

Nursing students' raising concerns in clinical practice: A grounded theory study of the mentor-student dynamic

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Thesis summary

Raising concerns whilst on clinical placement is challenging for student nurses internationally. Until recently, registered nurses (nurse mentors) within the United Kingdom, facilitated learning and assessment in practice. However, limited research exists on how the dynamic between the student nurse and mentor influences decision-making after a student encounters wrongdoing. This constructivist grounded theory study aims to explore the dynamics of raising clinical concerns from the perspective of the student nurse and nurse mentor.

Thirty-seven semi-structured interviews were conducted with student nurses' (n=16), nurse mentors' (n=14), and personal tutors' (n=7). Concurrent data analysis and coding resulted in the development of a core category. The key findings from this study indicated that most of the student nurse participants did not perceive the mentor relationship or the organisational context to be a favourable environment in which to raise a concern. Instead, they bypassed the nurse mentor and raised concerns to either a clinical manager or more commonly the personal tutor.

These findings generated the grounded theory of 'reading the context' where decisions and behaviours were strongly influenced by their perceptions of the immediate interpersonal, organisational, and educational context. This theory describes the continual, contextual sensemaking that students utilise in, *traversing the process of raising concerns, balancing the mentor-student dynamic, and equipping with the right toolkit.*

This study recommends a renewed focus on enabling student nurses' to confidently raise concerns whilst working in clinical placements. Preparing students to raise concerns within the university should include first-hand accounts from their peers of the reality of raising concerns. Understanding how student nurses evaluate the organisational context of the clinical placement and the implications of this on patient safety should form part of the preparation for nurses involved in supervising and assessing student learning in clinical environments.

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Glossary

Term	Definition of Term
Academic Assessor	Academic Assessors are registered nurses or midwives who collate and confirm student achievement in the academic environment for each part of the programme. They work collaboratively with Practice Assessors (NMC 2018b)
Clinical Placement	A healthcare setting where a student nurse works on a supernumerary basis under the supervision of a registered nurse. In this study, placements ranged between 4 – 12 weeks in duration
Clinical Teacher	A full-time role with a remit for participating inpatient care delivery with student nurses in clinical placements
Freedom to speak up Guardian	Freedom to Speak Up Guardians is an alternative route to speaking to a line manager or supervisor and come from a wide variety of backgrounds. The role is impartial and involves listening, escalating, and providing feedback to the individual (Hughes 2019)
Link Lecturer	An additional role is undertaken by a nurse academic that supports student nurse practice-based learning and contributes to the quality of the clinical learning environment. There is no consistency in the roles and responsibilities underpinning this role (MacIntosh 2015)
Mentor	A registered nurse who has met stage 2 of the accredited mentor preparation and facilitates learning and assessment for student nurses in practice. (NMC 2008)
Practice Assessor	A Practice Assessor is a qualified nurse who is registered on the NMC register and nominated and prepared to assess student nurses in practice.
Practice Facilitator	Refers to staff employed directly by NHS whose remit is to support practice-based education and mentorship of pre-registration nursing students. Role responsibilities vary across the UK (NMC 2018b)
Practice Supervisor	A registered healthcare professional that practice supervision and learning with students that enables them to meet learning outcomes in practice settings (NMC 2018b)
Stakeholder	An individual or organisation that has an interest in the decisions made within the healthcare setting

CHAPTER ONE – Introduction and Background

1.1 Introduction to the chapter

Promoting patient safety and avoiding harm is a fundamental tenet of nursing practice and inherent within ethical and professional guidelines across the world (Royal College of Nursing 2010; American Nursing Association 2015; Nursing and Midwifery Council 2018a). Examples of unethical behaviour and the delivery of substandard care have been the subject of nursing research studies across all continents (Yeh et al. 2010; Solum et al. 2012; Ion et al. 2015; Fagan et al. 2016; Pohjanoska et al. 2018).

Within the United Kingdom, high profile reports such as the Mid Staffordshire Inquiry (Francis 2013), Vale of Leven Inquiry (2014), the ‘Trusted to Care’ Report (Andrews and Butler 2014), and the recent investigation regarding maternity services in Cwm Taf (Welsh Government 2019), identified serious care failings that resulted in high mortality rates and patient harm. Systemic Issues such as a toxic workplace culture or the failure of managers to listen and respond to employee concerns were evident within all the aforementioned organisations and instigated several recommendations to implement culture change. (Francis 2013, 2015; Mannion and Davies 2018).

Staff recognising and responding to unsafe practice is a key element of the culture change required within the NHS (Mannion et al. 2018). Raising concerns in clinical practice environments is a crucial element of prosocial behaviour that can address and prevent patient safety violations or substandard care (Francis 2015; Ion et al. 2015). However, interestingly, research studies indicate that nurse registrants and student nurses do not always report errors or raise concerns when they encounter wrongdoing (Schwappach and Gehring 2014a; Ion et al. 2016; Pohjanoksa et al. 2018). This is despite several policy imperatives and law changes that have acknowledged the challenges in raising concerns (NHS Wales 2013; Enterprise and Regulatory Reform Act 2013; NHS England 2016).

A recent NHS staff survey (2020) highlighted that 72.5% of staff felt secure in raising concern about unsafe clinical practice. Although this figure is an upward trend from 2017,

where only 60.4% of employees were confident that their organisation would address their concerns, the survey does not specify the reasons for this lack of confidence. There is evidence to suggest that registered nurses and nursing students believe that concerns will be ignored or not taken seriously. These perceptions of futility discourage individuals from raising concerns (Attree 2007; Monrouxe et al. 2014). As well as doubting the efficacy of raising concerns, fear of repercussions is frequently cited within the literature as a barrier to nurses speaking up. (Jackson et al. 2010a ; Moore and McAuliffe 2010 ; Cole et al. 2019). This positions raising concerns as a risky endeavour that is shrouded in uncertainty (Attree 2007; Bickoff et al. 2016; Ion et al. 2016).

Student nurses have a responsibility and duty to adhere to the NMC Code (2018a) and to raise and escalate concerns if unsafe practice is observed in clinical practice. Exposure to a diverse range of practice settings enables students to observe care with 'fresh eyes'. Government reports within the United Kingdom have recognised the contribution that student nurses can make in promoting safety and monitoring care standards (Keogh 2013; Francis 2015).

However, raising concerns can be challenging for the student whose novice status and desire to be accepted into the culture of the clinical placement can inhibit speaking up (Thomas and Burke 2009; Levett-Jones and Lathlean 2009; Yeh et al. 2010). Furthermore, inexperience and the sometimes-perceived dissonance between nursing skills taught within the university and the reality of clinical work contributes to uncertainty and a lack of confidence in responding to poor practice (Ion et al. 2015; Blowers 2018).

At the outset of this study, student nurses were supported and assessed in clinical practice environments by a nurse mentor. The role of the nurse mentor was to facilitate learning opportunities and assess practice outcomes (NMC 2008). In doing so, the mentor had a significant impact on the quality of the student's placement experience, in relation to their transition into the culture of the placement and the achievement of practice learning proficiencies (Levett-Jones and Lathlean 2009; Jack et al. 2018; Harrison-White and Owens 2018). In 2018, new pre-registration nurse education standards were developed, and a new model of practice learning was introduced, this will be discussed in section 1.8.

The mentor-student dynamic is an area that is under-researched in relation to student nurses raising concerns in practice settings. A small number of qualitative studies have cited the importance of the mentor-student relationship as a factor influencing the reporting of concerns (Bellefontaine 2009; Harrison-White and Owens 2018). However, there is a paucity of research that specifically focuses on the mentor-student relationship and how this may influence student decision-making on raising concerns. In addition, how the nurse mentor responds and supports students who raise clinical concerns has received sparse attention within the literature.

Aim of the study and research questions

The aim of this study is to explore the dynamics of raising clinical concerns by student nurses, from the perspective of the student nurse and nurse mentor. To achieve this overarching aim, the following research questions will be answered within this thesis:

- How do student nurses make decisions to raise a concern in clinical practice and what enablers and barriers influence decision-making and action?
- What is the nurse mentor's perception of their role when students raise concerns and how would/do they respond to student nurses who raise concerns?
- How does the dynamic between the student nurse and nurse mentor influence the raising concerns process?
- What are the outcomes of raising concerns and how does this impact on the study participants, patients and staff within the practice setting and/or university?

Although not specifically included in the original aim outlined above, personal tutors were interviewed in phase two of the study following theoretical sampling (see section 3.13.4). Therefore, an additional research question was developed.

- How does the personal tutor respond to and support a student nurse who wishes to raise a concern?

1.2 Structure of the thesis

This thesis is divided into eight chapters which provide a detailed overview of the research journey and the process undertaken to conduct this qualitative, grounded theory study. A synopsis of each chapter's content is provided below.

Chapter One – Introduces the study and sets the scene for the reader. The aim and research questions underpinning the study are outlined and the structure of the thesis is provided. The context of the study in relation to student nurses' raising concerns and the role of the nurse mentor is introduced. A general overview of patient safety is provided, as well as considering how raising concerns can enhance safety and quality of care for patients within clinical settings. This chapter will summarise the key models of whistleblowing within the non-healthcare arena and consider how these have been adapted to a nursing context, before outlining legislation in England and Wales and guidance underpinning whistleblowing. Finally, an overview of pre-registration nurse education in Wales provides the context for this study.

Chapter Two – Outlines the literature search strategy as well as justifying how the grounded theory approach selected, influenced the timing and type of literature review undertaken (Charmaz 2014). Research studies pertaining to nurse registrants and student nurses and raising concerns are appraised and areas of focus and knowledge gaps within the topic area are identified.

Chapter Three - explores and justifies the grounded theory methodology selected to meet the aim of the study. The influence of my philosophical stance on this research is considered. The methods used to conduct the study and generate and analyse data are delineated, as well as how coding procedures led to the development of categories and a grounded theory. The process of recruiting participants and gaining ethical approval are outlined, as well as highlighting how consent, confidentiality and data protection complied with the principles of research ethics.

Chapters Four, Five and Six – Present the findings of this study, which developed through undertaking initial, focused, and theoretical coding (Charmaz 2014) and organised into three categories. These include; *traversing the process of raising concerns* which explores the trajectory of student nurses' raising concerns, *balancing the mentor-student dynamic* which explores the interpersonal relationship between mentor and student and how it influences students' decision-making to raise a concern and *equipping with the right toolkit* which explores the knowledge, skills and support required for students to be able to confidently raise concerns and for mentors and personal tutors to support students

through the process. The findings are interspersed with rich and in-depth data extracts which enable the participant's voices to be heard and add rigour to the study.

Chapter Seven – The discussion chapter links the proposed grounded theory to contemporary literature. The findings add to the body of knowledge about student nurses' raising concerns and outline how the outcomes address the research gap which was identified at the outset of the study.

Chapter Eight – The implications and recommendations for nursing practice, nurse education, policy development, and future research are presented here as well as an overview of the strengths and limitations of the study. Finally concluding remarks and a personal reflection complete this thesis.

This section has introduced the topic of raising concerns and outlined the aim and structure of this thesis. The following sections further set the scene for the reader and present a background to whistleblowing and raising concerns. Firstly, the topic is contextualised with an overview of patient safety and the key role that nurse registrants and student nurses can play in identifying and reducing patient harm by raising concerns. Attention then turns to review models of whistleblowing that have been instrumental in aiding our understanding of the process and consider how relevant legislation and guidance in England and Wales underpin whistleblowing and raising concerns. Initially, the section below discusses the terminology that is used within this thesis and reflects on the origin and meanings associated with whistleblowing and raising concerns.

1.3 Definitions and terminology

The origins of the term whistleblowing have been debated within the literature, with Eby (1994) suggesting that the term referred to a referee blowing a whistle to signal an act of foul play. Alternatively, a policeman blowing a whistle as a way of alerting public attention to wrongdoing has also been proposed as the original meaning of whistleblowing (Bolsin et al. 2011). Over time, whistleblowing, influenced by Nader (1972) took on the more metaphorical meaning of disclosing wrongdoing within organisations (Vandekechove 2006). Two polarised perspectives of a whistle-blower tend to be presented, with a whistle-blower being lauded as a courageous hero or as a traitor who has betrayed colleagues or an organisation by disclosing information (Lachman 2008a; Mannion et al. 2018).

However, the term raising concerns is deemed a preferable term for whistleblowing (Jones and Kelly 2014). This may be due to the stigmatised activity of whistleblowing which has negative connotations and has long been associated with ‘snitching’ or ‘grassing’ on colleagues (Attree 2007). Dame Janet Smith noted the interchangeable use of these two terms when chairing the Shipman Inquiry and expressed a reluctance to use ‘whistleblowing’, although its widespread use within organisational policy at that time was acknowledged (Shipman Inquiry 2004).

Arguably, one of the most widely accepted and frequently cited definitions of whistleblowing is provided by Miceli and Near (1992) and originates from the business literature.

“The disclosure by organisation members (former or current) of illegal, immoral, or illegitimate practices under the control of their employers, to persons or organisations that may be able to effect action” (p15)

This broad definition encompasses external whistleblowing as well as internal processes, although some academics argue that the term whistleblowing should only include disclosure to external agencies (Farrell and Peterson 1982; Gagnon and Perron 2019). According to Gagnon and Perron (2019), the association of whistleblowing with external disclosure is incongruous with most nurses experience of whistleblowing which is predominantly internal.

An early definition by Ahern and McDonald (2002) described a whistle-blower as someone:

“Who identifies an incompetent, unethical or illegal situation in the workplace and reports it to someone who may have the power to stop the wrongdoing” (p305)

This broad definition shares similarities with Miceli and Near (1992) and includes illegal activity, a feature that is absent in Blenkinsopp et al. (2019) more recent definition of whistleblowing:

“The raising of concerns about unsafe, unethical or poor-quality care to persons able to effect action” (p738).

This definition captures more accurately, the types of concerns that healthcare staff are more likely to raise in clinical practice. However, the use of the term ‘raising concerns’ within a whistleblowing definition, adds to the ‘conceptual muddiness’ associated with the synonymous use of these terms (Gagnon and Perron 2019, p4). For raising concerns to ‘qualify’ as whistleblowing, specific criteria need to be upheld which reflects

whistleblowing law (Public Interest Disclosure Act 2015) and is summarised below by the NMC (2021a).

- A person making a disclosure is a 'worker' with a contract (includes student nurses)
- The concern is considered by the person to be in the public interest.
- Wrongdoing must have occurred in the past, present or likely to happen in the future
- A person has failed to comply with a legal obligation
- Health and safety have been endangered (or likely to be)
- The environment has been (or is likely to be) damaged
- A miscarriage of justice has occurred or is likely

For nursing at least, this provides clarity on when a disclosure becomes a whistleblowing activity. An associated term of 'bell-ringing' has also been proposed within the literature to refer to 'outsiders' such as patients, relatives or other healthcare professionals who report poor care (Miceli et al. 2014; Mannion et al. 2018). From this description, there is a question about whether student nurses, who often perceive themselves as 'outsiders' are in fact 'bell-ringers' as opposed to whistle-blowers. The need for further research on the experiences of outsiders' whistleblowing has been identified (Culiberg and Mihelic 2017).

In addition to the use of whistleblowing and raising concerns to highlight wrongdoing, other related concepts such as the use of voice within healthcare are also evident within the nursing literature. According to Tarrant et al. (2017), voice within the clinical workplace can be utilised in 'speaking out' which is directed towards peers, or 'speaking up' which is used in upward communication to managers or supervisors, to signal improvements as well as identifying wrongdoing (Tarrant et al. 2017, p.8). There is general agreement in nursing research studies that the concept of 'speaking up' involves the assertive use of voice that may involve questions or challenges to inform others of wrongdoing (Sayre et al. 2012; Fagan et al. 2016; Fagan et al. 2020). However, Mannion et al. (2018) argue that speaking up is more serious than raising concerns, which they describe as a low-level strategy routinely used in practice.

Therefore, the terms, 'raising concerns', 'speaking up' and 'whistleblowing' are still interchangeable to an extent, but within this study, the term 'raising concerns' is deemed

to be the most appropriate. The NMC (2019a) captures the essence of raising concerns in the following description, which is particularly pertinent to student nurses' raising concerns in this study.

“If you are raising a concern, you are worried generally about an issue, wrongdoing, or risk which affects others. You are acting as a witness to what you have observed, or to risks that have been reported to you and are taking steps to draw attention to a situation which could negatively affect those in your care, staff, or organisation” (NMC, 2019a, p7)

The next section provides an overview of patient safety and its relevance within the raising concerns literature.

1.4 Patient safety in healthcare

Patient safety is integral to all elements of healthcare systems and involves the identification of safety risks as well as implementing measures to address patient harm (World Health Organisation [WHO] 2019). Patient safety is defined as “maximising the things that go right and minimising the things that go wrong for people experiencing healthcare” (NHS England and NHS Improvement 2019, p.6). Errors and adverse events routinely occur within healthcare settings and lead to avoidable harm, which makes patient safety a global priority (WHO 2019).

The extent and impact of avoidable harm occurring within healthcare systems were put under the spotlight with the publication of the landmark report, ‘To Err is Human’ (Institute of Medicine, 1999). The incidence of adverse events within hospitals in the United States was calculated to be as many as 98,000, each year with individuals dying needlessly due to preventable errors (Weingart et al. 2000). This report drew worldwide attention and was quickly followed by ‘An Organisation with a Memory’ (2000) which investigated the scale of failures within the NHS system and identified serious shortcomings in patient safety and the response and management of adverse events.

These key reports, published over twenty years ago, were significant in highlighting patient safety issues within the hospital setting. The rates at that time, identified that approximately one in ten in-patients experienced some form of harm (de Vries et al. 2008). Unfortunately, this figure has largely remained static and continues to be a global issue for healthcare (Slawormirski et al. 2017; Schiff and Shojania 2021).

The need to learn from errors, embrace culture change and improve reporting systems resulted in the National Reporting and Learning System (NRLS) and the National Patient Safety Agency (NPSA), established to improve reporting and analysis of errors (Donaldson 2000). However, the NPSA was abolished in 2012 and adverse and patient safety incidents within England and Wales are now reported to the National Reporting Learning System (NRLS) which is overseen by NHS England.

However, adverse events or instances of inadequate care should be differentiated from cases where there is a deliberate intent to inflict harm to patients. Well-known examples of these malevolent acts include Harold Shipman, the GP who was a prolific serial killer convicted of murdering fifteen of his patients, and Beverley Allit, a nurse who killed four children in her care (Marks and Richmond 2008). These highly publicised cases, although uncommon, bring into sharp focus the importance of voicing concerns when wrongdoing is witnessed or suspected. In particular, GP colleagues of Harold Shipman did document concerns, but these were unheeded and not thoroughly investigated. The failure of senior management to listen to those concerns enabled Shipman to continue killing for many years.

Therefore, raising concerns about patient safety issues can make a significant contribution to safety culture within the healthcare setting (Milligan et al. 2016). Raising concerns and promoting an open culture have been identified as key to patient safety and have led to lives being saved, but it is not without its challenges. Despite the progress made as a result of enhanced reporting systems, high profile campaigns and a move to a more open, learning culture, there is little quantitative evidence internationally of any significant reduction in adverse events (Schiff and Shojania 2021).

Healthcare staff not speaking up and raising safety concerns may be a contributing factor to the slow progress of patient safety improvements. Nursing research studies have acknowledged that the failure to report errors or unsafe practice can be due to a fear of social or professional repercussions (Bellefontaine 2009; Parlese et al. 2018). An anticipated negative reaction from an organisation or the likelihood of a manager not listening is likely to discourage reporting (Mannion et al. 2018; Coles et al. 2019), even though in some instances, the assumption of a negative reaction to concerns may be unfounded.

Nevertheless, organisational culture has frequently been implicated as the “culprit and the solution”, to the failures in quality of care identified in recent inquiries (Mannion et al. 2018, p.xxiv). In particular, Francis (2013) acknowledged how organisational cultures within the NHS prevented staff from raising concerns or resulted in negative repercussions for those who did so. The need for cultural change and a move to openness, transparency and candour was a key recommendation in the Francis Public Inquiry (2013). However, Mannion et al. (2018) argue that the broad sweeping need for cultural reform in the NHS belies the complexity of organisational cultures. Further research is required to explore relationships between culture and practice and focus on areas that will provide the most benefit for improvement (Mannion et al. 2018; Cole et al. 2019). In addition, future work needs to focus on how managers and senior staff in organisations can promote the clinical setting as an open and supportive environment for staff and student nurses to share concerns and provide sustained support and feedback (Garon 2012; Bradley et al. 2018).

The next section provides a brief overview of whistleblowing models that have been developed by academics within a range of disciplines (such as management, law, and psychology) that have informed theoretical development and understanding of the whistleblowing process.

1.5 Models of whistleblowing

Research has been conducted on all phases of whistleblowing decision-making, although an emphasis on the factors affecting an individual’s intent to whistle-blow has been noted in published research (Culiberg and Mihelic 2017). The extent to which whistleblowing models from academic literature have been adapted and utilised within a nursing context is discussed in this section.

Near and Miceli (1985,1995) have made a significant contribution to the academic discourse on whistleblowing. Their early work, which began in the 1980s examined the whistleblowing decision process in relation to the organisational climate, as well as individual and situational correlates of whistleblowing. A decision-making business whistleblowing model by Near and Miceli (1985) focused on five stages undertaken by organisation members, following the identification of wrongdoing and the subsequent actions and behaviour of the member and organisation (see figure 1 below).

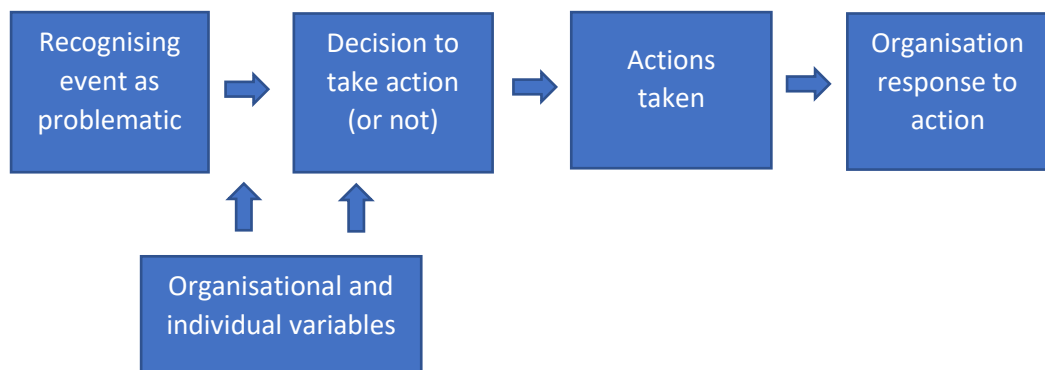


Figure 1 – Model of whistleblowing (adapted from Near and Miceli 1985, 1995)

Near and Miceli (1985) identified how variables such as knowledge, personal characteristics, the perceived efficacy of action being taken, and the personal costs of whistleblowing were considered and influenced whether the employee enacted whistleblowing. A later theoretical model (Near and Miceli 1995) examined the effectiveness of whistleblowing and identified individual and situational variables that influenced potential predictors of whistleblowing. These included the characteristics of the whistle-blower and the complaint recipient (wrongdoer), as well as the characteristics of the organisation and the wrongdoing itself.

Predictors of whistleblowing intent and behaviour have been underpinned by several theories. Mannion et al. (2018) identified that prosocial behaviour, power and politics, justice and institutional theories and sensemaking have all offered explanations for aspects of whistleblowing. However, Mannion et al. (2018) suggest that the decision-making nature of this process positions the cognitive perspective as the predominant theory in explaining whistleblowing intent and action (see figure 2).

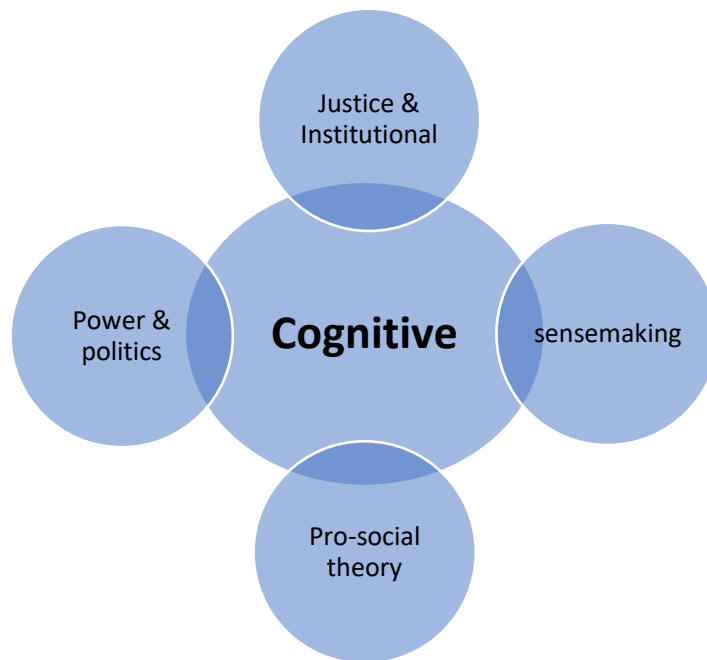


Figure 2 – Theoretical perspectives underpinning whistleblowing (adapted from Mannion et al. (2018))

Cognitive factors that influence decision-making can include ethical-behaviour models which emphasise the psychological process of whistleblowing (Chen 2019). Here the focus is on how moral decision-making can predict which individuals may be more likely to blow the whistle (Rest 1986). The influence of power and hierarchy has been examined from the whistle-blower perspective as well as the perceived power of the wrongdoer (Gao et al. 2015) and organisational response to whistleblowing, such as retaliation from organisations (Near and Miceli 1995; Mesmer-Magnus and Viswesvaran 2005).

Decision-making can also be influenced by an individual's interpretation of the wrongdoing they have witnessed as well as the information or signals received from others. This is known as a social information processing model and encompasses prosocial behaviour, attribution and judgements of responsibility, as well as how emotion contributes to the predictions of whistleblowing actions (Gundlach et al. 2003). A study by Blenkinsopp and Edwards (2008) examined the role of emotion within whistleblowing in a healthcare context. They identified the significance of the emotional reactions triggered when

wrongdoing is observed and situated this process as an ‘extended emotion event’ that continued throughout the whistleblowing journey. Sensemaking and interpretation appear to underpin emotional responses and behaviour that most likely result in ‘inaction’ (p.186)

Other contextual factors such as the impact of organisational rules and legal frameworks can also, to an extent, predict whistleblowing behaviours by the application of justice theory. This theoretical framework of justice has been utilised to examine how behaviours are influenced by legal mechanisms within organisations (Near et al. 1993; Alleyne et al. 2013). An overview of the individual and organisational antecedents as predictors of whistleblowing behaviour is captured in table 1.

Table 1 – Overview of predictors of whistleblowing

Predictors of whistleblowing	Research undertaken
Characteristics of the whistleblower Credibility Power Anonymity Personality and attitude Role of emotions in whistleblowing Demographic characteristics (gender, age) Ethical dilemma Situational variables	Near & Miceli (1995) Near & Miceli (1995); Mesmer-Magnus & Viswesvaran (2005); Bjorkelo et al. (2011) Near & Miceli (2002) Bjorkelo et al. (2010) ; Park et al. (2014) Hollings (2013) ; Henik (2008) Vadera et al. (2009), Mesmer-Magnus & Viswesvaran (2005) Zhang et al. (2009) ; Andrade (2015) Grundlach et al (2003) ; Vadera et al. (2009); Cassematis and Wortley (2013), Anvari et al. (2019)
Characteristics of the complaint recipient	Near & Micelli (1995)
Characteristics of the wrongdoer Credibility Power	Near & Micelli (1995) Near & Micelli (1995); Gao et al. (2015)
characteristics of the wrongdoing act Perceived seriousness of the wrongdoing Moral intensity Response to wrongdoing Types of wrongdoing	Hersh (2002); Somers and Casal (2011) Cassematis & Wortley (2013) Taylor & Curtis (2010); Chen & Lai (2014) Near et al. (2004)
Characteristics of the organisation Organisational culture & climate Ethical environment	Near & Micelli (1995) Berry (2004); Lachman (2008b); Kaptein (2011) Dalton & Radke (2013)

1.6 Organisational culture and whistleblowing research

Research on organisational culture and whistleblowing has identified that employees can be reluctant to undertake ethical behaviours and/or blow the whistle, if the organisation is perceived to be unsupportive or unlikely to address the wrongdoing (Trevino et al 1998; Miceli et al. 2009). Promoting an ethical culture where shared ethical behaviours exist can encourage employee whistleblowing (Berry 2004; Kaptein 2011)

The dimensions of organisational culture were examined by Berry (2004) who identified factors that facilitate or discourage whistleblowing. Encouraging open communication was achieved by; promoting environments that demonstrated shared standards and adherence to codes of practice, managers displaying fairness and a commitment to internal whistleblowing, leadership behaviour mirroring policy and empowering and supporting staff to voice concerns (Berry 2004). These findings resonate with nursing research which has also identified how supportive leadership and high-quality learning environments can foster open communication and encourage the raising of concerns within the practice setting. (Bradbury-Jones et al. 2011, Fagan et al. 2016 ; Cole et al. 2019).

