competencies should be a lifelong process for **all nurses**	Learning and developing competencies is mainly for **student nurses**, **qualified nurses mainly** deliver **nursing care**
7	Can listen carefully and tune into what people mean	Finds listening a distraction and prefers to get on with the job
8	Better for a **nurse** to be open and honest in all things	Sometimes its wiser to manage the truth in the best interest of all concerned
9	Resource constraints at work are no excuse for a lack of kindness, **compassion,** and sympathy	Accept that work pressures can leave les room for kindness, **compassion,** and sympathy
10	One should be prepared to challenge someone more senior if it is felt to be in the best interest of the **patient**	Should not challenge someone more senior under any circumstances
11	Enjoys making the decision within their area of competence	In a shared area of competence sometimes prefers other person to take decision
12	Owns their work and takes personal responsibility for their judgments and actions	Adhered strictly to guidelines and instructions which are at fault if things go wrong
13	One should take the time necessary to do a job properly	One must be quick and do the best one can in the time available
14	Is a good communicator and easily understood	Is not a good communicator, often misunderstood
15	Relates well to others	Often misunderstands others and has a problem relating to them
16	Can be relied upon	The real world can effect reliability
17	Works best with minimal supervision	Works best when managed by others
18	Generally understands the situation	Sometimes misunderstands the situation
19	Often pauses to reflect on how things have gone	Rarely takes time to reflect on how things have gone
20	Is always thinking about the other person	Focuses on their own needs and priorities

Appendix 10 Reflections on the test data collection

While participants were in the test environment, it was interesting to note that many were keen to share their experiences and seemed concerned to meet 'performance' expectations. Before starting the NMIST, one participant said, "*Don't tell me if it doesn't say anything nice*", whilst another stated, "*I hope I've given you the right answers*". Both these responses to the test environment suggested tension when making their choices during the test. Despite being familiar with aptitude tests both as a consumer and a participant, I shared these anxieties that I would also be found to be uncaring. I commented on my anxiety after taking the NMI when assessing its suitability for the study (Appendix 3). I considered that a disclosure of uncaring attributes would be exposed by the NMI and discredit me as a healthcare professional, stigmatising me as different to the professional norm. Goffman (1963) discussed stigma and spoilt identity, emphasising the stigmatised individual's double perspective of stigma, i.e., whether their difference is known or unknown. *"Blemishes of character"* are considered undesirable in both a personal and professional context (Goffman 1963, p.14). Goffman (1963, p.135) discussed a code of conduct advocated by societal rules which provides instructions on how to treat others and attitudes, as well as a political platform, which I considered reflective of the professional codes of conduct (HCPC 2016; NMC 2018b). Goffman's work resonated with my feeling of anxiety; if found uncaring, would my stigma be known? As such, I was conscious of my fore-conceptions and my insider/outsider status as I engaged with the students' transcripts. I considered my insider status to be that of a healthcare professional and a consumer of psychometric testing. I saw myself as a caring and compassionate Operating Department Practitioner (ODP). However, as I am not a nurse, my outsider status resulted in a naive stance of observation and meaning-making of the nursing profession. As I thought more about what values underpinned the caring and compassionate practitioner I reflected on the background of my thesis and the value statement explicit within the frameworks illustrated in Table 1. I considered the values that underpinned the caring and compassionate practice and could relate to the values described by the students (i.e., empathy, compassion, resilience) as the values that underpinned compassionate behaviours and also evident within my discussion. As such, I looked back on my own NMI results to explore my unspoken thoughts and feelings about care and compassionate behaviour. It came as no surprise to see that I completely identified with the 'model' nurse. As I explored my results from the tests, it was evident that I viewed the values of my real work-self as being the same as those of the 'model' nurse. Therefore, I had responded truthfully and considered my responses to be a genuine portrait of myself, painted according to ISA rules. I had responded to all the constructs for these entities on the preferred pole. However, several constructs suggested areas of tension: 4, team working; 8, managing the truth; 16, reliability and 20, thinking of

others. I could relate my responses to my being-in-the-world of an ODP and lecturer as I am occasionally required to make decisions and work on my own. I am also privy to information which cannot be shared. I am pragmatic in my view that sometimes events that happen beyond my control can affect reliability and, whilst I do prioritise the needs of others, there are occasions where I also have to consider my own needs. Therefore, I was comfortable with my values being exposed by the test. Consequently, through my insider status, I believed I had a clear view of how caring and professional values would appear. As such, I considered these fore-conceptions whilst engaging with participants' meaning-making of caring and professional values during the process of the interviews and the analysis of the students' transcripts. I felt that this privileged position enabled me to move from my insider status as an ODP and my position of knowledgeable doer to a position of naivety as an outsider to the nursing profession. This allowed me to be attentive to the participants' meaning-making of their lived experiences.

Appendix 11 Reflections on the semi-structured interviews process

Smith and Eatough (2016, p. 65) considered the interview very much a *"one-sided … conversation with a purpose",* with the less said by the inquirer, the better. As such, I considered the language used when questioning and gave the students time to respond. Whilst familiar and somewhat confident about interviewing, I was conscious of my status as a novice IPA researcher in terms of achieving the free-flowing conversation required with IPA in-depth interviews. I was aware of the potential for the interview schedule to take priority rather than be a guide (Smith and Eatough 2016, p.56), rather than joint construction (Lillrank 2012). To overcome these issues, I tried to become an active listener and utilised prompt questions to facilitate clarity and explore deeper meaning when needed, as well as helping to support and empower participants so that the interviews became reciprocal and co-produced (Smith et al 2009a, pp.63-78; Lillrank 2012, p.282).

Though at times I felt my voice was evident during some of the interviews, I had commented in my field notes:

> *I think I rambled a little bit and rather than letting them do the talking, I tended to want to fill in blanks.*

Examples of this would be with Paul and David, for different reasons. Paul's interview was the quickest, which was in line with the time he took to complete the NMIST and NMI. His responses were short, direct and had little elaboration, so much prompting was required on my part. David required more exploratory questions as he seemed to repeat his responses and not understand my questions. Initially, this concerned me. Lillrank (2012, p. 284) describes this phenomenon within interviews as a *"natural"* conversation of two strangers discussing a potentially sensitive topic in the *"social setting"* of an interview. On reflection, I believe that my role as a researcher in these interviews became the *"helping voice",* which aided Paul and David to articulate the tacit knowledge they found hard to verbalise (Lillrank 2012, p. 285). This meant that during the interview, first, my position became one of 'knowing' as a healthcare professional/admissions officer/student and, second, I could probe at times by drawing on my experiences to help with their meaning-making (Eatough and Smith 2008, p. 189). Whilst this was a privileged position, I ensured that the participant's voice took priority in the analysis by engaging with the hermeneutic cycle. In addition, my father passed away just before starting the interview phase of the data collection. I was unsure whether my father's death had any impact on my interviews at the time. However, on reflection, the recordings show no suggestion of avoidance or guarding around what could be considered sensitive topic areas in the context of his bereavement. Furthermore, several years and several iterations passed before the finished work, so I feel my father's passing did not affect my analysis in any way.

When discussing NMI results in the interviews, most participants seemed to initially focus on their value scores. As such, it could be argued that providing a participant with their value themes alone would have been sufficient information before the interview. However, the value themes facilitated an introduction to the phenomena of caring and professional values in the interviews, enabling a funnelling down from the wide-angle lens of the value theme to the narrow lens of individual construct responses. This elicited self-reflection and deeper meaning-making of caring and professional values for the participant, which is congruent with the hermeneutic cycle of IPA.

Lastly, as previously acknowledged, whilst predicting adverse consequences or distress arising from the interview is complex, I had not anticipated that the interviews would elicit any emotional or distressing topics. However, I found that the majority of participants shared deeply personal insights into their meaning-making around care and caring, which unfolded through each case study. Although all interviews went well and without untoward incidents, the fifth interview was the most memorable, with the participant disclosing deeply personal information about a challenging time in their life. For the purposes of anonymity, this person's pseudonym will not be revealed and no personal details given. This student came across as being open and happy to participate in the interview. I started the conversation by explaining why I had to record the interview, the areas I was interested in discussing and the procedure for consent before once again thanking them for participating. The interview went well. I liked the student from the outset. They came across as sincere and I felt we had things in common, as we had both come from less privileged beginnings. There was no hesitancy throughout the interview, which seemed to flow well. As the interview terminated and the recording devices were turned off, the conversation turned to this participant's fellow students' discussions of patient information outside the care setting. The participant started to talk about their own experiences, mentioning their personal hardships and experiences of mental and personal violence. I felt moved by what I considered was the participant's stoic attitude to these traumatic events. For this student, care and compassion were synonymous with integrity, so sharing these experiences was a meaningful disclosure.

Clark and Sharif (2007) discussed the seduction of the caring interview, describing the intimacy of being listened to and accepted by a stranger who expresses interest, care and concern. The interview is, therefore, an emotional relationship with somebody who listens and understands the interviewee (Lillrank 2012). For me, listening to this participant became my *"ethically important moment"* (Guillemin and Gillam 2004, p. 265). I was surprised at the level of disclosure and felt unsure about what to do with the information I had received. I do not think there was ever any intention to share these stories as they only unfolded once the

audio tape recorders were turned off; therefore, I feel that informed consent to share this information was not given. As such, only the recorded interview has been included in their case study. However, my experience led me to consider the emotional labour of the interview. What I had previously believed to be a neutral topic had developed into something much more sensitive. Therefore, I was far more aware of the potential for the questioning process to raise sensitive content, which I had not fully considered before. However, I do not feel I was guarded or that I avoided sensitive topics in the remaining interviews; in fact, I felt more prepared should they arise. After the interview, I was initially embarrassed by the strong emotions I had displayed as expressions of compassion and comfort. However, as time passed and I reflected further, I came to regard my reaction as indicative of my caring values, as I had displayed empathy. I understood my role in the interview was conflicting as I moved between my professional roles but, ultimately, my values as a human being drove my need to comfort the student during their distress. This experience gave new meaning to the student's accounts as I constructed my interpretations. I began to question the emotional labour of carework and the role that empathy has to play with the authenticity of care. After the interview, I discussed my experiences with my supervisors and several months passed between the participants' interview and my analysis of their transcript. Consequently, I felt I had distanced myself from the emotional tension of the interview, so I do not feel that this has impacted my analysis, which has also been reviewed by my supervisors.

Appendix 12 Reflection of the analysis process

During analysis of participants' transcripts, Smith et al. (2009a, pp. 90-91) described the text becoming fragmented as it is *"deconstructed"* through the process of analysis. This involves moving from the whole interview to parts, illustrated by themes, and back to the whole again within each individual case (Smith 2007; Smith et al. 2009a). I found this process extremely difficult. As I deconstructed the transcripts into sections of text that were relevant to the aims of my study, they were clunky and long-winded. My initial experience of analysis was reflective of van Manan's (2017; 2019) concerns that IPA is a psychological *"therapy-oriented"* research methodology rather than a phenomenological approach (Smith 2018). I initially delved with gusto into my first transcript, dissecting the self (the student) in comparison to the other (the 'model' nurse). *Psycho*analysing each line with reverence, rather than analysing the text, produced analysis that had little relevance to my study. Rather than becoming immersed in the data, I quickly became overwhelmed, with 150 themes emerging from the analysis for my first case. I can remember feeling like I was doing a PhD in psychology rather than a doctorate on VBR. Returning to my notes, my confusion was palpable:

> *I'm also struggling with my own language and keep on having to remind myself I'm not a psychologist so I don't need to use their language ... [I need to] keep myself grounded [as] I'm an ODP (insider/outsider, admissions tutor, healthcare professional, lecturer, guardian of the profession, patient and woman). [What] do these words mean to me? … I'm struggling with the "legitimacy" of my own analysis.*

Only when I read an article by Pietkiewicz and Smith (2014) did I finally have that 'light bulb' moment. In the article, their extract of an interview to illustrate analysis touched on a delicate health-related subject. I could see how that related to the complexities and slipperiness of values. As a result, I began to understand how to analyse the 'interpretive meaning' from the text. However, the cases still failed to come together again 'as a whole' and continued to read as disjointed pockets of information rather than an individual's account. I struggled to 'understand' where I was going 'wrong'. Going back to my notes, I had written about a *"lot of anxiety I can't see the depth, I can't see a rich dialogue … What I see is bitty conversation".* During this time, I read Engward and Goldspink (2020), whose writing reflected my own experiences as they emphasised there was no easy route through the data. The hours of commitment to the data took much longer and this process was far more complex than I anticipated. Moments of clarity disappeared like spectral ghosts at two in the morning as I battled with the question 'What did that mean?' Engward and Goldspink (2020, p.45) used the analogy of living with *"data lodgers"* to describe the experience of the

analysis process, in which the data is always with the reflexive researcher. Finlay (2008, p.3) described this as the phenomenological attitude which continually changes as the *"dialectical dance occurs".*

However, this was only half of the story. Whilst the idiographic interpretation of the NMIST and NMI data in and of itself was straightforward, how to clarify this for the reader within the text took as much, if not more, effort. This related to the reader's clarity and understanding of potentially complex tests. This became increasingly frustrating as my own presuppositions clouded my view. I was so embedded within *my* understanding of the test that I failed to engage with *my* phenomenological attitude during this process. I did not see where there were overlaps and gaps in understanding between the supervisory team. Long and often frustrating supervisory dialogue teased out the obvious and obscure so that the data became representative and transparent.

However, only towards the end of my journey, and probably with about the fifth iteration of chapter 6, did I realise the absence of the 'bits', i.e., the description and context in between the analysis of the extracts, described by Smith (2011) as the 'pearls'. I had actually commented on this in my notes: *"I feel a little bit disassociated from the story and not seeing the particular"*. This reminded me of Denzin and Lincoln's (2013, p. 7-11) analogy of the researcher as a bricoleur and maker of quilts, in which the interpretivist-bricoleur pays attention to the fluid interconnected images and representations, which structured each case as a sequence of parts that connected to the whole. This was missing. I returned to the transcripts, engaging again with the students' accounts. I began seeing the connections, described by Ashworth (2015, p.12) as the web of meaning, which must be described. As each student's account unfolded, it brought with it individual meaning-making of caring and professional values and new horizons of understanding (Finlay 2003, p. 108) through the students' experience of the VBR phenomenon. Only then did 'the hidden' became obvious and each student became a 'gem' (Smith 2011).

Appendix 13 Exemplar report

Dear student : Test 2 Results

Once again thank you for participating in my research.

Please find below your test scores for Test 2. First an explanation about what the scores mean.

The test looks at how appropriate and significant are the value choices or 'value dimensions' you are bringing to the nursing workplace and how you apply them to self and others (e.g. honesty Table 2: 08: which of the two options offered would you apply to someone you are appraising and how strongly do you feel it applies). Think of honesty and other 'value dimensions' as nursing attributes – attitudes and values.

Sets of nursing attributes contribute to this assessment of your value based approach to nursing. Each set of attributes constitutes a 'value theme': see Table 1. Attributes and value themes were derived from research work relating to values based assessment and were confirmed with senior and highly respected nurses. The six 'value themes' are; person centredness, accountability, trust, integrity, commitment to personal development and teamwork.

So, each 'value theme' is made up of a set of carefully chosen attributes selected from the twenty you responded to. The software applies a procedure called identity structure analysis (ISA) to the responses you provided when appraising self and others using each of these attributes in turn.

Your score is calculated by first scoring each 'value attribute' in the cluster of values and then summing those scores to provide a score for each 'value theme': see Table 4. For example, the value theme 'commitment to personal development' uses four value concepts: commitment to learning, attitude to decision making, taking responsibility and reflecting on how things have gone. The resulting score is a percentage of the maximum score that could have been achieved.