However, in organisational cultures where speaking up is discouraged and ethical behaviours are absent, employees may refrain from whistleblowing (Morrison 2011; Kaptein 2011).

1.6.1 Organisational silence

A model of organisational silence, published in the business literature by Morrison (2011), is underpinned by a cognitive and emotional process. Before speaking up, the likely outcome of using voice (perceived efficacy) is considered alongside the negative costs of speaking up (perceived safety of voice), such as retaliation or feelings of futility. An individual's motivation to benefit the organisation versus the consequences of speaking up was judged by individuals before deciding whether to enact voice to highlight wrongdoing. In some instances, the fear of being labelled negatively and damaging collegial relationships, accounted for employees remaining silent (Morrison 2011)

This model of employee voice (Morrison 2011) has been adapted to a nursing context by Okuyama et al. (2014) who developed a speaking up for patient safety model and Fagan et

al. (2016) who developed a concept analysis of student nurses' raising concerns. Both models identified some overlap in the contextual and individual factors that influence speaking up. However, Fagan et al. (2016) argue that student nurses' subservient position and short duration in clinical settings present different challenges to those seen in registered nurses. For the student nurse, the perceived negative consequences of speaking up (perceived safety of voice) included social isolation or failing the placement. These potential repercussions were considered alongside the response and support from staff and supervisors and resulted in students speaking up or remaining silent.

There appear to be a small number of nursing researchers who have adapted theoretical models to a nursing context (Bradbury-Jones et al. 2011; Okuyama et al. 2014; Fagan et al. 2016). However, despite the similarities noted within models of whistleblowing, including the factors influencing intention and action, there is a noted lack of "cross-citation" between the nursing and the academic literature (Blenkinsopp et al. 2019, p.740). Furthermore, the well-developed whistleblowing models within the non-healthcare arena could potentially be adapted to a nursing context to explicate the process of raising concerns. This is a potential area for development within nursing research (Lewis et al. 2015; Blenkinsopp et al. 2019).

A review of the literature related to registered nurses and students on raising concerns and whistleblowing is presented in chapter two. The next section provides an overview of legislation and guidance underpinning whistleblowing and raising concerns.

1.7 Legislation, policy and guidance

National Health Service (NHS) employees who disclose confidential information considered to be in the public interest, are protected by the Public Interest and Disclosure Act (1988). This law protects against unfair dismissal or negative treatment as a result of whistleblowing. Within the act, 'reasonable' disclosures include criminal activity, health and safety risks, failing to comply with legal obligations or any imminent or actual environmental damage (PIDA 1988). In April (2015) the Act was amended to include student nurses and midwives and to offer protection from retaliation if they engaged in whistleblowing.

Since 2015, the Duty of Candour legislation was instigated to ensure that all health care professionals were open and honest with patients and families who experienced adverse events or errors (Care Quality Commission 2015). Although a related concept to whistleblowing, the benefits of being open and transparent and the challenges of speaking up when mistakes are made apply to both (Hilton 2016). The Duty of Candour is a statutory and professional responsibility within England although it is not operational within Wales until 2022. The Welsh Government's Quality and Safety Framework (2021) outlines similar principles of being open and honest with people if something goes wrong with their care and refers to staff speaking up if poor care is witnessed.

In 2013, the All Wales Raising Concerns (Whistleblowing) Policy was published to provide a national framework for staff on how to report and address concerns. However, the policy was criticised at the time, by the British Medical Association, for its emphasis on the threat of disciplinary action if the policy was not adhered to, rather than encouraging openness and transparency (BBC News, 2013). This policy was updated in 2018 with an emphasis on the importance of listening and responding to concerns raised and a clear commitment to supporting those who raise concerns (Public Health Wales, 2018).

Professional regulatory guidance on raising concerns has gathered pace since the publication of the Francis Report (2013) and 'Freedom to Speak up Review' (Francis, 2015). The latest edition of the NMC Code (2018a) also emphasises nurses' responsibility to raise concerns and states that "you act without delay if you believe that there is a risk to patient safety or public protection" (NMC, 2018a, p.12). Alongside the Code, the NMC (2019a) and RCN (2020) have published additional guidance on raising concerns which provide useful resources and case studies that can be adapted to the workplace. Confidential advice on raising concerns is available via Protect (formerly known as Public Concern at Work) which is an independent whistleblowing charity that can be accessed for support at any point during the whistleblowing process. This is not guidance as such but may be signposted by professional bodies or regulators such as the NMC or RCN.

The opportunity for individuals to access advice anonymously is also available via whistleblowing telephone hotlines. However, dealing with concerns from an anonymous source can be more challenging to address if specific details are not provided. Guidance on whistleblowing and raising concerns provided by the NMC (2019a) and the RCN (2020)

apply to student nurses. However, it could be argued that student nurses are potentially in a difficult situation as non-employees of the NHS, yet still fall under statutory requirements. The final section of this chapter provides a brief overview of pre-registration nurse education within Wales.

1.8 Pre-registration Nurse Education in Wales

Student nurses in Wales undertake a three-year (or equivalent part-time) undergraduate nursing programme, delivered across eight universities. Nurse education within Wales has been in the enviable position of taking a national approach to the implementation and maintenance of educational standards since 2001. This has provided standardised processes and a consistent approach for educators, clinical staff, and nursing students (Health Education and Improvement Wales, HEIW 2020).

The nursing undergraduate programme is based on a 50% split between theory and practice which enables student nurses to relate theoretical concepts to a variety of clinical practice settings (NMC 2010). As already identified, student nurses are expected to raise concerns if unsafe nursing practice or poor care is witnessed whilst working in the clinical environment (NMC 2019a). This places an expectation on nurse education providers to ensure that students have the requisite knowledge and skills to be able to confidently detect and escalate concerns.

Furthermore, the importance of integrating patient safety principles into the curriculum was recognised as an international priority by the WHO (2010) who developed a multi-professional patient safety programme to integrate patient safety learning into existing curricula. The need to recognise adverse events and key risks of healthcare and to be able to report them forms part of the educational programme. However, it is unclear how many health education providers are specifically using this programme (Milligan et al. 2016).

From a UK perspective, the importance of embedding patient safety principles into nurse education programmes have been clearly outlined in reports, as well as professional regulators (NMC 2010; Francis 2013, 2015; Higher Education England 2016). The pre-registration education standards (NMC 2010) that were in place when this study commenced, emphasised the importance of providing safe, evidence-based nursing practice and this was evident within the All-Wales Practice Assessment Document (HEIW

2010). The requirement for student nurses to “raise concerns promptly through appropriate channels and modify care where necessary to maintain safety” was also stipulated within the pre-registration standards (NMC 2010, p.5).

Practice learning for the student nurse participants in this study was underpinned by the ‘Standards to Support Learning and Assessment in Practice (NMC 2008) for nurse mentorship. Therefore, student nurses undertaking clinical placements were assigned to work with a nurse mentor who had undertaken an NMC-approved mentorship preparation programme (NMC 2008). Student nurses and nurse mentors were required to work together directly or indirectly for at least 40% of their time on placement, a directive of the NMC (2010) nurse education standards.

The role of the nurse mentor was focused on assessing students’ practice outcomes as well as supporting and facilitating learning opportunities (NMC 2010). This model of practice learning evaluated well if the mentor and student were able to work together for the designated period and developed an effective relationship that enhanced learning (Devlin and Duggan 2020). Unfortunately, challenges were evident if the mentor-student relationship was disharmonious, or if working patterns were not in alignment (Cusack et al. 2020).

Moreover, critics highlighted the difficulties for mentors in supporting and nurturing student nurses, as well as undertaking summative assessment decisions (Bray and Nettleton 2007; Stuart 2013). A PhD study exploring failing students in clinical practice, acknowledged the conflict between the nurturing and assessment functions of the nurse mentor role and identified that in some cases, mentors ‘fail to fail’ students’ clinical assessments in practice (Duffy 2003, p.5). Other more recent studies acknowledged the emotional toll of failing a student in practice, identified the support required for nurse mentors and questioned the patient safety implications of failing to fail students clinical assessments (Vinales 2015; Hughes et al. 2016).

The title and aim of this thesis reflect the model of practice learning in place when the study commenced, which is to explore the dynamics of raising clinical concerns by student nurses from the perspective of the student nurse and nurse mentor. However, during this PhD candidature, new NMC pre-registration standards were developed that resulted in the

demise of the nurse mentor role and the introduction of the practice supervisor and practice assessor (NMC 2018b). New standards for student supervision and assessment (NMC, SSSA, 2018) were developed in response to some of the challenges identified within the nurse mentor role, as well as creating a more flexible and innovative approach to practice learning. The change to supervision and assessment and the potential impact on the process of students raising concerns will be revisited within the discussion chapter.

1.9 Chapter summary

This chapter has provided a rationale for exploring the dynamics of raising clinical concerns from the perspective of the student nurse and nurse mentor and identified the lack of research on this topic. The student nurse has a responsibility to contribute to the patient safety agenda which is outlined within policies, government reports and professional drivers. However, the challenges associated with whistleblowing and raising concerns have been identified within the academic literature and specifically within nursing research studies.

Whistleblowing models have examined the factors influencing an employee's willingness to speak up and proposed prosocial, ethical, and psychological theories to predict the intent to whistle blow. However, very few models have been related to a nursing context, which is an area for development.

An overview of nurse education within Wales has been presented which contextualises the practice learning model in operation at the outset of this study in 2015. The following chapter provides an integrative review of the literature.

CHAPTER TWO – An integrative review of the literature

2.1 Introduction

This chapter critically explores the scholarly literature published on raising concerns in relation to registered nurses and nursing students. The terms ‘raising concerns’ and ‘speaking up’ reflect contemporary research studies on this topic. However, as the term ‘whistleblowing’ was evident in earlier reports and studies, these terms will be used interchangeably throughout the chapter.

For this study, an integrative review was considered to be the most suitable. An advantage of this approach is that it evaluates the broad research evidence through the inclusion of both qualitative and quantitative research approaches and can provide a holistic overview of the topic area (Whittemore and Knafl 2005; Dhollande et al. 2021). However, Whittemore and Knafl (2005) acknowledge that using such a wide range of methodologies can lead to a lack of rigour and bias. To overcome this limitation, the search strategy will outline the robust and systematic approach adopted in locating empirical evidence for this literature review.

The purpose of a literature review and its position within grounded theory methodology is also deliberated and discussed. Key literature pertaining to registered nurses and their perceptions and experiences of raising concerns is critically appraised as well as existing evidence on students speaking up or raising concerns in clinical placements. Finally, literature related to the nurse mentor and the role of academic staff within the process of raising concerns will be evaluated.

2.2 Positioning the literature within grounded theory

The purpose of a literature review within a PhD thesis is to demonstrate knowledge and understanding of the chosen topic area, to identify the key players leading research and to analyse, debate and synthesize current literature (Philips and Pugh 2015). Identifying gaps in the literature is also crucial to provide context and a justification for undertaking a particular study (Deering and Williams 2020).

Undertaking a literature review within a grounded theory study presents a dilemma for the novice researcher. It is not the inclusion of a literature review that is the topic of debate,

but rather when the initial review should be conducted and how extensive this should be (Giles et al. 2013). Glaser and Strauss (1967), who founded the grounded theory methodology, advised against engaging with the literature early in the study. They were keen for categories to form naturally from the data, with no preconceived theories or frameworks from the literature that could stifle the grounded theory process (Dunne 2011). However, Strauss' stance on this altered, when in his later work with Juliet Corbin (Corbin and Strauss 1990), they advocated an early review at the beginning of a study to stimulate research questions and direct theoretical sampling. Nevertheless, Glaser (1998) maintained the original position, which held that reviewing literature contaminated the ensuing data collection, analysis, and quality of the study whilst inadvertently imposing ideas on the work (Glaser 1992; Charmaz 2014).

Dunne (2011) supported Corbin and Strauss's position by stating that the idea of avoiding contamination is unrealistic, as all researchers embark on their study with some prior knowledge of the topic area. In addition, there is also a pragmatic rationale for undertaking an early literature review, as ethical approval for a PhD study requires a literature review to justify why the study is required (Dunne 2011). Nevertheless, it is important that the researcher takes steps to acknowledge the influence of preconceptions, knowledge, and past experiences to reduce bias (Giles et al. 2013). Reflexivity is, therefore, advocated as an important activity within the grounded theory process to overcome potential bias and contamination.

A reflexive approach involves the researcher examining their own experiences and decisions in a transparent way, which in turn allows the reader to assess the influence of these factors on the research process (Bryant and Charmaz 2007). Memo writing is an integral part of reflexivity whereby self-reflection becomes explicit (Charmaz 2014). Utilising reflexivity, whilst undertaking the literature review, aims to recognise the body of work written on a particular topic and promotes an open mind to the possibilities of developing a theory that is grounded in the data (Giles et al. 2013).

A constructivist grounded theory approach (Charmaz 2014) was selected as a suitable methodology to meet the aims of this research study and is critically discussed within chapter three. Charmaz (2014) advocates an early review of extant literature to determine what has been done before and to demonstrate an understanding of the leading research

on the topic area. As the study progressed, Charmaz (2014) acknowledged that “material may lie fallow” (p.307) as no further literature exploration is undertaken until categories of data have been fully developed. However, ideas from earlier literature may resonate whilst developing findings. These can be scrutinised through written memos to guard against unwittingly contaminating the data analysis (Charmaz 2014).

At the beginning of my PhD journey, a broad overview of the whistleblowing and raising concerns literature about nursing and healthcare students was undertaken to ascertain the nature and scope of extant literature and in doing so, identify gaps in understanding. This was instrumental in the formulation of my research questions and the development of a research proposal, which was a requirement for ethical approval. I refrained thereafter from conducting a more extensive literature review until data collection and analysis were completed. However, during this fallow period, data alerts via Zetoc and Google Scholar continued, to keep abreast of all new research published on this topic area.

Consideration was given to the inclusion of an additional literature review section, to highlight research published between 2016 and 2020 on raising concerns. On reflection, a decision was made to weave contemporary literature into one integrative review chapter. However, additional literature from the non-healthcare arena that underpins the grounded theory is situated within the discussion chapter. The next section presents the literature search strategy.

2.3 Literature search strategy

A robust and systematic approach to the literature search was undertaken. Databases including; the Cumulative Index to Nursing and Allied Health [CINAHL], SCOPUS and PubMed (including MEDLINE) were accessed and searches were conducted on ‘raising concerns’, ‘whistleblowing’ and ‘speaking up’ involving registered nurses and student nurses. Support from the librarian was beneficial in selecting and combining search terms. The Boolean operator ‘OR’ was used to broaden search results such as student nurse, nurse, undergraduate and pre-registration. The Boolean operator ‘AND’ was combined with the key search terms to focus on the specific topic of student nurses and registered nurses raising concerns. A comprehensive list of key search terms can be found in the appendices (see appendix 1).

Further studies included in the review were located by manual searching of research articles and reviewing reference lists. The inclusion and exclusion criteria for this study are outlined below.

Inclusion criteria

- ❖ English language literature
- ❖ Studies conducted between 2000 – 2020
- ❖ Studies relating to nurses' perceptions or experiences of raising concerns
- ❖ Studies relating to student nurses' perceptions or experiences of raising concerns
- ❖ Studies relating to nurse mentors or academics perceptions or experiences of supporting student nurses with concerns.
- ❖ Reviews on raising concerns/whistleblowing in registered nurses or student nurses
- ❖ Grey literature such as editorials or discussion papers.

Exclusion criteria

- ❖ Studies not published in English
- ❖ Brief items and opinion pieces
- ❖ Studies conducted before 2000
- ❖ Studies focusing on other healthcare professionals

The gradual change in terminology from 'whistleblowing' to 'raising concerns' was evident within the search strategy. Nursing studies between 2000 and 2010 frequently denoted 'whistleblowing' and later studies between 2010 and 2020 saw the advent of the term 'raising concerns' within the healthcare literature. The emergence of the term 'speaking up' has also been used globally, but particularly in England with the introduction and proliferation of 'Freedom to Speak up Guardians' in the NHS (Martin et al. 2021). These terms are used interchangeably within this review to reflect the terminology selected by the researchers.

The decision not to specifically explore whistleblowing in other health care professions was driven by the need to undertake a focused approach in reviewing research studies about registered nurses and student nurses. However, a small number of the research studies in this review recruited nurses as well as a wide range of other allied health professionals such

as doctors (Tarrant et al. 2017), pharmacists (Monrouxe et al. 2014), physiotherapists (Mansbach et al. 2012), nursing assistants (Jones and Kelly 2014) and dentists (Rees et al. 2015). These research papers provided useful information about nursing and related insights into other professional groups' perceptions and experiences of raising concerns. The literature search strategy captured a total of 68 research papers that were included in this integrative review (see figure 3).

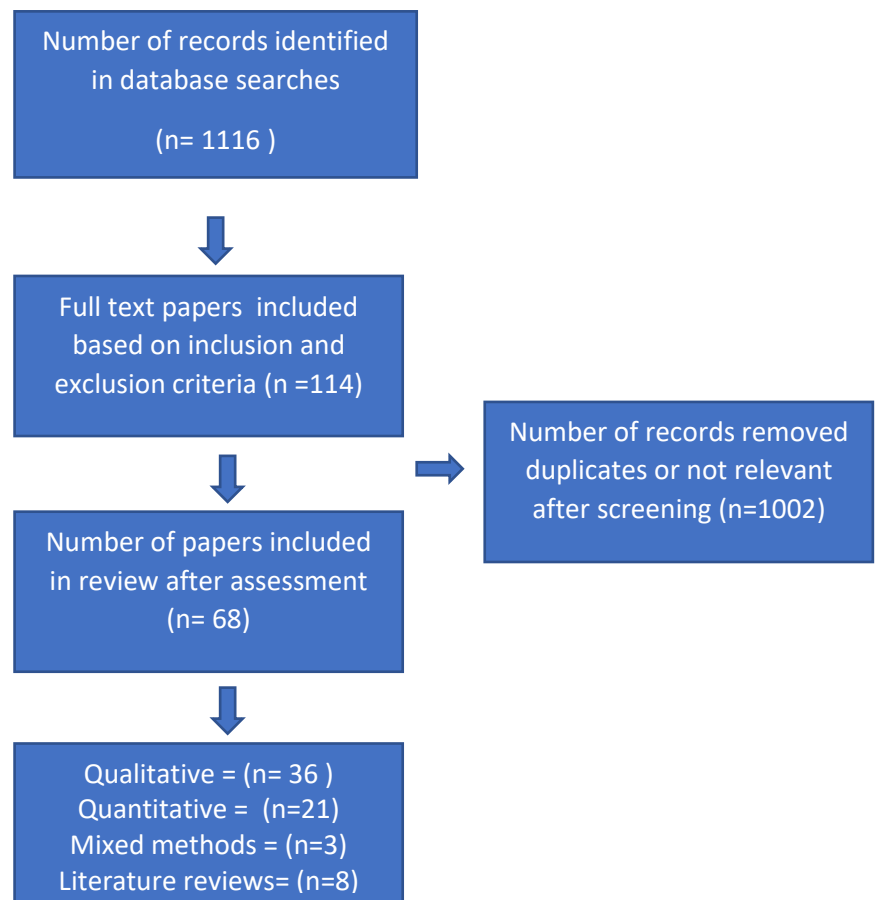


Figure 3 – Diagram of literature search results based on PRISMA (Moher et al. 2010)

Database records were screened through the application of the inclusion and exclusion criteria listed above, where several papers were discounted. Scanning the titles and abstracts of the remaining records further determined eligibility. At this point duplicates and papers that were deemed not relevant were rejected. The remaining research studies were read in full to assess suitability for the integrative review, resulting in studies relating to whistleblowing and raising concerns with registered nurses (n=28) and student nurses

(n=32). An example of the data extraction template, developed to integrate and synthesise key literature is provided in table 2 and the full data extraction for this integrative review can be found in appendix 2.

2.4 Overview of whistleblowing research in nursing

This integrative review includes studies on whistleblowing and raising concerns that focus on registered nurses and nursing students. Qualitative research has been utilised more frequently in this area, although earlier studies on the topic were dominated by a quantitative approach (Moore and McAuliffe 2010; Black 2011). Large-scale surveys utilising a cross-sectional design were adopted by Malmedal et al. (2009) who examined registered nurses' attitudes to reporting in nursing homes (N=616) and Pohjanoska et al. (2018) who investigated healthcare professionals (N=226) experiences of observed wrongdoing and potential whistleblowing acts.

Likert Scales have been used to assess beliefs and experiences related to reporting (Ahern and McDonald 2002; Firth-Cozens et al. 2003; Parlese et al. 2018) and hypothetical vignettes to predict behaviour when faced with ethical dilemmas (Mansbach et al. 2013; 2014). One limitation, which has been cited within the literature, is that hypothetical scenarios may not reflect the behaviour or decisions made in real-life situations (Mesmer-Magnus and Viswesvaran 2005), although arguably this principle could apply to several data collection methods including interviews. However, FeldmanHall et al. (2012) argue that the moral choices made within hypothetical scenarios do not replicate the complex contextual factors which influence behaviour and accompany moral decision-making in the real world.

Table 2 – Example of Data extract for research studies in the integrative review

Author, date and country	Aim of study research question	Methodology data collection/analysis	Sample and context	Findings
Ion et al. (2016) UK	To explore how nursing students account for decisions to report or not report poor care witnessed on placement and examine implications	Qualitative study using discourse analysis Semi-structured interviews	13 undergraduates students at a UK university during 2013. They were asked to consider their response to episodes of poor practice witnessed on placement.	Those who report, justify their actions with positive internal characteristics like the strength of character or commitment to professional regulation. Here a positive self-image is maintained. Non-reporters attribute decisions to external factors beyond their control and to which any other reasonable person would do.
Blowers (2018) UK	Explored students, mentors, and lecturers' experiences of professional integrity in pre-reg education	Qualitative GT approach SS interviews and focus group Thematic analysis of data using constant comparison	12 student nurses 5 mentors 6 lecturers UK university – 4 fields of nursing	Meanings of integrity– patients at centre of care & concept embedded in practice. Doing the right thing – is complex. courage needed Speaking up – influenced by confidence & novice status. Students negotiated a fine balance. Mentors & lecturers – setting the scene important for encouraging speaking up.

Nevertheless, surveys and questionnaires enable researchers to collate large amounts of data and make generalisations that can be applied to the wider population (Swanson and Holton 2005; Moule et al. 2017). In relation to patient safety and raising concerns, a number of nursing studies within this integrative review provided valuable quantitative data on; attitudes to reporting (Firth-Cozens et al. 2003; Malmedal et al. 2009); whistleblowing beliefs (Ahern and McDonald 2002); reporting behaviours (Grube et al. 2010; Black 2011; Cole et al. 2019); willingness to blow the whistle (Mansbach et al. 2013, 2014; Alingh et al. 2019) and experiences of whistleblowing (Davis and Konishi 2007; Moore and McAuliffe 2010, 2012). Within the nursing student population, survey designs were utilised to examine professionalism dilemmas faced by students (Monrouxe et al. 2014); ethical problems (Erdil and Korkmaz 2009) reporting behaviours (Ferns and Meerabeau 2009; Parlese et al. 2018; Halperin and Bronshtein 2019) and the impact of educational interventions on speaking up (Kent et al. 2015).

Studies within the qualitative domain have also focused on speaking up or raising concerns amongst registered nurses (n=12). Areas of nursing research include; perceptions of whistleblowing (Garon 2012; Jones and Kelly 2014); factors influencing whistleblowing (Attree 2007; Jackson et al. 2010a; Prang and Jelsness 2014); speaking up (Schwappach and Gehring 2014a; Law and Chan 2015; Tarrant et al. 2017); the process of whistleblowing (Ohnishi et al. 2008) and the consequences of whistleblowing (Jackson et al. 2010b; Peters et al. 2011; Wilkes et al. 2011).

The largest number of qualitative studies occurred within the student nurse studies (n=21). The focus of research included; factors influencing raising concerns (Bellefontaine 2009; Ion et al. 2015, 2016; Fisher and Kiernan 2019); perceptions and experiences of raising concerns and speaking up (Fagan et al. 2020; Brown et al. 2020); incident reporting (Epsin and Meikle 2014); moral distress (Wojowitz et al. 2014; Chua and Magpenty 2019); ethical dilemmas in practice (Callister et al. 2009; Yeh et al. 2010; Solum et al. 2012); moral courage and professional integrity in speaking up (Bickoff et al. 2016; Blowers 2018), workplace abuse and challenging clinical environments (Thomas and Burke 2012; O'Mara et al. 2014; Rees et al. 2015; Harrison-White and Owens 2018) and exercising voice and empowerment (Bradbury-Jones et al. 2010; 2011).

Many of the qualitative papers used a narrative design (n=26), although Ion et al. (2016) used discourse analysis which can be useful in uncovering the nuances in language and expression (Parahoo 2014; Magashoa 2014). In this study, discourse analysis enabled the researchers to differentiate between those students who reported and those who remained silent (Ion et al. 2016).

Four studies selected a grounded theory research design (Attree 2007; Ohnishi et al. 2008; Blowers 2018; Harrison-White and Owens 2018). However, it was noted that Ohnishi et al. (2008) used open and selective coding to analyse the data but did not incorporate all the key tenets of a grounded theory study, such as the constant comparative method and simultaneous data collection and analysis. On the other hand, Blowers (2018) utilised a constructivist grounded theory approach, to explore students', mentors', and lecturers' experiences of professional integrity. Grounded theory procedures such as coding and constant comparison of the data clearly utilized the Charmazian approach, although there was no reference to memo writing which is an integral part of constructivist grounded theory development (Charmaz 2014).

Phenomenology was the study design of choice in three studies exploring raising concerns (Bellefontaine 2009; Solum et al. 2012 and Fisher and Kiernan 2019). Two of the studies used a hermeneutic approach to interpret the student nurse experience. However, Bellefontaine's paper provided limited information on the methodology employed within the study.

Ethnography appears to have been under-utilised within the nursing whistleblowing literature, with only one study noted in this review. Tarrant et al. (2017) explored speaking up behaviours in intensive care units across England. The ethnographic approach included 900 hours of observations, alongside 98 interviews with varying grades of doctors and nurses. Challenges, pre-emptions, and sanctions such as humour, sharp words and gentle reminders were interventions frequently used by staff members to raise concerns about risk and deviations from policy and guidelines. Jones and Kelly (2014) identified the use of similar informal tactics in their earlier study. Tarrant et al. (2017) described these communication strategies as 'low-level social control' mechanisms used in an attempt to halt wrongdoing (p.8). In most cases, these strategies maintained safety, although were not as effective when used across professional groups and when addressing behaviour in an

individual from a more senior hierarchy. This resonates with many studies which highlight clinical hierarchy as a barrier to raising concerns (Thomas and Burke 2009; Yeh et al. 2010).

Two of the qualitative studies utilised longitudinal studies (Bradbury-Jones et al. 2011; Law and Chan 2015), where study participants are revisited over an extended period to explore changes in perceptions and experiences over time, which is an advantage of longitudinal design (Derrington 2019). However, Polit and Beck (2014) acknowledge that a decreasing attrition rate is a particular shortcoming of this method. However, in the studies discussed here, this did not appear to be an issue, with only one student in Bradbury-Jones et al. (2011) research leaving the study and no attrition reported by Law and Chan (2015).

The most frequently used method of generating data within the qualitative domain were interviews (n=21) whilst other researchers including Blowers (2018) and Fagan et al. (2020) selected focus groups (n=4). However, some researchers enhanced the credibility of the study by using method triangulation of interviews and focus groups. According to Noble and Heale (2019), this method can overcome the bias of using a single method.

Four of the research studies within this review utilised a mixed-method approach (Levett-Jones and Lathlean 2009; Rees et al. 2014; Jack et al. 2018, 2020). This research design incorporates two divergent paradigms, which can enable the researcher to combine the strengths of quantifying data, alongside the inductive narrative that qualitative research can offer (Gray 2014). However, knowledge and experience of both research designs are necessary to conduct a mixed-methods study, which can be problematic (Jogulu and Pansiri 2011). The next section outlines the themes selected to present the integrative review.

2.5 Themes for the integrative review

A thematic analysis was conducted to synthesise the review findings and to identify similar topic areas within the research. The themes were discussed as part of supervision and feedback helped to guide the definitive themes for the integrative review and reflected a good fit with the data. The generated themes are outlined in figure 4 below and discussed further.