Having been used by you in the appraisal process the software provides a report with your ratings for each attribute on each entity involved and, applying this data, provides a numerical estimate of the appropriateness and significance for you of the six nursing 'value themes'.

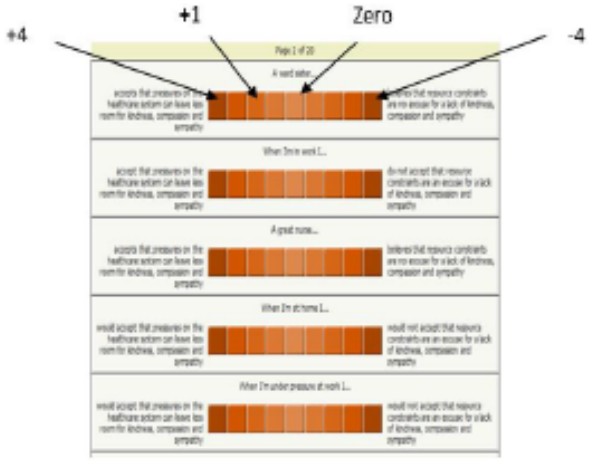
Table 1. Value themes and related attributes by question number

Value theme	Attributes by Question Number
Person centeredness	1, 2, 5, 7, 9, 14, 15 and 20.
Accountability	1, 2, 3, 5, 8, 9, 10, 11, 12, 13, 16, 17, 18, 19.
Trust	1, 2, 12, 13, 16 and 17.
Integrity	8, 10, 13, 16 and 17.
Commitment to personal development	6, 11, 12 and 19.
Team Work	3, 4, 14, 15, 16, 17, 18, 19 and 20.

Responses to questions in the test are scored as follows: the centre response (5) scores zero with responses going out from the centre scoring from 1 to a maximum of 4. If these scores are on the value preferred by you they attract a positive number (+1 to +4) – see Figure 1: this will be a negative number if the contrasting version of the value is used (-1 to -4): see Figure 1.

1

Figure 1. Response scoring process when personal preference is on the left



The software notes which aspect of the value dimension you aspire to (the choices made by ideal self – your value 'system') and treats that as the attitude you admire in self and others. It then looks at your responses about yourself and others and works out what weight and emotional significance you attach to each of these nursing value preferences. This is where your scores estimating the significance for you of individual attributes and value themes come from. Please see Table 2 below for the full wording of the polarised value concepts.

Note that your personal preferred value may or may not be the same as the professionally preferred nursing value. Your choice and the weight and emotional significance you give to it is used in the scoring process. The S-score is your personal score as a percentage of the maximum possible score on component values of the value theme. An S-score of around 55-60 (55 - 60%) seems about average for a cohort of trainee nurses.

You were also asked to answer each question about self within different contexts e.g. real work self and real self under pressure. For this research, I was particularly interested in your responses to your real work self and how you see a model nurse. Your responses to the questions about self at work and model nurse are set out in Table 3.

As indicated above your responses have also been used to calculate a score on each of the six value themes. Your scores on the value themes are set out in Table 4. By way of comparison I have included results from your own group: Table 5. The narrative points out some significant features characteristic of you. You are encouraged to draw your own conclusions.

Please remember that discussing your report with other participants before the research work is completed will risk undermining the value of the results. Please remember too that your results are confidential, personal and easily misinterpreted so it is in the interests of all that you do not discuss your results with your cohort. Additionally, please remember that your results are not shared outside of this study and will have no bearing on your future studies.

Table 2. The professional nursing attributes and values used in the test, with the contrasting alternative

	Professional value*	Contrasting option
01	Believes that patient dignity and human rights must always take precedence	Sometimes medical care needs come before patient dignity and human rights
02	Believes that the safety of patients must come before everything else	Accepts that realistically patient safety may suffer because of pressure on staff and hospital resources
03	Routine and unpleasant tasks are part of everyday role of all nurses	Routine and unpleasant tasks should normally be the responsibility of less skilled nurses
04	Nurses work best when working closely with others in a medical team	Nurses work best when their individual competence, character and decision making is encouraged
05	Can influence people and get them to follow instructions	Finds it hard to influence people and get them to follow instructions
06	Learning and developing competencies should be a lifelong process for all nurses	Learning and developing competencies is for student nurses; qualified nurses mainly deliver nursing care
07	Listens carefully and can tuned into the needs of patients and work colleagues	Finds listening a distraction and prefers just to get on with the job
08	It is better for a nurse to be open and honest in all things	Sometimes itis wiser to manage the truth in the greater interest of all concerned
09	Believes that resource constraints are no excuse for a lack of kindness, compassion and sympathy	Accepts that resource constraints can leave less room for kindness compassion and sympathy
10	Thinks one should be prepared to challenge someone more senior if felt to be in the interests of the patient	Should not challenge someone more senior in any circumstances
11	Enjoys making decisions within their area of competence	In a shared area of competence sometimes prefers the other person to take decisions
12	Owns their work and takes personal responsibility for their judgement and actions	Adheres strictly to guidelines and instructions, which are at fault if things go wrong
13	would take all the time needed to do a task properly	One must be quick and do what one can in the time available
14	Is an excellent communicator and is always understood	Not a good communicator and is often misunderstood
15	Usually understands and relates well to others	Often seems to misunderstand and has problems relating to others
16	Can be relied upon to deliver on their commitments	May not meet commitments due to real world constraints
17	Manages time and workloads with minimal supervision	Works best when being managed by others
18	Generally, understands situations	Sometimes misunderstands situations
19	Often pauses and reflects on how things have gone	Rarely takes time to reflect on how things have gone
20	Is always thinking about the other person	Focuses on own needs and priorities

*Left hand text is the professional value. Right hand text offers a contrasting value. Both relate to one theme e.g. honesty.

Results and comment provided in collaboration with Colin McNeill Research Psychologist at Identity Exploration Limited:

I look forward to discussing your test results with you at interview but should you require any further information please do not hesitate to contact me.

Sherran Milton. Email:

Identity Exploration Ltd

Data and comment

(A) Your perception of yourself as a nurse and of a great nurse

Data

Table 3. Scores indicating your perception of 'self at work' and 'a model nurse' using these value themes

Questions	Professional value*	Contrasting value	Real work self*	A model nurse*
01	**People's dignity comes first**	need for help comes first	3	4
02	**Safety at work comes first**	resource limits may reduce it	4	4
03	**Unpleasant tasks done by all**	done by less well paid	4	4
04	**People work best in a team**	**work best on own**	-1	-2
05	**Can get people to follow instructions**	finds it hard to	0	2
06	**Learning competence is lifelong**	is for new workers only	2	4
07	**Listens carefully**	listening a distraction - get on	2	4
08	**Better be open and honest**	wiser to manage truth	1	1
09	**No excuse for lack of kindness**	pressures can be excuse	4	4
10	**Challenge authority if in best interests of work**	do not	1	4
11	**Enjoys decisions when competent**	prefers others do it	2	4
12	**Takes responsibility for own actions**	sticks to guidelines	-1	3
13	**Take time needed for tasks**	do best in time one has	2	4
14	**Good communicator**	not a good communicator	2	4
15	**Relates well to others**	has problems relating to others	2	4
16	**Can be relied on**	real world can affect reliability	2	4
17	**Works with little supervision**	works better if managed	1	4
18	**Generally, understands situations**	sometimes does not	0	4
19	**Often pauses to reflect**	rarely does so	1	2
20	**Always thinks about others**	focusses on own needs	2	4

* Left hand text is the professionally preferred aspect of the value dimension. Right hand text is a contrasting value. **Bold text** indicates the aspect of the value 'dimension' you aspire to, your ideal; the value 'dimension' itself was used to appraise yourself and others one way or the other.

Positive scores of 1to 4 indicate strength of feeling associated with **your approval of self at work and a model nurse, with 4 strongest. Negative (minus) scores indicate use of the contrasting value whether that was left hand or right hand – indicating lack of approval by you. Zero (0) score means you could not decide.

Comment on your perception of yourself as a nurse

When you think of yourself at work as a nurse you have a clear concept of what is expected of a great nurse and can contrast that with your own strengths and limitations. You are conscious of wholehearted agreement with the great nurse on some values and of some similarities and differences of degree and kind. These are all set out in Table 3 and we would encourage you to try to make sense of them yourself.

Generally, the differences between you as a nurse and the great nurse you conceive of are small but substantial (score of 2 as against 4). Is it that you are, sensibly, quite aware of your lack of experience of nursing and this effects your conviction about your own attributes?

Here are some points of difference to consider. Use them to help think about your other responses.

You think (Q04) that ideally nurses work 'best on their own' but when at work, on balance (-1), you can see that nurses work best as a medical team. You perceive 'a model nurse' as believing in teamwork a little more strongly than you do.

You perceived 'self at work' as unable to decide if you had difficulty understanding situations (Q18 = 0) whereas the 'model nurse', as perceived, generally understands situations (Q18 = 4). Why did you have difficulty choosing between options?

You believe quite strongly (Q12) that the great or experienced nurse takes responsibility for their own actions whereas at work, on balance (-1), you prefer to stick to guidelines.

Similarly (Q10) you would be rather wary of challenging someone in authority in a patient's interest (1) while you believe strongly (4) that the great nurse would do so.

You think that even a great nurse has some difficulty getting people to follow instructions (score 2 on Q05) but you are unable to say how successful or otherwise you are in this regard (0). Why did you have difficulty choosing between options?

(B) A measure estimating the appropriateness of your personal nursing values and their significance for you

A self-report profile using six 'professional nursing value themes'.

Data

Table 4. Your Test 2 scores on the six nursing value themes

1026108a CHARACTERISTIC NURSING VALUES	S^{TOT} score (%)
PERSON CENTREDNESS	57.75
ACCOUNTABILITY	49.06
TRUST	51.49
INTEGRITY	40.29
COMMITMENT TO PERSONAL DEVELOPMENT	43.92
TEAM WORK	41.34
MEAN	47.31

Table 5. Mean scores for the group of students using Test 2

GROUP: CHARACTERISTIC NURSING VALUES	S^{TOT} score (%)
PERSON CENTREDNESS	59.20
ACCOUNTABILITY	52.58
TRUST	50.49
INTEGRITY	47.42
COMMITMENT TO PERSONAL DEVELOPMENT	51.27
TEAM WORK	55.16
MEAN	52.69

Comment on your characteristic nursing values:

Your score on person centredness (Table 4: S = 57.75) is good and in line with the cohort average (Table 5: S = 59.20). Along with accountability and trust these are your strongest personal values. Scores on the latter two values are also about average for your group.

Your weakest score is on Integrity (40.29) and is below average for the group (mean = 47.42). With similar modest scores on commitment to personal development and team work the implication is that these characteristics need work for they are dragging down your overall score. Team work (S = 41.34) is well below the group mean score (S = 55.16).

A trusting nature and weakness in virtue (integrity) could be a challenging combination for a nurse.

The positive side is that your average score across all personal nursing values (mean = 47.31) is not far below the group mean (52.69). However, if your approach to the test was genuine and this set of scores are a true reflection of your nursing values there is quite a bit to think about here particularly your rather weak commitment to personal development.

Comments on your personal centredness:

Table 6. Scores indicating your person centredness characteristics

Questions	Professional value*	Contrasting value	Real work self*	A model nurse*
01	People's dignity comes first	need for help comes first	3	4
02	Safety at work comes first	resource limits may reduce it	4	4
05	Can get people to follow instructions	finds it hard to	0	2
07	Listens carefully	listening a distraction - get on	2	4
09	No excuse for lack of kindness	pressures can be excuse	4	4
14	Good communicator	not a good communicator	2	4
15	Relates well to others	has problems relating to others	2	4
20	Always thinks about others	focusses on own needs	2	4

Personal centredness value theme facilitates exploring your care values in a little more detail. Overall this is your strongest value theme.

You have a feeling about what the good nurse should be however, overall you feel that you do not make the mark quite yet. Your reticence seems to be around communication skills particularly an example would be Q14 and Q15 where even though you understand a good nurse would communicate and relate well with others you feel that this is not quite so for yourself.

This is less so for your care values as here you are quite clear that a good nurse would always put safety and kindness first and see yourself already having these aptitudes (Q02 and Q09). While you understand that just on balance it would be beneficial for a nurse to get people to follow instruction(Q05) you have chosen not to respond. Why is that?

Appendix 14 Ethical approval

School of Healthcare Sciences
Head of School and Dean Professor Heather Waterman

Ysgol Gwyddorau Gofal Iechyd
Pennaeth yr Ysgol a Deon Yr Athrawes Heather Waterman

22 April 2016

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Ms S Milton
School of Healthcare Sciences
Cardiff University

Dear *Mr Milton*

An Interpretive phenomenological Analysis exploring value based recruitment through the students' personal meaning of care and professional values

At its meeting of *19 April 2016,* the School's Research Governance and Ethics Committee considered your research proposal. The decision of the Committee is that your work should:

Pass –and that you proceed with your Research after discussing the reviewers' comments with your supervisor

The Committee has asked that the lead reviewers' comments be passed onto you and your supervisor, please see below.

1. Social or scientific value; scientific design and conduct of the study e.g.

- Is there evidence present in the proposal of the use of accepted scientific principles and methods, including statistical techniques, to produce reliable and valid data?
- Is the research question important and necessary?
- Is the research design and proposed qualitative or statistical analysis able to answer the question?
- Is there involvement of patients, service users, and the public, in the design, management, and undertaking the research?
- Is there a clear aim for the study?

Reviewers comments/issues for discussion

The study has a clear aim and the stated method appears appropriate and able to obtain valid and reliable data. The research question is important and necessary; the applicant offers an excellent rationale for the study. The research design should offer greater insight into a complex phenomenon. I can understand why the researcher has chosen to include both Kelly's repertory grid and the NMI and this has been clearly articulated. Whilst Kelly's repertory grids are an old and rarely used approach these days they are very useful for gaining an ideographic understanding of care values and to facilitate the individual semi-structured Whilst I think the study is a little complicated, I believe it should provide credible insights into an important topic within healthcare

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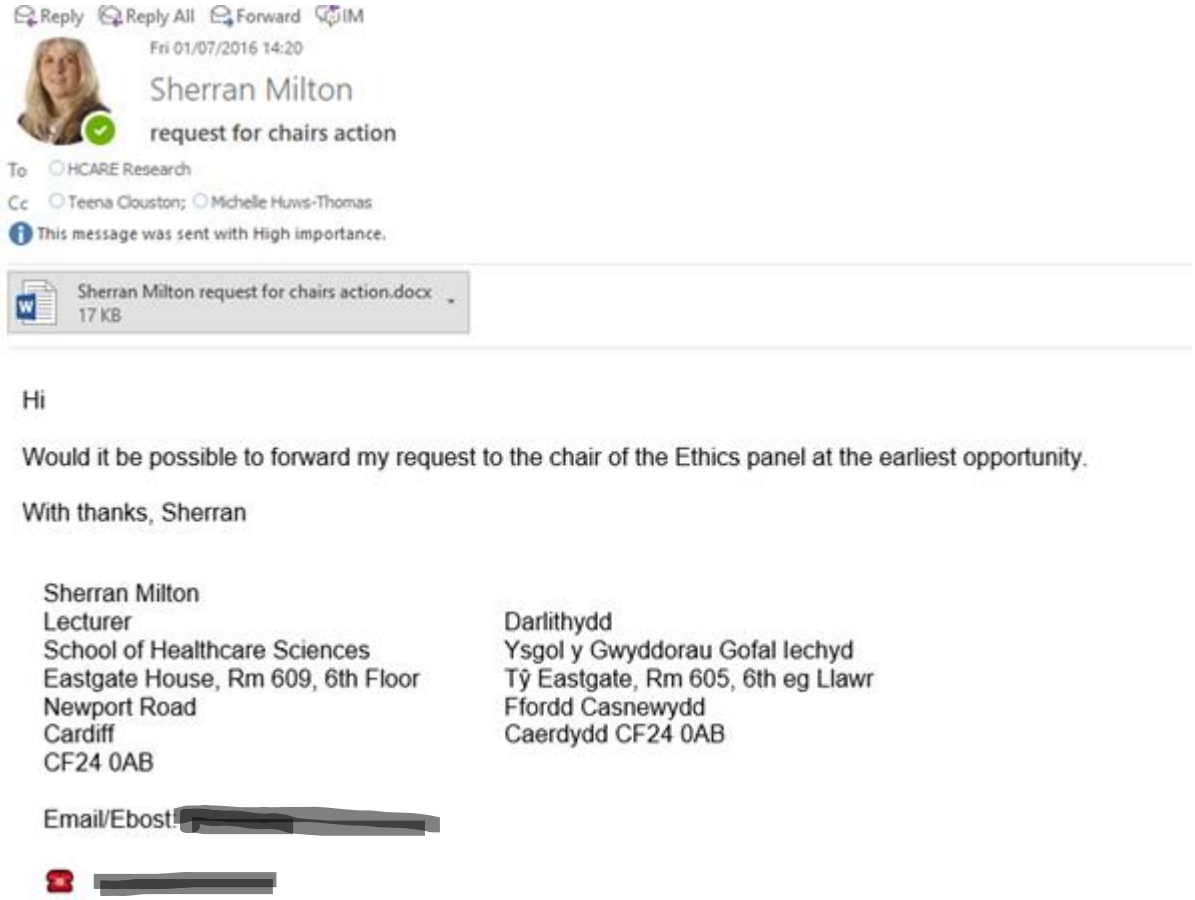
Mae Prifysgol Caerdydd yn elusen gofrestredig, rhif 1136855

Ethical approval for NMIST



Reply Reply All Forward IM

Fri 01/07/2016 14:20

Sherran Milton

request for chairs action

To HCARE Research

Cc Teena Clouston; Michelle Huws-Thomas

This message was sent with High importance.

Sherran Milton request for chairs action.docx
17 KB

Hi

Would it be possible to forward my request to the chair of the Ethics panel at the earliest opportunity.

With thanks, Sherran

Sherran Milton
Lecturer
School of Healthcare Sciences
Eastgate House, Rm 609, 6th Floor
Newport Road
Cardiff
CF24 0AB

Darlithydd
Ysgol y Gwyddorau Gofal Iechyd
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Ffordd Casnewydd
Caerdydd CF24 0AB

Email/Ebost: [redacted]

[redacted]

Request letter

Sherran Milton
Lecturer
School of Healthcare Sciences
Eastgate House, Rm 609, 6th Floor
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CF24 0AB

Request for chairs action

Since submitting my research proposal there has been a change to my field of study which has implication to the data collection methodology of my intended research.

This field of study is moving at a fast pace and the Nurse Match Instrument which is one of my data collection tools has been developed further. The new instrument, Nurse Match Selection, has been developed to focus particularly on university recruitment of nurse candidates. It is felt the addition of the Nurse Match Selection as a data collection method will not only ensure that the study maintains pace with the field of research but will also enhance to the studies outcomes.

Agreement has been secured by the developers, Identity Exploration, to use the Nurse Match Selection for my research in addition to the Nurse Match Instrument. I am therefore requesting that the Nurse Match Selection be added to my research proposal.

There are no further ethical concerns other than those already outlined within the original proposal document and this request is made with the support of my supervisors.

Yours sincerely

Sherran Milton

Ethical approval granted

From: Marie Nation
Sent: 13 July 2016 11:19
To: Sherran Milton
Cc: Michelle Huws-Thomas ;
Subject: RE: request for chairs action

Dear Sherran

Please find below the response from Sally Anstey re your minor amendment. I will put it on the agenda for Chairs Action for the next meeting which is July 26th.

"Thank you for submitting your request for minor amendments to the data collection instrument
for your Prof Doc thesis. The addition of the Nurse Match Selection instrument is well justified and is approved on chairs actions as a minor amendment to the previous ethics approval.
Good luck"
Kind regards
Sally

Regards

Marie

Appendix 15 Paul's themes and subordinate themes with corresponding quotations

Theme 1: Caring values		
Subordinate theme	Quotes	Page and line numbers
Care and experience	I think they think I'm alright, because I would not have a job and I wouldn't be here, I would not have **got through** the interview, so I must have some level of confidence in my ability to care for people and my ability to be professional. I must have, or I would not be here.	3. 83-87
	You can **build on it**, but I do believe there is a certain **natural**, you know it's a **life experience** thing isn't it? If you have got more **life experience** you can **empathise** with more people…	2. 52-58
	your ingrain values isn't it like your honesty, your sense of empathy and that sort of thing… if you haven't got that sense of duty then you're not going to help the patients when your **busy** or when your stressed and that's not fair. That sense of responsibility and empathy. That's really important and that's something that you can't really teach.	2. 40-53
	My experience has made me a bit more **pragmatic** I suppose to some people having [not] got any … **as time goes on your responsibilities get a bit larger and time gets a bit shorter and then you get into that rushing mode** when you chat but you're conscious that **you haven't got two minutes.**	7. 195-201
	I had worked in the area and got **bad habit** left over and as hard as I try to reset and come back fresh, **I have got preconceptions I have got prejudgements and that sort of thing. Which isn't good that's and advantage some people that have not done care before have got they are coming in fresh.**	9. 245-250
	we are doing theory at the moment and **gold standards** and sometimes what you learn in the classroom and being the best way in the classroom and **being the best way out there**	10. 299-302
	we are taught now is everything its gold standard isn't it it's what you really should be doing, isn't it, you shouldn't be cutting corners, you shouldn't be you know and then of course being away from the ward has made you more idealistic in your viewpoint like. brought you back down to basics I suppose.	9. 258-263

Professional values	it's hard to say because I have worked as an HCA for so long it's just **ingrained** in my work isn't it you know. professional values encompass so much I suppose. Because care is just a part of what you do, professional values also encompass you working with your colleagues. You're working under supervision, your supervising others you know. you have got the 6Cs which is what caring, compassion competence, courage, communication that's it isn't it? Caring, compassion, Competence, courage, communication. I'm missing one, but yeah that's the 6Cs Professional values. I'm **working towards** that now. I'm **going from** being a HCA to being (deep intake of breath) a nurse now, So, it's getting more professional isn't it	3. 66-67 3. 68-72 2. 59-63 3. 75-77
Theme 2: The ideal nurse		
Subordinate theme	Quotes	Page and line numbers
Nurse in the making	Cause it's **an ideal,** its, its, its, you haven't got a little pragmatism or anything with it, its, its, this is how it should be, but with myself it's more **this is how I am at the moment with the fact with I've worked**. I can view the model nurse and the ideal way down there, and I can view myself here and see what I'm working towards If I scored myself 4/5 on some of them statements cause they're not really statements as such their **things you do** aren't they and umm I then **there would be no room for improvement** that's **me saying I'm 4 or 5 and as good as I'm going to be in this situation.** To me now it's nice its quite good it's nice its nice to know that I am able to view the **timeline** and a **bit of modesty** about it Challenge authority. I remember that question vividly and I know that a model nurse should [challenge authority], I put that way down there in the timeline for me were as I am further down here	6. 167-172 7.199-201 7.208-212 6. 177-178 5. 149-152

	some of it was a little surprising I mean umm the honesty thing I trust others, I know that I am quite a **trusting person**, which, which has bitten me on occasions but the integrity thing I, I yeah, I scored quite low on that which surprised me like. I think I am quite **trustworthy**. I think it's because I've been learning the theory of nursing these past few months, I suppose the practical nature of what I was doing before, so maybe a little bit more idealistic because I've been off the ward for a bit, I've been not working 12 hour shifts four days a week and getting tired and busy and not being able to do anything	5. 128-132 5.149-151
Theme 3: The experience of value-based recruitment		
Subordinate theme	Quotes	Page and line numbers
The MMI	**looking for the certain characteristics in people** that that that **beneficial to the profession** I did so many interviews around that time I get them muddled up between the different universities but. Yeah, **the video of the elderly gentleman** we had to say how that made us feel and that was quite interesting. The **origami** was really interesting. *Paul: I was quite lucky with that I had the **heads up** before the interview* *Inquirer: Oh, right?* *Paul: The student nurses on the ward had done it the year before yeah.* *Inquirer: So they actually said?* *Paul: Swansea I knew what to expect at Swansea, Cardiff, and UWI they are all similar.*	11.335-336 11. 313-318 11. 223-236
Getting the whole picture	**I was much more comfortable with the MMI** and I preferred the MMI, but as far as which one reflects me best I'm not sure umm that's not really my call like, that's who's ever is interviewing me and who ever knows me know but I much preferred the MMI. I think if that was a recruitment process [indicting to the Test paperwork] then that would have been **extremely stressful.** I wouldn't like it I think you can learn more by conversation in the MMIs we done than you can from that, you know, umm. It's nice its interesting but I wouldn't rely on it. I wouldn't. I, it's not my call, I wouldn't like it if you were relying on that, but I wouldn't like it. partially almost most certainly it does reflect partial but whether you get the whole picture I don't' believe so, because the questions are open to interpretation as well aren't they even though they are chosen	12-13. 370-375 12. 351-355 12. 360-364

	words and stuff if I interpreted the questions slightly different to what it should have been interpreted as then my results can be way, way off.	

Appendix 16. Lisa's themes and subordinate themes with corresponding quotations

Theme 1: The caring position		
Subordinate theme	Quotes	Page and line numbers
The caring attitude	empathy to me is a key issue of caring as I don't think that you can really truly be in a caring position if you haven't got empathy that you could see things through other people's eyes	1-2. 14-18
	I think that would probably reflect on and this is going to sound bad I know on how much I trust other people rather than rather than being trusted myself because **I'm an absolute stickler for trust if somebody tells you something then you should respect that** you know.	24. 584-603
	The nurse is easy to approach she's, she's friendly, she might come in with a smile she might like have you know just be easily umm easy to talk to then you know for them to approach and friendly and everything like that	5.106-108
	I don't know why it's like that because I don't think so I think I'm a good communicator	18. 436-436
	Not so much caring but yeah, a bit too soft really	2. 39
	Friendly hopefully, yeah, I think I'd be easily approachable you know I think I'd come across; I get on pretty much you know with most people so I think I probably be easy to talk to, yeah, I got a **caring attitude**.	5. 99-109
	Well a job well I see it as a job that you would enjoy do doing because, because you go into that line of work for reason **because you want to do it** because you want to send **want to be a nurse** if you don't really, **don't give a damn about people**	6-7. 142-147
	I'm not in it for the fact that there is a **paid job** or anything you know you should come into it because you care really shouldn't you	6. 135-138
The professional manner	Well you know they're (professional values) **important** aren't they you know we have to act in a professional manner have to respect people's dignity, peoples autonomy. You know (pause) you have too (pause) it's the complete them as much as caring is a holistic umm profession you know we have to be, **cover all areas** don't we, we have to have everything you know.	2. 21-27

	I think wouldn't it be nice if all nurses who went into this profession were behaving or acting in their roles as we are being taught you know. she said I've got a job in one of the local nut houses over the and I was like I was appalled I was absolutely appalled I was absolutely gobsmacked. And then knowing that there are people who work in the profession who really are the opposite and can really make people feel quite uncomfortable. I have this real conflict that they are, we are being taught these values in the classroom which I honestly believe in, I'm totally believe in them, and I'm not saying, **I know the I'm like everyone lives a life outside of their jobs and everything else,** but it's like being told this is what people should have to go into nursing this is really what we should be doing and it's pumped in to day after day after day you know you know about **the NMC code even in your life outside,** professionalism all this and that. And it's like when it be an ideal, and yeah, we are being taught and ideal eventuality but it isn't that real.	13. 315-317 16. 375-377 15.356-359 13. 301-310
Real v the ideal	Inside I have a real confliction of what I been taught in the classroom and really if I'm honest with you I know isn't always the case in the hospital settings or community settings and I think then I have a real bit of a conflict with that really. I'm a little **bit like a member of the public** who has had any training at the moment because anything I could answer is based on experience. I had a discussion last night about nursing actually because there's somebody in my daughter-in-law's family has really been really ill in hospital and is had to have his arm amputated and those things going on and is **absolutely shocking,** it's actually, is actually exactly the same things as we had been taught about right now in relation to the Francis report about patients being fed or being told sorry we haven't got any time to feed them. We all know that that isn't true that every nurse out there, well there wouldn't be things like the Francis report would there and I wasn't in the case and to hear things that are still going on it's quite **appalling** really, we live in the 21st century were not in Victorian times now you know I am quite passionate about it really to be honest with you I have this **real conflict** that they are, we are being taught these values **in the classroom** which I honestly believe in, I'm totally believe in them, and I'm not saying, I know the I'm like everyone lives a life outside of their jobs and everything else, but it's like being told this is what people should have to go into nursing this is really	15. 349-352 12. 280-283 12. 288-294 13. 319-326 13. 301-310

	what we should be doing and it's pumped in to day after day after day you know you know about the NMC code even in your life outside, professionalism all this and that. And it's like when it be an ideal, and yeah, we are being taught and **ideal eventuality** but it isn't that real. It's like being told when you go out into placement you can see things and hear things and you really shouldn't let be dragged into just going down it's okay to talk about these people like this and we all do it you know and it's you know so you're supposed to like make a stand. Maybe, maybe it's easier to respond to the ones that are shouting loud yeah to run to the ones that are shouting loud then to the once of the quietly sitting there and aren't really able to complain and it's quite awful really because they sometimes are the ones who really need to be fed the can't get a drink themselves with thirsty, they can't go to the toilet themselves. I'm not saying that the ones that are shouting further help can't, can do all those things but sometimes maybe it's easy to leave those ones to last because they're not so demanding a not so loud then make in a fuss they are not disturbing everyone.	25-26. 627-632 20. 486-497
Theme 2: Judging the good nurse		
Subordinate theme	Quotes	Page and line numbers
It's not clear cut	I haven't worked in care then it was like, the only it wasn't difficult to answer them just for me it was like whose point of view um I looking at here because I'm not a nurse because I'm not nurse yet nobody just started training and because I have is, **probably if I had worked in care then I would have approached differently.** I found that the whole of this (indicating to the report on the table) really quite umm I wasn't really where I was supposed to **place myself** because to me **the questions were directed as if what do you think as if I already worked as a nurse but I haven't worked in care** I found times that I umm I don't know really, they were a few times that I found while I can't really answer **I need to go in the middle** of the because I can't really judge don't really want to judge either way because of higher got the authority to do that yet if you know what I mean I just thought it isn't as clear-cut as that you know what I mean is **not as clear-cut** as umm. And **I felt like I can't really judge** that in just one question because it's just such a massive area.	26. 644-651 3. 51-56 3. 58-63 8. 189-198