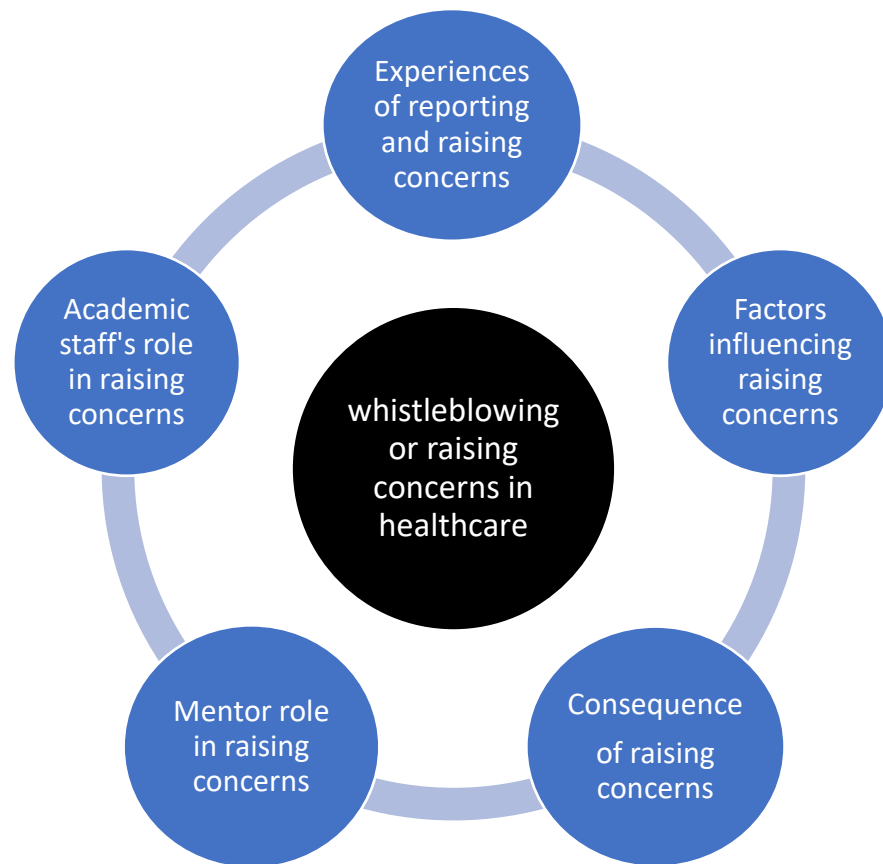


Figure 4 – Themes for whistleblowing or raising concerns in healthcare

2.5.1 Factors influencing raising concerns

Registered nurses and students will inevitably witness care or behaviour within a clinical setting that does not meet the professional and ethical standards expected of a nurse (Ion et al. 2016). Once poor practice has been identified, the individual weighs up the benefits and potential risks of taking action to address the wrongdoing (Attree 2007; Schwappach and Gehring 2014a; Ion et al. 2015; Bickoff et al. 2016).

Internationally, several research studies have explored the factors influencing how healthcare professionals respond when confronted with wrongdoing. In particular, the barriers and enablers to raising concerns have been the focus of contemporary research studies amongst student nurses (Ion et al. 2015; Bickoff et al. 2016; Fisher and Kiernan 2019), registered nurses (Malmedal et al. 2009; Jackson et al 2010a; Cole et al. 2019) and studies involving the wider healthcare team (Firth-Cozens 2003; Monrouxe et al. 2014; Rees et al. 2014).

Fisher and Kiernan (2019) explored the factors that influenced whether student nurses spoke up or remained silent. They distinguished between the intrinsic and extrinsic factors that may inform or prompt raising concerns. Intrinsic factors refer to an individual's personal beliefs, characteristics, moral stance and ethical principles, whereas extrinsic factors pertain to outside influences that may affect students' propensity to speak up. These include interpersonal relationships, leadership and hierarchy and the features of the organisational culture (Jackson et al. 2010b; Jack et al. 2020).

The following sections, explore these factors in more detail and table 3 below provides a summary of the research studies that have identified intrinsic and extrinsic factors which influence raising concerns.

Table 3 – Factors influencing decisions on raising concerns in healthcare

Intrinsic Factors	Literature source
Moral courage	Bickoff et al. 2016; Blowers 2018; Fisher and Kiernan 2019
Personal values and beliefs Futility	Attree 2007; Black 2011; Monrouxe et al. 2014; Schwappach and Gehring 2014a; Bickoff et al. 2016
Utilising professional guidelines	Jackson et al. 2010b; Ion et al. 2016
Confidence	Bellefontaine 2009; Levett-Jones and Lathlean 2009; Callista et al. 2009; Bradbury-Jones et al. 2011 ; Gunther 2011; Ion et al. 2016 ; Blowers 2018
Perceived seriousness of the act	Schwappach and Gehring 2014a
Past experience/exposure to raising concern	Ion et al. 2015 ; Bickoff et al. 2016, Cole et al 2019
Perceived status and identity	Reid-Searle et al. 2009; Yeh et al. 2010; Monrouxe et al. 2014; Blowers 2018; Fisher and Kiernan 2019; Chua and Magenty 2019.
Uncertainty of the concern or action	Moore and McAuliffe 2010; Monrouxe et al. 2014; Ion et al. 2015

Extrinsic factors	Literature source
Team relationships	Orbe and king 2000; Levett-Jones et al. 2007; Gunther 2011; Rees et al. 2014
Mentor-student relationship	Bellefontaine 2009; Harrison-White and Owens 2018; Brown et al. 2020, Jack et al. 2020
Hierarchy and leadership	Bradbury-Jones et al. 2007; Malmedal et al. 2009; Ferns and Meerabeau 2009; Fisher and Kiernan 2019; Chua and Magenty 2019
organisational culture	Attree 2007; Garon 2012; Cole et al. 2019
Being labelled negatively	Moore and McAuliffe 2010; Fisher and Kiernan 2019
Fearing repercussions	Orbe and King 2000; Attree 2007; Malmedal et al. 2009; Black 2011; Cole et al. 2019; Halperin and Bronshtein 2019; Fisher & Kiernan 2019; Jack et al. 2020

2.5.1.1 *Intrinsic factors*

As discussed in the previous section, intrinsic factors relating to an individual's beliefs or personal characteristics that may influence decision-making and behaviour after witnessing poor care (Ion et al. 2016; Bickoff et al. 2016). For example, in a study by Ion et al. (2016) discourse analysis was used to explore how students justified their reporting and non-reporting behaviours after witnessing poor care. Student nurses (n=13) described how personal qualities such as strength, determination and confidence increased reporting behaviours. A commitment to working within professional codes of practice and presenting a positive professional image also facilitated speaking up behaviour.

In contrast, individual perceptions or beliefs can also act as a barrier to reporting concerns. Monrouxe et al. (2014) examined health care students' narratives of professional dilemmas. This UK qualitative, cross-sectional study undertook focus groups and individual interviews with dentistry (n=29), nursing (n=13), pharmacy (n=12) and physiotherapy (n=12) students. Undertaking two different data collection tools as well as including participants from a cross-section of health care groups enhanced the rigour of this study (Moule et al. 2017). The participants believed that raising concerns was futile, which

deterred the health care students from speaking up, a finding also cited in other studies within nursing (Orbe and King 2000; Attree 2007; Black 2011).

Identifying poor practice often presents an ethical dilemma for nurses and can lead to moral distress (Erdkil and Korkmaz, 2009), a finding particularly prevalent within the student nurse population. Moral distress is said to occur in situations when an individual is aware of the right thing to do, but various constraints make it difficult to pursue the right action or prevent harm (Jameton 1984). The literature is replete with instances where student nurses feel unable to enact the desired action after witnessing wrongdoing. For example, qualitative studies carried out in Taiwan (Yeh et al. 2010) and Malawi (Solum et al 2012), explored ethical issues experienced by nursing students through focus groups and interviews. The student nurses' (n=44) in Yeh et al's (2010) study expressed their frustration and sadness at being unable to raise concerns when patients were mistreated by staff. The student's lack of courage was perpetuated by a sense of powerlessness and fear of seniority which resulted in inaction and silence. Similarly, the students in Solum et al. (2012) study experienced conflict when they witnessed unethical behaviour but felt unable to initiate the correct action.

Moral distress can be experienced when standards of care are seen to be compromised or do not align with an individual's expectations (Pauly et al. 2009; Chua and Magpenty 2019). The dissonance between the theoretical element of undergraduate nursing programmes and the reality of clinical practice contributes to uncertainty, conflict and disillusionment and has been well documented within the healthcare literature (Ion et al. 2015; Fisher and Kiernan 2019; Fagan et al. 2020).

Past experience of raising concerns can also influence an individual's perception of the efficacy of reporting wrongdoing. For example, Davis and Konishi's (2007) study in Japan, explored registered nurses' whistleblowing experiences (n=24) and noted a reluctance to blow the whistle if they had previously suffered undesirable consequences when raising concerns. Similarly, studies exploring student nurse decision-making found that hearing negative accounts from peers who had reported wrongdoing, discouraged students from speaking out (Ion et al. 2015; Fagan et al. 2020).

Confidence in challenging and speaking up is also an influential intrinsic factor that can determine whether student nurses raise concerns (Levett-Jones and Lathlean 2009; Blowers 2018). Ion et al. (2015) found that nursing students enhanced confidence in raising concerns appeared to be linked to course progression and a related increase in knowledge and clinical experience accrued over time. Moreover, students who experienced uncertainty or were not confident about whether a concern warranted reporting were more likely to remain silent (Bradbury-Jones et al. 2010; Ion et al. 2015).

Student perceptions of their social identity were a contributing factor to decision-making in Fisher and Kiernan's study (2019). Here students considered their position and status in relation to the organisational culture of the clinical milieu. A desire to fit in, coupled with their perceived junior status, had an inhibitory effect on students voicing their concerns. Similarly, a qualitative longitudinal study by Bradbury-Jones et al. (2011) identified that student nurses believed their novice status precluded them from speaking up. Student perceptions of their novice status contributed to feelings of powerlessness and a fear of reprisals which have been cited within the literature as barriers to raising concerns (Gunther 2011; O'Mara et al. 2014; Fagan et al. 2020). The next section explores the extrinsic factors that can influence decision-making about raising concerns.

2.5.1.2 Extrinsic factors

Contextual factors pertaining to the organisational culture, support structures and leadership can all affect an individual's decision to voice concerns (Attree 2007; Schwappach and Gehring 2014b). Studies have found that responses and action (or inaction) from managers and senior staff within organisations appeared to either facilitate open communication or deter staff from speaking up (Monrouxe et al. 2014; Halperin and Bronshtein 2019). The importance of the manager's role in creating an open, speaking up culture was identified in a study conducted in the USA by Garon (2012). The nurse's ability to speak up in the workplace was explored and findings identified that having a supportive manager encouraged reporting and enhanced patient safety and staff satisfaction.

Unfortunately, raising concerns can be associated with a fear of repercussion (Bickoff 2016), reprisals (Orbe and King 2000), damaged collegial relationships (Jackson et al. 2010b), workplace retaliation (Cole et al. 2019) and punitive action (Fisher and Kiernan

2019). It is troubling that the fear of reprisal has shown little sign of abating over time and continues to distress and prevent healthcare staff and students from taking action to address wrongdoing (Jack et al. 2020).

Perceptions of power and its relationship to raising concerns have been discussed in a number of studies involving student nurses (Thomas and Burk 2009; Bradbury-Jones et al. 2011; Fisher and Kiernan 2019) and registered nurses (Law and Chan 2015). Studies by Bradbury-Jones et al. (2011) and Monrouxe et al. (2014) found that healthcare students did not feel able to challenge senior colleagues and felt disempowered. By virtue of their role and experience, registered nurses were seen as powerful individuals who could potentially make life difficult for the student if concerns were raised.

Qualitative longitudinal interviews conducted by Law and Chan (2015) set out to explore the process of speaking up among newly qualified nurses (NQN) working in intensive care in Hong Kong. The authors utilised a triangulation of data collection methods including unstructured interviews, focus groups and documentary analysis which enhanced the validity of the research (Denzin 2009). The unstructured interviews were repeated at 12, 18 and 24 months, which enabled the researchers to monitor progression across the career continuum. The NQN's all described challenging encounters when attempting to voice concerns regarding patient safety to senior nurses and doctors. There were examples where the NQN's attempts to voice concerns were overridden by staff in authority. These "mis-educative" episodes were disempowering and impacted on the NQN's professional identity (Law and Chan 2015,p.1843). These findings suggest that perceptions of subordination within clinical hierarchies are not exclusive to nursing students, but may also impede reporting by newly registered nurses. Developing assertive communication after experiencing a negative communication encounter requires positive reinforcement and support from mentors and colleagues. In this study, positive responses to speaking up resulted in personal growth and learning.

Student nurses in particular are keen to 'fit in' and reluctant to 'rock the boat' by raising concerns during placement experiences (Levett-Jones and Lathlean 2009; Bickoff et al. 2016). Potential reprisals such as being blamed, excluded or shunned (Levett-Jones and Lathlean 2009; Ion et al. 2015; Jack et al. 2020), labelled as a troublemaker or accused of

not being a team player can all have a detrimental impact on clinical relationships and inhibit the raising of concerns (Fisher and Kiernan 2019, Fagan et al. 2020).

Failing the placement, or challenges in progression within the nursing programme, were perceived repercussions of raising concerns described by students in numerous qualitative studies (Bellefontaine 2009; Monrouxe et al 2014; Ion et al 2015; Brown et al. 2020; Jack et al. 2020). In recent studies by Fisher and Kiernan (2019) and Fagan et al. (2020), student nurses were conscious of this tension and often refrained from speaking up until the end of the placement, or when practice assessments had been completed and signed off. Registered nurses also highlighted negative career consequences associated with whistleblowing and reporting such as the fear of losing their job, being overlooked for promotion, or facing the threat of disciplinary action (Orbe and King 2000; Attree 2007; Halperin and Bronshtein 2019).

Exploring the factors that influenced decision-making identified a clear relationship between individual characteristics and contextual factors. For example, workplace culture and hierarchies which exist externally are processed internally, resulting in perceptions of fear and futility. In this sense, one factor appears to feed the other. The following section explores how nurses and student nurses respond to and address instances of sub-standard care or wrongdoing.

2.6 Experiences of reporting and raising concerns

This section provides an overview of empirical studies which focus on the experiences of nurses in relation to raising concerns. Quantitative studies by Firth-Cozens et al. (2003); Moore and McAuliffe (2012) and Pohjanoska et al. (2018), utilised questionnaires to examine the experiences of reporting poor care. In Firth-Cozens et al. (2003) study, nurses, and doctors (N=624) completed a questionnaire which identified that 93% of nurses who observed poor care considered reporting, while 63% did report. Similarly, 89% of doctors considered reporting, compared to 62% who actually did report. Although 19% of all study participants suffered victimisation by colleagues and managers as a result of raising concerns, most of those who reported said they experienced no reprisals and would willingly report again.

In Moore and McAuliffe's studies (2010, 2012), the results indicated that 88% of the nurse respondents witnessed poor care with 79% reporting what they observed. Moore and McAuliffe (2012, p.333) claim, as a result, that there is a 'culture of silence' prevailing within Irish hospitals. However, this assertion has been challenged as misleading by Jones and Kelly (2014), as the results demonstrate that a high proportion (79%) of the sample did report poor care. The researchers way of thinking appears to be an example of being caught up in the so-called 'whistleblowing/silence' dichotomy, where decisions of whistleblowing are delineated into two choices, speaking up or remaining silent (Teo and Caspersz 2011, Pg. 238). However, this fails to consider the informal communication that may occur in the middle ground between silence and speaking up (Bradbury-Jones et al. 2011, Jones and Kelly 2014).

Davis and Konishi (2007) surveyed nurses (n=24) to discover their perceptions and experiences of advocacy and whistleblowing. Although scant information was provided on the sampling strategy and ethical approval processes, the results found that physicians had been reported more frequently by nursing staff. This is in direct contrast to Ahern and McDonald's (2002) earlier study where nurses were found to be less likely to report doctors and believed that physicians' orders should be followed.

Black's (2011) American quantitative study examined registered nurses' attitudes about reporting patient safety concerns. A random sample of registered nurses (N=1725) were invited to complete a large-scale survey, with a response rate of 33% (N=564) achieved. The results identified that 34% of nurses had not reported concerns. The reasons for not reporting included a fear of reprisal (44%) and a sense of futility that no action would be taken (38%). These results echo Attree's (2007) qualitative, grounded theory study in which registered nurses (n= 142) were interviewed to explore the factors that influenced nurse decision-making in relation to care quality. Despite utilising different research methods, the findings were similar to Black's (2011) study and revealed that the nurses had little confidence in the organisational reporting system and predicted that nothing would be done to address the issues raised. Undertaking a qualitative approach yielded richer data on the reasons for non-reporting. However, Black's quantitative study contributed to shaping legislation on whistleblowing protection in Nevada which may have been aided by the large-scale survey.

In contrast to the findings by Attree (2007) and Black (2011), other quantitative studies identified positive attitudes toward reporting care by nurses and students (Malmedal et al. 2009; Mansbach et al. 2013; 2014). These studies investigated willingness and attitudes to reporting, although Malmedal et al. (2009) Norwegian study also examined whether age, education or length of nursing experience affected reporting behaviour. The results from each of these studies indicated that students and registrants were prepared to report misconduct and wanted to correct wrongdoing. Malmedal et al. (2009) result demonstrated that 66% of nurses indicated that they would report wrongdoing. However, older staff appeared to be more reluctant to report than their younger colleagues. The authors speculated that older nurses may have fewer job opportunities and could be protecting their careers by not raising concerns. However, this may suggest age discrimination within the healthcare setting and demonstrate some problematic assumptions on the part of the researchers which is speculative. Furthermore, older nurses may have significant experience within their field which arguably could enhance job opportunities. Therefore, caution is required when interpreting results in relation to age and raising concerns.

Mansbach et al. (2012, 2013, 2014) undertook several similar quantitative studies in Israel, examining nursing, physiotherapy and nursing students' willingness to report misconduct. Convenience samples were used for all studies and registered nurses, physical therapists and nursing students were asked to consider vignettes that presented ethical dilemmas relating to a colleague and manager's misconduct. The students completed a questionnaire on a course as part of an ethics survey and this was distributed at the end of the lecture. This may explain the response rate of 83%, which is considerably higher than expected for a survey (Parahoo 2014). It is not clear whether the students were offered any incentives for completing the survey. The results indicated that the respondents were willing to report poor practice and take action, particularly if patient care was compromised. Whistleblowing was more likely to occur using internal channels than reporting externally and the students rated the manager's conduct as more serious than a colleague's wrongdoing. The authors did not provide an interpretation for this, although it is possible that students may have higher expectations of an individual in a leadership role.

Studies exploring student nurses' experiences of raising concerns and reporting have been undertaken by Ferns and Merrabeau (2003) and Rees et al. (2014). Both studies found that the majority of the student participants reported poor care. The percentage of students reporting was higher in Rees et al's (2014) more recent study (79.3%). However, indirect methods of reporting as well as formal mechanisms were included in Rees et al. (2014) study which makes direct comparisons problematic.

Parlese et al. (2018) conducted a national quantitative study in Italy to examine student reporting behaviour. Students (N=9607) were asked to complete a four-part Likert scale to indicate if they had the opportunity to discuss and report errors or near misses during their last clinical experience. The results indicated that only a small proportion, 1603 (16.7%) of students always reported safety issues, just under half, 3904 (33.4%) sometimes reported and 800 (8.3%) did not report. However, there was no correlation to how serious the errors were perceived to be which may have impacted reporting behaviour. Contextual reasons for not reporting included inadequate staffing and poor role modelling in practice settings where clinical instructors fixed errors rather than reporting. Students who were supervised by nurse teachers were less likely to report errors. The authors surmised that this may be associated with the nurse teacher's role as evaluator which could be detrimental to their academic career.

Similar barriers to reporting have been found in studies relating to nursing students and staff in supervisory roles (Thomas and Burke 2009; Ferns and Meerabeau 2009). On a positive note, students who did disclose patient safety issues, worked in high- quality care settings, where there was access to learning opportunities and an open safety culture. The recommended national strategies across Italy to address this included a focus on developing a no-blame clinical culture to encourage reporting. The study by Parlese et al. (2018) also revealed that students who were older were less likely to report which resonates with Malmedal's findings (2009).

Reviewing the studies on experiences of whistleblowing paints a varied picture of reporting behaviours. When registered nurses or student nurses witness substandard care, they may choose to speak up, remain silent or utilise more indirect ways of highlighting their concerns. Several research studies have alluded to informal strategies that have been used

as a precursor to formal reporting or as an alternative method of bringing attention to wrongdoing. These are discussed in the next section.

2.6.1 Informal approaches to raise concerns

Jones and Kelly (2014) have described a tendency within the literature to categorise staff responses to wrongdoing as either consisting of whistleblowing or silence. This fails to acknowledge the informal channels that staff may use to signal discontent. In their study, strategies such as the use of humour or “having a word”, were used as a way of communicating concerns (p.10). Informally chatting with peers was also utilised as the first step of a ‘ladder approach’ in Epsin and Meikle’s (2014) study. Here staff would similarly escalate concerns up the ladder of authority if informal methods were ineffective.

This dichotomy between speaking up or remaining silent was identified in a study by Bradbury-Jones et al. (2011). Thirteen UK students were interviewed and participated in focus group discussions. Hirschman’s (1970) work on exit and voice provided a theoretical framework to apply the findings. There was evidence that students were silenced in clinical practice, particularly in the earlier stages of training. Students in this study revealed that if they needed to speak up about poor practice they could ‘exit’ (taking no action), ‘voice’ which involved speaking up to report poor practice, or alternatively could utilise a ‘negotiated voice’. Strategies such as apologising for asking staff lots of questions and carefully selecting an opportune moment to voice queries or concerns were examples of using negotiated voice. Students were self-aware when negotiating their voice and attempted to strike a balance between appearing assertive, but not overconfident when communicating concerns (Bradbury-Jones et al. 2011).

Other strategies have been described in research studies to signal awareness of wrongdoing to others and to keep patients safe. In Orbe and King’s (2000) study, staff who witnessed unsafe care or made potentially serious errors, monitored the patient closely themselves to note signs of deterioration rather than reporting. Orbe and King (2000) suggested that informal methods were sometimes more effective than utilising formal reporting mechanisms. However, there is a danger that near-misses and potentially harmful situations evade formal reporting channels which may limit the opportunity to learn lessons and prevent future errors.

McDonald and Ahern (2000) noted how manipulation was utilised to highlight concerns without the need for direct confrontation. Here manipulation occurred when topics were casually broached by nursing staff, in the presence of patients and colleagues, to address deficiencies in care or information. This strategy downplays any wrongdoing but can potentially signal to the wrongdoer that action is required to promote patient safety. Similar strategies were highlighted in a later study by Schwappach and Gehring (2014b), which included the use of non-verbal gestures to signal without alarming the patient and were used as an alternative to escalating concerns more formally. In Tarrant et al. (2017) research, pre-emptions such as suggestions or banter were effectively used to highlight low level issues, but could develop into sharp words or more insistent communication if patient safety was compromised. However, these strategies were not always successful if an unequal power dynamic between staff was evident.

Collectively, these findings suggest that informal approaches to address concerns are utilised by healthcare staff either as a first-line approach to highlight awareness of risky behaviour, or as an alternative to escalating concerns. Potential avenues for future research would be to focus on the extent to which these informal sanctions and strategies are utilised and their efficacy in signalling awareness of poor practice in an attempt to halt wrongdoing. The next section reviews research studies that focus on the consequences of raising a concern and in particular the physical and emotional effects of whistleblowing.

2.7 The consequences of whistleblowing or raising concerns

Individuals who blow the whistle or raise a concern can be perceived as a courageous employee or viewed as a troublemaker (Firtko and Jackson 2005; Jones and Kelly 2014). For some, the impact of speaking up can have detrimental effects on the whistle-blower's professional life as well as physical and emotional effects (Jackson et al. 2010a). The nursing literature on this topic identified several research studies where staff and nursing students experienced negative consequences because of raising concerns or had an anticipated fear of repercussions that can impact whistleblowing decisions (Orbe and King 2000; Jackson 2010a, 2010b).

Professional consequences

Jackson (2010a) utilised a qualitative narrative inquiry to gain insight from nurse whistleblowers and subjects of whistleblowing (n=11). Findings were themed into; reasons for whistleblowing, the culture of silence and fear of speaking out. Similar to the staff in Orbe and King's (2003) study, the nurse participants identified their role as patient advocates which compelled them to speak out. The overriding whistleblowing experience for the nurse participants was fear, and they described working in a "climate of fear" (Jackson et al. 2010a, p.2198). The culture within the organisation was hostile, with an insidious 'culture of silence' and pressure on staff to keep quiet and maintain the status quo. Speaking up had a profound effect on working relationships and nurses discussed feeling marginalised and bullied by colleagues and treated with hostility after speaking up. A limitation of this study, recognised by Jackson et al (2010a), is the volunteer bias. They described the potential for participants with negative or unresolved experiences to offer to take part in the study.

The negative consequences of speaking up were also evident in other nursing studies (Orbe and King 2000, Firth-Cozens et al. 2003; Jackson et al. 2010b). McDonald and Ahern's (2000) postal survey highlighted a number of undesirable consequences that were described by staff who raised concerns including being snubbed or ostracised by colleagues (14%), being threatened (10%), pressured to resign (7%) and demoted (4%). A paper drawn from the same study by Jackson et al (2010b) explored the consequences of whistleblowing from multi-perspectives (the whistle-blower, bystander, and the subject of the whistleblowing). This appears to be one of the few studies within nursing that have reported the effects of whistleblowing from these different standpoints. Hostility in the workplace was a common finding as were suspicion, bullying and exclusion from their peers. This had a deleterious effect on collegial relationships for all involved, including bystanders who felt ostracised. More recent studies have identified how raising concerns had a negative impact on workplace relationships including victimisation by the manager (Firth-Cozens et al. 2003). Whistleblowing has also had a detrimental effect on physical and emotional health which will be explored within the next section.

Physical and emotional effects of raising concerns

A Canadian study by O'Mara et al. (2014) conducted focus groups to explore nursing students' experiences of challenging clinical environments. They found that the impact of raising a concern manifested itself in physical effects such as difficulty in sleeping, anxiety, and vomiting (O'Mara et al 2014). Interestingly student nurses (n=54) appeared to suffer these physical effects, regardless of whether they reported poor care or not, and experienced anguish when confronted with poor care that they felt unable to rectify.

The emotional impact on nurses involved in a whistleblowing event, and on their families, has been explored in studies by Peters et al. (2011) and Wilkes et al. (2011). Both studies were drawn from Jackson et al's (2010a) larger study and focused on the emotional effects of whistleblowing from the perspective of the whistle-blower and the subject of the whistleblowing incident. The findings revealed that both the whistle-blower and the subject of concern were traumatised by the events, with their health and well-being suffering dramatically as a result. Participants described feelings of emotional distress coupled with anxiety and depression, which in some cases lasted for more than a year after the event. Physical symptoms such as panic attacks, nightmares, and an inability to cope in the workplace were also reported. The subjects of the whistleblowing also reported similar complaints of depression and anxiety and in addition, feelings of being unjustly treated. This study emphasizes the far-reaching physical and emotional effects of whistleblowing, a subject that has not been studied extensively within the nursing arena.

Another topic area that has received scant attention is the impact of whistleblowing on immediate families. Wilkes et al. (2011) research revealed the strain on family relationships in the aftermath of a whistleblowing event. Verbatim quotes, from the participants who had reported wrongdoing or been the subject of the reporting, paint a vivid picture of depression, anxiety, and marital breakdowns. Children within the family also suffered psychological damage as a result of the whistleblowing process.

In Ohnishi et al's (2008), very small qualitative study, two nursing staff blew the whistle to the media after witnessing large-scale misconduct at a private hospital in Japan. Their experience of whistleblowing and the emotional impact of doing so were captured through

in-depth interviews which lasted around three hours each. Immediately following the whistleblowing, the overriding emotions were guilt, pride, and a fear of retribution. Years after the event, the whistle-blowers felt regret that they had not spoken up earlier and relief that they had left the job and had spoken out. As reporting misconduct externally is relatively uncommon in healthcare settings, more detail on the impact of reporting externally would have enriched this study. The case of Margaret Haywood, a nurse who was struck off the nursing register and later reinstated after secretly filming poor practice (Gallagher 2010), illustrates the negative reprisals of whistleblowing to the media and research in this area is negligible.

Many studies have identified the moral distress that nurses and student nurses experience when they raise concerns (Lindh et al. 2008; Gunther 2011, Rees et al. 2014). Fear of negative repercussions appears to pervade the student population and has been frequently cited as a barrier to raising concerns (Fisher and Kiernan 2019; Brown et al. 2020). However, there appears to be very little evidence to indicate that students fail their placements or are removed from the course as a result of raising concerns (Ion et al. 2015; Fisher and Kiernan 2019). This suggests that anticipated fear may be worse than reality, although further research is required to fully understand the consequences of student nurses raising concerns.

The body of research in this area demonstrates that witnessing poor care may in itself provoke physical and emotional responses, which can result in anxiety and moral distress regardless of whether a concern is then raised. Loss of collegial relationships and the emotional fallout of whistleblowing illustrate the negative outcomes associated with speaking up and acting as patient advocates.

2.8 Role of the mentor in raising concerns

Research studies have cited the importance of the nurse mentor role in enhancing a student's socialisation in the clinical setting, providing quality learning experiences and supporting students who raise concerns (Bellefontaine 2009; Harrison-White and Owens 2018; Blowers 2018; Jack et al. 2018). Nurse mentors are expected to work alongside students for at least 40% of the placement time to facilitate learning and assess practice

outcomes (NMC 2010). As a result of this prolonged contact, students are keen to develop a collegial relationship with the mentor, feel a sense of belonging and fit into the wider team (Levett-Jones and Lathlean 2009; Fagan et al. 2016; Jack et al. 2018).

However, the fear of failing a clinical placement or experiencing negative consequences from the mentor or wider team can influence student nurses' decisions regarding the disclosure of concerns to their mentor (Bellefontaine 2009; Jack et al. 2020; Fagan et al. 2020).

Bellefontaine (2009) undertook a small-scale qualitative study (n=6) to explore the factors that influence student nurses' reporting concerns. A phenomenological approach was used although the lack of methodological detail, particularly in relation to data analysis is a weakness of the study. Semi-structured interviews were used, but the author does not confirm if the interviews were recorded. The mentor-student relationship was cited as significant in student decision-making on raising concerns. Students were cognisant of the influential role of the nurse mentor within the team and worried about mentor support being withdrawn or retaliation from the mentor or senior staff if they reported concerns.

Furthermore, concerns about failing the placement and being considered a 'troublesome student' were identified, with similar findings apparent in more recent studies (Bickoff et al. 2016; Fisher and Kiernan 2019). A mentor who was approachable and inclusive enhanced students' feelings of belonging and facilitated reporting, which supports the findings of Levett-Jones and Lathlean (2009) and Brown et al. (2020).

Bellefontaine (2009) recommended a greater focus on raising concerns within mentor preparation programmes. This appears to be one of the few studies that have identified the importance of the mentor-student relationship in influencing whether the student reported poor practice.

Jack et al. (2018) utilised a mixed-method approach to explore student nurses' perceptions of unfairness whilst working in clinical placement. Although the study was not specifically focused on students raising concerns, the importance of the mentor advocating for students and 'legitimizing student concerns' was identified. However, the acknowledgment that mentors might feel unconfident in supporting student concerns due to the fear of negative consequences from senior colleagues is an interesting perspective. This could be

one explanation why some mentors do not respond appropriately when student nurses report concerns in clinical practice.

In a more recent study, Jack et al. (2020) explored nursing students' experiences of care delivery across three different sites (two in the UK and one in Australia), using a survey to obtain numerical and qualitative data (N=265). The majority of the sample reported positive experiences of observing compassionate nursing practice. However, witnessing poor care and neglect was reported in students from all three sites, which highlights the existence of unsafe nursing practices in other countries. The potential repercussions of raising concerns were described by students, such as fears regarding placement assessments and employment, which echo other research findings (Brown et al. 2020; Fagan et al. 2020). In most cases, students' fear of reprisals appears to be anticipatory and there is little evidence that negative consequences occur when students do raise concerns. However, in Jack et al. (2020) research study, a small number of students (n=2) did experience repercussions because of raising concerns. Reports of a mentor refusing to provide a reference for a job and being ignored by the clinical team for 'complaining', provide disheartening examples of why students are reluctant to raise concerns to their nurse mentor or clinical manager.

There is a significant gap in the literature about the role of the nurse mentor in raising concerns, and in particular, a dearth of research studies that directly explore the influence of the mentor-student dynamic on student decision-making after witnessing poor care. An exploration of the mentor-student relationship in relation to raising concerns is a central theme of this thesis and will be explored in more detail within chapter five.

2.9 Role of academic staff within the raising concerns process

The literature review also identified a lack of research studies that specifically explored the role of university academics within the raising concerns process. However, Blowers (2018) explored experiences of professional integrity from the perspective of the student, mentor, and lecturer. Findings revealed that students sought reassurance from lecturers and mentors about the presence or absence of integrity in the nursing care they witnessed. Here, lecturers and mentors discussed the importance of being approachable and assisting students with queries as a way of facilitating speaking up. In comparison, the nursing

students in a qualitative study by Wojtowicz et al. (2014) were faced with clinical instructors who did not facilitate speaking up behaviours. After seeking advice from clinical instructors, following the observation of poor practice, they noted that some instructors avoided confronting the nursing staff. They excused this lack of action due to not working in the clinical area. This, however, demonstrated poor role-modelling and deterred students from speaking up.

A greater number of studies have focused on the implementation of educational strategies to enhance knowledge and skills in raising concerns and reporting wrongdoing. Rees et al. (2014) suggested there was a need for nurse educators to provide the opportunity and safe space for students to discuss professionalism dilemmas with peers. Other strategies recommended within the literature included interprofessional learning on professional dilemmas through role-play (Monrouxe et al. 2014) and a focus on how and when to report incidents (Epsin and Meikle 2014). Ion et al. (2016) recognised the challenges for students in raising concerns in clinical practice. They argued that educators should explore the facilitative and inhibitory factors influencing raising concerns and emphasised the pro-social aspects of whistleblowing as opposed to inaction. Ion et al. (2015) acknowledged that educators needed to support students through the raising concerns process and at times may need to consider intervening to assist. While this is a useful and constructive recommendation, any interventions by academic staff need to keep the student proactively involved in the process to enable them to learn how to raise concerns independently. The absence of research studies on the role of the personal tutor within the raising concerns process will be addressed and form one of the research outcomes underpinning this study.

2.10 Chapter summary

This integrative review has identified a plethora of research studies that have explored the perceptions and factors that influence nurse registrants and student nurse decision-making on whether to raise concerns or not. It is evident from this body of work that intrinsic and extrinsic factors can facilitate or inhibit raising concerns. An anticipatory fear of negative consequences is particularly prevalent among nursing students and appears to be exacerbated by their perceived novice status, need to belong, and fear of failing assessments, which all contribute to their vulnerability. This fear pervades, despite

relatively little evidence that students actually experience negative consequences (Milligan et al. 2016).

Blenkinsopp et al. (2019) argue that there has been an over-emphasis on the decision-making phase and a subsequent lack of exploration of the latter stages of the whistleblowing process that examines what happens when individuals blow the whistle and the outcomes of doing so. Attention now needs to focus on how to address the barriers that seem to deter healthcare staff and students from speaking up and reporting (Ion et al. 2016).

Studies have identified that informal strategies are often used as a precursor to formally escalate a concern and are positioned in the middle ground between silence and formal reporting. Exploring the efficacy of these as a precursor or option to reporting would address a gap in the literature. Empirical evidence has examined the experiences of whistleblowing and identified a variable picture in nurses' and student nurses' willingness to speak up and the factors that influence reporting behaviour. However, there appears to be a lack of research on the positive impact of reporting, this could be overcome by recruiting purposive samples of staff to provide a rich insight into their positive experience.

Given the contextual factors that appear to influence this process, studying the workplace culture, team relationships and leadership may provide further insights into how to enhance the landscape for speaking up and raising concerns. There have also been limited grounded theory studies on this topic, despite its suitability for studying social processes such as raising concerns.

Few papers discuss the difficulties of interviewing in this topic area or the challenges inherent in researching an emotive topic. This can potentially be a cathartic experience for research participants as unfinished business, or a lack of closure can come to the fore. This may be particularly evident when staff and students feel silenced or have raised a concern that was not listened to or taken seriously.

The aim of this literature review has been achieved and the gaps identified have informed the research questions for this study. It also provided the opportunity to consider an appropriate methodology for this study. The next chapter presents the methodology and methods selected for this research study.

CHAPTER THREE – Methodology and Methods

3.1 Introduction

The aim of this study is to explore the dynamics of raising clinical concerns by student nurses, from the perspective of the student nurse and nurse mentor. This chapter discusses and justifies the decision to utilise a constructivist grounded theory methodology (Charmaz 2014) as offering the best “fit” with the aim of the study and the extant knowledge in this area.

This section will start with a discussion of how my philosophical stance influenced every aspect of this research study. The selected research design incorporates the values and beliefs inherent in our assumptions of the world. The origins of our knowledge base also influence the methodology and approach which in turn underpin the methods used to gather and analyse the data (Parahoo 2014). These elements cannot be viewed in isolation as they are inextricably linked and collectively inform all stages of the study design. (Crotty 1998; James 2015). To contextualise this study, an overview of my epistemological and ontological stance will be presented as well as an explanation of how these inform the methods chosen for this study.

3.2 Epistemological and ontological position

Assumptions about the nature of knowledge and the way we understand our existence are fundamental in shaping how we perceive and act in the world (Denzin and Lincoln 2013). Epistemology is defined as the study of knowledge and requires us to question how we come to know, whereas ontology is the study of the nature of existence and being (Crotty 1998 p.8). These philosophies of knowledge and reality are interwoven and underpin the way social reality is viewed (Krauss 2005; Olsen 2011). Furthermore, Crotty (1998) contends that epistemology and ontology should be considered in tandem as both influence the theoretical perspective selected for a research study. In contrast, Weaver and Olsen (2006) argue that our ontological or philosophical perspective shapes our understanding of what constitutes knowledge. These abstract beliefs provide a set of assumptions that help to guide the actions of researchers (Guba and Lincoln 1989).

At the start of my research journey, I considered my ontological position which was firmly rooted in the uniqueness of human beings and the subjectivity of meanings and experience. As a researcher, I was aware that my values, beliefs, and assumptions influenced my interactions with participants and that research data is co-created between the researcher and participant, all of which concurs with a constructivist position (Charmaz 2014). A constructivist paradigm assumes a relativist ontology where there is no absolute truth, but multiple interpretations of knowledge that are contextual to the circumstances that a person finds themselves in (Parahoo 2014).

My knowledge base, or epistemology, was considered in relation to my culture and upbringing, as well as my schooling and exposure to further education. As a registered nurse, my passion for practice learning was integral to my role as a nurse educator. For the majority of this PhD journey, I worked in the NHS as a clinical teacher. This role involved training and supporting nurse mentors in clinical practice. Therefore, I had an in-depth knowledge of the roles and responsibilities of nurse mentors, the undergraduate nursing curriculum, and the process of clinical learning and assessment for student nurses. I was also conversant with the policies and guidelines pertaining to raising and escalating concerns from a university and NHS perspective. However, the focus of my role was on supporting the nurse mentor rather than the student nurse.

I was aware that students were undertaking clinical placements in busy and sometimes understaffed practice settings. Occasionally, students would approach me with a concern, and I would ensure that they were supported in escalating these. However, I knew relatively little about the trajectory of the raising concerns process from a student nurse, or nurse mentor perspective. This prompted my interest in exploring how student nurses raise concerns whilst undertaking clinical placements and how the mentor-student relationship might influence this process.

Therefore, my knowledge of practice learning and my experience of supporting nurse mentors in clinical practice has influenced my research topic and the methodology selected to answer the research questions. Within the next section attention now turns to introduce the theoretical perspective that underpins the chosen methodology (Crotty 1998) and provides a lens through which to view the study.

3.3 Theoretical perspective

Symbolic interactionism is a theoretical perspective rooted in social psychology which studies human social behaviour (Benzies and Allen 2001). The influence of John Dewey's work on pragmatism contributed to George Mead laying the foundations of symbolic interactionism (Jeon 2004). Mead was an American philosopher, sociologist and psychologist who explored the role of behaviour and interaction in creating knowledge (Hall 2013). Mead differentiated between two types of action seen in society; a non-symbolic interaction whereby humans have an immediate (sometimes automatic) response to the action of another, whereas symbolic interaction involves interpretation of the action and seeking the meaning inherent in the action (Blumer 1969). Symbolic interactionism is an interpretivist research perspective that informs a range of methodologies (Crotty 1998). Blumer (1969) coined the term 'symbolic interactionism' and articulated three assumptions of symbolic interactionism which are relevant to my study in table 4 below (Blumer 1969; Annells 1997).

Table 4 – Assumptions of symbolic interactionism

Assumptions of symbolic interaction	How assumptions relate to this study
<ul style="list-style-type: none">• that human beings act toward things on the basis of the meanings that these things have for them• that the meaning of such things is derived from, and arises out of the social interaction that one has with one's fellows• that these meanings are handled in, and modified through, an interpretive process by the person in dealing with the things he encounters	<ul style="list-style-type: none">• how participants make sense of the raising concerns process.• the influence of the mentor-student dynamic and students' relationships with relevant others, such as personal tutors and clinical staff• decision-making and subsequent actions in relation to raising concerns were influenced by contextual sensemaking in clinical practice.

Blumer (1969) proposed that people interpret social situations and derive meaning which affects their behaviour. In relation to this study, which explores student nurse and nurse mentor perceptions and experiences of raising concerns, this concept resonated, and I was

able to identify symbolic interactionism, located within grounded theory specifically, as suitable lens to position my study.

3.4 Research Methodology

The research methodology encompasses the overall strategy of the study and is underpinned by the researcher's philosophical stance. A quantitative research methodology is supported by the positivist, or scientific paradigm, which centres on the belief in a single, identifiable reality (Guba and Lincoln 1985). Denzin and Lincoln (2013) maintain that the epistemology of positivism is objectivity, with researchers remaining neutral with little or no interaction with subjects. However, the scientific paradigm did not align with my philosophical assumption of multiple interpretations of knowledge.

This study was centred on the social context of raising concerns and involved interacting with student nurse and nurse mentor participants. Adopting a quantitative methodology and presenting the results through factual statements and numerical data (Trueby et al. 2015) would not provide the rich data that was required to meet the aims of the study. Instead, an interpretive paradigm that could make sense of the process of students raising concerns, and interpreting the meanings ascribed to the phenomenon, was deemed to be appropriate for this study. Qualitative research was therefore selected as an appropriate design to answer the research questions. This decision was underpinned by my ontological position that raising concerns was likely to be individually experienced, invoking multiple realities which are subjective and interpreted by human beings in different ways (Krauss 2005). Although student nurses, nurse mentors and personal tutors (whose influence appeared as the study evolved) perceptions and experiences of raising concerns were influenced by their views of reality, I was also conscious that their experiences could also be constructed within the shared social context of culture, hierarchy, and interpersonal relationships.

Several qualitative designs were considered for this study including phenomenology, ethnography and grounded theory. A small number of research studies exploring raising concerns from the student nurse perspective have utilised a phenomenological approach (Bellefontaine 2009; Fisher and Kiernan 2019). Both studies explored the subjective lived experience to explore what influences student nurses' ability to raise a concern. The study

findings add to the body of knowledge on the factors that influence speaking up. Phenomenology is concerned with the lived experiences of humans, whereas grounded theory seeks to explore the key psychosocial processes that occur in a social setting. Of course, there are overlaps between the two, with both utilising an interpretivist approach, exploring real-life situations, and relying on the interaction between researcher and participants (Gelling 2011).

However, the goal of my thesis was to develop an explanatory theory of the basic social process of raising concerns, from the perspective of the student nurse and the nurse mentor. This goal was closely in keeping with grounded theory (Stark and Trinidad 2007) and as a result, phenomenology was rejected.

An ethnographic approach was also initially considered for this study. Ethnography is “the study of social interaction, behaviours, and perceptions that occur within groups, teams, organisations, and communities” (Reeves et al. 2008 p.1020). Ethnography’s anthropological origins make it an ideal methodology to study cultures through detailed observation, although observation is not the only tool of data collection. Interviews and documentary analyses can be conducted alongside observational studies and increase the validity of the research through triangulation (Moule et al. 2017).

Non-participant observation of students and mentors in the clinical settings could have been utilised for this study. However, the need to raise a concern may not have arisen during the observation period. Furthermore, raising a concern may not necessarily be an identifiable occurrence, but undertaken in more subtle or circumlocutory ways (Jones and Kelly 2014). My presence in the clinical environment, as a non-participant observer, could potentially have influenced how the participants reacted to concerns raised. The reasons outlined may explain the relatively few ethnographic studies undertaken on this topic, although a notable study on speaking up within intensive care units across the UK utilised an ethnographic approach including observation, interviews, and use of diaries (Tarrant et al. 2017)

The preceding literature review chapter identified only a small number of research studies on raising concerns that utilised a grounded theory approach (Attree 2007; Blowers 2018). There appears to be a lack of grounded theory studies which have explored the

interactional, processual, and relational nature of the mentor-student dynamic in raising concerns. Therefore, utilising a grounded theory methodology for this study will address a substantial gap in the literature.

3.5 Grounded theory methodology

Grounded theory is a practical, interpretive methodology, that is well suited to the study of social processes and gaining an understanding of the meanings, concepts, and interpretations of social actors in a variety of settings and contexts (Heath and Cowley 2004; Suddaby 2006). Grounded theory has been used as a methodology to study a diverse range of disciplines such as education (Vancell 2012), physiotherapy (Ali et al. 2018) and business studies (Boadu and Sorour 2015), which illustrate the applicability of this approach in developing theories to advance practice.

A number of different approaches within grounded theory can be adopted by researchers such as classic (Glaser and Strauss 1967); Straussian (Strauss and Corbin 1990) and constructivist (Charmaz 2014) . However, there are central tenets of grounded theory that should form an integral part of all grounded theory research (Glaser and Strauss 1967; Jeon 2004). These are briefly defined below and discussed further in this chapter.

- *concurrent data generation and analysis* - an iterative approach is adopted whereby data are generated and analysed concurrently before the researcher repeats the process with another set of data (Maz 2013).
- *constant comparison* - involves constantly comparing and asking questions about the data which is fundamental to developing concepts, categories and their properties (Holloway and Galvin 2016). This cycle continues until data saturation occurs and where no new findings emerge (Morse 2015).
- *Theoretical sampling* - is a method of data collection for generating theory, where the analyst “jointly collects, codes and analyses data and decides what data to collect next and from where” (Glaser and Strauss 1967 p.45). Theoretical sampling is driven by the emerging concepts from the initial data analysis, rather than being established prior to data collection.

- *Theoretical sensitivity* – is a “multidimensional concept” which requires the researcher to develop an insight into the participant’s world as well as having the capacity to reconstruct meaning derived from the data (Mills et al. 2006 p.4)
- *Memoing* - incorporates the process of writing down ideas during data analysis and capturing the meaning of conceptual ideas and insights (Birks and Mills 2011). According to Charmaz (2014), the researcher has to reflect and consider the relationships between codes and categories, this helps to develop and refine the analysis.
- *Theory generation* - A grounded theory approach demands that the researcher moves beyond the description of the topic area towards a theoretical rendering that identifies key explanatory concepts and the relationship among them (Glaser and Strauss 1967).

The following section will review the evolution of grounded theory and the early work of the proponents of this methodology.

3.6 Evolution of Grounded Theory

The grounded theory methodology was first developed by Glaser and Strauss (1967) as a form of revolt against the positivist research approach, which was the dominant paradigm of the 1960s (Suddaby 2006). Grounded theory was described in their book, *‘Discovery of grounded theory’* as a rigorous methodology that could generate theory systematically through the emergence of data (Hall et al. 2013). This approach became known as classic or a ‘Glaserian’ grounded theory approach (Stern 1994). Glaser’s background in quantitative research complemented Strauss’ social science background which was heavily influenced by symbolic interactionism and pragmatism (Stern 1994).

Integral to the classic grounded theory was the constant comparison of data and theoretical sampling. The desired outcome of this method was to discover latent patterns of behaviour that could explain the main problem that participants were experiencing (Elliot and Higgins 2012). Despite the success and continued use of the classic method worldwide, critics argued that the emphasis was on abstract explanations rather than practical application of the methodology (Hunter et al. 2011).

Over time, Glaser and Strauss's approach began to diverge, with Strauss's collaboration with Corbin signalling a new direction and a modified approach to grounded theory. This was outlined in their book the '*Basics of qualitative research*' (Strauss and Corbin 1990), which featured a set of analytic techniques designed to make sense of qualitative data. However, Glaser (1992) critiqued their analytical methods and presented divergent ideas on, for example, philosophical standpoints and the timing of the literature.

Strauss and Corbin (1990) clearly identified that their grounded theory approach was underpinned by symbolic interactionism and pragmatism, although there is debate over the theoretical standpoint of the grounded theorist (Liquorish and Seibold 2011). In terms of the classic grounded theory approach, Glaser (1992) argued that the inductive nature of the grounded theory process precluded any predetermined theoretical frameworks, and that the researcher should remain 'theoretically flexible'.

But the area of greatest divergence was in relation to the coding procedures used within the grounded theory data analysis. Strauss and Corbin (1990) developed an elaborate coding technique that was criticised as being overly prescriptive and complex (Melia 1996). They also designed several analytic tools including a coding paradigm to help researchers 'illuminate conceptual relationships between data' (Hallberg 2006 p.145). Glaser (1992) vehemently criticised the use of the framework as 'forcing' the data into predetermined concepts, rather than allowing the data to naturally emerge.

Despite the Glaser and Strauss divide, their ground-breaking work inspired researchers to follow the 'purist' (classic) grounded theory approach or to adopt a modified version of grounded theory. A second generation of grounded theorists who had worked alongside Glaser and Strauss emerged in the 1990s and developed their work in new directions. Examples include Charmaz who developed constructivist grounded theory (CGT), Adele Clarke's situational analysis and Wuest who utilised a feminist grounded theory approach (Morse et al. 2016)

3.7 Grounded theory – which approach?

As a novice researcher, the decision to utilise the grounded theory methodology was relatively easy. However, selecting a specific version of grounded theory was far more challenging. The myriad of philosophical debates and the conflicting and at times misuse of

grounded theory were bewildering. For example, the evolving nature of grounded theory has resulted in researchers 'cherry-picking' elements of the grounded theory methodology (GTM), but not adhering to the fundamental tenets of a particular grounded theory (Holton 2016). This selective approach can result in a dilution of the grounded theory (Engward 2013). Before selecting a particular grounded theory approach, Evans (2013) advises researchers to review each particular grounded theorist's underpinning philosophy and their cognitive style and to consider how this aligns with their research methods and the researcher's own study.

The classic grounded theory espoused by Glaser and Strauss (1967) did not resonate with my philosophical stance. Although Glaser (1992) argued that any theoretical lens can be applied to the classic method, he positions the researcher as undertaking a neutral, detached stance, which was not how I envisaged the role of the researcher in this study. To address the aim and answer the research questions, establishing a rapport before and during the interview with the participant was, I felt, integral to the interpretation and co-construction of data in grounded theory methodology (Charmaz 2014). For this reason, classic grounded theory was not selected for this study.

Strauss and Corbin's (1990) evolved grounded theory approach did reflect my thinking about their view of human beings as active agents. The Straussian approach demonstrated a shift in their perception of how meaning is co-constructed during data generation, which alluded to constructivism (Mills et al. 2006). On first inspection, the analytic tools and detailed coding procedures were appealing to me as a novice researcher. As I delved deeper, however, they appeared to be overly complicated, which deterred me from choosing this approach.

On the other hand, the constructivist grounded theory approach aligned well with my ontological assumptions of multiple interpretations of knowledge that are contextual. The interaction between researcher and participant during data generation and the opportunity to interpret the process of raising concerns through co-construction was appealing. The guidance provided by Charmaz (2014) for coding and rendering participants' experiences into theoretical analyses was detailed but not restrictive or stifling. In fact, Charmaz (2014) encourages the researcher to be creative and instinctive. I was drawn to this idea of letting the data and my instinct lead me, rather than following a more rigid,

analytical path. Although, this creative approach was anxiety-provoking, there were a plethora of examples on how to conduct key elements of a grounded theory study provided in Charmaz (2014). As data generation and analysis occurred simultaneously, I adapted to the iterative rhythm of interviewing participants and interpreting the meaning of these interactions that culminated in the co-construction of data. However, as the level of theoretical analysis developed, I resisted the urge to try and force connections between categories which were not fully formed. In this sense, there is a need to 'hold your nerve' and have faith in this grounded theory approach. From a personal perspective, Charmaz's (2014) advice of continuing to work intuitively with your data was reassuring and led to the development of a coherent theory. Therefore, a constructivist grounded theory approach was deemed to be the most suitable for this study and was selected.

3.8 Constructivist grounded theory

Kathy Charmaz was a student of Glaser and Strauss and was recognised as the first researcher to explicitly define her work as constructivist grounded theory (Hall et al. 2003). Breckenridge et al. (2012) suggested that constructivist grounded theory occupies the middle ground between positivism and post-modernism. This approach has maintained the inductive and emergent approach of Glaser and Strauss's original work, with the focus on iteration to uncover meaning and action that Strauss accentuated (Charmaz 2014). Unlike traditional grounded theorists, Charmaz (2014) asserted that theory is constructed by the researcher and participant, rather than being discovered or verified by the researcher (Allan 2003).

The term 'constructivist' was chosen by Charmaz to emphasise the researcher's involvement in the interpretation and construction of subjective data (Charmaz 2014). Constructivism challenges the belief that there is an objective truth and accepts that there are multiple constructions of truth that are contextual and specific (Hallberg 2006; Hall et al. 2013). The social constructivism used by Charmaz (2014) describes the importance of social context, interaction, and interpretive understandings as being ingrained in the social fabric of society. Here, the researcher is attuned to the subjectivity of the world around them. Charmaz (2014) also suggests that the mutual processes of interpretation and action seen within symbolic interaction make this the major theoretical perspective associated with grounded theory.

In relation to the position of the researcher, the premise is that realities are created or constructed through the interaction between researcher and participant. This aligns constructivist grounded theory to a relativist ontology within a subjectivist epistemology. Mills (2011) maintains that a constructivist grounded theory approach should incorporate the following features seen in table 5.

Table 5 – Features of a CGT applied to the current study (Mills et al. 2006)

Features of CGT	Applied to the current study
<p>Theory grounded in the participant’s and researcher’s experiences The researcher plays an active role in reconstructing experience and meaning through the interrelationship with the participant.</p>	<p>Steps are taken to enable the relationship to develop and enhance mutual understanding. Email contact beforehand and / or phone calls to develop a rapport before the interview. Informal chat before interview starts to further establish rapport.</p>
<p>Counteracting power imbalance Create a more equal power balance to prevent the participant from feeling subordinate to the researcher. Giving control to the participant</p>	<p>Enabling the participant to choose the time and date of the interview. Choosing the setting for the interview and establishing a relaxed environment. Informal chat and sharing information about oneself. Emphasising my position as student undertaking research as well as acknowledging my role as a clinical teacher</p>
<p>Explicating the position of the researcher within the grounded theory study Utilising a reflexive stance to ensure that the researcher’s ‘voice’ is at the heart of the grounded theory study</p>	<p>Using intuition to uncover tacit meanings. Using memos throughout the research journey to develop theory. Ensure reflexivity via discussions with supervisors.</p>

In order to reconstruct meaning and produce a theory, a researcher needs to develop highly abstracted concepts (Mills 2006). Utilizing a reflexive stance toward the data, and the use of memos ensures that the voice of the subject remains at the heart of the grounded theory (Higginbottom and Lauridsen 2014). Charmaz (2014) emphasises the importance of going beyond the surface to search for tacit meaning. The researcher is encouraged to use their

gut instinct and intuition during the creation of data and active interaction with participants. Concerns or feelings may not have been articulated, but subtle signs and nuances may be recognised and incorporated into concepts. In addition, the researcher is free to contribute their ideas to the mix of multiple realities. This is discussed further in section 3.17.

The sections up to this point have justified choosing a constructivist grounded theory [CGT], guided by Charmaz's (2014) approach. The following sections present the CGT methods, these were employed to generate data as well as outline the active coding procedures and theorising of data analysis that resulted in a substantive grounded theory.

3.9 Sampling in constructivist grounded theory

A non-probability sampling technique was used to initially identify participants who could potentially illuminate the phenomena of interest and provide rich data. This approach, consistent with CGT (Charmaz 2014), is known as purposive sampling and enables the researcher to sample a population with a purpose in mind (Parahoo 2014). Student nurses who had undertaken a clinical placement and nurse mentors who had completed an NMC approved mentor training programme were included in the sample. This sampling approach excluded experienced nursing staff who may have been involved in responding to student concerns, but had not fully completed mentorship training (for example awaiting assessment). The sample of nurse mentor participants who volunteered to participate, were all experienced mentors with at least 5 years experience of supporting students (see section 4.1). There was a notable absence of novice mentor participation, which is a potential weakness of the study. It is possible that junior mentor's did not feel that they had the requisite experience to volunteer for the study (despite attending mentorship training). Furthermore, I had already developed a rapport with a number of the experienced mentors, but I had not met the novice mentors before, which could have influenced their decision to volunteer for the study. Following the initial interviews with nursing students and mentors (n=14), a theoretical sampling approach was introduced where new participants were recruited in an attempt to address gaps in the data and compare to the emerging theory (Parahoo 2014). In this study, new lines of inquiry about

the role of the personal tutor within the raising concerns process, were uncovered which were not anticipated at the outset of the study. Theoretical sampling took the study in a new direction and is discussed further in section 3.15.5. The inclusion and exclusion criteria for student nurses and nurse mentors are outlined in tables 6 and 7 below.

Table 6 – Inclusion and exclusion criteria for student nurse participation

Inclusion criteria	Rationale
➤ Student nurses from one university, undertaking adult, child, or mental health undergraduate nurse training programme	➤ To include students from all three fields of nursing and increase the diversity of experience
➤ Student nurses who have undertaken at least one clinical placement within their undergraduate programme	➤ Student nurses have experience of learning in a clinical setting which enables discussion and reflection on raising concerns
Exclusion criteria	Rationale
➤ Students from allied health programme or midwives	➤ Focus of the study is on nursing students and their nurse mentors. which precludes the involvement of other students in this study
➤ Student nurses who have not undertaken a clinical placement	➤ will not have experience of learning in clinical settings alongside a nurse mentor

Table 7 – Inclusion and exclusion criteria for nurse mentor participation

Inclusion criteria	Rationale
➤ Nurse mentors in one health board who have undertaken NMC approved mentorship preparation programme (2008) and who meet all current NMC requirements	➤ All staff acting as nurse mentors to nursing students must undertake NMC approved preparation (2008)
➤ Mentors who have had the experience in supporting and assessing student nurses since undertaking the mentor preparation programme	➤ Nurse mentor experience of supporting and assessing students on placement is a pre-requisite of this study, to develop an understanding of the mentor-student dynamic.