	Well I haven't worked in a ward I haven't worked in the profession and I haven't competed my training as, as a nurse so I really didn't like feel I was in a position to judge what was a good nurse or what was a bad nurse really as I was writing the beginning of the course and everything. I've had maybe visiting patients or like I've got a relative in a care home was going to be there forever and things like that you know, so it was like well I have been situations **where patients are not really happy** and they do think the nurse has to give all the time and tell just one person and that easy to understand but sometimes they have to try to see to lots of patients Maybe I have got a bit of the conflict in what my, in what I believe or what I, what I think should be right and maybe what isn't right. You know because I answered the questions, so to me maybe and through the questions yeah maybe the answer them how I feel it should be or **how I feel sometimes is in reality** I'm doing mental health and I've been on the other side and probably most people don't even know that and so maybe **it's not fair for me to judge** people because may be more people have nurses like that but I do because I've been on the other side and I do think that people are supposed to abide by these values and they should really A lot of these questions seemed the same all the way down, they're not, they are different but I was just like working out the grading and thinking that, well, I was just working out the grading and thinking that, at one point I did think oh maybe I should, start, **keep ticking for each end** really you know maybe I should think about the questions more really I don't know really; I don't really know if you liked those results really or not. Umm I can't remember a lot about them I just thought my initial thing was, oh well. It didn't really make me feel very good about myself to be honest. Lots of minuses on there	3. 66- 70 4. 78-85 14. 329-334 24. 599-603 7. 154-161 9. 217-222 18. 430
Different and clever	**A bit self-conscious at first thinking oh bugger I don't really know what to expect now**, what you take on a camping trip or about the survival kit and things like that and you these things, **you know these things they tell you there is no right or wrong answer, but you know you go home and you keep thinking about** should I have bloody took that whisky on the camping trip, you know, alcohol, cleaning or whatever was things there was think **did I make the right choice** but it doesn't matter I'm here now. I just thought differently and um totally different going into these **different scenarios or different or talking to people**.	22. 536-549

	I think it was actually I don't think it was anything **as nearly as bad.** I was quite nervous going to it but I didn't think it was bad, I thought it was quite funny, I thought it was clever, I thought it was a **clever way to interview people.**	22. 550-556

Appendix 17 Nicky's themes and subordinate themes with corresponding quotations

Theme 1: The good and bad nurse		
Subordinate theme	Quotes	Page and line numbers
Dignity and safety	Cause I thought I was an **empathetic, nice person** but this (indicating to her report) does not reflect that do they [laugh]	3. 49-50
	And so the qualities I think I'll bring to it is I am calm I am **calm and reassuring.** All my friends tell me all their problems all the time (emphasis on all) because they say you're a really **good listener.**	9. 211-214
	And she told me her entire life story in about three minutes and I had done the blood and everything and she said I am so sorry, and I just burst, I did the bloods, taped her up and burst into tears. And I said I am so sorry I don't Know what happened and she **cried with** me and she gave me a hug and she said don't worry, she said I'm really glad you did because I know that your human	10. 230-237
	OK, patients dignity comes first. Umm yeah for me it always does, umm needs for help comes first	3. 58-59
	I mean things like patient's dignity from me to **no-brainer for me**. It, yeah, always comes first. **Safety at work,** as things like that I can answer them quite quickly because I know from my perspective there is no thought process required, **that is a given.** Isn't it? You know, safety, patient's dignity, making sure people **understand what their meant to be doing** and they follow the **instructions. As written**! And that you **listen, carefully** because you missed bits. And then you make **mistakes** and then healthcare you, that you can't make mistakes there's no room, is there.	20. 487-503
	So I suppose it's taken me a long time to realise this is what I wanted to do, and the initial **lightbulb** was when I like children and my first experience.	5. 115-117
	This really calm reassuring voice, and I thought how do you do that? You have got to have that in you to be able to that. The **patience, time the care compassion and empathy.** Everything that we are taught in our first few weeks to a month is everything that **she did naturally**.	7. 155-162
	You have got to have that in you … the one thing that stood out for me were the midwives I thought they are amazing I mean I get this whole Florence Nightingale thing they are amazing and I was really in awe of the profession	7. 134-137

	The girl who I was allocated gave me a telling off and said you shouldn't have left the ward. It was a procedure for her she just wanted to get his cannula out, out of the room, clean up the bed. Next person in. And that was really obvious. I just hope I'm not going to be like that, because obviously they are under pressure aren't, they. They may be short staffed **Its critical isn't it. Because I have seen lots of nurses and I really are wonder why they are doing job. Were they like that when they started? Have they changed due to the pressures of the job? Has it made them like that or are they always like that.** That's the, I just wonder. And there are some **lovely**, don't get me wrong, as you know you have done it far longer than I have there are some **amazing people** in the profession and you think oh god, yeah, I can see why you do this, cause you are fantastic. So they are in **the minority** the ones that should not be doing it, I hope.	14. 318 -319 16. 381 -386 28. 710-720
The code	**Consistency and competency and professionalism and leaving your stuff outside the door** and the two, the two issues we had with nursing, well I had with the nursing girls was the one who didn't introduce herself I know well that that didn't **sink well** from me cause I thought ironically, we had just done it the week before in Uni about it and I thought this isn't what they're supposed to be doing. This is not what they're teaching us So how quickly that changes, that scenario changes from a positive to a negative experience. And that was maybe because she had **a bad day maybe she had a telling off** or something, I really don't know. I mean it has been quite **thought provoking** and that's one thing definitely, well there have been lots of things but its statements like that really that you read it and think god yeah that it **really important.** Especially if you are in a situation where it is difficult, and you just have to keep going through your head NMC code, patient's dignity. Patients being really horrible and abusive and violent. Ok just switch off from that their dignity comes first and I've got to be professional I've got to treat them with care make sure they get what they need. It's like that putting on a façade isn't it	15. 346-350 14.340-343 16. 378-381 27. 672-675 27. 676-684
Maturity	**I can see the organisational stuff, being able to talk to people and tell people or ask people to do things.** I'm constantly trying to put myself in other people's positions. And I think as you get older, I'm 45 now I'm 46 this year. That **all slots into place** and it makes sense doesn't it? That you can be in **someone else's shoes** and actually think, God, I wish I had said that, that way. You should have done that in the different way	11. 260-267

	you obviously question why you're here and think we all do all the time. Especially at this stage because it's hard for a mature student with family and you're just adding something else into the mix aren't you. And so, every day it is a question mark. Am I doing the right thing? I'm leaving my children at 7 in the morning to drive to Cardiff in the traffic to sit in a lecture to then have to do my assignment.	24. 601-608
Theme 2: Measuring values		
Subordinate theme	Quotes	Page and line numbers
Light and dark numbers	I had a slight panic initially. Because I was reading it and I'm thinking okay, it can't be complicated because I do try to simplify stuff and that's one thing that the military has taught me. Is we have this acronym KISS, keep it simple stupid. And I try to relate that to as much as I can in real-life situations. Which is why I, I don't really panic and sometimes I think I should be panicking now, but I'm not. Why aren't I? And that's the first, initial thing anything, any test situation with me is a panic. And I do the same with the numeracy exam. I was sat in front of, I had practised for weeks and weeks, every day I was doing it, and I sat down, and my mind went completely **blank** because you do you panic don't you, you think I'm going to fail this and I am not going, and have to do it again	18. 444-456
	I think I must that back here somewhere and thought this is an overview of me as a person so if I answered this in the **wrong way it's going to make me out to be some kind of monster** that I shouldn't be doing. I don't know why I, my brain, I just think all sorts of weird stuff.	19.467-471
	I didn't really understand on the and. That's just me being a **Muppet.** It was the **Lighter colour a bigger number than the darker number?**	3-4. 65-76
	well I did mine completely the wrong end of the scale. **You couldn't base those results on taking people on. You would have to interview as well wouldn't you. Cause I think, I suppose I'm trying to justify my existence here,** in my case I don't think that's always a **true reflection** of who I am	29. 723-728
	When I saw my results, I thought oh my God I should not be doing nursing… I'm going to be and horrendous nurse (laugh).	4. 90-92
The good MMI	**I loved mine,** and everybody else I said that too thought I was really weird, and um, cause I had an interview at Swansea which was very different to the one here. **So we were in bigger groups in (name withheld) we had to, you had to get your voice out there basically. Where this one was more specific to you as a person.** And those individual ones we did with all **the cubicles where you had to fold the napkin, watch the film and those things.** And I just love stuff like that. **And then chose items where you had to take things with you from your plane crash**,	28, 696 - 707

	and why did you choose them. And that's, and yeah, I really do enjoy things like that. **I like a challenge** I like to be made to think about things and that. And then the film came on and the only part I can remember of it, is there is an **I think it's a man or a woman sat on a toilet with their pants around their ankles in a lift. And my initial response was horror. Oh my god that's like your worst nightmare … I could feel myself welling up.** I was going no, I'm not going to cry, I'm not going to cry	30. 749-760
The gatekeepers	mean in an interview people can put on an act effectively can't they. Well you must know as staff and when your interviewing people, you must know who's going to actually be suited to the role and who isn't. Because you have got to be good judges of character to do what you do. And you have worked in the profession long enough to know who you could work with and who you couldn't work with	29. 745 30-31. 775-780

Appendix 18 John's themes and subordinate themes with corresponding quotations

Theme 1: Care and caring		
Subordinate theme	Quotes	Page and line numbers
Empathy	care to me is being able to **support** someone whether it's **through medical, emotional or social changes in their life**. It's, to me it's not so much being able to empathise or sympathise with them it's more being able to guide them **help** them and support them because, I'm, empathy. **I don't put a lot of tacked on to empathy really.** Cause **I don't know you can truly understand what somebody is going through because everyone approaches situation's differently.** So, I feel empathy doesn't really help, or has much **weighing** on how I care for people as much as maybe another student nurse would put it on it's probably very difficult for people to pull **themselves back from having too much care** for that person. Like if they **might relate to them, like they remind them of someone and so if you put too much empathy and too much feeling on to one patient your possibly be ignoring the others or not giving them equal care.** So, I think drawing feelings back slightly from the care will make sure your get, you're giving an even spread to all the patients and you're not then affecting your own emotions because it's going to be terrible going to work	2. 53-65 4. 94-108
The code	well see because we [nurses] have got **the NMC code,** that kind of covers the areas of caring. But then you've also got thing where it draws in the more **legal side** of it so like confidentiality and anonymity, promoting autonomy things like that so I'd say they are relatively. Yeah, they are separate they just, that professionalism will **encompass care,** and this is **how you should go about caring** and this is **acceptable** and this is not acceptable. So caring is more I'd say your own **interpersonal beliefs** and how you would [care]. Whereas your professional is this is what the NMC say's this is what you should be doing, and this is how you should go about it, if you are met with this this is how you should approach it	4. 75-88
Theme 2: The nurse		
Subordinate theme	Quotes	Page and line numbers
The Ideal nurse	I'd say the staff umm probably **compensate** a lot more because umm the NHS staff were more **friendly** than those in the private hospital. They seemed to very much you know **this is my paid job** it's what I do here you go	6. 149.157

	I'm off. Gone. But where is in the NHS the nurses would actually sit and talk to me. Like if they were on break they would come and have a chat. So, it's so that was very much, I've always kind of had the idea that **we should all help each other,** but there, is, should never be this umm oh this person rich they should do this and this person…. It should be we are the same species we should all support each other **regardless of who we are** I see a nurse as someone that would put their patients above all, above all else. So as I was saying about the financial, we said right this is my limit, but then I need to do something else for this patient. **Someone that's willing to help no matter what the case.** Someone that has good organisation skills, good team working skills. Is able to lead a team as well as follow and be in a team. So when I like look at myself that way I, I, I believe that I have all of those qualities Because everyone would have a different idea of what they what they would deem an ideal nurse because some would say if **they need to be extremely intelligent** to do this and others would say they need to be **extremely compassionate**. So, so I am from what, a **little bit off the idea** of what I see to be as the ideal nurse. The ideal nurse from me as someone, umm, I would probably leave the very much onto the intellect side **they need to know what they're doing** because I would rather have a nurse that was very much knows what they're doing comes in and get it done. Than some of them that come in and offers me a cup of tea but has absolutely no idea of what they're doing. (Laugh) so I think for me it is intellect based as well as knowing what they're doing and how to deal with situations. Umm with umm again like **pushing feelings aside** to get on with the **job** and to **work with patients**. So it's less of the high this morning dot, dot, dot, dot, dot it's more of an okay this is what we going to do today are you okay with this? And **getting on** with it rather **than all the chitchat that tends to go on.**	5. 120-125 8. 205-214 15. 414-422 16. 426-438
Theme 3: Getting on with the job		
Subordinate theme	Quotes	Page and line numbers
Communication	because we did this test [NMIST] like in the third week of University, so I was very unsure, think I was a bad communicator I get distracted, because, because I was very much **struggling to make friends** I was really struggling to **relate to other people**. But then after we've gone through this is [NMI] about a month or two months later. We've done a **communication course**, we had a **chat** like about, **I've started to relate to people a bit better and had actually gone through different ways of communicating.** So I **perked up a little bit** because actually I am **quite good at communicating,** I just don't like people. So that was quite easy identified	17. 469-483

	then, so I think then coming back to the second one [NMI] I was like yeah, I am actually, a good communicator it's the deeper issues that was affecting this	
Teamwork	**I wasn't surprised** with the teamwork score, but because obviously **the way the questions were formed**, I was quite, when I was going through them, I was quite certain I'm going to be quite low on this one I think that comes from a lot of the questions related to teamwork is how well do you **relate** to others and how well do you get on with other people. Which I don't, so if it calls for like working in a team and I have to **I put away all of that and I get on with it.** But because the questions are more how would you relate to this, I wouldn't, I'd be **terrible.**	12. 326-331 9. 232-238
Theme 4: Measuring nursing values		
Subordinate theme	Quotes	Page and line numbers
The terrible truth and the miserable nurse	I think I was initially quite worried because like I have social anxiety and can **fail this miserably** because it's going to say you know do you **like** working with people? No, **I will if I have to**, but I really don't. So, it was worrying that you know is this going to come back know you're a terrible nurse. So, it was a bit of a worry admittedly. I wince every time and it would be like oh you know how would you react to this situation and I know that's not the best, that's not the thing a good nurse would do. And it is what I would sort of argh. There were certainly times that I thought this is a terrible answer but it's the truth I wasn't like, when I got my results back I wasn't like, ohh you know **I'm miserable nurse**. Cause that's the point of being on this course is because at this point and I know that on this course I will develop to eventually be, be what I want to be the ideal nurse **I would be alright with being used,** because it's going to give it a better idea of the people that you, really, well you really want. Because again they can perform really well at all the mini interviews and then do this and then you find out or actually they're really not very good at, at things like, they've got really bad trust really bad integrity for example, and that's when you start may be call them back in and say right these your results how would you improve this. **It's not necessarily gonna be a no but how would you improve that and then at least it shows some willingness that they are willing to change and willing to adapt and willing to learn.** Yeah. I'm definitely going to take, take, them away and look and say right I need to do this I need to do this.	12. 305-311 12. 315-318 14. 375-380 22-23. 622-633 19.540-541

The lock in	**in my head it was it was an idea of I'm going to be locked in an office with one person they'll interview me for half an hour then I'll be locked in a room with another person.** So it was like it was not just one interview it's loads so I was quite **panicky**. So, when we arrived on the day I was **terrified** and then with a kind said we gonna call you in groups, I was like, okay can do this in a group. And then when they were the stations, I **relaxed** a lot. So I thought thank God".	20. 559-371
	so when you got in and they had like sort of all these **little almost games** some of them it was quite **enjoyable,** and it really made you think about oh why are they making me do this? **When you walked away you would think oh they are making me do this because of that and you're thinking, ooh did I do that right.**	21. 573-581
	Umm, I would be all right with being used, because it's going to give it a better idea of the people that you, umm, really, well you really want. Because again they can **perform really well** at all the mini interviews and then do this and then you find out or **actually there really not very good at,** at things like, they've got really bad trust really bad integrity for example and that's when you start may be for them back in and say right these your results how would you improve this. It's not necessarily gonna be a no but how would you improve that and then at least it shows some willingness that they are willing to change and willing to adapt and willing to learn.	22-23. 622-633
	I'd say actually this one [pointing at the NMI feedback] does it better because in the multi mini interviews we had like the desert one but I think that was more your logic thinking quick thinking and then you have, the only one that I really say actually looked at all care values and stuff was really one when we had to watch a **video**, which was how could you **make you feel** and that was really it, and then the rest of them were more how you communicate, how do you, how would you communicate with somebody who can't talk, what would you do in this scenario at University and how would you. So, it was more very much focused on your skills rather in your care values I'd say, the multiple mini interviews	23. 644-657