Exclusion criteria	Rationale
➤ Staff who are not nurse mentors	➤ Will not have the knowledge and experience to discuss the topic of the study
➤ Mentors who have not supported or assessed any student nurses since undertaking the mentor preparation programme (NMC 2008)	➤ Will not have direct practical experience of mentoring student nurses to draw on

3.10 Ethical approval process

Ethical approval must be undertaken before any research study commences. Applying for ethical approval to interview student nurses and nurse mentors was undertaken via the Integrated Research Application System (IRAS) which reduced repetition and simplified the process. Permission to undertake the research study was requested from the School Research Ethics Committee (SREC) to interview student nurses and the NHS Research and Development (R&D) department of the Local Health Board to interview nurse mentors. Ethical approval was granted by the university Research Ethics Committee following minor amendments (see appendix 3). The local NHS research and development team approved the application to access mentors in their NHS workplaces with the proviso that individual clinical managers were also approached to give permission for nurse mentors to be interviewed (see appendix 4).

3.11 Accessing study participants via gatekeepers

Parahoo (2014) emphasises the importance of gatekeepers, who are individuals with the authority to provide access to the research site and participants. Once ethical approval was given to progress with the research study, letters were sent electronically to the gatekeepers within the university to provide information on the study and to request access for the recruitment of student nurses. Permission was granted by the Deputy Head of School (see appendix 5).

Accessing nurse mentors was more challenging as research participation had to be negotiated alongside clinical commitments. Taking part in this research required mentors to be released from their clinical duties, and I was aware that this would be dependent on staffing and clinical workload. Permission from individual clinical managers was sought for staff to be released and all managers confirmed their approval via email. Only on one occasion was a research interview cancelled at short notice due to a staffing deficit, but this was rearranged for a later date.

3.11.1 Recruiting student nurses

Student nurse recruitment began by reviewing module line plans to establish which cohorts of students were attending clinical placement or undertaking theory within the university. In the first instance, I visited student groups at the start of their lectures and provided a brief overview of my proposed research. An information sheet was left with the students, which outlined the aims of the study and provided my contact details should they wish to volunteer or gain more information on the study (see appendix 6). This information was also uploaded onto the virtual learning environment which was accessible to all student nurses. A total of 16 student nurses agreed to participate in an interview.

3.11.2 Recruiting nurse mentors

Information about the research study and researcher contact details were advertised on the nurse mentor intranet site of the local health board which was accessible to all mentors (see appendix 7). A poster was also displayed in all clinical areas where mentors were working (see appendix 8). This method of recruitment resulted in a total of 14 mentors contacting me to participate in an interview.

3.11.3 Recruiting personal tutors

As a result of theoretical sampling, personal tutors were recruited to phase two of the study. An email was sent to all nurse lecturers within the university outlining the aims of the study and my contact details. Personal tutors who expressed an interest in participating were sent an information sheet outlining the aims of the study (see appendix 9). As a result, seven personal tutors consented to participate in an interview. The following section outlines the methods used to generate and co-construct data for this study.

3.12 Data Generation

There are several factors which should be taken into account when making decisions about how to generate data. Selecting a method that can best answer the research question is key, but researchers should also consider timescales, research skills and experience and practicalities such as accessibility (Polit and Beck 2014). For this study individual interviews or focus groups were considered as potential tools to generate data and engage directly with student nurses, mentors, and personal tutors.

Focus group interviews involve a small group (5-10 people) sharing their views or experiences simultaneously, this is a time efficient method of generating data compared with individual interviews (Moule et al. 2017). Discussing the perceptions and experiences of raising concerns with a group of mentors or student nurses has the potential to capture rich data and may have encouraged openness amongst the participants. However, I was also mindful that group dynamics can have a negative effect if, for example, individuals dominate discussions and discourage quieter members from contributing (Polit and Beck 2014). As a novice researcher I was concerned that conducting focus groups would be challenging, particularly as the subject matter was potentially emotive. After careful deliberation, focus groups were discounted and individual interviews were selected as a more favourable method of generating data for this study.

Interviewing is the most commonly used data collection method in qualitative research and is a suitable way of ascertaining opinions, exploring experiences, and yielding an insider (or emic) view directly from that person (Olsen 2011; Rowley 2012; Green and Thorogood 2014). Holstein and Gubrium (1995) acknowledged that interviews are shaped by the contexts and situations in which they take place. The dialogue between an interviewer and interviewee can range from a formulaic and rigid structure to a less structured (or semi-structured) interview or can be completely unstructured (Holstein and Gubrium 2003).

Structured interviews consist of a standardised set of questions which are asked in the same way and in the same order. There is little room for the interviewee to elaborate and the researcher remains detached from the interview process. Foley et al. (2021) argued that this rigid approach is unsuitable for grounded theory as the researcher needs to be responsive to the dialogue between researcher and participant and be able to steer the

interview in a new direction. I rejected the structured interview approach as it appeared too restrictive to answer my research questions.

At the other end of the spectrum is the unstructured interview which encourages the participant to talk freely around a theme with little or no pre-written questions (King and Horrocks 2010). The flexibility of this approach was appealing as participants are given the freedom to tell their story. However, Rowley (2012) warned that the lack of structure could be a daunting prospect for novice researchers who are inexperienced at interviewing.

As a relatively novice researcher I was keen to use a topic guide when conducting the interviews. The interview guide outlined some broad, open questions, but with the freedom to probe, explore and adapt the wording or order of questions (Foley et al. 2021). Conlon et al. (2020) suggested that semi-structured interviews were more appropriate for grounded theory studies when the researcher has some understanding of the topic area but needs to explore concepts in more depth. Therefore, semi-structured interviews were utilised for this study and undertaken in two phases (see figure 5) so that theoretical sampling, a key element of grounded theory, could be carried out to build theory (Conlon et al. 2020)

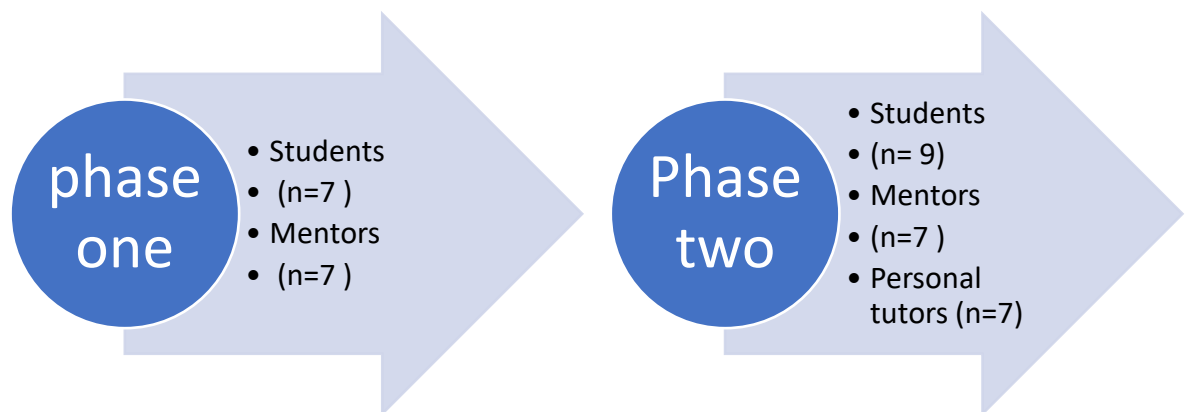


Figure 5 – sequence of phase one and phase two interviews

3.12.1 Preparing for the interview

Marshall et al. (2010) suggested that the interviewer's presentational self is crucial to the success of the interview. The demeanour, dress sense, perceived power and rapport between the interviewer and participant can all influence the respondent's impression. After considering these aspects, I selected an outfit that was smart but was careful not to look 'corporate', as this could have created a barrier between myself and the interviewee. To counteract other potential effects of a power imbalance I emphasised my role as a student researcher, which according to Charmaz (2014) can help to decrease status differences.

Moreover, it is possible that nursing students may have seen me in the clinical setting, liaising with nurse mentors and senior clinical staff. To some extent I may have been perceived as an 'insider', this could have influenced their perceptions of me and subsequently affected the way in which they responded to my questions. Overall, I attempted to negate the potential for 'social desirability bias', which occurs when interview participants portray themselves in a positive light by responding to questions in ways that they perceive to be more socially desirable, rather than reflecting their true feelings or actions (Holden and Passey 2009).

At the beginning of each interview, I explained my role, reiterated that confidentiality would be protected throughout and displayed a warm and open persona in order to relax the participant and encourage rapport (King and Horrocks 2010).

An interview guide was prepared for the first set of student nurse interviews (appendix 10) and nurse mentor interviews (appendix 11). Both interview guides included questions on placement learning and perceptions of raising concerns. These were derived from the early literature review undertaken and reflections from my own clinical experiences. Prior to the interviews, a pilot interview was carried out with a student nurse and a nurse mentor colleague to check the quality of the recording equipment and to ensure that my questions were easily understood. After playing back the recording of the interview, it was difficult to hear all aspects of the interview clearly. Therefore, the angle of the voice recorder was re-positioned during the interviews to enhance the audibility and quality of the recording.

The final element of preparation involved visiting the interview venue in advance to check that the environment was conducive and comfortable. Desks were removed as these can create a barrier and formalise the interview setting. Chairs were positioned at right angles to create an informal space and a 'Please do not disturb' sign was placed on the door to prevent interruptions. I was conscious that some participants were undertaking interviews during their coffee or lunch breaks. Participants were provided with water for the interview and given light snacks to take away at the end of the interview, these were well received. Finally, a certificate was provided for student nurses which acknowledged their contribution to a research study (see appendix 12). For mentors and personal tutors, the certificate could be used as evidence towards NMC revalidation (see appendix 13).

3.12.2 Interviewing in Grounded Theory

Interviewing is a commonly used data collection tool in grounded theory studies (Charmaz and Belgrave 2012). Although all variations of grounded theory utilise simultaneous data collection and analysis, specific grounded theory approaches shape the interview and analysis of the data (Charmaz and Belgrave 2012). The contrasting approaches of classical, Straussian and constructivist grounded theory result in distinctive interview styles (see appendix 14) which are influenced by the purpose and approach of the study, the researcher's philosophical positioning and the relationship between the participant and researcher (O'Reilly and Kiyinba 2015).

My approach to interviewing was informed by features of the intensive interview which, according to Charmaz (2014), focuses on how participants portray their experiences and assign meaning to it. This style of interviewing "creates and opens an interactional space in which the participant can relate their experience" (Charmaz 2014, p.56). Interview data that is generated within this interactional space reflects an interpretation of the participants' world at that time, which is co-constructed between researcher and participant (Charmaz and Belgrave 2012).

3.12.3 Conducting the interviews

The premise of constructivist grounded theory is the acknowledgement that the participant and researcher bring their own agenda, priorities, and concerns to the interview (Charmaz 2014). These may be verbalised but can also be identified through subtle nuances such as

facial expressions, gestures, or hesitancy. In this sense the interview aligns with the theoretical lens of symbolic interactionism which views the interview encounter as a reciprocal process, underpinned by interpretation which influences action and subsequent responses (Charmaz 2014).

With this in mind, I set the tone of the interview by asking some general open questions, the pace and tone of the interview was adjusted according to overt or more subtle cues from the participant. Starting the interview with some general information about the interview format can relax participants and encourage rapport building (King and Horrocks 2010). Broad, open questions were deployed, such as, 'can you tell me about your nurse mentors on clinical placements?' As the interview progressed, and rapport was built, the questions became more detailed. For example, 'what factors influenced your thinking on whether to raise a concern? The relationship between researcher and participant develops as a result of the connections which are co-constructed during the interview (Charmaz 2014). After conducting a few interviews, I reflected on my perception of co-constructing data (see box 1).

BOX 1 - Memo Co-construction of data [25/6/16]

As a new CGT researcher, I was intrigued by the process of co-constructing data. I had read Charmaz's work on conducting intensive interviews but was anxious and intrigued to put this into practice. I have participated in qualitative interviews, but not experienced this style of interviewing. Developing a rapport with the participants is an important aspect of CGT interviewing. Would I be able to build a relationship with participants in a one-hour timeframe? Part of my role as a nurse educator is to establish rapport quickly with mentors, so I already have this transferable skill. During the interviews I was approachable, open, and able to share perceptions and experiences, which encouraged rapport building and is advocated in CGT. However, this does not mean leading participants down a particular path but offering a viewpoint or acknowledging what participants were saying. It was a 'freeing' experience to be myself and not worry that my true self was revealed. Some participant stories resonated with my experiences as a nurse mentor/educator, and I was able to express my opinions and add meaning or validation. This interview style sees the participant doing most of the talking, but body language, emotions, pauses were interpreted by me and the participants. Making sense of these overt or more subtle signals were recorded as field notes after the interview and adapted into memos.

3.12.4 Critique of interviewing

Interviewing has been critiqued as a data collection method which is overused, time consuming, misunderstood, and open to bias (Atkinson and Silverman 1997; Alsaawi 2014). Furthermore, it has been argued that the interview process does not represent an authentic experience, but is a performance (Silverman 2017). Participants may not accurately recall past events or may alter their stories depending on what they think the researcher wants. This perception was verbalised by a nurse mentor in my study who exclaimed, “this is ruining your project as it’s not what you want to hear”.

In constructivist grounded theory, data is co-constructed between the participant and researcher. Glaser (2012) criticises the CGT interviewing method and argues that the role of the researcher in co-constructing data can overshadow the voice of the participant and become just the voice of the researcher (O’Connor et al. 2018). However, Charmaz (2014) refutes this claim and believes the researcher can exercise reflexivity throughout the research process to mitigate against forcing the data and dominating the constructed interview data. Reflexivity will be discussed later in the chapter.

3.12.5 Writing and using field notes

As the interviews were audio recorded, there was no requirement to document detailed notes during the interviews. However, accompanying field notes were a useful adjunct to capture observations of the interview and to add context for developing memos and evolving theory. (Montgomery and Bailey 2007; Phillipi and Lauderdale 2018). I was concerned that note taking might distract the participants and affect the flow of the interview. However, jotting down a phrase or idea was a useful aide memoire to return to a topic for clarification or to note any non-verbal gestures or changes to demeanour which may be pertinent to the data analysis. After the interview, more detailed field notes were written as my initial impressions were expanded upon. Field notes added an extra dimension to the audio recording and provided more detail to integrate into memos (see box 2).

Box 2 – Field notes following mentor interview [12/12/16]

The interview with Brett was very insightful. Despite me providing information on the purpose of the study, Brett was keen to tell me about the process of raising concerns about a student's conduct, rather than students' raising and escalating concerns. This is the first time that I have come across this situation, and I did find it challenging at times to keep the interview on track. I did keep referring to students raising concerns and he did provide some very interesting insights – although mainly based on perceptions rather than direct experiences of supporting students with concerns. His data does seem to diverge from other mentor perceptions and is very thought provoking. I need to compare his data to all the other mentors as his may be a 'negative case'.

I am concerned as I have gathered a lot of data which is irrelevant to this study. I need to listen to the interview again and see if I could have done anything differently to keep the interview on topic?

3.12.6 Transcribing and managing the data

Azevedo et al. (2017 p.159) defined transcription as the “transformation of oral speech into a written, meaningful text”, and acknowledge that this process has received scant attention within the research literature. Transcribing data can be a time-consuming process, with a one-hour interview taking between three and eight hours to complete (Marshall and Rossman 2016). Despite these challenges I transcribed all the interviews. This was a physically demanding task which I had to complete in stages. However, immersing myself in the data enabled me to pick up on subtle nuances that a transcriptionist may have missed and further honed my analytical skills.

A large amount of interview data (1,546 minutes) was generated during this study. I deliberated on whether to use computer assisted qualitative data analysis software (CAQDAS), such as NVIVO, to organise my data. NVIVO has the capacity for document preparation, coding (researcher defined or in-vivo), retrieval, links to memos and has concept-mapping features (Gray et al. 2017). However, despite the benefits of using CAQDAS, I was concerned about the time required to fully optimise the software. Therefore, I decided to analyse the data manually. The next section provides an overview of data analysis utilised for this grounded theory study.

3.13 Data Analysis

This section will outline the procedures used to code the data and will guide the reader through the process of data analysis. Data generation and analysis was conducted iteratively involving constant comparison across all data sets to identify similarities and points of divergence (Charmaz 2014; Giles et al. 2016). Memos captured the reflections and interpretation of the events that participants shared with me, and these were utilised to evolve fundamental codes into categories and culminated in theory development (Charmaz 2014). Figure 6 provides a diagrammatic representation of the data analysis process and subsequent sections will explicate how the coding was undertaken.

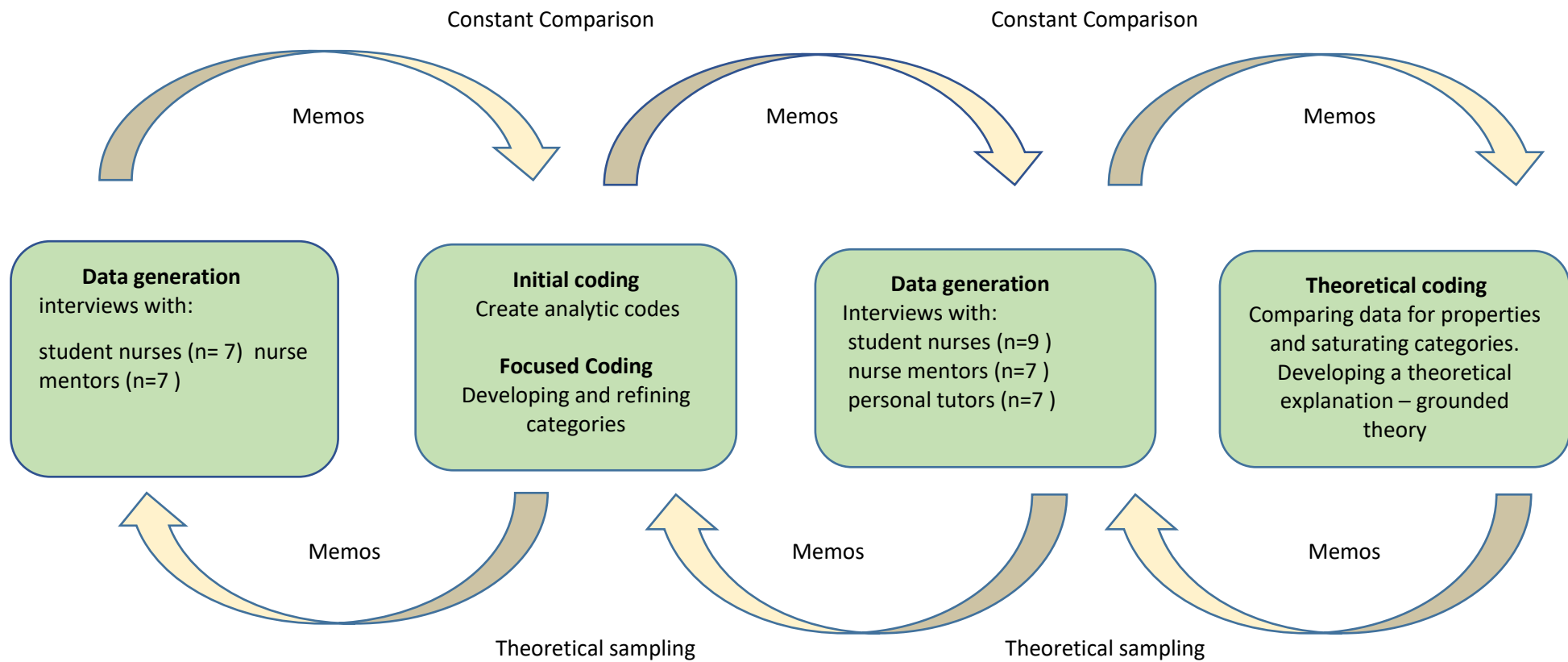


Figure 6 – Overview of the data analysis process in constructivist grounded theory

3.13.1 Coding

Coding is the first step of data analysis utilised within all grounded theory approaches, with the aim of evolving the level of analysis far beyond description in order to develop a substantive theory. Both Glaser (1978) and Strauss and Corbin (1990) refer to the first stage of coding as open coding, which involves ‘fracturing the data’ into small parts and assigning descriptions to the codes (Jeon 2004; Walker and Myrick 2006). This initial stage of coding is a demanding and time consuming process, whereby the data is scrutinized through line-by-line coding from as many different angles as possible (Walker and Myrick 2006). The constructivist coding process involves initial coding, focused coding, and theoretical coding (Charmaz 2014). Figure 7 below provides a summary of the coding process, although in reality the process was far more iterative than linear.

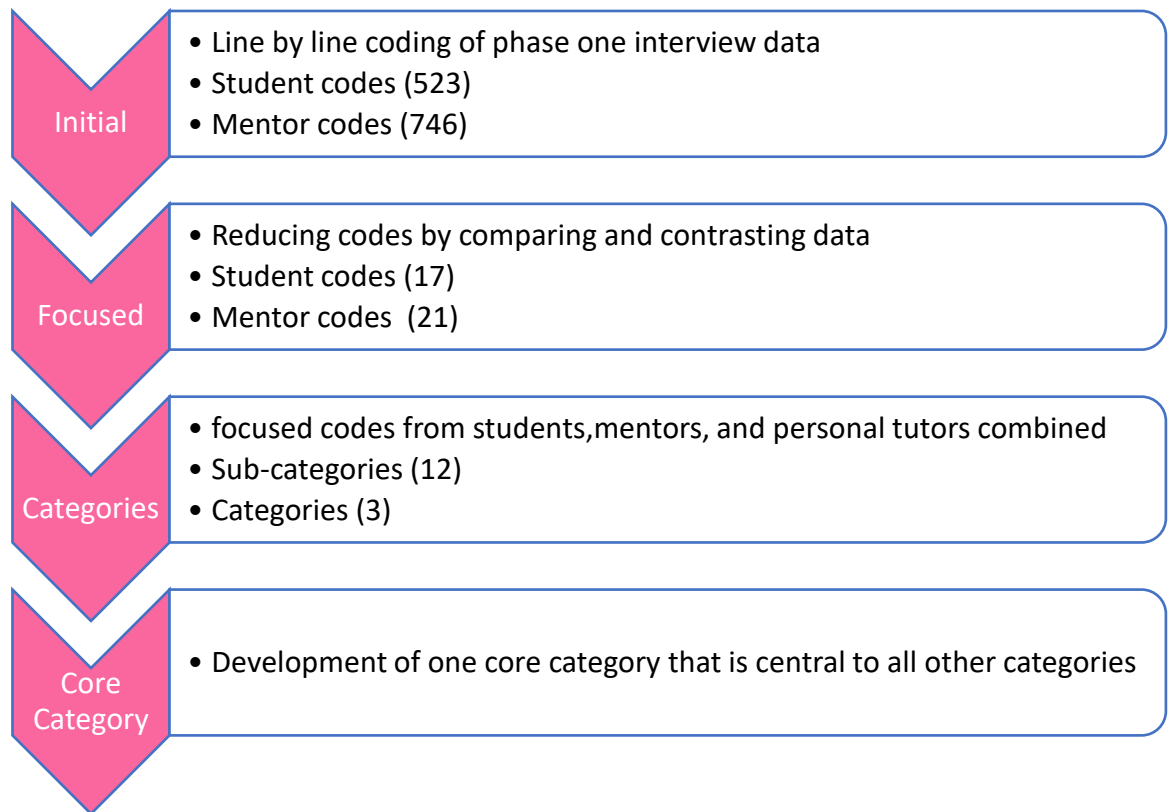


Figure 7 – Overview of coding process

3.13.2 Initial coding

Following transcription of the interviews, line-by-line coding was undertaken to capture the meaning grounded in the data and to “see the familiar in a new light” (Thornberg and Charmaz, 2014 p.156). This initial coding phase required careful reading of the interview

transcript and assigning names or conceptual labels to every line of text (Maz 2013; Charmaz 2014). Initially, I found labelling every line challenging and I realised that I was overthinking this initial process. Charmaz (2014) encourages the researcher to be spontaneous, open minded and flexible and to just begin to 'grapple' with the data, however clumsy that might feel. I soon began to code more instinctively and to just describe what was happening in the data. This allowed me to immerse myself in the data and to make sense of what the student nurses and mentors were telling me. An example of the initial coding process is shown in table 8 below.

Table 8 – Example of line-by-line coding for student data (phase one)

Initial codes	Interview Excerpt (Emma student nurse)
Fitting in Proving your worth Proving you're not 'too posh to wash' Getting stuck in	I think to me it is fitting in with health care support workers. So, they want you to prove that you don't mind getting stuck in and you are not 'too posh to wash'.um so you are really trying to help them as much as possible.
Willing to help Demonstrating work ethic Displaying enthusiasm Being friendly	So, I think there's a big part in the first couple of weeks of showing that you are a worker and help and you're not shying away from anything. I think for the qualified you just need to try and be friendly as possible and enthusiastic.

The researcher needs to keep an open mind and utilise a flexible approach to coding. All possible theoretical directions should be considered, and codes can be altered or renamed if necessary (Charmaz 2014). Incidents were compared in order to generate codes. Birks and Mills (2011) described an incident as an action or characteristic that is repeated within the analysed data.

Coding the phase one student nurse interviews generated 523 codes. Although the number of codes was initially overwhelming, it was evident that many of the codes were repeated or similar in meaning. Grouping these codes together into themes substantially reduced the number of codes that I needed to work with. Analysing and comparing the first set of student nurse interviews highlighted a number of areas that I was keen to explore in more depth, these occurred within the phase one nurse mentor interviews including.

- **Debating the next step** – Students appeared to consider a number of factors that influenced decision-making on raising concerns. What are mentors perceptions on the factors that may influence student decision-making? Comparing the data will identify similarities or contrast the student nurse data.
- **Playing the naïve student** – How do mentors perceive students use of informal strategies such as questioning practice. What is their experience of this and how do they respond to students who use these indirect methods?
- **Bypassing the mentor** – Students have suggested that if the mentor is deemed to be unapproachable or unsupportive then they bypass the mentor to raise concerns. Is the mentor aware of this happening? What is their perception of responding to student concerns?

The interview guide for the nurse mentor interviews was developed with these topics in mind and encompassed open questions that prompted discussion on mentors' perceptions and experiences of supporting students with clinical concerns. The phase one mentor interviews generated 746 codes. However, over 200 of these were subsequently deemed redundant codes, resulting from 'straying off topic' during one of the interviews. Although I had taken Charmaz's (2014) advice of remaining open to all redundant codes, they offered limited or no insights into the research question and objectives. This illustrates a disadvantage of line-by-line coding which requires researchers to code all the data, irrespective of whether it appears to be relevant or not. Nevertheless, the process of initial

coding allowed me to make sense of what was happening in the data and to interpret the constructed codes. Using a gerund, which is the noun form of verbs, is advocated by Charmaz (2014) to promote action and behaviour within codes (see table 9). Reflecting on my codes and refocusing on process and behaviour provided fresh insights and new developments.

Table 9 – Example of gerunds used in coding data

Examples of gerunds used in coding student data	Examples of gerunds used in coding mentor data
Questioning your mentor	Identifying theory-practice gaps
Gossiping amongst staff	Exposing students to practice

Ensuring that the participant’s voice is preserved is crucial within data analysis. One way of achieving this is to use the research participant’s words verbatim from the transcripts, which are referred to as ‘in-vivo’ codes (Maz 2013). In this study, I was struck by the powerful, rich, and thought provoking in-vivo codes that were provided by participants. Elliot and Jordan (2010) caution against overusing in-vivo codes as this can result in an undeveloped, descriptive analysis. However, I disagree with this assertion as over-reliance on description can be overcome by unpacking in-vivo codes through analysis to extract implicit meaning and a true reflection of a participant’s thoughts (Charmaz 2014). The student nurse and nurse mentors in-vivo codes were significant in developing my ideas within the early stages of data analysis (see table 10).

Table 10 – Example of in-vivo codes

In-vivo code	Meaning attached to in-vivo code
<i>'Playing the naïve student'</i> (Owen, student)	This code was used by a student nurse to describe how he used his student status to frame concerns as a question.
<i>'Seeing things in black and white'</i> (Ellie, mentor)	This phrase was used by a mentor to explain how student nurse expectations of practice settings reflects what they are taught within the university setting and does not match the reality of clinical practice

Coding the phase one student nurse and nurse mentor interviews moved from initial coding to a more abstract form of coding, which is known as focused coding.

3.13.3 Focused Coding

After amassing over 1000 codes within the phase one interviews, I had to decide which initial codes 'made the most analytic sense to categorise the data incisively and completely' (Charmaz 2014, p.138). Reducing the number of codes is undertaken by theming similar codes together into groups and noting where the codes overlapped or repeated each other. This process of reduction involved sifting through the most frequent and most significant codes. Focused coding is presented as an intermediate level of coding, whereby comparing codes with earlier codes is carried out to conceptualise them and drive the direction of the emerging findings (Charmaz 2014). This process was undertaken manually, where the initial codes were cut into individual strips (see Image 1).



Image 1 – Example of manual coding

This method enabled me to visualise all of the initial codes clearly and easily in their entirety and to focus on the codes that were emerging as meaningful. Charmaz (2014) advocates looking at what is revealed within the codes, as well as identifying what is unspoken or absent. Field notes and memos were useful in documenting the more subtle nuances that I noticed during the interviews or reflected on during data analysis. Similar codes were grouped together, and the participants’ perceptions, experiences and actions were compared for likeness and variations within the text (Charmaz 2014).

In the table below (table 11) an example of comparative data is presented, which illustrates divergence in how concerns were raised by students and to whom. Sally (student nurse) discusses concerns with her mentor whilst in placement. In contrast, Kath (student nurse) does not speak up until after the placement when she discloses her concerns to a nurse lecturer.

Table 11 – Example of comparison of data

How did you raise your concern?	
<i>“Well, I finished placement then and I came back to uni. At the end of every placement, you had a bit of a meeting where people ask</i>	<i>‘So, I explained to mentor that I was really not happy about what was going on in there and I don’t think it’s safe and I don’t think she should</i>

about the placement, concerns that sort of thing. So, I went to speak to the lecturer and explained to her what I'd seen and she said, 'I think you need to raise concerns' and told me how to do it um so I did". (Kath, student)

be left at home with him when he is not allowing anyone in to see her. So, my mentor agreed with me and when we went back to handover, she brought it up' (Sally, student)

In coding and comparing these two data extracts, I was particularly interested in what prompted these different approaches to raising concerns. In subsequent interviews a number of contextual factors were identified that influenced students' decisions on raising the concern, such as who they spoke to and the environment in which they felt most comfortable in doing so. Further comparisons from the entire student data revealed that none of the students raised concerns directly to their mentor, they approached the personal tutor or the clinical manager instead. Writing a memo, accelerated the development of a more conceptual focused code to explore further.

Box 3- Memo – Seeing the university as a safety net

After comparing the first seven student interviews, It appeared that none of the students raised a concern directly to their mentor. Not getting along with their mentor was one reason cited, as well as the fear that raising concerns to the mentor could potentially lead to negative consequences for the student. Interestingly, nearly all of the students had raised their concerns with their personal tutor or an academic member of staff. Speaking to someone away from the clinical environment was perhaps seen as a safer option? This fits with what the students told me about not wanting to cause trouble on the placement. The university appears to function as a safety net for the students. They can speak to a personal tutor who they already know and discuss their concerns away from the environment. This focused code will be compared against the interview data generated for phase two of this study.

Initial codes were raised to more conceptual focused codes. The process of amalgamating initial codes resulted in 15 focused codes that were significant in the process of making sense of and accounting for the data (See table 12).

Table 12 – Example of focused codes following phase one interviews

- | | |
|------------------------------------|---|
| ❖ Feeling unwanted by your mentor | ❖ Bypassing the mentor |
| ❖ Developing rapport | ❖ Feeling beholden to the mentor |
| ❖ learning your place | ❖ Reporting wrongdoing |
| ❖ Debating the next step | ❖ Seeing the university as a safety net |
| ❖ Weighing up the pros and cons | ❖ Responding to concerns |
| ❖ Seeing things in black and white | ❖ Enabling students to raise concerns |
| ❖ Acknowledging repercussions | ❖ Remaining silent |
| | ❖ Playing the naïve student |

Charmaz (2014 p.141) contends that focused codes have more “theoretical reach, direction and centrality” than initial codes. There were codes which were interesting, but superfluous at this stage. For example, the students provided detail about how often they worked with their mentor and shift patterns. Although this was useful for context, the codes created from these descriptions did not possess ‘conceptual strength’ which is an important feature of a focused code (Charmaz 2014) and is the extent to which the code directly addresses or partially addresses the research questions.

To summarise, 15 focused codes were identified at the end of phase one data collection. A number of these codes were developed into tentative categories which are ‘concepts of a higher order’ that can be further examined and compared for characteristics of concepts (Vollstedt and Rezat 2019, p.86). However, tentative categories allow for flexibility and may well be adapted, discounted, or become permanent categories.

The focused codes and categories were tentative at this stage, gaps were evident that required new data to be tested and elaborated on (Foley et al. 2021). Theoretical sampling was employed to respond to the direction that the data was taking me.

3.13.4 Theoretical sampling

Theoretical sampling is a strategy that guides the researcher in a particular direction in order to check the emerging theory. Sampling decisions are also directed by the gaps in the data which prompt new questions to be answered. This can involve re-interviewing

the same individuals or sampling new participants to build and refine category development (Charmaz and Bryant 2010). Theoretical sampling guided the phase two interview data which involved further interviews with new nurse mentors and student nurses to populate or fill the focused codes that were created during phase one.

Exploring the concept of power within the mentor-student relationship was a key area that I felt warranted further attention (see appendix 15 – memo on power). I was also keen to recruit mentors who had supported a student who raised a concern whilst on placement. Within phase one, some of the mentor participants had spoken hypothetically about students raising concerns but had no examples to draw on. Sampling different mentors who had direct experience of students' raising concerns would populate the properties of the codes and categories identified in phase one. Student nurses had also alluded to using informal ways to highlight sub-standard practice. I wondered if mentors were aware that students consciously utilised these strategies as an alternative to formal reporting mechanisms.

A brief interview guide was developed to reflect these new areas of enquiry, but I was mindful not to restrict the interview with a rigid interview schedule. The interviews provided an opportunity for me to enter the world of student nurses and mentors and to co-construct meaning from the stories that they shared with me. The iterative approach to the developing theory involved oscillating between data generation and analysis. This allowed me to tweak my questions in response to what the participants were telling me.

However, concurrent data collection became challenging when I had a flurry of interviews booked within a very short time frame and data was beginning to back up. As a part-time PhD student, this was a challenge that was overcome by re-scheduling a few interviews and giving myself time to transcribe and analyse before moving to the next interview.

During the analysis of phase one interviews, it also became apparent that most of the students had involved their personal tutor in the raising concerns process. Personal tutor involvement ranged from acting as a sounding board through to escalating the concern to someone higher within the university. Interviewing personal tutors did not form part of my original research proposal, but in light of these findings, an amendment was submitted to the university ethics committee (see appendix 16) and permission was granted to interview

personal tutors (see appendix 17 for interview guide). This provides another example of theoretical sampling where the data establishes new directions and in this case sampling a group that were not part of the original protocol, but an emergent finding that fluidly led me in a new direction.

3.15.5 Negative case analysis

Negative case analysis is an analytical strategy which identifies views within the data which appear to contradict major patterns in the data (Charmaz 2014; Hanson 2017). Constructing new knowledge through reflexivity can occur by searching for anomalies or 'contradictions' within the data, re-evaluation can then result in new understandings and meanings (Enosh and Ben-Ari 2016, p.579). Creswell (2014) concurs and suggests that including contradictory data reveals real life and enhances the credibility of the study. Whilst comparing the mentor interviews during phase one of data analysis, I noted stark differences in Brett's (nurse mentor) perceptions as to why students might raise concerns to university staff, rather than the mentor. In contrast to the other mentor participants, he felt that students who reported to the university were 'snitching' to get "brownie points" and could have some ulterior motive for using this route. Furthermore, he affirmed that students had a duty to speak up to their mentor, or other clinical staff, within the placement.

This prompted me to re-examine all the mentor data pertaining to students accessing support from university staff. Brett's views clearly contradicted the views of other mentors. On re-evaluating this data, it is possible that Brett's comments were influenced by a colleague's experience of a student reporting an issue to the university. Finding explanations for the negative case can strengthen the analysis and deepen an understanding of what the 'typical cases' mean (Kolb 2012). This influenced the development of the code '*seeing the university as a safety net*', which most mentor participants recognised was a valid route to use in raising concerns and could address the challenges of raising concerns in clinical practice.

3.15.6 Theoretical coding and sorting

Grounded theory is a research methodology that generates systematic theory from data (Elliot and Lazenbatt 2005). The outcome of a grounded theory study is the development

of a substantive, or formal theory. Theoretical coding is a dynamic process which entails reassembling the data after fragmenting it during the initial and focused coding stages of analysis. Thereafter, the relationships between codes are illuminated and move from tentative to more solid categories (Charmaz 2014). This active process involves conceptualising the relationships between events and experiences. This dynamic construction of category building is known as 'theorizing' (Charmaz 2016, p.228)

In this study, theorizing involved reviewing all of the data 'anew' and attempting to interpret the multiple realities of raising concerns in clinical practice from the participants and my own perspective. This approach encourages the researcher to sharpen the clarity of the analysis and formulate a coherent story. (Charmaz 2006). At this point of the analysis, theoretical links began to emerge into potential areas of theory construction (see box 4 below).

Box 4 - Memo – The theory is taking shape [8/1/19]

As the analysis has evolved, it is becoming clearer that the mentor-student relationship is significant, but not the only influence on students raising concerns. A number of contextual factors such as the team, ward manager and the organisational culture of the placement setting seem to also influence decision-making. Students are constantly monitoring what is going on within the clinical environment and responding accordingly. In this way their decisions and actions are underpinned throughout their placement experience by their sense making of the situation. I now realize what Charmaz (2014) was referring to when she advises to explore what is unspoken or absent within the codes.

Students have not directly mentioned sense making or assessing contexts, but through analysing and comparing the data – it has become apparent that this may account for how students enact the process of raising concerns. I have just had my 'aha' moment!! But I need to continue theorizing.

A crucial element of theorizing within a constructivist approach is to sort and integrate memos to create and refine theoretical links (Charmaz 2014). Throughout this study memos became more analytical and focused on determining the relationships and patterns within the data (see appendix 18). Memos were given titles and sorted by hand so that they could be organised in a logical format. The resulting analysis focused on the process of raising concerns, from when students identify a concern in the clinical setting through to the outcome. Theoretical sorting enabled me to visualise the patterns in the data and memos.

As I studied these interrelated categories, it occurred to me that although the mentor-student dynamic was significant in influencing decision-making and raising concerns, it did not fully explain what was going on. The patterns in the data became clearer in explicating how student sensemaking and interpretation of the context of the clinical placement was a consistent theme within raising concerns (see appendix 19). This psychosocial process was underpinned by students 'reading the context' of the clinical environment and looking for signals that indicated whether raising a concern would be met with a positive response or would be a risky endeavour. The core category of 'reading the context' formed the basis of the grounded theory and was central to all other categories within the data analysis. The grounded theory underpinning the process of raising concerns is discussed in more detail within chapter seven.

3.15.7 Theoretical saturation

According to Charmaz (2014) theoretical saturation occurs when the properties of theoretical concepts are well developed and, when undertaking constant comparison of categories, no new insights or patterns are gleaned from the data (Glaser 2001; Charmaz 2014). However, this concept encompasses far more than the commonly held claim of 'nothing new is happening' (Charmaz 2014; Morse 2015). Hennick et al (2016) argued that decisions on saturation are determined by a number of factors including the quality and length of time spent with participants as opposed to rudimentary sample size, the complexity of the research question, ontological positioning of the researcher and researcher experience.

Aldiabat and LeNavaneck (2018) identify the challenges for novice researchers in recognising theoretical saturation, with some declaring theoretical saturation prematurely, or engaging in prolonged data collection. As this study progressed, I pondered the concept of theoretical saturation and wondered whether reaching data saturation was actually possible. How do you know if the next interview participant will reveal something new and exciting, or not? Charmaz (2014) sums up my naïve thinking and acknowledged:

“Theoretical saturation is not the same as witnessing repetition of the same events or stories, although many qualitative researchers confuse saturation with repetition of described actions and/or statements” (p. 213)

According to Morse (2015, p.587) saturation should be determined by “saturating characteristics within categories that emerge as significant within the process of analysis, rather than focusing on particular details of individual events and random incidents”. This explanation was helpful for me in making decisions about theoretical saturation. For this study two phases of interviews enabled me to populate the categories, look for patterns in the data and develop abstract relationships (Charmaz 2014). Gradually, the development of theoretical categories enabled me to interpret the social process of student nurses raising concerns in clinical practice. Sharing transcripts, memos and theoretical discussions with my supervisors also gave me the confidence to judge when theoretical saturation was achieved.

3.16 Theoretical Sensitivity

Glaser and Strauss (1967) recognised theoretical sensitivity as the tension between the rigorous application of the grounded theory and the interpretive nature of the method. The term ‘theoretical sensitivity’ was coined by Glaser and Strauss in *‘the discovery of grounded theory’* (1967). They proposed two elements of theoretical sensitivity; the researcher’s sensitivity to their own personal assumptions as well as reflecting how their theoretical knowledge of the topic area is integrated into the study (Birks and Mills 2006). Therefore, personal beliefs and professional education and experience will have an influence on how theoretical sensitivity is enacted throughout the research process (Charmaz 2014).

Thistoll et al. (2015) argue that theoretical sensitivity is required to develop analytical coding processes and to make sense of them in the larger context of theory development. Reading around the literature is an important aspect of developing theoretical sensitivity

but requires careful balancing to avoid premature theorizing (Thistoll et al. 2015). However, other strategies that increase theoretical sensitivity include concurrent data generation and data analysis, memo writing, using ‘gerunds’ to keep the data active and comparing “data with data” (Tie et al. 2019; Charmaz 2014).

3.17 Reflexivity

Maintaining a reflexive approach is an integral tenet of rigour within qualitative research (Engward and Davis 2015), although there appears to be a lack of consensus in relation to defining this concept. Schwandt (2001 p.224) provides a definition that is split into three elements which capture the essence of reflexivity. This will be used as a framework to outline how I employed reflexivity throughout this study (see table 13)

Table 13 – Practical strategies to demonstrate reflexivity

Schwandt’s definition (2001)	Applying reflexivity in this study
(a) The process of critical self-reflection on one’s biases, theoretical predispositions, preferences	<ul style="list-style-type: none"> -Field notes and memos were written to identify my own pre-conceptions and to consider how they might affect the data. -Critiqued own performance and identified instances where I missed important cues or regretted not asking to follow up questions during interviews. - Reflected on developing my practice through memos and critical discussions with supervisors
(b) An acknowledgement that ‘the enquirer is part of the setting, context, and social phenomenon he or she seeks to understand	<ul style="list-style-type: none"> This is inherent within Charmaz’s (2014) CGT approach to the data which sees the researcher co-creating data. - The codes that I assign to the data and the way I develop the analysis is influenced by my own interpretation of how I make sense of the data. -The interaction between myself and the research participant will influence how data is co-constructed. -Perceptions of me as an educator or researcher, may also influence how the participants interact during the interview

(c) A means for critically inspecting the entire research process

-Being open and transparent throughout the research process. I achieved this through detailed explanation of all decisions.

-Providing detailed coding procedures which clarifies theoretical sampling, analytic development, and process of theorizing.

-looking for contradictions within data

-Narrative within memos and in the thesis which share the challenges and messy reality of undertaking research

At the outset of this study, I recognised that many aspects of reflexivity are naturally embedded within a grounded theory approach. For example, throughout this study the iterative nature of data generation and analysis enabled me to interpret the data from a dual perspective, both as ‘an insider perspective and the outsider looking in’ (Enosh and Ben-Ari, 2016). For example, I was able to draw on my previous experience as an “insider”, working clinically as a registered nurse and supporting student nurses as a nurse mentor. I enjoyed undertaking the mentoring role, but also acknowledged the challenges in providing direct patient care alongside facilitating and assessing students. Therefore, some of my prior assumptions and expectations about supporting student concerns resonated with the perceptions and experiences that the nurse mentor participants shared with me.

My ‘insider’ knowledge and experience enhanced reflexivity in two ways. Firstly, having self-awareness of how my perceptions and experiences could potentially cloud, or enhance my interpretation of the data was important, and having strategies to mitigate against both. But equally, the advantages of possessing this insider knowledge allowed me access to the world of clinical practice which I understood and had been part of. Many staff remembered me as a ward-based nurse and still considered me as a member of that particular community of practice. Feeling accepted as an ‘insider’ was a significant advantage in developing a rapport with study participants and resulted in rich data which I was able to analyse and interpret from a number of vantage points.

Taking a step back enabled me to reflect on what was really happening in the data, rather than making surface assumptions (Hoare et al. 2011). In this sense, introspection is an

integral element of reflexivity which involves being attuned to my own preconceptions and requires critical reflection on the 'self' as researcher (Denzin and Lincoln 2013). Finlay (2008) suggests that introspection is predominantly a solitary activity where internal dialogue is used to challenge our experiences and the meaning, we ascribe to them. Introspection may involve acknowledging uncomfortable truths about ourselves and I shared many of these throughout the study. However, being open and transparent is an important element of reflexivity and increases the robustness of the research (Engleward and Davies 2015).

Within the literature there appears to be inconsistency in relation to how reflexivity is understood, and the approaches used to demonstrate reflexivity (Finlay 2002; Doyle 2013; Darawsheh 2014). Enosh and Ben-Ari (2016) argue that reflexivity is not confined to the researcher, it encompasses how the research participant employs reflexivity and their interaction during the research process. The process of reflexivity is therefore positioned as a dynamic activity that continues throughout the research study. (Finlay 2002).

Reflexivity can be further employed through memo writing; this provides a vehicle to challenge one's own assumptions and to re-examine the data (Charmaz 2014) process. The next section focuses on the importance of memo writing within grounded theory.

3.18 Memo writing

Memoing is a fundamental part of a grounded theory study and Charmaz (2014) maintains that memoing details the significant aspects of the analytic journey. The writing of theoretical memos is a fundamental activity that engages the researcher with the data throughout the research process so that theory is grounded in the data (Lempert 2007). Memos provide a record of ideas, insights and thoughts about the data and can be used as a reflective tool by the researcher (Mills et al. 2006b). However, memos are also a means of displaying rigour by providing an audit trail for all research activities undertaken and methodological decisions made (Birks and Mills 2011). The focus of memos is not description, but to 'conceptualise the data in narrative form' (Lempert, 2007 p.245).

Birks and Mills (2011) point out that memo writing also provides an opportunity to identify any deficiencies in thinking and to interrogate the data, this ensures that abstract concepts are developed and refined. The researcher can write memos and construct analytic notes,

which will help to fill out categories and record ideas for theoretical sampling (Charmaz 2014). Lempert (2007) recognises the skill required by the researcher to develop effective memo writing and acknowledges that early memos can be untidy, chaotic, and disjointed. This process allows the researcher a free rein to be creative and uninhibited in the writing of the memos (Charmaz 2014).

Memos do not have to be shared, although they can be refined to illustrate how analytical thinking has advanced or been utilised to overcome particular challenges in developing abstract conceptualisations. As a novice researcher, I found writing memos useful in helping me to think deeply about the data, it enabled me to generate questions, make connections to literature and inspired me to explore ambiguities within the data. Memos have also been used as the focus of supervision meetings to explicate my thinking and conceptualise my developing theories throughout my PhD journey (see box 5).

Box 5 – Memo on Social bases of power [21/5/19]

A critical discussion today in academic supervision on the Social Bases of Power by French and Raven (1959). Their framework really resonates with my data, and I think it fits well with the concept of the mentor-student dynamic.

As my supervisors are not familiar with their work, we had a useful discussion on how mentors use legitimate power, but there is the possibility that this power could be used to enact coercive power.

However, mentors do need to justify their reasoning for 'failing a student'. This would also require an action plan and discussion with a practice facilitator. If the mentor did want to fail a student just because they raised a concern, it would take a lot of planning and effort. It would be more likely that they would just be selective in signing outcomes rather than completely failing the student.

So far there is no evidence to suggest this misuse of power in this study?

3.19 Evaluating the quality of a grounded theory study

Using evaluative criteria such as reliability, validity, and objectivity to appraise qualitative research studies can be contentious due to their association with positivism (Polit and Beck 2014). These concepts are rejected within the interpretive paradigm where the aim is to explore the experiences of individual participant's and interpret and construct multiple meanings through interaction (Parahoo 2014).

The standards for evaluating rigour in qualitative methods were proposed by Beck (1993) as credibility, auditability, and fittingness. These were developed further by Guba and Lincoln (1989) who added confirmability to this criteria. However evaluative criteria, used to assess the quality of grounded theory studies, varies according to the approach selected. Table 14 outlines the criteria advocated in Glaserian, Straussian or Charmazian grounded theory. This study has been undertaken with Charmaz’s (2014) criteria in mind where key questions have been developed for the researcher to self-assess the quality of the study.

Table 14 – Criteria to evaluate grounded theory studies (Rieger 2018)

Constructivist GT (Charmaz 2014)	Straussian GT (Corbin & Strauss 2008)	Glaserian GT (Glaser 1978)
<ul style="list-style-type: none"> • Credibility • Originality • Resonance • Usefulness 	<ul style="list-style-type: none"> • Fit • Applicability • Concepts • Contextualising concepts • Logic • Depth • Variation • Creativity • Sensitivity • Memos 	<ul style="list-style-type: none"> • Fit • Work • Relevance • Modifiability

3.19.1 Credibility

Sandelowski (1986, p.30) suggested that credibility or truth value, “resides in the discovery of human phenomena or experiences as they are lived and perceived by subjects”.

The criterion of credibility asks whether the range, depth and number of participants included in the data are adequate. In addition, the quality of the evidence and links to analysis and findings are appraised (Charmaz 2014). I spent eighteen months engaged in gathering and analysing the data from thirty-seven study participants. This chapter has provided a clear audit trail of how research decisions pertaining to the coding, analysis and development of the grounded theory were transparent and clearly explicated. Theoretical

sampling was utilised to develop the evolving theory as well as the use of memos and field notes to acknowledge researcher pre-conceptions and influence on the study through reflexivity (Birks and Mills 2011). Perceptions, insights, and experiences of raising concerns were shared and interpreted to co-construct meaning. Rich verbatim quotes are interspersed throughout chapters four to six and ensure that the findings are grounded in the data.

3.19.2 Originality

Charmaz (2014) questions the new insights that have been constructed within research studies. The originality of this study is appraised by its contribution to understanding the social process of student nurses' raising concerns in clinical practice and the importance of context and sensemaking. Research from academic literature has been utilised and adapted to enhance knowledge in this area. Furthermore, this study provides original insights into how the mentor-student dynamic can influence decision-making and student's propensity to raise a concern.

3.19.3 Resonance

Within this criteria, researchers need to consider whether the categories depict the topic explored and link to the bigger picture (Charmaz 2014). For this study, the significance of the findings was considered in light of changes to practice learning as well as contextualised to nurse education and how academic roles may influence and enhance the process of raising concerns. Key findings were presented at research events within the local university and at an international research conference, where delegates (including student nurses) expressed how the findings resonated with their experiences of speaking up, which meets these criteria. Conferences, seminars, and academic supervision stimulated reflexive thought and critical debate prompted lines of inquiry that had not been considered.

3.19.4 Usefulness

Charmaz's (2014) last criteria is practical and considers whether the grounded theory analysis can be used to develop or extend research in other substantive areas. The need to speak up after witnessing wrongdoing is applicable to other healthcare professions. As a result of undertaking this study, there are various strands of related research topics which

would further enhance understanding of this phenomenon. The recommendations and implications for research are outlined within the concluding chapter. The final section of this chapter considers the ethical considerations that were inherent when undertaking this research study.

3.20 Ethical Considerations

The dignity, rights, safety, and wellbeing of participants must be the primary consideration in any research study (Research Governance Framework for Health and Social Care in Wales 2012, p.8)

This study was carried out in accordance with the principles outlined in the Research Governance Framework for Health and Social Care in Wales (2012) and the local university's Research Integrity and Governance Framework (2017). Informed consent, confidentiality, the potential risks versus benefits to the participants, as well as risks to the researcher were considered and discussed within the next section.

3.20.1 Informed Consent

Informed consent is a crucial element to rigorous ethical research practice and should be obtained before recruiting participants to a research study (RCN 2011). The fundamental tenets of informed consent relate to the ethical principle of autonomy and the right for individuals to make their own choices. According to Beauchamp and Childress (2019) there are three elements that pertain to exercising autonomy and include; the individual acts intentionally, the individual has the capacity to understand and that the decision is made of their own free will with no undue influence or control. The following principles of informed consent were applied within this study.

Box 6 – Principles of informed consent

- The purpose of the study, rationale, and details of data collection methods
- How long participation will be
- Who is involved in the study?
- Potential benefits and risks of the research
- The practicalities and expectations of taking part
- Details of confidentiality and anonymity
- How data will be managed and used
- How data will be protected and stored and for how long
- That involvement is voluntary, and participants can withdraw at any time
- The written information must be accessible and in a language that is easy to understand
- The research has been approved by an ethics committee

RCN (2011)

All potential participants were provided with written information sheets which clearly outlined the aim of the study. Individuals did not consent to taking part until they had had time to consider the benefits and risks of participating in this study. A copy of the consent form was sent to participants prior to the interview but was not signed until the day of the interview (see appendix 20). Before completing the consent form opportunities were provided for the participant to meet and discuss the study and highlight any concerns via email. No further information was requested by the participants prior to the interview. However, Charmaz (2014) acknowledges that informed consent encompasses more than merely having a consent form signed. The researcher has an ongoing responsibility to be attuned and alert to the participants non-verbal gestures, that could indicate the need to check participants' ongoing consent to being asked 'intrusive' questions during the interview process (Charmaz 2014).

All participants were reassured that they could revoke their decision to participate in the study and withdraw at any time. The paper consent form was the only document generated by the study which included personal data. Following the interview, the consent forms were locked securely in a cupboard that was only accessible to the researcher. These

documents will be destroyed at the completion of this study in adherence with the university's Data Protection Policy (2018).

3.20.2 Confidentiality and preserving anonymity

In this study confidentiality has been maintained by anonymising all identifiable data and assigning each individual a pseudonym. All data were kept on a password protected computer with no access available to any other person. The principles of the Data Protection Act (2018), General Data Protection Regulation (GDPR, 2018) and the University Confidentiality Policy (2015) were adhered to.

In this study, it was envisaged that student nurses could potentially discuss instances of poor or unsafe care being observed whilst on placement. As a registered nurse, I abide by the NMC Code (2018a) which clearly states that registered nurses must:

“Share necessary information with other healthcare professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality” (Section 5.4)

Before the commencement of the interview, the consent form was reviewed and discussed with participants. In particular my professional responsibilities in upholding the NMC Code (2015 – at the time of data collection) and the obligation to pass on information if patient safety was breached. All participants agreed to this and signed the consent form. During the interviews two student nurses described care that was sub-optimal and had not been reported. Although participants did not identify specific areas, it was possible for me to ascertain which placement areas they were referring to. These clinical areas had previously supported student learning but due to concerns about patient care and staffing deficits, student placements had already been temporarily suspended. The university link lecturer's, clinical managers and educational leads were working collaboratively to address the issues raised and systems were in place to monitor and enhance standards of care. Therefore, I was satisfied that patient safety issues and the quality of care were being addressed and I was able to maintain student confidentiality.

3.20.3 Data Storage

All personal information and data collected for the study, such as written notes, tape recordings, transcribed interviews, and consent forms, were stored according to the

principles of the Data Protection Act (2018). All participant information which held identifiable personal details were locked in a drawer which was only accessible by me. A university computer was used to store information generated from the transcribed interviews, memos, and field notes. Computer files with data pertaining to the study were password protected. A laptop computer was also utilised throughout the research to transcribe and analyse the interviews, this was also password protected. Back-up files for both computers were created to protect against accidental or malicious damage or data loss and devices such as USB sticks or portable hard drives were encrypted. All data will be securely held as outlined within the university Data Protection Policy (2018)

3.20.4 Risk versus Benefits

Considering the potential risks versus the benefits of undertaking research can be difficult to predict in qualitative research (Houghton et al. 2010). However, researchers have an obligation to anticipate the possible outcomes of a study and to abide by the ethical principle of non-maleficence, which assumes that no harm will come to the individual as a result of participating in the research (Gelling 2011).

This study explored the emotive topic of whistleblowing and raising concerns, where there was potential for participants to experience distress during interviews and relive experiences where they were confronted with poor care and/or experienced repercussions because of speaking up. Only one student (Ryan) in this study described experiencing repercussions as a result of raising concerns. Although he did not become visibly upset during the interview, he recounted his story with long pauses in the conversation. Reflecting on his experience of speaking up could potentially have had a detrimental effect on his well-being. Therefore, strategies were put in place to address this, and Ryan was given information on how to access support. Student nurse participants were provided with the name of the placement lead lecturer. This was a new role within the university and a placement lead had been allocated for adult, mental health, and child fields. These lecturers were impartial and well placed to support student nurses. They agreed to provide any additional support, and to signpost students to other support services if required.

For nurse mentors, a Practice Facilitator was available to provide support if they felt the need to discuss any concerns that arose from participating in the study. Practice Facilitators

cover all clinical areas of the local health board. However, as the researcher for this study, I was exempt from providing this support as there could potentially be a conflict of interest.