Appendix 19 Claire's themes and subordinate themes with corresponding quotations

Theme 1: Caring values		
Subordinate theme	Quotes	Page and line numbers
Care and caring	Caring means **being concerned** about other people and taking action to **make things better** for them. Or, not always **taking action** but **being aware**, and doing what you can to **ease their suffering**, I guess. I think I'm a caring person **I feel for people you know, I was sitting at home in tears yesterday watching the news**, and, **so I have that instinct** I think you know human beings don't really do to you know to care about people, umm, and but you and you've and **I think through my life I realised you have got to care for yourself as well you can't make everything about other people because you burnout so you have got to keep that balance as well. And you can't control people, you can't go around trying to fix people and change people that what, not what they want sometimes you know; the respectful thing do is let people be who they want to be and make their own choices** whether they are the ones you make or not. So, umm you know sometimes being caring means **not doing anything**, but umm yeah for me I guess, the caring is the, the I don't know, the feeling and the action then have **two different meanings for the same thing aren't they.** Yeah, I see that as **blindingly obvious** really, umm I think that's it awful to think that somebody might be doing a job like nursing and **not feel** for the people that their looking after, you know. The idea of somebody **ending up** in the profession just because of, I don't know, because of a financial reason or something or you know maybe it's their only option or something is, is **horrible** really	1. 12-15 3-4. 59-77 5. 97-104
Professional values	Professional values, to be honest, I think like for me that I use, I would like my values to be the same were ever I am it's not something that I would put on to come to work and take off again at the end of the day if you know what I mean. Umm so, but you know but the professional values umm I mean in terms of treating people, things like treating people with respect and you know and just (big sigh struggling with words) umm you know umm **there are so many, so many different things** To mean professional values, is kind of being a decent human being, I don't, you know, **I don't like this idea of professional having really judgmental and critical thoughts but not saying them and putting a nice face on** and then going home and enjoying those thought, laugh, that's not, that's not really how I see it to be honest. **I think it's more about being a professional person than having some values that you put on for the day.**	2. 21-29 2. 36-46

	I think that professionalism is just an **act** then it doesn't, then people will pick up on that, generally at some level people have a sixth sense for whether people mean what that their saying and people can be very skilled communicators but you, you still, you know it still, people it effects peoples level of trust I think, you know you see it in things like politics and so on, people aren't necessary aren't necessarily bound by a professional code. But you know that some people ring truer than others I think	3. 48-57
Theme 2: Recruitment integrity		
Subordinate theme	Quotes	Page and line numbers
Language of the tests	I think I was just frustrated because I felt it was like trying to get to something and I felt like well if I answer that question properly, I can't give you the answer that you want me to give you. Um I guess I still I have still got a little bit of IT geek in me and if you say something like, **always,** I'm probably going to disagree, you know were as if you were asking something you know is likely or common or often or ideal or whatever then I probably would have said yes 100% but if you say always, something that is, well there is always going to be an exception, so that's a **very black and white word** to use, so I might completely disagree with always, were actually I don't mean never, in the slightest I mean, yes pretty often Yes, I worked in the NHS for years I've done all sorts am I've been a manager in the NHS. So yeah, I think interesting that I came out with different answers I might have answered it differently across the two quizzes and again a person is a very odd erm as well because if you think you're thinking about toileting people think that its **unpleasant** but if you care about somebody you don't even necessarily think about it as unpleasant you might get a sense of reward of caring for somebody it's a kind of an odd word and then routine tasks you can think well may be part of being a good leader and organiser is getting the simple routine things done by people that you know efficiently if you see were so you know and yeah it was kind of two different questions in one for me I think on the first one I was just, I was frustrated by the language and I just ended up in that frame of mind well I can't say always so I will **completely disagree** or umm you know taking things **very literally**, I think by the second one I just set into a little bit more trying to be a little bit softer about how I answered it, yeah, **I just wasn't in such as rebellious mood that day I think.** So there is speaking carefully and communicating well isn't there, there were ones about **trying** and ones about **achieving** so I think maybe **skewed** it a little bit. Umm I got a bit frustrated at times, umm, partly because of the questions it was asking umm and I've done lots of different types of work and **I behave very differently in different kinds of work** so, I am think like you know, I	8-9. 179-192 18. 449-456 9. 208-209 5-6. 113-142

	mean I've had jobs in care I've had jobs were I'm an information analyst and I sit in front of a screen and it talking to people is general not part of my job. Umm, and I've had jobs were its my role to lead and jobs were its my role to follow. So how, what, the things it was looking at you know, you know the think of a colleague whose' attitude you didn't umm you know and I don't think that about many people. The last person I could think of was somebody I worked in, that was in information analysis, and what makes somebody, (laugh) and **what's a bad attitude for an information analyst, isn't necessarily what you would think was a bad attitude for a nurse**. So I felt like you, you know so I felt I answered to a couple of the questions you know thinking about this person, and I'm thinking well I had better be consistent but I felt like you know I was, it was **miss representing** or it **wasn't giving you the answers you were looking for.** And then there was things like what would a good nurse do? And I was like, oh, I'm not a judgmental person do you know what I mean (laugh) so there are lots of ways to be a good nurse and like some of them I could say yes, any, anyway I could imagine a good nurse, it would always come out at this end of this scale (indicating the preferred pole). But some of them I find that real hard. Yeah, and the ones were its more different is generally to do with communication where I think **there is more to learn, there is more to practice** in some situations that's asking you to weigh two values and again somebody who's being in more situations that are difficult were things are little more grey and little less black and white is going to answer differently than somebody who is just kind of coming into it I'm thinking about mental health nursing, you know, people want to leave you can't let them. That what I'm thinking about, they have got a right to liberty but you're not going to let them out the door. Umm so I think an adult nurse might have answered that differently	10. 238-240 28-29. 716-731 13. 312-318
Paper faces	I I've studied computer science so I've worked in information analysis I know a lot about how things are measured and numbers and I, I don't, I don't know, **it's a drop in the ocean of numbers** out there and you know if I had been to an interview and they said oh you know you didn't get in because we don't think you've got any integrity and we can't really trust you based on how you answered **I'd be fuming I'd be absolutely fuming.** But you know it's a **piece of paper** saying how I answered them and how it adds up that's not something **I'm goanna get emotional about because it has no impact on me whatsoever.** Yeah, no I trusted the piece of paper that said I'm not going to get kicked out of uni if I tell you the truth and you don't like it so (laugh).	14-15. 342-354 8. 168-170

	Yeah, **it's not something that I would attach a lot of personal meaning or importance to really** because I know that you know. I would not see it as a measure that I particularly trustful of. I think if I were interviewing people and I had the choice of talking to somebody or getting them to **tick some stuff** I would talk to them. Umm, (long pause) you see you don't assumingly you wouldn't get to see your results so it would all be transparent and you would not know what, you would not know if they have a true picture of you or not anybody know how much of getting turned down was values and how much was **15 million people have applied for this and there was only 50 places**. umm but yeah, I think you know if, I don't know if, I don't think I scored less than the group on anything, but you know if somebody said to me oh you know, your integrity levels weren't high enough or whatever, umm I but then I have that reaction I've, every interview I do **I go and I be myself** and if they don't like me that's great it's not a good thing for me to be there. Well exactly, you know what I mean, I don't know if I scrapped through and I did terribly on one of the things or if I you know got 100%, I've literally got no idea. I think I probably given somebody a much clearer opinion, I could give somebody uhm, a more accurate representation on myself in less time, less of my time, face to face. **I would respect the university more for ahh taking the time to judge people in person.** I think, and I would, and for me as well when I do think **interviews are two way, you get an idea of what you're getting into and it's nice to have the opportunity to do that to come and talk to the people because you know as a** student, I was in a position of choosing between two universities and lots of different things go into that **choice**. But **the personalities you meet on the day make a difference as well**, and so yeah, I think would probably if I had done this and been offered Cardiff and the MMI at [name withheld] I'd have felt more **confident** that I am going to get on alright there because they have **seen** me, we have talked and they still want me to come.	19. 465-475 20. 494-496 23-24. 594-610 25-26. 642-656 25. 626-631 29-30. 754-771
Theme 3: The MMI experience		
Subordinate theme	Quotes	Page and line numbers
MMI as the strange	When I got to it my first one it completely freaked me put but again, I knew what I was expecting the second time the Cardiff one was more normal, but **I think it would have effected like which order you get them in, might have affected the result quite a lot.** Like I did the aeroplane one 5th out of 6th then the 6th one was to watch a	20. 501-507 21-22. 517-538

	video about privacy and dignity and then talk about it. I had **gone fully** into the plane situation and was still thinking about the plane situation and I didn't have any focus at all for this video umm and kept trying to ask me things and I was pretty much blank because my brain had just been consumed with what am I going to do with these items when I don't really who are we and who are the people (laugh) do you know what I mean. things like communication skills this is measuring my measurement of whether I think that they are good enough were as that was you know, tell this person how to make and origami bird so that was very specifically can I can I get this person to follow my instructions, you could tell by what happened whether I could or not. So yeah, it's it, that's would you know, that origami exercise would have been a much more accurate measure of my communication **providing the person that was assessing it was fair umm and you know equally peaceful throughout the morning** (laugh).	25-26. 642-656

Appendix 20 *Fiona's themes and subordinate themes with corresponding quotations*

Theme 1: Values		
Subordinate theme	Quotes	Page and line numbers
Fluffy hats	So care to me kind of **automatically falls in to like healthcare** so it's being kind of **professional caring** for somebody in a **non-judgmental way** umm meeting their mental and physical needs to **the best of your abilities.** That, the other kind of side which is care and caring you kind of cross over into the professional field, I think caring its **fluffier** its little more blurry it's potentially what you kind of say to your friend like oh your so caring. Which I don't know I don't know why that's how I see it my head. But then at the same time I've had working as a support worker I've had people going ohh your so caring so I think probably that's my own perception of the two words cause obviously kind of like a patient hasn't been able to separate the two but I have in my head.	1. 6-23
	Umm I suppose so, then its (laugh) no I was, was going to say then it's of you know when you break it down does that mean that the care that you are **delivering** with your **professional hat** on does that mean that you don't actually care about the individual, you just do it because it's your job. So that then kind of makes it sound a bit **mean**.	2. 27-33
	I suppose like umm, I could only really compare it to like umm to my previous work experience umm and I think some of the characters that I worked with or umm they were they had kind of been in hospitals, umm they had been quite **institutionalised** and umm they saw very much, people **doing stuff for them as care.** Were as I saw giving them skills and encouraging them to be independent as care. Umm, so that is what I mean, their perception of care may have been somebody umm like making all their food for them doing up their shoelaces making their beds, umm you know were as I would be more kind of let's do it together. So that what I mean by their perception of like traditional care as opposed to mine. I favour mine but as long as it meets the individual's needs, I do favour mine cause they are not umm **I think that they absolute satisfaction that they have once they have done something for themselves** like beats all the umm (groan) kind of like pre like.	7. 146-164
	I think probably when I go to work or when I go to uni, I have a like my **uni hat** on, or my **work hat** on and when I go home I have got my hat on. Not that I am complete opposites in **those characters,** but I think I have to have those hats I think they, they help me, not kind of like. **I go home and I am like snappy with my partner and I swear and I'm a bit lazy those aren't like great characteristics to have as a student nurse or as a, a support worker within healthcare. And I know that but I can't be, I have to have that kind of that separation, yeah. I think its resilience; I think you know you have**	15. 367-378

	to let off some steam and you have to kind of give it a good old swear. The fact that I know that those characteristics do not translate well into the professional world that's a good thing.	
Going the extra mile	I think I am I think I'm caring I think that I, I think **I'm quite sensitive to peoples like body language and that flash of uncomfort** that they might give you then they try to hide a way. So I'm quite **sensitive** to that, and I try to, cause I'm not perfect, but **I try not to push in, I try to take a step back** but then sometimes you know you're not perfect. So I think that's kind of like quite a **caring skill** to have. I don't mind **going the extra mile** for somebody cause I would much rather, I try to see every day as, like when I go home and I like come of a shift I always, when it comes to like, like finishing the day of at work, I always think like have **I tried to do the best**, like no matter what it is have I tried the best. And if I can actually say I have then that kind of I feel quite pleased with myself but if I can honestly say like no you haven't you have been **cheeky** today then I will go back out and **I try to make up** that I feel whatever it is that I didn't do like 110%. Like that promised cup of tea that you have not got round for to kind of I'm really sorry about that and I think like that's caring".	6. 112-133
Butterfly's and guns	I think being professional, I think is something that you have to work out throughout many years only because it is constantly **evolving**. And you're constantly meeting different people umm and you do meet people that kind of have a different perspective to you and their going to catch you out. Umm so I think, I think to meet somebody who is like 110% like professional and have full kind off **integrity** within their role I like take my hat off to them I think it's like it's, I think it's difficult. I think being professional to me is keeping your **opinion** to yourself, and not having you vision blurred by the work culture or by, or anything like that that could basically. So that kind, so that kind of like having your opinion, a **good opinion** and **sticking to it**. And I think, I think you have to be kind of be a **real strong person** to have that cause I think some people can be **swayed.** You know, which is fine if your swayed the better but if you know, if what you thought was **the right thing to do,** but you allow somebody to sway or take a short cut then that's like a bit sad I think and a reflection of like your potential kind of like belief". I can't kind of construct my argument as well as they can and I find it too awkward. When I have been assertive or delegated duties I find it awkward Yeah like I would not say that I would, I would think that I, that I that I would do that or that I encourage but I would say that definitely seen it. People have been in the same job for x amount of years and or they have been working with a, like the other day I did like an agency shift with umm a rehab centre and there was this gentleman umm for you know X, Y, Z he's now in a wheelchair and he can't move his legs and he one functioning arm but even then it's a bit of a struggle and umm and his ahh his vocabulary is really poor and it's his processing ability is kind of delayed so you'll ask him one question and then two minutes later he'll answer it umm which is like fine. So basically, he said, he'll ask me for a cup of tea if I went and got him a cup of tea and will want a second cup of tea within like half an hour and the staff were like ohh **he's going to have you running rings,** and I was like what else am I doing, what else am I doing this morning? I'm bored if he wants a cup of tea its fine and then I went and gave it to him and he was like I don't want it. And I was like so cheeky (smiling). But it was	3-4. 51-60 4. 66-79 17. 404-407 8-9. 179-219

	fine, and then obviously like what they said and then he was like didn't want it but he like tested me. He obviously didn't want it and was like your cheeky and I just thought it was funny and then I came back to check on him and he was like he seemed to me he seemed distressed I'm in pain I want some pain killers so I went and got the staff to get him some pain killers and **they all just sort of rolled their eyes**. Now I got ahh here he goes again (groan) and I was like I don't care what you think has he had any pain killers in the last 24 hours or last 6 hours like just give them to him. Cause it's like you don't know and he probably was in pain sat in chair and a bed and stuff like that and I think that they have potentially well I don't know who they are as people but you don't know if that is kind of poor management the culture of the workplace or they have been exposed to this patient for too long so that they feel that they know him better than he knows himself.. so they are like uhm (groan).	
	They do have meaning, I think its again the confidence thing I think I have to and integrity umm that's like a big one for me because there have been situations in the past were I felt really strongly about something but I've been **intimidated** really easily by other people so I have been like, okay I don't know, umm and that really frustrated me then and it frustrates me know and that is something that I really want to work on and a lot of these the questions as I said it highlighted **double standards** and I won't be completely transparent in the way that I practice so obviously it's kind of as I said **double standards** no I want to like stand across the board and yeah kind of umm like go back to the integrity thing I think potentially why have I kind of weak in the past and it's because I have been intimidated by people and they just seem to know more than me when even at the time I feel like no I know I do know more than you but that I just thought whatever reason I just can get it out. And **I can't kind of construct my argument as well as they can and I find it to awkward I have been assertive or delegated duties I find it awkward** which is something I really want to work towards and when I think about a good like nurse that I have worked with before is that that kind of take on board what you have said they are like Yeah, yeah, yeah they are very kind of interested in why you have got that opinion and then they'll somehow give you theirs and you kind of go oh yeah that's good but you don't feel like they have pushed it.	16-17. 386-415
	I think umm but with any role it can be quite task led. Your put **under pressure for X, Y and Z** and it can be quite drained by they like a particular environment or by characters. And I think it could be **quite easy to lose that compassion or lose that caring side** and I think it's really important to keep it.	8. 168-175
	I think like in regards to like a nurse when you meet a good nurse you know that you have met one cause they are absolutely like butterfly's when it comes to communication and people skills and that is like the nurse I aspire to be.	4-5. 81-90
	they are very kind of interested in why you have got that opinion and then they'll somehow give you theirs and you kind of go oh yeah that's good but you don't feel like they have pushed it. **They just stick to their guns and they are very kind of factual positive way and you kind of end up taking it on board and you feel empowered by** it, like how good is that.	17-18. 412-417