During interviews, some participants enquired about accessing policy and guidance on raising concerns. The nurse mentors were encouraged to utilise the local NHS Health Board Raising Concerns Policy (2015) and to access a flowchart which forms part of the guidance. The flowchart illustrates the steps to be taken if poor care or unprofessional behaviour is witnessed. Nursing students were actively encouraged to access and utilise the university Raising Concerns Policy (2016). I was also happy to answer any queries at the end of the interview, and could have requested further guidance from my supervisors and/or the School's Director of Research Governance.

It was important to inform participants that there were no direct benefits to them from taking part in the study, although it is hoped that the study will eventually enhance the support and training provided to student nurses and mentors within the local health board and university. However, many of the study participants appeared to enjoy telling their stories and felt there was value in researching this topic. The following data extracts illustrate their thoughts on this process.

"This has given me a really good insight to what it's going to be like when we are qualified as we will have to be mentors then as well' this experience has been really valuable" (Carys, student nurse)

"I just think it's about time somebody looked at this topic. I think it's one of those hidden areas of student nursing. They can raise red flags at an early stage, and I think that's vital to the organisation and we should value their feedback and value our mentors who want to help them. I haven't got any answers but I'm really glad that you're looking at it" (Kim, personal tutor)

3.21 Chapter summary

This chapter has provided an overview of how a CGT approach was used to underpin the methods carried out in this study. In recruiting student nurses, nurse mentors and personal tutors, data was co-constructed and analysed using the coding procedures advocated by Charmaz (2014). The development of theoretical codes and the process of sorting and integrating memos has evolved the data analysis and development of categories. The relationship between the categories and explanatory power of one major category led to the creation of a core category. This core category provided an insight into the process of

raising concerns which is heavily influenced by the context of the clinical culture and the relationships within the practice setting and the university.

The reflexive approach employed throughout this study illustrated an acknowledgement of how the researcher's personal assumptions can influence the study and the steps taken to mitigate against this. Maintaining the dignity, rights and safety of participants was achieved through informed consent, adhering to confidentiality and data protection, outlining the ethical approval process and consideration of the ethical principles of autonomy and non-maleficence throughout the research process. The following chapter presents the findings that were derived from the interpretation and construction of data with nursing students, nurse mentors and personal tutors.

CHAPTER FOUR – Traversing the process of raising concerns

4.1 Introduction to the findings chapters

The findings presented in the following three chapters are congruent with a constructivist grounded theory approach. As discussed within the methods chapter, theoretical categories were constructed through the constant comparison of data and a process of active coding and theoretical sampling. In keeping with the tenets of grounded theory, memos have been written to capture thoughts and insights and to demonstrate reflexivity and theory development. The data generated from study participants have been integrated throughout the findings and highlight similarities, as well as contrasting experiences across the three groups. Rich verbatim data extracts capture the social construction of perceptions, insights, and experiences of the raising concerns process. All participants were assigned a pseudonym to preserve anonymity (Given 2008). A summary of the participant characteristics for phase one and two of the study are provided in tables 15 and 16 below.

Table 15 – Summary of participant characteristics for phase one

Student nurses	Age range	Field of practice	Year of nurse training
Faye	18-25 years old	Adult Nursing	3
Mel	18-25 years old	Adult Nursing	1
Neil	40-54 years old	Mental health Nursing	1
Sarah	18- 25 years old	Mental Health Nursing	2
Cath	40-54 years old	Adult Nursing	2
Emma	26-39 years old	Adult Nursing	2
Owen	40-54 years old	Mental health Nursing	2
Nurse Mentors	Age range	Field of practice	years as mentor
Brett	40- 54 years old	Mental health Nursing	Over 10 years
Tina	26 - 39 years old	Adult Nursing	Over 10 years
Nicola	26 - 39 years old	Adult Nursing	6 – 10 years
Michelle	40-54 years old	Adult Nursing	Over 10 years
Zara	40 - 54 years old	Adult Nursing	Over 10 years
Ellie	26 - 39 years old	Adult Nursing	6 – 10 years
Claire	40 – 54 years old	Adult Nursing	Over 10 years

Table 16 – Summary of participant characteristics for phase two

Student Nurses	Age range	Field of practice	Year of nurse training
Becky	18-25 years old	Adult Nursing	2
Carys	26 - 39 years old	Adult Nursing	1
Donna	18-25 years old	Adult Nursing	2
Gareth	26 - 39 years old	Mental health Nursing	1
Helen	18 – 25 years old	Adult Nursing	2
Ryan	26 – 39 years old	Adult Nursing	1
Jess	18 – 25 years old	Child Nursing	3
Sally	18 – 25 years old	Adult Nursing	1
Paula	18 – 25 years old	Adult Nursing	2
Nurse Mentors	Age range	Field of practice	years as mentor
Leanne	26 – 39 years old	Mental health Nursing	Over 10 years
Fran	40 – 54 years old	Adult Nursing	Over 10 years
Liz	40 – 54 years old	Mental health Nursing	Over 10 years
Ann	40 – 54 years old	Adult Nursing	Over 10 years
Tracey	26 – 39 years old	Adult Nursing	Over 10 years
Yvonne	40 – 54 years old	Adult Nursing	Over 10 years
Georgie	26 – 39 years old	Adult Nursing	Over 10 years
Personal tutors	Age range	Field of practice	years as tutor
Charlotte	26 – 39 years old	Adult Nursing	4 years
Mia	26 – 39 years old	Adult Nursing	3 years
Kim	40 – 54 years old	Adult Nursing	3 years
Simon	40 – 54 years old	Adult Nursing	4 years
Olwyn	40- 54 years old	Adult Nursing	15 years
Barbara	40 – 54 years old	Adult Nursing	2 years
Sian	40 – 54 years old	Adult Nursing	10+ years

Collating data on participant characteristics was undertaken to provide the reader with contextual information and an insight into demographic variables. Thirty-seven participants were interviewed for this study. This included fourteen nurse mentors, sixteen student nurses and seven personal tutors. The majority of the participants were female (n=

31) and male (n=6), with most students in the age group of 18-25 and mentors and tutors predominantly in the 40-54 age category. The student nurses' were primarily from the adult field (n=11), mental health (n=4) and child health (n=1). The mentors and personal tutors were predominantly adult nurses with three mentors from mental health taking part. All mentors had been undertaking the mentor role for at least five years and personal tutor experience ranged from two to fifteen years. Data analysis did not specifically seek to explore the relationship between personal characteristics and the process of raising concerns. However, factors such as experience and age were identified by several participants as impacting on relationship-building and raising concerns.

Analysing the data yielded three categories that encompass the study findings chapters entitled: *traversing the process of raising concerns*, *balancing the mentor-student dynamic* and *equipping with the right toolkit*. This current chapter explores the entire trajectory of the raising concerns process and is the largest of the three categories. The sub-categories of *identifying concerns*, *debating and sensemaking*, *acting on concerns (or not)* and *reacting and responding*, provide an illuminating insight into the reality of students' raising a concern whilst working in clinical placements.

In Chapter five, the category, *balancing the mentor-student dynamic*, focuses on the mentor-student relationship and explores whether the dynamic between mentor and student influences students' propensity to raise concerns directly to their mentor. The subcategories include *first impressions count*, *developing rapport*, *perceptions of influence*, *status and power dynamics* and *supporting students to raise concerns*.

Chapter six captures the way in which clinical and academic staff support students to raise concerns within the category, *equipping with the right toolkit*. The study participants reflect on how nursing students, mentors and personal tutors are prepared to raise concerns and support student nurses to do so. Strategies to enhance the process of raising concerns are highlighted. The sub-categories include *preparing students and mentors to raise concerns*, *utilising policies and guidance*, *accessing support* and *developing confidence in speaking up*. Finally, the key findings of this study are summarised and culminate in the presentation of the grounded theory, an overview of all categories and subcategories within the findings are presented in figure 8.

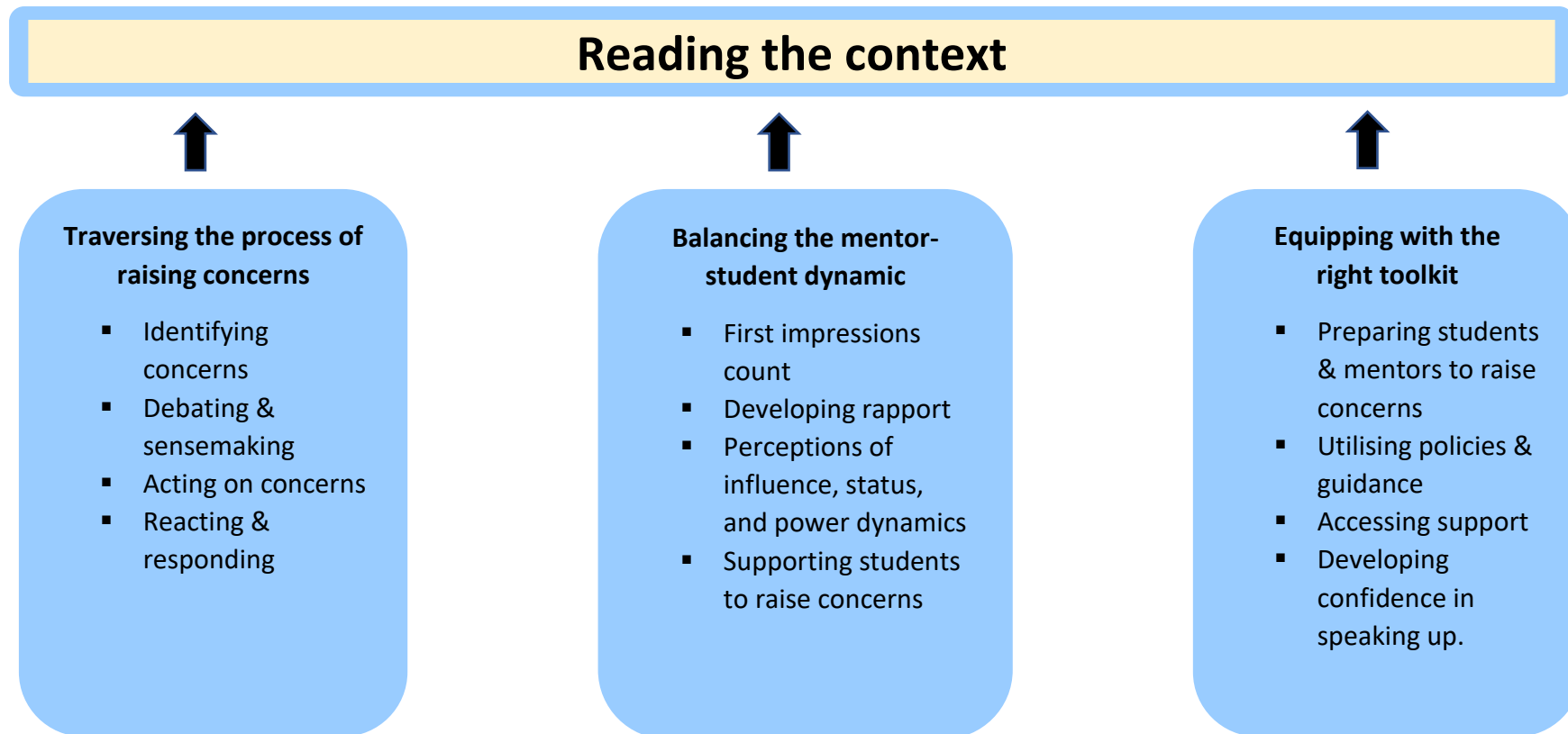


Figure 8 – Overview of core category, categories, and sub-categories

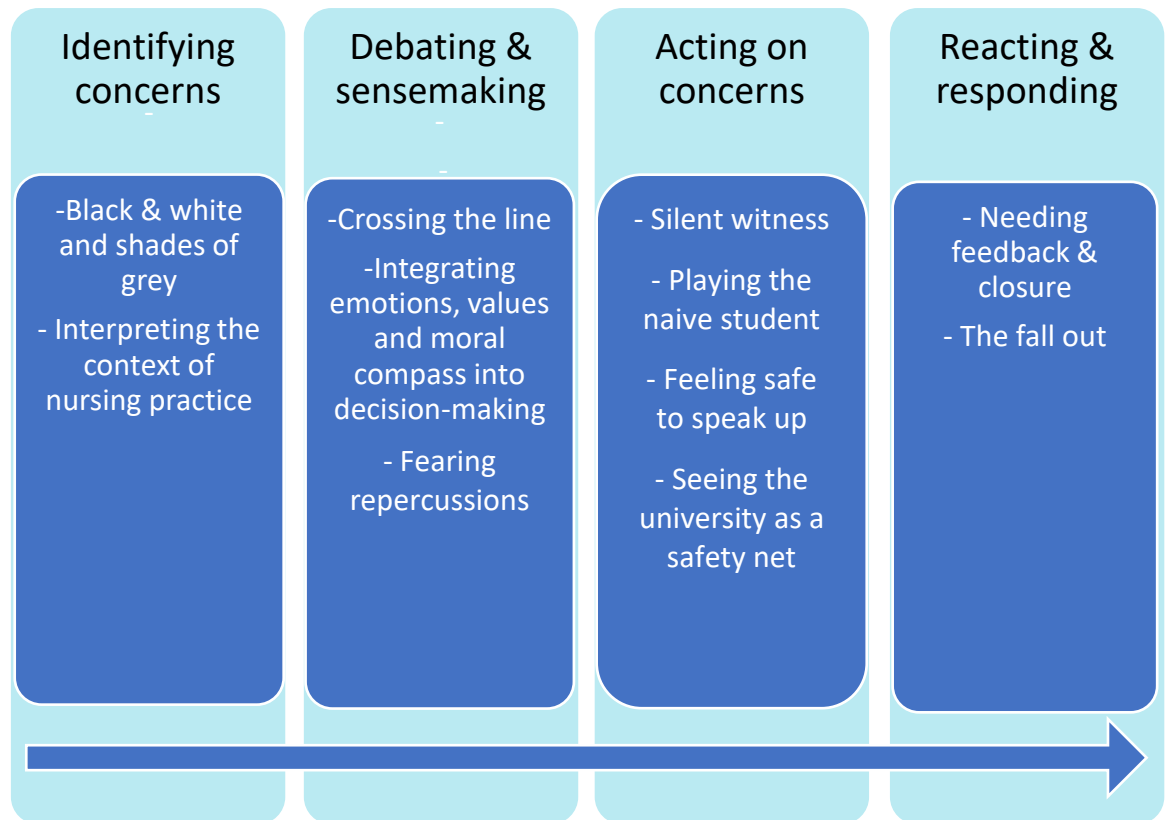


Figure 9 – Traversing the process of raising concerns – overview of categories

The diagram presented in figure 9 above, provides an overview of the subcategories underpinning, *traversing the process of raising concerns*. The first section presents the concerns that were identified by the student nurse participants whilst working in clinical placements. It also highlights contrasting perspectives on the context and interpretation of care delivery.

4.2 Identifying Concerns

Student nurses across the UK spend approximately 50% of their undergraduate programme working in practice settings (NMC 2015). In this study the participants undertook at least seven clinical placements during their nurse training. Clinical placements are diverse and expose learners to primary, secondary, and tertiary care settings. During the interviews the students discussed how they had observed care on clinical placements which they perceived to be unsafe or inadequate and had witnessed behaviour that made them feel uncomfortable. These concerns involved, for example, poor nursing practice that clearly compromised patient safety and instances where they believed that dignity and respect towards patients was lacking.

At this point it is important to understand the nature of the concerns raised in order to subsequently theorise about raising concerns. Figure 10 outlines the areas of concerns that student nurses witnessed whilst working in the clinical environment.

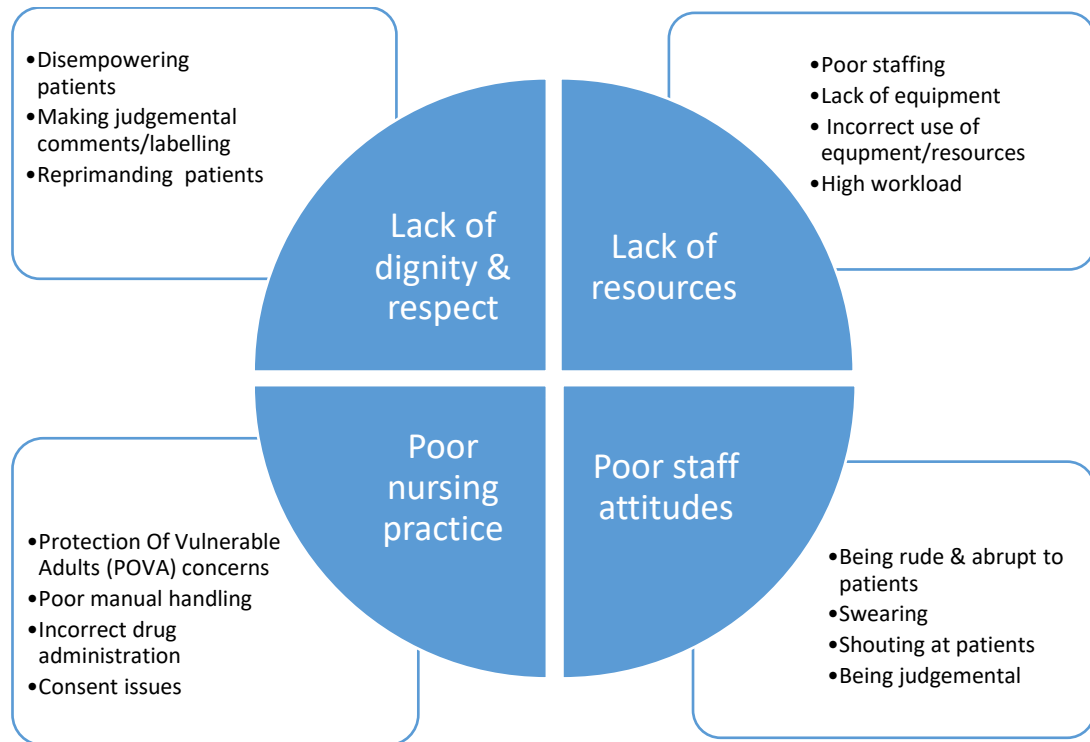


Figure 10 – Areas of concern identified by student nurses

The following data extracts demonstrate that students are capable of identifying valid concerns. The extracts also provide important contextual understanding and insights into some of the problematic episodes experienced by the student nurses during placements. For example, many of the students witnessed healthcare staff failing to follow safe manual handling techniques, suggesting that manoeuvring patients incorrectly was commonplace in clinical practice.

Yes, um I'd seen quite an obvious mistake in manual handling, and they'd made the patient a bit distressed at the time as well. (Helen, student nurse)

Poor moving and handling is one that we hear quite a lot of where a patient is moved incorrectly as they haven't got the right equipment. It might be the patient being pulled up the bed. (Sian, nurse academic)

Manual handling training is a mandatory, standardised educational programme that provides students with the appropriate skills and knowledge to undertake manoeuvres

safely. Therefore, students are easily able to identify manual handling that does not conform to the techniques taught within the university. The following comment suggests that staff may modify their usual practices when students are present.

I certainly remember on my first placement; I think it was to do with manual handling and moving a patient from chair to bath. One of the support workers said, 'shall we do this?' and the other one said 'oh we don't do that when the students are here. (Owen, student nurse).

This raises questions about variable standards and safety of care, where adhering to policy only occurs when there are students observing. This reinforces the extended definition of workplace culture as being, 'the way things are done around here... when no-one is watching'.

Mel (student nurse) identified a number of concerns on her first-year surgical placement.

On the ward where I didn't really have a positive experience, I found that their staffing levels were consistently a problem... to the point where I was being left with massive workloads, maybe at times about ten patients.... I can't give them painkillers as I'm not qualified you know. I would say 'can you come and give this patient some paracetamol' and they've gone 'yes ok' but they've got a list as long as their arm, so it could be two hours before I can get a hand off someone. I found that quite stressful as it's such a massive workload and there's only so much you can do as a student with two hands. (Mel, student nurse)

Poor staffing levels were highlighted as an issue by Mel, and alluded to by other student participants, who described how inadequate staffing impacted on workload and subsequently the quality of patient care.

They were really overworked which sounds like an excuse. It was a heavy ward, so in comparison to some wards where the HCSW are doing a lot of personal care and washing and dressing, the nursing staff were doing a lot of stuff as well. So, they were struggling for time and that's when the impatience came out. (Emma, student nurse)

Not all of the identified concerns occurred in secondary care. Sally (student nurse) escalated serious concerns whilst on a community placement in year two of her nursing programme. An elderly woman was being nursed at home by her relative who was reluctant to allow healthcare professionals (other than community nurses) into the home to assess and provide treatment. This posed a challenge for the community team who were cognisant of their responsibility in providing timely care and advocating for vulnerable clients (NMC, 2018a). After visiting this patient with her mentor, Sally was upset by what she witnessed.

One lady we were looking after, she had advanced dementia, she wasn't eating, wasn't drinking. She was still for active treatment... We went to this lady's house to do wound dressings. She was totally bed bound, she couldn't see, she couldn't hear. We were changing her dressings and she got distressed and her whole body was broken down from head to foot. She was covered in sores and all her stomach was blistered and everything. It was horrific! We managed to change as much as we could, but she was just screaming crying 'get off me, get off me' and you think how much of this is dementia and how much of this is her actually telling me 'Get off me'. Because she was distressed, tears running down her eyes, I believe she was obviously in a lot of discomfort and pain, so we had to stop. But she just wanted to be left alone and kept saying she wanted to die. (Sally, student nurse).

The data extract above provides a harrowing account of a vulnerable lady who was clearly distressed and whose medical needs were compounded by sensory and cognitive impairments. Sally believed that this lady was at risk due to her pain, skin breakdown, inadequate nutrition, and her incapacity to verbally express her needs to the staff. These safeguarding concerns were raised by Sally and her mentor and subsequently addressed through the Protection of Vulnerable Adults (POVA) procedure. Sally's experience of raising concerns and the outcome for this patient will unfold in subsequent sections of this chapter.

Many of the concerns identified by the student nurse participants were in relation to medicines management. Carys found herself in a challenging situation after witnessing her mentor violating medicines policy on several occasions. In one example analgesia was administered despite being contraindicated due to the patient's medical history. Carys became more concerned after a discussion with her mentor about medication errors.

We were going through the competencies and she [mentor] said 'what would you do if there's a drug error?' and I said, 'tell the patient first of all, go through and escalate it, record'. She said, 'no'. I said, 'excuse me I don't understand?' and she said, 'it depends on the toxicity of the drugs. You probably wouldn't tell'. I asked, 'why wouldn't you tell the patient because you are going to have to bring medical team in and you don't know about adverse reactions?' and she said 'well they will sue you (Carys, student nurse).

The dialogue between Carys and her mentor identified a number of serious concerns in relation to patient safety. The mentor's willingness to conceal a medication error revealed inadequate knowledge and understanding of local drug error procedure and the potential

for harm to patients. Furthermore, the mentor lacked professional responsibility in being open and honest with patients when things go wrong (NMC and GMC 2015).

The next section focusses on concerns relating to unprofessional attitudes and behaviour encountered by student nurses during their clinical practice experience. In the data extract below, Neil observed staff displaying judgemental attitudes about patients during the clinical handover.

To give you an example of the attitude's thing, on the last placement, an acute mental health setting, every morning there would be handover. You would have one or two nurses doing the handover and they'd begin by describing a patient and say, 'I don't like him or her' and 'they are a pain in the whatever'. You think where is the unconditional regard for these patients? You can't be starting a handover with that. You are influencing other staff nurses, there are NA's in there, students, and I think that is pretty bad you know. On the flip side they would also say 'I like this person he is really nice' but again shouldn't we be neutral? (Neil, student nurse).

Neil's extract reveals his surprise at the comments made openly by nurses during the handover and the potential for these personal judgements to influence other staff members' perceptions of the patients. Students also observed poor communication interactions between nursing staff and patients. Cath (student nurse) observed a healthcare support worker displaying an unpleasant attitude towards a patient during her first year of training.

The way they were speaking to the patients and their body language I thought was really unacceptable.... swearing in front of a patient because she refused to wash her hands... The patient was like 'I don't need to wash my hands, they're not dirty', but this NA turned her back to the patient, but was clearly still in hearing distance from the patient. She said, 'I don't come to work to be spoken to like beep, why should I be spoken to like beep'. I was shocked. I can appreciate that the patient was a little abrupt, but you do have to maintain that professionalism and if you want to vent you tell someone else later. You don't stand in the middle of the ward area where not just that patient can hear, but all patients can hear as well. (Cath, student nurse)

Cath was appalled by the unprofessional attitude of this individual, speaking to the lady in such a derogatory manner within earshot of other patients was a shocking incident to witness.

This introductory section has presented several data extracts that clearly illustrate student nurses' witnessing a range of practices which they tried to make sense of and identified as

a 'concern'. The perceived seriousness of the concern varied from episodes that were unacceptable, and had clear safety implications, to situations where students felt uneasy about the behaviour they observed. Some of these concerns were raised and others were not, this theme will be revisited in subsequent sections of the chapter. What was also evident within the data was the fact that students' perceptions of what amounted to concerning episodes differed from nurse mentor and personal tutor perceptions, this is explored further in the following section.

4.2.1 Black and white and shades of grey

During the interviews, nurse mentor participants recognised that a student nurse could witness poor care or safety breaches in clinical practice and was well placed to identify and escalate concerns. However, there was a strong feeling that teaching within the university setting did not always reflect the reality of the clinical workplace. The phrase "they just have black and white" was coined by Ellie (nurse mentor) to describe this perceived theory-practice disparity.

Ellie: sometimes for us ... I'm not saying that we break rules or anything, but I think they [student] have to be mindful that sometimes there are going to be days when things don't quite happen in the way it should, either because the ward is too busy or understaffed or something might have happened that day. I think students don't always grasp that concept. They just have black and white, right, and wrong and that is what they stick to. Yes, I agree with it, but I also think they need to know that it's not always realistic.

PB: where do you think the black and white view comes from?

Ellie: From the university I guess as that's where they are getting their information. I mean the university is telling them what should be done and then they are coming out and seeing the reality and it probably doesn't sit comfortably with them does it.

Ellie argues that students do not fully understand the realities of nursing practice because of the dichotomy between what the students are taught versus the complexities in practice settings. Similarly, Mia (personal tutor) refers to the 'black and white' and acknowledges that university teaching can reinforce rigid perceptions of care delivery and contribute to concerns being raised by students.

I think students when they are very novice, they see black and white and maybe we teach black and white and maybe that's something we need to work on because there is so much grey area isn't there? I'm not saying there is an excuse for poor care, but they haven't got the experience behind them to be able to rationally think

why something might be being done in a certain way and why it might be different to what they've been taught. (Mia, personal tutor)

The phrase, 'shades of grey' was used by personal tutors to encompass the uncertainty, complexity, and messiness of clinical practice. Gaining experience in clinical environments teaches students, according to Mia, how to rationalise uncertainty and respond to situations which are unforeseen and deviate from the norm. The personal tutors recognised that students may not have had the preparation or experience to consider the rationale for changes in care delivery or to adapt to unexpected situations. Simon argues that teaching in the university is 'idealistic', which adds further credence to a perceived theory-practice gap.

I think our teaching is idealistic...I haven't laid hands on a person for five or six years. I see my role as getting students to be critical thinkers, problem solvers and understanding how to apply skills and knowledge. We can certainly introduce them to techniques and strategies like reflective practice for what they are doing. I don't think our role is to teach them how to do nursing. There is such an absolute canyon between theory and practice here. People teach students things here including myself that perhaps are out of date (Simon, personal tutor).

Here, Simon acknowledges his role as facilitating reflective practice and promoting critical thinking rather than teaching nursing. Describing a theory-practice gap as 'an absolute canyon', may in part explain why some student nurses' perceptions of clinical practice is unrealistic and could potentially lead to 'concerns'. The salient point from this data is that the complexity and challenges of clinical practice may be at odds with student expectations. These expectations are informed in the classroom but may not always fully reflect the reality of care which is delivered within the clinical environment.

Tracey (nurse mentor) acknowledged how the 'evolving' nature of nursing practice influences the way skills are taught and demonstrated by clinical staff. These factors may conflict with student expectations and lead to concerns being raised.

We've all trained over different years in different places and because nursing is ever evolving and all research based and there are all these things that have changed so much...it might be equipment; it might be nursing style. It might be that something new is happening. We might be using a different type of dressing to the one that you've learned about. (Tracey, nurse mentor).

Tracey alluded to a number of factors that can result in variations in care delivery. These cannot all be attributed to idealistic practices, or a theory-practice gap per se, but reflect

contemporary practice issues which in some cases may be organisational and out of an individual nurse's control. In the final sub-section, nurse mentors discuss how student nurses' interpretation of the context in which care is provided can potentially account for students raising concerns.

4.2.2 Interpreting the context of nursing practice

During the mentor interviews, the importance of understanding the context surrounding care delivery was discussed. Several nurse mentors described how students would sometimes raise concerns because they did not fully understand the overall context of care. This is another example of things not being black and white, but grey. Michelle (nurse mentor) considered this in relation to student nurses' raising concerns when they may not be fully conversant with an individual patient nursing plan.

You could have a patient on a covert medication policy, but the student may not have been fully aware of that or aware of the history of the patient, but they may see you crushing tablets in a yoghurt and might think 'oh they are trying to drug her' or 'they are sedating the patient'... So, maybe what is perceived as bad practice isn't actually, but it is something that's been looked at and implemented for that patient's benefit. Because sometimes it's like miscommunication a lot of the time (Michelle, nurse mentor).