Theme 2: Complexity and desirability		
Subordinate theme	Quotes	Page and line numbers
This isn't black and white	I mean when you become a bit older you become quite fearful of things and you understand complexities of things	26. 659-661
	I was constantly thinking this is kind of straight forward answer but I can't compare it to a straightforward situation because health care and individuals are so complex this isn't black and	13-14. 314-336
	I've only really met like one ward manager and she was like horrible and I think I can't really use that to taint my whole vision of ward managers but then I've only go that to compare it to	11-12. 271-283
	they are only goanna have their imagination or here say to answer that question. I don't think it would be fair.	26. 641-645
	I could however I could either do what's like what **the obvious or I could, could go with like my honesty** and how I feel and that's and that was kind of the **constant battle** I had but I do think that I answered it like truthfully I don't think that I, well no she needs the, she needs honesty.	12. 291-298
	even though you have been like we are not going to tell anybody the results its between you and me part of me is like (sharp intake of breath) what if I am like really bad at this and she has to?	11. 255-262
	So I was like marking myself on like because I went because I think because I know like how complicated things can get and I was constantly thinking this is kind of straight forward answer but I can't compare it to a straightforward situation because health care and individuals are so complex this isn't **black and white** that's why I kept marking myself quite **low** because I can't **guarantee** that I can walk into a room and talk to an individual and their going to get what I am on about I can't guarantee that. So I felt that. It was wrong of me to suggest that I can suggest that I can do everything like that like my communication my umm my delegation and **everything like that is a 100%** because I don't know what I am going to be walking into so I kind of so I thought that's probably like why I got lower and then I thought ohh I should of kind of given myself kind of really high and I was kind of no that's not like I'm not being true to myself and I can't guarantee like everything and I know the experience I have and I know that I am good at certain things I was just like what if I am in a bad mood one day what if I umm patients in a bad mood and I can try my best but it's just not happening.	13-14. 314-336
	So did you almost see this as a pass fail thing then? Yeah I suppose I did yeah I did and that's where I kind of felt myself considering that matter that when I start thinking about how I gave my answers and what I was feeling and why I was like	14. 347-354

	why I ranked myself either quite low and it was because umm you like **lack of confidence** and umm not being able to ensure that **I can do what it says on the tin,** cause I can't. Ok I thought I was kind of like ohh I fall quite short of these umm but I think what I kind of I think this the test umm to me when I look back I was like ohh no was that it was more that got **confidence issues** and **I don't like to be cocky** As I say I think its going away from it and thinking about it, and yeah and just seeing just how because when I was the first time round I kind of as I said I kind of I got the gist of the questionnaire then I went away thought about it reflected on it and umm I thought I just can't give you yes or no answers it's just so complex. And I think the second time round I kind of stuck to that a bit more, umm and I **felt more comfortable as well and I felt I was able to justify it better that I was being truer to myself.** I really want to work toward I aspire to be	13. 308-312 23. 578-586 17. 408 5. 90
Seeing the person.	It was good it was interesting because I had been to like carers interview at [name withheld] and they did it **completely different** umm I think I was I think I was free cause **I had looked into the MMI and wanted to know everything about it like where it came from the point of it and everything** so I did quite like that umm and then I was a bit of mixture of interview nerves plus kind of umm anxiety about the MMI umm to see what was going to happen and that I think when I actually did it I was OK well **I was like fine I kind of walked away and I was kind of like if they don't give me a place I don't know what's wrong with them,** umm but I felt like fairly confident that I was being true to myself um my ooaa I remember the students were actually harder to convince than the people doing the, there was like two student that accompanied the um the professional that were doing the interviewing and they were so much harder to win round than the professionals they were just like dead faced, yeah I was like come on. I still think that it's a bit **peculiar** that they don't have a group assessment to see how you would work in a group. With its nursing **your constantly with groups of people** with **the computer** you're not really interacting with the person **you're not getting a feel for them** and I think really important because **you could do everything by the book** but if you haven't got the approachability. Yeah this was very professional this was very kind of that aspect that kind of area were as the MMI was more about how you how you worked as a person how yeah how your brain worked and how you perceived stuff which was fine were as **this was very much right you're a nurse you're on the shop floor what do you think**	24-25. 596-615 25. 617-618 28. 696-701 25. 630-636

Appendix 21 Mary's themes and subordinate themes with corresponding quotations

Theme 1: Values		
Subordinate theme	Quotes	Page and line numbers
Unspoken things	I guess it's something that inside but I feel like it's always like a doing verb as well if you know what I mean like caring, I guess it depends, I think it's something that is **obvious** that you need but it might me a **little bit hard to pinpoint** but I guess it is kind of like caring compassion and empathy like. I think it's like something that can't really be taught like **you either have it or you don't** I don't know like maybe it can be I'm not sure but I kind of feel like yeah it's kind of something that you kind of **your either that kind of person or you're not,** I don't know. I think they yeah they definitely should be caring they definitely need to be umm yea I guess cause it's like a bit of a like hard thing to define isn't it so it, it is kind of a bit of an **unspoken thing that you have got to have those qualities.** I think caring is definitely a **massive part of it** umm but I think the professional values kind of keep everything at a **higher standard** because you can be caring about somebody but you can also sort of if it's **done** in a way that's not **thought through properly** it not got any standards involved that's not very helpful so I guess it's kind of a standard. The professional values keep caring at a high level. Does that make sense?	3. 51-55 4. 78-85 4. 70-75 2. 24-31
Selflessness	I haven't really had any colleagues that I don't like really, but well I kind of get on with people really easily so I've never really had any issues like that but there **are a few people that I find a bit more difficult to work with and they are people that don't kind of go above and beyond for other people.** For like clients and stuff and that's the only thing that will annoy me at work, is when like people aren't putting like service users first. And that was quite interesting to think about because yeah I could not really think about a colleague that I don't like but the only times I have been annoyed like a little bit annoyed is when it's like they like not kind of **going out of their way** for a service user. Well not like out of their way but like you know they are not showing enough compassion or whatever.	5-6. 107-120
Burnout and mindfulness	I mean I guess you could learn some of it but kind of like putting other people first I guess kind of does but then obviously there is kind of the whole thing of becoming burnt out and things like within the profession so that certainly changes that. And I've like, I've had burn out with my other job before and it is just, it's **horrible** you just you just can't care about people	12. 283-293

	like, you just like have to take a couple of weeks of or whatever like you know and then like it kind of comes back, yeah it's a horrible feeling and **I guess maybe that would like impact if someone has been in the job for two long maybe.** Well the scores I guess are better aren't they like what where the value is I suppose umm yeah so let's have a look. Umm I guess I've probably got the ideals like [pause] oh I don't know I guess again these I think might have been taken into consideration, time pressures and things. Umm. [pause reading results] always thinks of others, I think maybe I was going a bit from a place where I need to, cause obviously coming from my last job, that **maybe I do not need to always think about others and sometimes I do need to think about myself.** Umm. Maybe I was still in that mind set umm after being a little bit kind of burnt out by everything. Yeah I guess its interesting with the, like the comparison of kind of were the values might go considering like I'm actually in work and you know tired [laugh] jaded and all of that it's kind of being really mindful of all of those kind of things as well, you know you don't want to get to the point were your not like being compassionate or you. Not like I don't think it gets to that point but I think like you can be like it can impact you, you can like get really tired like I said **there is only so much of you to go round isn't there you've just got to be really careful of that kind of thing**	16. 383-395 21-22. 526-536
Theme 2: The test		
Subordinate theme	Quotes	Page and line numbers
Confidence	I think like being like slightly **above average** on, on the personal cantered scores, like I said it's something like I think it is a skill of mine and that is hard for me say like or to don't have very much confidence like. It's just **nice** like yeah I guess. Even for me, like even for my own confidence I guess. Its not like, I don't know. It's like hard to admit when you've got a skill so yeah its **nice**. I'm just not a very confident person, yeah so I find it really hard. It's taken me about 15 year for me to like admit that I've got a skill in like talking to people and that's about as far as I can go. But I'm not a overly confident person so yeah that the only other thing that I can think about. I think may be like potentially like the content of some of the lectures we have had has kind of like **shaped my ideal of the model nurse**. umm and stuff and yeah because yeah and then maybe like, like maybe seeing myself a bit more in that as its gone on potentially. Yeah so that the only things that I think of that would have **influenced** the scores that's more of a confidence thing, feeling like I'm not, because I'm not like that experienced in healthcare and stuff	20. 502-506 21. 508-511 18. 449-461 13. 320-323

	Cause again I guess confidence comes into it as well you might have somebody who doesn't answer as well as maybe they would work and that would be kind of a shame	25. 613-618
The model nurse and me	I don't know, I don't know I just think I've just got a bit of a view of nursing as being like you know **special kind of people** that are obviously because I do think that this is like the core of it so umm yeah you kind of think that umm yeah. I guess cause they have **inspired me to come into nursing** and maybe they would understand it more or maybe I don't know. it [the test] was kind of like asking what your best friend would think and **she's very like me, so it was like, so it was like and obviously we value that in each other.** I was like thinking because they **need to be able to work on their own as well.** Obviously, they have got to be really good in a team **but you have also got to be able to work on your own and make your own decision and things.** I do enjoy decision making but I don't feel competent. I can't like imagine being that competent yet do you know what I mean, that seems like a million miles away". because of where I am I feel like that is going to be challenge like, especially on placement and stuff, like if I see something that's not right. Take time for tasks… I think for that one I was really considering time pressures and worrying cause I am really worried about that. You know I am actually going to have the time to do you know, to do a proper job?"	11. 268-272 20. 492-494 5. 96-100 8-9. 196-200 13-14. 328-331 14. 334-337 13. 323-328
Pinch of salt	Well I guess it's making sure that it's the **right types of person for the job** because it is I think like I've already been saying it's, there is something quite innate that you have got to have like to be able to it which I guess like yeah like compassionate and caring it's a bit more I don't know it's like, yeah you do kind of need to have that **I don't know how easy it is to test for it** I don't know you kind of **obviously** have your model of a nurse and **you put yourself close to that wouldn't you**. **Like, like cause good communicator, good teamwork, good listener that kind of all the skills you need. Cause as a nurse you're like yep yep yep to all of those things.** Yeah I don't know I think I can see how I think it would be **useful.** I think it would be useful to do it with the applicant but, I don't know with **a pinch of salt, and not rely.**	23-24. 570-577 24-25. 602-616

	Yeah no I don't know I just kind of thought that, yeah if **I just answered honestly then like hopefully I'm not going to get something back that I'm not a complete psychopath** [laugh]. I say it was different but it's not like but it's not like an actual recruitment task, I guess it's because **you don't like have to worry about being a certain way** it's just what you think isn't it, so yeah I think like obviously the interviews were a bit more intense and yeah you were trying to come across a certain way in like evidence like you are X Y and Z so yeah umm yeah so this is like a little bit more enjoyable I guess cause it's like genuinely just seeing what comes back.	7. 153-156 29. 693-701
Theme 3: The MMI		
Subordinate theme	Subordinate theme	Subordinate theme
Demonstrating understanding	I prepared for the interview, like I need **to make sure I say this and demonstrate this and make sure that I understand this. So you know it is almost like yeah they're going to have a list of things they're looking for aren't they** and, you know, I guess you have kind of got to demonstrate you understand**. Do you understand the role, do you understand why you're there, why you want to be on the course** and that kind of thing so yeah. Yes it's kind of like a job interview kind of isn't it. But whereas this [NMIST and NMI] kind of **gives you those things and you score**" probably this [NMI] this feels like it's in **a lot more depth**, and yeah and feels a bit more **robust** so yes. I don't really, like with the MMI I didn't, well I could **see what they were getting at in certain, different stations**. But yeah I don't know how well yeah I don't know how well; cause I guess it's like at interview I don't know how well it would have come across and it was kind of more **up to you to say the right things** were here it's the statements are there and you have got the say whether you agree or disagree. Like I might have missed out half of these things in the interview I might not have just said them or thought about them at the time or whatever. That was really fun I think. I have quite liked to have had a bit of a longer **chat** with one person because I can't remember, like I can't remember who was there and I kind of think like have been a bit nicer to have that and then a **longer interview with someone.** Like not a formal one like a bit more of an informal one. So I could see like what they were getting at with the multiple interviews and I like it was fun it was nice so yeah. But like I know there was one question on dignity one about like integrity. So it was asking about like what would you do if someone was cheating in an exam. Why do you want to be or what do you think nurses do? Why do you want to be a nurse was one of the questions. And there was kind of ones that were like about, yes, how your verbal communications, like explaining to somebody how to make a house, I think it was, and then how to, what would you do if you were stuck up a mountain with various things. I don't know how well that one went. So yeah I thought, I did quite like it, because you could see what they were kind of try to test you for and stuff which is	26. 648-658 25-26. 629-642 22-23. 541-567

	obviously you need to know like before going into the course. **But I do I think it would have been nice to have like a one to one like informal chat with someone for a bit longer as well.**	

Appendix 22 Pauline's themes and subordinate themes with corresponding quotations

Theme 1: Being the nurse		
Subordinate theme	Quotes	Page and line numbers
Emotions and relationships	I always look at it as it's **something personal** it is something that you would want done for yourself, so you look at it as if I was in that position how would I want my care to be given and **how would I want to be looked after** and sort of just (pause) **sort of putting myself in their shoes** in a way sort of thing	1. 25-29
	Having like, sort of, a **good emotional relationship** with someone. And sort of help with sort of how they are emotionally attached to you to **create** a like, I want to say a **symbiotic relationship.**	2. 47-58
	But it's still, it's not just like in workplaces i**t's something that you do in your everyday life**. So it's like, insuring that someone is happy. If they like, like not feeling any stress or feeling like down or like anything like that. **So it's like looking after them emotionally as well as like making sure that yourself that you are emotionally capable of doing it as well.**	3. 80-85
	I think it is something as like there is something that needs to be done and with that because the amount of cases that have come out of like with everything it does sort of make you feel that maybe that there is something that was **missed** like perhaps like earlier on but then at the same time you do have a lot of good nurse and you only get one or two that would give you a bad name.	5. 145-150
	well my mother was a nurse so like when she was like working she was she's retired now and I do feel that she is caring and **compassionate** she's **brilliant** obviously she's my mother (laugh). And I, because there have been so many like **incident reports** and **reviews** into like care given to patient that I think that there is something that perhaps needs to be **monitored** then within for everyone in like the caring professions like carers, nurse, doctors everyone I think need to have like some sort of monitoring of how they are doing it which they do have umm but I do think like care and compassion is something that needs to be like for like a blanket case for everyone because of the role that you are doing I think it does it sort of for nurse as well as for student nurse then	6. 167-175
	in a way it's like how you have been brought up to act and its sort of… it's something you want to do instinctively then.	3. 80-85

	I'd like to hope that they want to copy me like copy what I do cause I want say **I know everything but like from like fundamentals of care** I feel as if because with my experience I know how it's done, but I sort of I hope people think **I know what I'm doing** and would follow me and like listen to what I'm saying. I think they have the **fundamentals** of like what you learn how to they know how to do that but I think like the emotional side of **it is not quite there**. They sort of like **robotically** going, doing, doing the task rather than **sort of responding to like the patient** or like the resident or something like that. I do sort of like not **mimic anything that they do** cause of I am aware that, or I, I feel that **they are not quite up to standard then.**	4-5. 126-130 4. 112-119
Guidelines	I see them as a sort of a **guideline on like, how to care** for someone and how to look after them how to. If it's sort of a way of protecting yourself as well as sort of protecting them, the patient. Because it, you know, where there guidelines are. **You know what you are meant to be doing and if you're not doing them then it's your own fault, because you are meant to know them.** And it could let some patient because then its (pause) it allows them to **feel umm secure** that what you are doing is the right thing because that's what you have been **taught** to do that's what the guidelines are say you are supposed to do. So It, I think it's very **important** as a nurse to have these guidelines **because if you don't have them then you don't have a set rule for everyone to follow when that way you get like different, different like methods of doing a certain task**. So by having a guideline by having a, a set of rules that you follow it means that if something does go wrong you weren't following the rules because that what everyone's supposed to do so it's it protects you then in that way. and sort of like so from like lectures and stuff and I sort of do feel that I have the **instinct to be a nurse** ... but... it's just getting the like umm **procedures and stuff down now as well so it's sort of back it up then**	2-3. 59-76 3. 87-90
Theme 2: Assessing values		
Subordinate theme	Quotes	Page and line numbers
The test	the first one was a bit more **nerve racking** than the second one because I didn't **know what was I was doing** or (laugh) You're going into **something completely new** so I was like ummm (laugh) but umm I think ohh it was all right I did alright I think no it didn't really faze me it was the actual test and what it was and what I was meant to do etc.. because I was coming into this with very little nursing experience so it's like what are they going to ask me to do, what do they (laugh) **I don't know anything.**	6. 80-83 7. 193-196

	what like when it was refereeing to like umm a person you admire sort of thing I was looking at I was thinking of my mother and sort of doing that and then someone I did not want to **imagine** myself as I was thinking of like the other career that I spoke earlier about like the robotic movement and stuff so there is like a remembering like when I was in work and like who I **didn't want to mimic** and who I would mimic and it sort of bringing up the emotional attachments that you have with those sort of people sort of creating my mother in like a **glow** like **making her perfect** and sort probably big gold star for me I think but yeah it was I do sometime like now I think back and sort of did I purposely make it lower for those like I didn't like just because of the fact that I didn't like how they did their work and made it so that my mother was even better than perhaps she was because I have **positive emotions** for her so I don't know whether I did that. I think I sort of like when you discussing the nursing I sort or saw it as how wanted to be when I umm graduate as a nurse and looking at myself like as I was like two years ago I think it was so it's like looking at what I was as a carer so it was I wouldn't say I was **exactly like a nurse** I didn't move my mark up to be the same as a nurse **I sort of moved it down** because I was like uuuhh I was only a carer then so I was like ummm so I moved it down a bit like but I think I was like trying to I wouldn't (sigh) I wouldn't say I was trying sort of belittle what I was doing two years ago because I did fell like as a carer, I was doing I was (long pause) I was doing good I was like I was doing a good job but I was I didn't want to sort of make it seem as if I was a nurse already because I'm not. I sort of feel I am at the moment not a model nurse I'm not there yet so I sort of felt that I needed to improve in order to get there before I am actually there yet. So I think I did sort of perhaps mark it down a bit because I was I felt I'm not there yet **so move it down a bit t**his is what I want to be this is what I am now sort of thing I think it was because (pause) I we had **a few more lectures** and I got a better like umm **impression** of what a nurse is compared to what perhaps I thought at the beginning of the year so I think my answers did sort of were like umm affected by that because I had the lectures beforehand so they did sort of **colour my opinion** and they did make a little difference so I think probably that's why my answers and different I would probably feel as if like, oh was it **good enough** or isn't a good enough to like, the means to let me like **slide through** like. Or is it like, is it not good enough, do I like **improve**? **is this something I can improve on**? And not to just like maybe **try next year** or something like that. I think at the moment with the results I would be happy because I am pretty happy with the results so yeah.	7. 207-222 8. 234-245 12. 373-379 13. 392-398 16. 503-508
The report	because my scores were **pretty good** I would be **happy** for it to be used but I think if I did have umm lower then I probably would be a bit more panicky about it	16. 499-502

	It does sort of give me more of like the **confidence** that **I do have like the personality for being a nurse.** It just sort of like, I say that like if I didn't feel that way before I did sort of feel like, oh I could be a nurse. It just sort of **boosts** that to say you have got the **personality** as well for backing you up to do it like sort of thing. I feel pretty **proud** of myself really that it was they were good (laugh) so yeah I was quite proud of myself what is my **marks** so yeah I think that I said really just **affirms** that I've joined like I've made the right **choice** like with going into nursing because there was something I have been thinking about doing it for a number of years but it was only like last year that I said yeah I'm doing it … like apply now sort of thing so I think it does sort of back up that I made the right choice and that I'm doing the right thing at the moment so yeah so it gives me a bit more boost of confidence like with that I suppose I see it as like a test like an exam. I think I would try and sort of like **build** myself up to be **how I see a model nurse** as I think I will sort of push myself to become what I see as is like a nurse so I think it will sort of (pause) **colour my opinion** of myself and sort of like try to build on myself up to that roll and that I feel a nurse is so **it will make me work harder to be that nurse** then so yeah I think it will like look into it in the future	10. 290-299 10.304-306 10. 321-326 10. 309 14. 440-445
The MMI	I think this may have reflected better [indicating the NMIST results] because, especially the second set of results [NMI], because I knew what was happening and I was sort of perhaps **reading a lot**. Like before the multiple mini **I looked up on the internet** what it **means** to be a nurse and things. Like **making notes** like of those kind, of **those kind of those** coming in. So that when I got to the actual interviews **I had something in my head of how, what the answers they were looking for** sort of thing. But with this [indicating to the test results] it does sort of, you kind of know what the answers that they are looking for, but it is more of your own personality then as well. Because you do have the, what do you think the role of a nurse is and what you yourself feel you are, so it does sort of represent you as an **individual** more than perhaps the multi mini's because for my own experience **I practiced what needs to what I felt needed to be said**. ummm one thing I do remember is I felt like I was **repeating** the same thing over and over again with like I think it was **nerves** more than anything and like only one thought popped into my head and that was all I could like keep saying (laugh) especially for like the first one I went into I did feel as if I was repeating myself over and over again but I think I was like as I was going on I did sort of **calm down a bit** and I was able to give **more than one answer** so umm but yeah I think I can understand were like the each test like each of the booths came in like what it was trying to sort of umm look at as you as a person umm I think well most of them I could I could probably identify like with communication with compassion and then as well with umm I think one of like I guessing is knowledge like how much you know and what you would do for like emotional	17. 512-525 15. 456-481

	and physical like wellbeing ummm (pause) but yeah I think I would looking back at it I can identify but at the time I was like oh god get everything out (laugh) it was a bit like **knowledge like throw it out** and hopefully I'll pass (laugh) at the time but looking back at it **I can see now why each booth was chosen and why like each task like was chosen for you to do** and they did sort of it it does now sort of affirm that that yeah they were useful they were good for like **assessing people** coming in to enable to identify if you have the right personality then for the roll like sort of thing so I think it's better than like an interview an interview you sort of you even more nervous for that rather, then this the multi minis because it sort of like it have mini interviews but then mini interviews but **less daunting** as like three people sitting in front of you and your like ohh	

Appendix 23 David's themes and subordinate themes with corresponding quotations

Theme 1: Being the nurse		
Subordinate theme	Quotes	Page and line numbers
Caring and competence	Caring means **being there for someone.** Looking after them and **treating them well.** And, you know do whatever you can to, for the person you are caring about. And do **as much** as you can the best of your **ability** you know that's and, if anyone come to you, asking you your help and then try to **help** them out. And caring is like you know like compassion and you know like it's, they know, they know you **want** someone to **help.**	4-5. 64-74
	professional values mean you know you **learn something,** you've been **trained**, you entered to the professional and then you gonna **apply** that	7. 109-113
	as a profession yes if you become a profession your to be trained to be a nurse or social care or anything else you are **willing to care.** Your willing to help someone. That's what I believe is the professional way	5. 78-85
	In family care for example you know you got children umm (pause and stumbles over words) you care about them, you don't want them to be **harmed**. You don't want to, you don't want to be to them you know to be **sick** or **ill** that's what you care about. But when you come to the err umm someone ill or in professional. Its sick its err you know umm you **need some help** and professional you know when your **competent** you are going to **help** them out.	6-7. 97-105
	you know the person you are caring about, **dignity.** You have got to give them value you've got to **respect** that value. That's, that's all in the professional way of the nursing so you got you know look you have got to respect that value for an individual	9. 128-135
	Ohh okay well, this I entered into this course yes you know three four months but I've been, I've did you know caring job about 2 3 months it was good. You know you've got to be you know umm interact with someone you know umm **isolated,** so someone is **sick,** someone **can't who you know look after him themselves**. So, you know that that's. make me you know, feel you know umm rewarding and makes you feel you know happy, because you are helping someone.	9-10. 139-148
	competent means you are **physically competent** to do the task it's not only about you know, clinical signs. It there for any complicated way of thinking. But as if first stage or as a beginner you confident that means are you	30. 503-515

	able to something physically maybe. You know I think of it like that you know are your health physically fitness that's competent I think that way as well. But competent in the other way as well when you become a qualified nurse you know what you're doing as you able to do this when you are given a task to do something that way I was thinking	
	well you know when I work in my caring work and my supervisor he was happy ummm one day you know we went to one of the elderly man. He can't do look after himself. He was lying down and then umm (pause) we arrived we had a phone call from a nurse she said that he you know this person has been lying down nobody is here can you send someone we had already been there in the morning, but, umm bout ahh 11 o'clock or something when the nurse comes he was lying down the once you did your caring, his breakfast everything you have to go. And then we have a phone call. I don't have a car so that this provider we wait together then we find him then I went there you know I ask him how you feeling and we lift him up put him in the chair. We change everything. So he's seen that you know, he was happy and then he said to me that was a **good job**, you know you did a **good job**. So he was happy, he gave me a lot of day off. (laugh)	10-11. 156-176
	absolutely, yes, they have to be you know, that a **pre-sequel you know of the Department of Health I think**. So **you have to be compassionate and caring** you said compassion and caring yes. Because, **if you're not compassion how you going to do your job?** You know you need to have some thoughts some capacity oh yes so, yes of course you need to have be compassion to be you know kind you need to be you know you need to be you now like enthusiasm yeah to be fair so caring and compassion always they came together, and umm they **should** they err every single you know nurse or **caring person should have compassion and caring and courage and those thing, the 6Cs yeah.**	12-13. 185-200
The novice nurse	Works with little supervision, it should be you know supervised properly it isn't not a little it should be, I'm first ward.	27. 454-456
	I learn from this [indicating to his report] I reflect from that. And I don't know so on the way down I will I develop this type of things you know that as a student nurse you know you need supervision proper supervision a lot of supervision I think.	29. 482-486
	Even the, you know the qualified nurse to make a decision, decision making, she need to be competent she knows what [she's] doing. She, you know, 100% sure to prescribe or to decide. So you need to be quite competent.	30. 503-515
	Competence means you know what you're doing you, you are 100% sure of what you are able to do the task that's what I believe it competent means.	25. 495-497

	She doesn't need any supervision I'm a little bit your know on the way down	27. 406 28. 481
Theme 2: The values experience		
Subordinate theme	Quotes	Page and line numbers
Soothing negative something positive.	Interviewer: Was it easy to understand the questions? David: Absolutely straight forward yes And then it goes, then you say **something negative and then there is something positive**. Which one you answer make you **confused.** Is it the middle one or is it the next one, or you know. Just when I did it if it's positive if **I think that's the right answer, I just tick it on that side**, on the left hand side. If it's the right hand side and the right side I will click on next to it. That's what I did you know. So if you did like you know choices you like that, that, will be aright in it. You understand which one the answer is the right answer I think this is like umm (long pause) like a test is like a normal test umm as you say this is nothing to do with your interview nothing to do with anything you don't you don't umm you don't make yourself feel **stressed** out or you don't make yourself umm prepares to much and but if something is **valuable** or something is you know you have to do it if you don't do it you won't get it then you are going to be thinking you are going to be (laugh) working hard and then you are going to sit down and you are going to **try your best.** But This is you know like a voluntary thing yes. As **volunteer** you thinking you know we are going to learn something are we going to help someone that the way I was err umm I take it I was thinking because I said I you know the questions, **how they umm put together** and err it makes you you know **freaky** but overall you know umm I've scored this for and I think it's very good. when I read it I understand that I understand that which, which answer is fitting. But you know when you want to answer. **I don't know how it works for me you know.** So a bit confusing about that on the first time you do not know what the test is all about so once you did that test whether you fail or passed you have some idea so when the next time you go. **You look it's going to be similar or a lot alike so the second one I think I have first one experience that will help me to do the next one you know good.**	42. 714-715 13-14. 205-219 39-39. 648-661 21-21. 355-357 15. 228-232 32. 546-551

The manual	this one make me you know um **amazed** you know I was **not expecting** this one	21. 347-348
	I didn't I thought you know I was, you know I didn't respond you know **positively** but when I see the results now it's good I think now that I **did well**	21. 350-352
	it's just good you know if you if you pass your test umm you did something then **pass** umm it makes you happy so makes it to work hard again err that err that's the way it is you know if you **pass your test** and then you are going to have another test and then you are going to work for that and then	24. 364-369
	I will **work on it** on my own you know that's what I get for this feedback is you know for it, **try to develop myself**, is my homework.	25. 415-418
	It means you know you have some **ideas**; you have some, you know more. You know **extra information** that what I think you know. Maybe they are going to be like a **guide or a manual**, manual yeah. I will say I will reflect on this so **I will use this for some time** but after in the future I will develop myself during my course so that's what I think	34. 572-576
Making connections	in MMIs I think, **you don't expect the things** you know in the interview. You are **expecting something else.** But you find something different then, so that that makes you know err you know like **nervous** about it but **it gets good there.** So that the only thing that I find it. **I didn't expect something** there you know I think it's something and it was different. So I managed to do that everything single thing, so it was good it was a **good experience**. Yeah but you know at the same time as well **I find relevance to the course the questions.**	34-34. 586-596
	It's different, it's totally different this is a Test this is your going to sit down at the computer in front of the computer and then the Test. That one is you know communication skills that's different that you know you are speaking to the, you know, you are speaking to **the person face to face**. So you know, you know they will look at your **confidence** they will look and see you know your communication skills, they will look at you know different types of things, it's not about the Test. Test is you are going to have something you learn something and then you get Tested you go is that a fail or you got a pass"	35-36. 603-615
	No, this is not reflecting me no. This is, this is different this is, this is someone is a having experience. **This is someone who is a model nurse and then the bad nurse, good nurse in it**. So how are you gonna you know? **How are you going to be weighed, weighing someone related with this?** I don't think so. Because once you learn something if you do not apply it and then you gonna, gonna see, you are gonna you know, find out what the person is. Not really, because of this [indicating to the Test reports] you know you can't say this person is not	40-41. 676-701

	trustful, this person he won't do this stuff he won't do this he won't do that. That's not the way it is. But the person is, in the interview they can see you. [at interview] they will look at **your confidence** you're **worth** and your **background** what you have done and everything. From then whether this person **fit or not**. That way not only one person is **judging** you some other persons **about twelve persons,** or something, every single one is going to share that idea whether this person **good enough or not.** This one is a computer-based Test, so that's different. This one [indicating to the Test reports] you need to learn from this. I think so yeah so this is a totally different thing. MMI is **person to person connection.** This one [indicating to the Test reports] you think to, you need to have the experience to answer this questions, that's what I think"	44. 751-756

Appendix 24 Anna's themes and subordinate themes with corresponding quotations

Theme 1: Care and closeness		
Subordinate theme	Quotes	Page and line numbers
Caring and compassion	**looking after all the people's needs** really, I just umm I came into this before I was I carer so I think in a way care for me means you know how people can **do the things that they can't do on their own** home. But also in hospital were people aren't able to do for themselves you do it for them or help them to do it for themselves. Umm (pause) and I suppose caring in ways of **the family sense** don't you when **you care about people** you try and **look after them** and do **nice things** for them so. Cause it just means looking after people (laugh)	3. 48-59
	I think I'm really caring, but I think that cause people always tell me that I'm really caring so. But I just do what **comes naturally to me**. yeah I like looking after people I'm a little **bit of a mother hen.** I like looking after people and **feeding** people and you know just **making them as happy** as I can make them. And if they're in **discomfort** or anything I always try and **relive** it or do anything that I can to make a **situation better**. and I've always been like that.	8. 164-179
	No I, **I think you can't be taught it** I think it is something you either have or you don't and if you don't have it it's too difficult.	8. 184-186
	They should be [caring and compassionate] **because if you're not caring and compassionate then your cold**. And people in hospital are usually there in their time of need and they want it most. When your ill you go back to almost being a bit childlike you want people to look after you and be sympathetic and things. If you're not caring or compassionate, especially compassionate, **if you can't almost put yourself in someone's shoes how can you make the situation better for them?** Otherwise it seem to I would to say clinical, but that especially for nurses maybe with doctors you don't have to be as caring and compassionate, but for nurse you do	10. 225-239
	I always try and make things better and **I don't like to be in the middle of drama or anything** I don't like to cause upset to anybody And like I know in the test like there was something like something about honesty like. And like in that sense I thought about it and thought sometimes if it's **really important** then I will tell someone but if it something like (pause) I don't think that your hair looks very good or something then I wouldn't say it… yeah I couldn't bring myself to **hurt someone feelings** in that way I don't know	9. 197-213

Close yet distant	I don't know because I feel like when they, they say it .. like **I think oh yeah that is my value. that is my own values.** But when I think I don't know **I'm a bit tired when I think about professional values.** I don't know just have to be caring open honest you have to be honest definitely. You have to, I don't know just be professional there is just a way that you are professional but **I can't explain it.**	7. 152-160
	I do I do see them differently but it's hard for me to explain it like, I know that they are different. When I'm, when I'm, **if in the sense of caring and giving care I know it's different**	6. 123-127
	Professional values, I suppose this I don't know you give someone all the care that they can possibly need and then you have to be professional in yourself. You can't, **it's not like when your, if you mum's ill you give her a hug and a kiss.** When your professional you give them the care the same as you would maybe with your mum but you wouldn't give them the hug and the kiss. I think that's, that's, that's the way I see it your professional **you have to sort have take a step back rather than be to involve.** I think that's in the care sense I don't know. It's hard to think about that.	5. 92-105
	To protect yourself I suppose. I think you have to in a way you have to put so sort of barrier but you do get emotionally attached even if you try not to.	4. 73-82
	Whereas well you would not get personally involved but you know with nurse especially when people are in hospital for a long time you get know they family and you **build up that sort of therapeutic relationship** with people.	11. 250-254
Theme 2: The values experience		
Subordinate theme	Quotes	Page and line numbers
The test	I suppose in a way I felt a bit nervous cause I thought is going to **reflect really badly** on me because there are something's that maybe aren't (sniff) for nursing or the **NMC** would be a **high value** but maybe for me aren't as high. Ummm I do value them but may be not as much as I should and I do know that about myself but when you're actually putting it down you think oh should I change it is this going to make me look bad but.	14. 344-357
	I think you see it as like, like I said, like I want to be really honest but I think you could definitely not be honest with it and. And you know if you when you apply for nursing you know exactly what they are look for. You research it don't you. You know exactly what to write in that personal statement what to say in the interviews. **So you know what you should be clicking to give you the best chance to get into Uni** and I suppose **if I'm brutally honest if I was doing that as an admissions test I would probably wouldn't have had the same results.** I wouldn't have because I so	15. 362-377

	desperately want to come here. I wouldn't have been as honest I and I would have said **yep I'm really, really good at everything.** with this test (indicated to the results) you knew what exactly they were looking for I think you could **fake** this test more **easily**. Because I knew my self you kind of know what their looking and **I could have just scored myself higher on everything**. And come up like you know really well whatever. I don't know what really well is on this but I think it's, I don't know I think it's easier to fake this because if you can you're not going to be really, really honest and say that I would not challenge anyone ever if you knew that was going to affect your **dream career** really isn't it.	35. 966- 981
The report	I answered every question **really carefully** I do take my time anyway its part of who I am. Umm and I was **really really honest** I thought ah I know what they want you to say but just thought no. be as honest as you possibly can and you will have a **true reflection** of yourself then	12. 282-289
	Yes definitely you, that why I was say like, I have to be honest like in this because for me personally what would be the point of doing it otherwise you know **it's voluntary so why would you lie** to yourself and lie to you? It makes no difference to me, so you have got to be as honest as you possibly can.	28. 789-798
	I was a bit **disappointed** in myself actually and I had a bit of self-doubt I thought is this going to make me can I do it cause I went to uni before and I dropped out after the first year I did teaching so it's kind of a similar sort of thing. And um I just hated it and I though ahh **I don't want it to happen again**. So I had a little bit of a **crises of confidence** in myself in that sense but then I talked it through with everyone and they said no I think you're ready for it this time and I do feel more mature and things. And yeah I don't know it give make me worried about my **lack of commitment to work** and things but then I thought if I know that's a weakness and **I can see it on paper that's a weakness I know where to work on it** and it should be alright so it was **good to have that sort of reflection** yeah	17. 432-448
	Higher and lower I don't know I suppose you just think it isn't a score out of 100% I think you kind of (pause) I don't know indoctrinou (sic) [indoctrinated] no that the wrong word…you know you always think **you have to get a higher score as possible otherwise it's not good**	20. 535- 540
	yeah well it would be would it if you were getting into uni on it, it would be pass fail and probably that would be a fail because I have **scored too low** on some of these things and so they would say no, but then I if you were just going on this that does not tell you anything about a person really, because now I can talk to you about it I can explain why I picked these answers And I think if you are actually gonna do this for all nurses to come into uni you're not going to have the time sit down actually talk about why they have scored something like this and so in that way I don't know that it does work	21. 543-556

The model nurse and me	Oh the personal development I know that's a weak area for me I'm so **lazy** when I get home I literally just lie on the sofa like it's terrible (laugh). And I know that about myself but then in some ways I think it is a reflection and it isn't because essays and things like I've got one due in about I think 6 weeks but I've already started it. So If I need to do it, it will be done but I also think like especially like when I'm a qualified nurse and hopefully I'll have some children am I really gonna come home formwork and **sit down and do a load of research** because (pause) my mum and dad didn't and I can't imagine (laugh) having time to do it if that makes sense so that's why I scored myself low for that in like a few years I just don't it's hard to **balance** it I think. Especially for people who do PhDs and things it must be really difficult if you have children, family and getting yourself and sit down and do it and I know myself that I was definitely a weakness. Motivation to sit down when I could be mopping the kitchen or something (laugh)	16-17. 403-425
	I think I probably about the same in the wider profession I know this thing with commitment to personal development is low but I can't, I know a few nurses and I know that maybe their commitment to personal development **isn't what it should be**. They do the bear minimum of what it can do but then they have **busy lives** its hard isn't it. They **work long shift** a lot of the time they do a lot of over time cause their **wards are understaffed** and so they are not researching and they are not trying to do extra things unless someone puts them on a paid course or whatever.	21. 563-593
	Well in that sense though the way that I answered it yes but obviously you develop you, personal, personal development happens all the time every day is personal development because you learn something new every day and actually do so I think in that sense like the researching sense maybe it doesn't get done but obviously you learn loads on the ward on **you meet new people and they teach you things especially if their students** there's people always wanting to teach you everything. So in that sense **development does happen organically** it just happens on its own and you don't have to worry about it. But I suppose like doing a portfolio or something that's different isn't it and you do have to do that and **I know you have to do that so I would do it (laugh) To keep my job.**	22. 598-614
	accountability what have I got slightly under I think that's because I was thinking of myself as a student. And it's hard to know how accountable you would be... well you wouldn't really. You would be accountable but not as much as if you're a qualified nurse and **I think it's hard to work it out unless you've been in that situation.** Until I've been on a ward or been out in the community I'm not exactly sure. And I think it's hard without actually having the experience in hospital it really hard to know yourself you just have to kind of guess based on previous experience and I worked as a career and I was accountable and luckily, I didn't really make any mistakes so I don't know how, how massively accountable I was and before that I worked at folly farms so you don't you're not really accountable for anything there.	18. 463-482
	I well I think I couldn't really, I think there is only one thing that I scored myself as the same the same as. Outcomes these outcomes first. **But I think I'm just at the start I can't I have to be realistic I'm not perfect I'm I've only just started. And I think if you score on the same plane as what you consider a model nurse for everything then**	23. 630-647

	how can you develop cause you already think your there don't you. But you're not you've only just started. So you have to (pause) there is a lot of learning that because that and becoming what you to be I think and (pause) and special just qualifying (laugh) because then you have to go out and do it on your own and you **develop** even more. And I think that I think that's why I think you have to see yourself as a difference between the student and actual nurse especially a nurse that's got a lot of experience	
	That its wiser to manage truth I think **if it's important and it's about someone's health then yes you need to say it but (pause) if it's not (laugh) you don't have to say it If it's something that doesn't need to be said I'd rather not say it.** I'd rather not say it's horrible or I don't like the colour you painted your house. I'd rather not.	19. 494-503
	Oh this is another one of those open and honest in all things. **It's that in all things** that, that, that's why I say maybe. Not in all things in, things that you need to say yes **but not in all things.**	27. 744-747
	Yeah I'm not sure if that's means that I'm not I can't be trusted or I'm trustworthy or not really **or that I'm just I'm just so scared of confrontation** I wouldn't say anything	32.888-891
	Oh no **challenging someone more senior this is definitely something that I am not able to do I**. I don't like conflict and I know that you should challenge someone. But if it's a consultant and me I'm not going to challenge them and I think especially as a student answering this. As a student then this definitely, **definitely there is no way** I would challenge someone obviously if it's something like really dangerous but if it's medical and I think I haven't got as much knowledge as that person then I probably wouldn't do it.	27. 750-762
	Oh yeah so I couldn't really remember that I yeah that is something I would really struggle to do **I really struggle to challenge people** especially people that are in authority. That is just I know that I would, I would, I've always been like that and I could not answer back to a teacher or as a child there is no **naughtiness**	28. 781-788
Being observed	I thought it was a bit **rushed** I would have preferred a bit more time I quite like a **normal interview.** I know that so umm I know a lot of people don't like them but I quite like the one were just sit down and **talk to someone** but that's just that sort of person I am I like talking to people. So some of them were a bit weird. **That origami thing** I couldn't do that I knew I knew I would not be able to do it's just something I can't do that **my brain doesn't work like** that I could explain it but I couldn't do it myself.	32-32. 901-916
	I don't know I think it was worse when I didn't know what to expect it wasn't really **stressful** I would have just liked to have been able to say more to people. Yeah and I just keep rambling so **5 minutes isn't enough for me** when I have to talk to someone about something.	33.918-928

	don't know I was just get nervous I think that's just a standard thing for me umm **collywobbles** my mum calls it (laugh) I don't know I think because I knew I was going be really honest and maybe it would not look so good. Ummm but with the actual interviews I was really nervous it was like two days before my wedding.	39-40. 1110-1118
	they don't really explain it to you beforehand and then afterwards well you know nobody explains it you either.	33. 932-933
	I think honestly that MMI for like honest, and like because your sat in front of someone, **and you have to say something more do something** or whatever is probably better because your actually. **What I personal didn't understand what they were looking for** or know what they were looking for in those well in **some of them you did but with some of them was like ask me about dignity**, so I knew how to answer them but other ones were like a plane hits, a plane crashed and you need to choose. Well you don't really know what their looking for there so you just have to kind of whereas with this test you knew what exactly they were looking for.	34. 953-965
	you don't know how good somebody actually is at caring or doing the job until they actually do it so unless you're going to start hauling people into a fake hospital you're never really going to really know either way are you. I suppose both reflect on values the only thing with this is [indicating to the NMI results] **you don't get to speak to someone** unless you do it with an interview and I think you can tell a lot about a person by talking to them. So maybe the MMIs reflect the person better because this is like **behind a screen isn't it** it's just a set of results.	36-37. 1018-1032

Appendix 25 NMIST and NMI group results

Participant	Personal Centredness		Accountability		Trust		Integrity		Personal Development		Teamwork		Individual Mean	
	Test 1	Test 2	Test 1	Test 2	Test 1	Test 2	Test 1	Test 2	Test 1	Test 2	Test 1	Test 2	Test 1	Test 2
David	35.29	50	18.28	39.01	21.51	16.67	20.67	41.54	11.7	46.15	20.78	42.74	21.37	38.35
Pauline	52.8	86.37	53.95	66.84	50.39	60.71	70.3	67.88	62.4	69.86	70.4	70.7	60.04	67.36
Anna	61.14	66.33	47.81	44.94	29.84	31.74	47.9	38.62	25.09	26.07	68.15	60.76	46.65	44.74
Mary	77.52	90.28	70.82	81.51	70.84	84.01	55.46	69.47	78.67	84.14	65.78	76.84	69.85	81.04
Fiona	50.56	51.03	41.9	37.44	43.01	35.07	41.45	32.2	19.1	32.07	38.2	34.49	39.04	37.05
Claire	57.11	59.75	43.71	56.53	52.14	68.45	42.16	55.34	51.98	67.05	57.75	64.06	50.81	61.86
John	37.74	68.19	62.82	62.69	59.1	61.26	65.05	55.51	68.06	57.29	50.18	46.08	57.16	58.5
Nicky	-43.57	40.99	-14.25	43.93	-8.41	40.37	38.95	46.59	-39.83	45.15	-17.62	37.06	-14.12	42.35
Lisa	25.95	35.96	23.78	32.08	12.83	14.48	18.63	21.88	20.12	32.34	16.72	33.37	19.67	28.37
Paul	40.34	57.75	41.34	49.06	43.74	51.49	27.54	40.29	33.08	43.92	38.29	41.34	37.39	47.31
Group Mean	39.488	60.665	39.016	51.403	37.499	46.425	42.811	46.932	33.037	50.404	40.863	50.744		