Although covert drug administration is only used in rare situations, this extract highlights the importance of providing a comprehensive clinical handover that includes contextual information and alleviates 'miscommunication'. Otherwise, concerns could be raised erroneously by student nurses, as was the case for Liz (nurse mentor) in the following extract.

He [student] would be challenging. like, he did it to me and said 'I don't think the way you did that was right, I'm going to tell on you... he went to different staff and said Liz has done this and I'm really not happy that she has done that. Luckily, they were both people that know I am quite thorough and said pretty much the same that I'd said. I had to pull him in and say, 'I've explained to you why I did that and given the rationale. (Liz, nurse mentor)

After further discussion with Liz and other team members, the student realised that he did not understand the full context of the client's treatment plan and his concerns were allayed.

Long-term patients may develop therapeutic relationships with nursing staff and engage in informal banter. As Brett explained, students witnessing this on clinical placements could potentially misinterpret these interactions.

We should treat people with respect and dignity. How that is perceived by an observer could be wrongly interpreted. If you know a client for years you might act in a particular way that could be taken wrongly and reported to the uni, but it might be in the context of a joke. So, how do you as a student differentiate between a joke and something that is meant as serious? I can say things sometimes and if an outsider was hearing that, it could be misconstrued, whereas it's not meant in that way (Brett, nurse mentor)

The extract above provides an interesting example of how students (or anyone within earshot) could potentially interpret humour in different ways. This is not necessarily related to long-term patients but could be applied to any health care setting and with any patients or colleagues. Similarly, the following data extract describes the way a community team interacted with each other when they were away from patients. Georgie (nurse mentor) is aware that these conversations could be perceived as unprofessional or disrespectful and was keen to pre-warn students that they might witness these interactions.

Our office is a very interesting environment. We are away from patients, the doors are shut, and it's the place where staff come to let off steam. They have finished the mornings nursing and that might have been very challenging. I don't like swearing and they do get told off for swearing. However, quite often, inappropriate things are said in that environment, but it is letting off steam. It's the 'you know what's said in the staff room never be heard outside the staff room'. Um, I always warn the students about that because I think the first time you hear that it can be a little bit shocking and maybe upsetting. (Georgie, nurse mentor).

This private space (which is referred to at times as 'backstage') provided an opportunity for staff to vent and 'let off steam' and may also have served as a coping mechanism to deal with the daily stressors of the nursing role. Georgie was mindful that student nurses could misinterpret these conversations. In the extracts above, the communication encounters are clearly seen as part of the sub-culture of Brett and Georgie's clinical environments. However, their comments illustrate an awareness of how the behaviour and interactions of clinical staff could be perceived negatively by student nurses. In Brett's example, a long-standing therapeutic relationship between a nurse and client could manifest itself in informal communication which could easily be misconstrued as over-familiar or inappropriate by students. Brett recognised the potential for situations to be misread but

does not mention whether the mentor should discuss these communication styles with students. Interestingly, Georgie described the importance of pre-warning students about such interactions. The memo below is an extract of my thinking following my interview with Georgie (Box 7)

Box 7 – Memo Backstage communication [30/7/17]

Georgie describes how her staff interact with each other differently, when they are away from the patient. These informal chats resonate with Goffman's (1959) work which explored the way in which individuals perform in 'front stage' and 'backstage' away from the glare of the public. Mentors appear to have insight into how these students might misinterpret these more relaxed and hidden communication encounters and label them as unprofessional. It appears that in some cases students are being 'primed' to lower their expectations and threshold of what is considered acceptable standards of practice. Invariably, this may reduce the risk of students' raising a concern or complaining about the witnessed behaviours. I wonder if nurse education focuses on these 'backstage' behaviours that students see in practice (hidden curriculum).

Becky (student nurse) was also pre-warned about a member of staff's poor attitude (HCSW) at the outset of the placement by the ward sister.

She said, 'she does have a bit of an attitude problem and we've tried to stop it, but obviously we can't change her personality' (Becky, student nurse)

This pre-warning appears to highlight an underlying acceptance of this individual's attitude problem and a sense that nothing can be done to rectify the behaviour. By warning Becky, the subtext of the message from the ward sister could be interpreted as, 'we know this goes on so no need to concern yourself' or conversely perhaps, 'I am alerting you to this so feel free to raise this as an issue'. Therefore, it is not surprising that students are often find it difficult to interpret the context of care and the myriad signals and potential misinterpretations that these pre-warnings from senior staff may trigger.

In these opening sections, student nurses have been shown to be able to quickly identify situations where patients were exposed to actual or potential harm and where behaviour fell below acceptable standards of care. However, the complexities of practice were also identified in the analysis of personal tutor and mentor interviews, this suggests that

students may inadvertently raise concerns because of the divergence between the idealistic skills taught within the university and the messiness of clinical practice.

An alternative explanation is that experienced nurses are practising in ways that are adaptive, or occasionally maladaptive, to the many challenges of working in busy clinical environments. This can occasionally result in the tolerance or normalisation of problematic practices or attitudes. Student nurses, particularly in the early phase of nurse training, may not have developed the knowledge and skills to adapt and acclimatise to new and variable ways of working in clinical settings. There may be a lack of information, provided in the classroom, on helping student nurses understand the importance of context. In fact, it may prepare students for a completely different, and some argued, overly idealistic context. The contextual factors surrounding individual plans of care could potentially contribute to concerns being wrongly identified by students. The next section will explore the decision-making process undertaken by student nurses' after observing wrongdoing in placement settings.

4.3 Debating and sensemaking

This sub-category of 'debating and sensemaking' explores the factors that influence student nurse decisions and behaviours relating to raising concerns. In some cases, the severity of the misconduct influenced students' decisions on whether to escalate a concern or not. The phrases, 'crossing the line' and 'tipping point' were used by students during the interviews to describe how they interpreted and made sense of the nursing practice and behaviour witnessed within the practice setting.

4.3.1 Crossing the line

The following data extracts provide insights into what behaviours constituted, 'crossing the line' and illustrate the complexities in reaching clear conclusions in relation to raising concerns. For example, Fran (nurse mentor) is very clear that colleagues hurting a patient or causing physical harm are actions that could not be tolerated and would lead to the student's concern being escalated.

I think it would depend on whether it was something that I could speak to them about and say, 'right you have got to change', say it was an attitude thing. But if they'd hurt a patient or something then I couldn't let that go. I think you've got to

distinguish between the two and the severity bit, and there is a line isn't there that you don't cross? (Fran, nurse mentor)

Fran differentiates between physical harm which was deemed to be more serious than a staff member displaying a poor attitude. She suggests that the latter could be dealt with informally by speaking directly to the person. There is a sense that although a poor attitude needs to be addressed, it may not necessarily constitute crossing the line. However, Cath's (student nurse) data illustrates the psychological distress that patients can experience when staff demonstrate a poor attitude.

There is one thing to be a bit short and you know, but when you're making patients cry and feel uncomfortable, for me that's crossing the line you know (Cath, student nurse)

These descriptions of 'crossing the line' appear to be determined by the severity of the act, although Neil discussed the ambiguity which this phrase represents.

It was just a bit of manhandling. It wasn't massively crossing the line, but it just looked a bit... We both saw it and weren't comfortable with it (Neil, student nurse).

Neil gives the impression that there may be different gradients related to this concept. In this case the incident is described as 'not massively crossing the line', which implies that the incident that Neil witnessed still constitutes crossing a line, albeit to a lesser degree. There is a sense that Neil may be downplaying the misconduct by referring to the encounter as, 'just a bit of manhandling', although by definition, this type of touching or holding someone roughly (Cambridge Dictionary 2021) clearly violates the NMC code (2018a). In this instance, Neil did not raise any concerns which illustrates how arguably a line can be crossed without sanction.

Patient safety issues were at the forefront of decision-making for Carys (student nurse). The phrase, 'tipping point' was used to denote a similar meaning to 'crossing the line'. In this instance, her mentor failed to meet the standards of The NMC code (2015) which was the 'tipping point' to escalating her concerns.

Apart from breaking pretty much most of the code, that was a real tipping point where I thought 'I'm going to have to flag this up. So it's patient safety first and foremost, and I was kind of, I can take it on the chin that maybe she didn't like me personally, but I couldn't take it that she was affecting patient care. (Carys student nurse)

Here, Carys emphasizes that she can endure being disliked by her mentor, but not willing to see patients suffer. In the quote below, Owen acknowledges that physical harm is easily identified as a reportable offence. However, echoing the previous section's discussion on the grey areas of practice, the 'near misses' and borderline behaviour were deemed far more problematic to categorise than observing physical harm and potentially made decision making more difficult.

I think it's easy if you walk onto a ward and someone is hitting a patient. That's easy as it is so clearly unacceptable there should be a line of people waiting to fill in the incident form. What is less easy is the near misses, the 'I almost gave the patient the wrong medication or 'I almost didn't do something'. Or the things that no one else knows about. (Owen student nurse)

Donna (student nurse) suggested that the frequency of the misconduct came into play when debating further action. Repeated examples of poor practice were more likely to lead to concerns being raised.

I think it would depend on what it was. If it was something minor like I don't know someone put the bed on wrong, I'd think fine one off. But if they kept on doing everything wrong again and again, I'd probably raise it with somebody. (Donna, student nurse)

I didn't feel comfortable to tell anyone as I thought maybe it was a one off and I'd caught this person on a really bad day (Cath, student nurse)

Cath also described the behaviour she witnessed as a 'one off', although unlike Donna does not specify if the behaviour was classed as minor. However, there is an attempt here to justify or rationalise the behaviour on the individual having a 'bad day'. In hindsight, more detail on what a 'bad day' actually means would have provided a deeper insight into Cath's quote. For other student participants, their personal values, emotions, and morals also influenced their decision-making.

4.3.2 Integrating emotions, values and moral compass into decision-making

For some student participants, decisions on whether to raise concerns were underpinned by intrinsic factors such as their emotional, moral, and personal values. In the following data extract, the timeliness of speaking up is also apparent. Here, Mel was concerned about the consequences of her patients not receiving their medications and this triggered strong emotions that influenced her decision to speak up.

I thought 'if I don't say something now something is going to go terribly wrong' and I'd rather speak up now and get something done. You know the patients were there a long time, I was attached to them, and I did think, "that patient hasn't had his tablets now and what implications could this have for him?" (Mel, student nurse)

Mel had clearly developed an attachment and close relationship with her patients and was keen to advocate on their behalf. Similar sentiments emerged in the following extracts from student interviews. Sarah's dialogue below describes how attuned she was to her emotional and instinctive reactions when decision-making.

I was seeing things that just didn't sit right with me and I was leaving and feeling really upset thinking, 'this isn't how I'd want my grandmother to be treated if she ever got this' and I thought 'that can't be right'. It was just so uncomfortable for me... I thought if my emotions are telling me, it's not right then it's probably not right. (Sarah, student nurse).

I just think that I wouldn't want anyone I know in my family to be treated in a bad way so if I see anything I don't like I would just question. (Jess, student nurse)

Both Sarah and Jess set a benchmark of expectations based on how they would like their own relatives to be treated. For Neil, decisions were also governed by his own moral conscience and differentiating between 'right and wrong'.

You've got your overarching own moral compass I suppose. That's always there and your in-built right and wrong. (Neil, student nurse).

Responding to a personal 'moral compass' appeared to be straightforward in some instances and there was consensus amongst students that patients being physically harmed constituted 'crossing the line'. However, other instances of wrongdoing were ambiguous and open to interpretation. The golden rule of "treating others as you would like you or your family to be treated" was evident within the data. However, a small number of students excused the behaviour if they considered the wrongdoing occurred only once, or if the perpetrator was deemed to be having a 'bad day'. The subjectivity of some of these assessments is worrying. However, one of the key factors that influenced decision-making in raising concerns was the potential for students to experience reprisals.

4.3.3 Fearing repercussions

All the student nurses considered the potential for repercussions to occur if they were to raise concerns in clinical practice. For example, students articulated their vulnerability and felt that speaking up could jeopardise their place on the nursing programme.

I feel as a student you are in a very vulnerable place. Because the uni and the ward are separated. When you go onto clinical placement, you are by yourself and if you fall out with a member of staff or you don't get on with your mentor... I think you have to be very strong to stand up. Because if you do stand-up, you are putting your nurse training in jeopardy (Faye student nurse).

Evoking the earlier discussion of the theory and practice gap, Faye viewed the university and the practice placement as separate entities, with student nurses being in a 'vulnerable place'. The phrase 'you are by yourself' illustrates that this perceived risk was accompanied by a daunting sense of isolation, especially if there was a difficult relationship with clinical staff. In addition, the perceived disconnect between the two organisations contributes to the positioning of speaking up as a risky activity in terms of the student nursing programme and future nursing career, a point also acknowledged by a nurse mentor.

Yes, future jobs. Because you never know, where you are going to end up do you? If you are planning on staying in the same place that you've done your training in, you don't ever know what jobs will be available when you qualify. That's a factor, I think. You can walk down a corridor and see people you've worked with or mentored. (Ellie, nurse mentor)

Ellie outlines the potential long-term risks and repercussions for students who raise concerns and describes how speaking up could jeopardise future employment and relationships with colleagues. The data extract hints at the toxic effects, or notoriety, of speaking up within the clinical culture and that it could incur reprisals. This could potentially influence students' decision-making on whether to speak up and could also underpin students' awareness of the need to adapt to each clinical environment and gain acceptance from the placement team. 'Fitting in' was critical to the success of the placement and many students felt that raising concerns could affect this.

It's hard enough going to a placement and fitting in and getting your place as it is without going in and putting in complaints about people. It could change everything you know (Cath, student nurse)

Yes, I think that's always a thought that people think, 'If I report this am I going to be outcasted in the team, are they not going to want to work with me? Will they want to talk to me? Are they going to be able to trust me?' (Helen, student nurse)

Here, Helen viewed the team as a powerful force that could collectively ostracise her if she reported her concerns. There was a powerful perception that raising concerns risked breaking the circle of trust and could be detrimental to working relationships.

I got really bad cold feet and I was like 'no I don't want to do it'. I just thought of the repercussions, like if it has to be fed straight back to the ward and the ward sister. If that happens when I'm there, I know she will really have it in for me. I actually emailed my personal tutor and said, 'I've changed my mind I don't want to anymore because I don't think I could deal with the repercussions whilst I'm still on the ward' (Mel, student nurse)

Mel had been on the placement for a number of weeks, she had witnessed unsafe practice and unprofessional behaviour from several staff including the ward manager. Her anxiety that the ward sister 'will really have it in for me', was based on her direct observation of the ward sister's behaviour within the clinical environment. The fear of repercussions comes through clearly within the data extract and highlights how Mel has based this fear on her appraisal of the ward sister's interactions. The ward culture and leadership were evaluated as an unsafe landscape in which to raise concerns and the fear of negative consequences is real.

During the interviews, students used metaphors and phrases such as 'upsetting the applecart' and 'rock the boat' to illustrate how speaking up was deemed disruptive to the status quo in clinical practice.

Neil: *You are on that placement to kind of rub along with people like any workplace I suppose, and do you want to be upsetting the applecart over an incident?*

PB: *Upsetting the applecart. Can you tell me more about what that means to you?*

Neil: *Well, you are going to get talked about. Like most places, you get that office politics and bitchiness, you know everyone knows everyone's business (laughs) which is inevitable. So, it's never going to be under the radar. There is no guaranteed discretion is what I'm trying to say I suppose. If there was, I think more incidents would be reported.*

As a student you don't want to rock the boat. You are very aware that you have to go back and work at that placement for however long and people do talk, so I think you are very aware that you are an outsider going in. (Cath, student nurse).

The data above highlights the student's perception of being an 'outsider' which resonates with earlier data regarding the separation of the university and clinical placement. There was a fear that speaking up would create disharmony and gossip within the clinical environment. Students appear to utilise sensemaking and look for clues to determine whether the culture is deemed to be open to concerns being raised or not. Neil's quote of 'no guaranteed discretion' illustrates his fears regarding confidentiality and appears to be

a clear disincentive to speaking up. The culture of the clinical placement is located here as an unsupportive environment, Neil has the impression that concerns would not be welcomed or kept confidential.

The quotes below demonstrate that mentors and personal tutors are also aware of student's fears in relation to the potentially negative consequences of speaking up in clinical placement.

Well, do they feel perhaps that they can't tell because they might be penalised on the ward if they are sort of telling tales on somebody. I can understand why some students don't want to do that because they might feel that they would be penalised in some way or be labelled as a troublemaker. (Yvonne, nurse mentor)

I think people worry about their reputations and are they going to be known as a difficult student (Mia, personal tutor)

Nurse mentors and personal tutors acknowledge these barriers to raising concerns, this suggests they are aware of the fact that the perceived separation of the university from the culture of the practice environment perpetuates this fear. The data above and that of the students show that they calculate the personal, professional, and relational risks of raising concerns. Their future as nursing students and registrants are perceived, at times, to be too high a cost to risk over raising concerns. How this shared notion of repercussions influences the dynamic between the student nurses, nurse mentors and personal tutors is explored within the next chapter.

The potential risks and repercussions associated with raising concerns are related to the fear of a negative placement experience and the disintegration of team relationships. Worries about being ostracised, labelled, or treated unfavourably appeared to be powerful deterrents to students' raising concerns. These worries were countered by a sense of personal values and morals which galvanised students' resolve when contemplating speaking-up. However, there was also an awareness that raising a concern could potentially have long-term repercussions which might affect students nurse training and future career.

Within this section it is clear that students appraise the culture within the clinical learning environment when assessing the likelihood of the manager, mentor and clinical team being receptive and supportive to concerns being raised. Decisions about raising concerns were made primarily on the student's perception of how serious and how frequently wrongdoing

had occurred. However, students clearly observe their environment and gather contextual information from the mentor, as well as other team members, which also contributes to decision-making. This sensemaking involves students interpreting how staff within the culture of the placement interact with each other and with students. This can provide students with a signal as to whether speaking up is safe or is likely to incur reprisals.

The fear of repercussions appears to be omnipresent and is a powerful component of decision-making within the raising concerns process. Students have an overwhelming desire to belong and 'fit in' to the clinical sub-culture, this is closely linked to the need to have a successful placement experience. The significance of the mentor-student relationship, and how the mentor's role as an assessor impact on student decision-making, has been touched upon but it is explored further within Chapter five. The following section focuses on how decisions translate into action (or inaction).

4.4 Acting on concerns (or not)

After weighing up the risks versus the benefits of raising concerns in clinical practice, the student nurse participants made the decision regarding what action to take. As the following sections will demonstrate, student decision-making resulted in a range of outcomes:

- For a small number of students, the decision was made to remain silent
- Utilising more indirect means to highlight poor nursing practice.
- Speaking to an approachable member of staff from clinical practice or the university

4.4.1 Silent witness

There were three students in this study who witnessed poor practice but decided not to voice their concerns. For example, Emma and Cath were first year students when they identified concerns on their placements. Emma's concerns were centred around a lack of respect and dignity towards patients, this appeared to be pervasive across the team. Cath witnessed a member of staff displaying an unprofessional attitude towards a patient. An uncomfortable and unprofessional 'ward ethic' made raising concerns seem futile for Emma, whereas for Cath being new to the placement contributed to her decision to remain silent.

Because it was my first placement on the ward, I didn't feel like I could raise any concerns...It wasn't just one member of staff, it seemed like it was the ward ethic. I didn't really know who I could have confidently raised it with. There wasn't anyone that stood out who I thought would deal with it professionally and confidentially. (Emma, student nurse)

I was shocked at the time, and I'd only been on that placement for a couple of weeks. I didn't feel comfortable to tell anyone. (Cath, student nurse)

After deliberating with another student Neil also made the decision to remain silent after observing incorrect manual handling.

Two NA's [nursing assistants] were on close obs with an elderly patient. She was in the chair in the dayroom and was trying to get up.... They kept saying 'sit back down' and she was still shuffling around trying to get out. After about 5-10 minutes, this charade of like 'sit down' they both just stood up, stride over to the patient and lifted her up and plonked her back in the chair.... We both saw it and weren't comfortable with it... I also think there's an element of learning from when you see that happening. You think 'that looks bad' and bank that one as how not to do it. We deliberated over it for a bit and thought let it go. (Neil, student nurse)

Despite not speaking up, Neil outlined the positives of this scenario and believed that learning occurred by observing 'how not to do it'.

The data extracts above, all involved students who were in their first year of nurse training when they witnessed poor practice. However, their rationale for not raising concerns diverged. Being a new student on clinical placement appeared to influence Cath and Emma's decision not to speak up, although the ubiquitous nature of the concerns coupled with a perceived lack of support also contributed to Emma's decision. In contrast, Neil's example resulted in a joint decision with a fellow student not to speak up based on their perceived severity of the wrongdoing. As discussed earlier in this section, the incident described by Neil does not appear to cross a line that would trigger action. Perhaps the junior status of these students is a further variable in whether a line is deemed to have been crossed or not.

This finding does trigger questions about whether second- and third-year students show less hesitancy in raising concerns, a point that will be considered throughout this chapter. However, Neil's data also reinforces how the perceived severity of the wrongdoing influences decisions and action, or in this case inaction. The challenge in raising concerns about a clinical team rather than one individual appears especially daunting for a first-year

student and illustrates the need for strength, courage and support in order to escalate concerns.

In this section, examples have been provided of students who chose to remain silent after raising concerns. The findings now move to those students who communicated concerns in a way that may not be identifiable as formally speaking up. Student participants utilised strategies to signal an awareness of wrongdoing as a precursor to formally raising concerns, or as an alternative to speaking up.

4.4.2 Playing the naïve student

The most common strategy utilised by students as an alternative to formally raising concerns was the use of questioning. Owen (student nurse) coined the phrase, 'playing the naïve student', to describe how he used his student status as a legitimate way to query practice.

It's all about framing it in the right way. Quite often I like frames like, 'I've been doing some reading and I've found some info on this, have you come across this before?' to try and change their practice. If I think you've done something that wasn't best practice and I say to you, 'that wasn't best practice' and you are my mentor, you might react in a way of 'who do you think you are?' (laughter). 'I'm the one with all the experience and you're not, so don't tell me how to do my job'. I will try to present it as, 'can you learn something from me? I've never had that thrown back in my face. Most nurses are quite happy to learn something new and I think if I was faced with defensiveness then that would probably flash more concerns' (Owen, student nurse)

Here, Owen describes the importance of providing evidence to mentors in a non-threatening manner as a way of indirectly raising a concern and providing an opportunity for the mentor to modify their practice. It is interesting that Owen felt that defensiveness from the mentor would in turn 'flash more concerns', and perhaps expose the mentor's reluctance to rationalise their practice or utilise opportunities to update their knowledge. A number of other students also used questioning to prompt others to correct, or at least to explain their behaviour.

I think a good strategy for students is to say, 'I've not used that before so can you tell me a little bit about that' (Helen, student nurse)

If I saw a nurse wasn't doing it right I might say 'oh, what kind of way do you do it on the ward because in uni they teach us this way, but maybe it's different here?' I think that's how I might approach it. (Faye, student nurse)

Although a few students referred to using this strategy in the clinical environment, only one nurse mentor recognised this informal approach of raising concerns through questioning.

Yes, sometimes I think students are asking very basic questions when they probably do know the answer... I suppose they might go 'oh right, they said to do it this way in clinical teaching in university (Nicola, nurse mentor)

Another strategy utilised as an alternative to raising concerns was students' role-modelling good practice, in this case after Emma (student nurse) witnessed her mentor rushing a patient when carrying out care.

PB: *So, when you were working with your mentor and this was going on, how did you respond?*

Emma: *I would just counter it by not being like that and saying to the patient 'don't worry, we can wait, take your time' just trying to counteract what she was saying.*

PB: *Did that have any influence on your mentor?*

Emma: *In that scenario no, but I have done that sometimes with HCSW and have noticed them changing their approach and almost mirroring what I'm doing.*

Circumlocutory methods, such as questioning, and role-modelling were utilised by students in an attempt to signal awareness of poor care and encourage mentors and others to rationalise and/or amend their actions. Students' status as learners enabled the legitimate asking of questions without directly voicing their concerns – so these indirect actions can be understood as not silence but equally not formally escalating concerns either. It is evident within the data that in some cases, these informal strategies were utilised because the clinical environment was perceived by students to be an unfavourable context to raise concerns directly.

4.4.3 Feeling safe to speak up

The majority of the student nurse participants (n=13) did raise their concerns after witnessing poor care and in this section, they recount their experiences. However, how they communicated their concerns, and to whom, was influenced by contextual factors which contributed to their decision to speak up.

The university's 'Raising and Escalating Concerns Policy' (2016) stipulates the actions that students need to follow if they identify concerns in practice placements. The policy directs students to inform their named practice link such as a mentor, educator, or manager

immediately after identifying an issue of concern. Student nurses in this study deployed the policy after assessing who they felt would support them in raising concerns. Table 17 presents an overview of who the students communicated their concerns to.

Table 17 – Overview of student nurses’ raising concerns

Name	Person student raised concerns to
Faye	Nurse lecturer
Mel	Personal tutor
Sarah	Personal tutor / ward manager
Cath	Nurse lecturer
Owen	Registered nurse
Becky	Nurse mentor
Carys	Personal tutor / ward manager
Donna	Nurse mentor
Helen	Personal tutor / ward manager
Ryan	Ward manager
Jess	Personal tutor
Sally	Nurse mentor
Paula	Personal tutor

As illustrated within the table, three students reported concerns directly to their mentor. Donna (student nurse) identified a number of concerns whilst working with an agency nurse in an acute setting. The concerns related to falsifying documents and failing to follow local hospital procedures. The serious nature of the nurse’s errors prompted Donna to report these concerns to her mentor and nurse in charge, whilst also attempting to rectify the errors.

So, I just went back and told the junior sister and my mentor what was going on whilst it was happening and I tried to correct her mistakes as much as I could. (Donna, student nurse, page 7)

The driving factor that prompted Donna to report concerns to her mentor was the positive relational dynamic which underpinned their relationship. Other students also reported having a supportive and approachable mentor who they felt comfortable with. This enabled the student to discuss concerns with their mentor, safe in the knowledge that their

concerns would be taken seriously and actioned. The factors which encouraged, or inhibited, students' raising concerns directly with their mentor are explored in more detail within the next chapter.

Student nurses who felt their mentor was unapproachable or unsupportive were fearful of the negative repercussions of speaking up. In these instances, speaking up directly to the mentor was considered to be an unsafe activity and students considered other staff who they could approach to discuss concerns.

In this study, Sarah, Carys, and Helen all opted to disclose their concerns to the clinical manager. The following extracts illustrate their rationale for selecting these individuals.

There were three ward managers. One was pretty much there every other day and the other two were there on and off. I had to pick which person to speak to. He [manager] was the one who had gone to the ward and welcomed us and gave us a workbook and he was the approachable one. One of the other ones was hardly ever there and the third one was friends with this mentor (Carys, student nurse)

I spoke to the ward manager... She was really lovely and very good. Not a manager who sat in the office all day. If the nurses and NA's needed help, she would be there, so she was aware. And I was much more comfortable working with her and felt this is how I'd like it to be. So, it was nice to see this was possible at that sort of level and that you can keep that kind of compassion (Sarah, student nurse)

Both students based their decision on the qualities that these managers displayed within the practice setting. For Carys, approachability and being student-centred contributed to her picking the ward manager that she felt would support her. For Sarah, demonstrating compassionate care was also a cue that the manager was likely to address her concerns appropriately. Interestingly, Carys did not select the manager who was friendly with the mentor, she perceived them as an unsafe person to discuss concerns with.

After witnessing poor practice on her placement, Helen (student nurse) considered who to discuss her concerns with as her mentor was not on duty when the incident occurred. Helen felt secure in raising her concerns to the ward manager.

The manager was very supportive and sort of opened a discussion about it and was willing to hear from my side but didn't just take my side but said she would speak to the person involved. (Helen, student nurse)

During the discussion, it did come to light that Helen had already emailed staff at the university to report her concerns, which appeared to disappoint the ward manager.

She said something along the lines of, 'Oh I hoped you would have spoken to me before you spoke to the university' but what I'd seen I felt I had to report it there and then (Helen, student nurse)

The ward manager expressed her disappointment that the issue had been raised to staff in the university, before being informed herself. However, reporting her concerns to the university, as well as to the manager, reassured Helen and appeared to contribute to her feeling of safety and security which is evident in the following extract.

I felt like I could trust the university in taking it further... and I was reassured by the manager that action would be taken. So, I felt comforted knowing that it would be done (Helen student nurse)

However, students' reporting concerns to the university before informing practice staff were deemed to be detrimental to partnership working, as illustrated in Sian's data extract below:

If I was a ward manager and poor practice was going on and I wasn't aware of it, I would be hugely disappointed if I suddenly get a call out of the blue from my assistant director to say 'did you know? I would be upset as a manager and I feel that that then creates a divide between the university and the health board' (Sian, Senior Academic)

Furthermore, Zara (nurse mentor) felt that concerns should be resolved at a clinical level, rather than complicating the issue by involving the university.

I think going straight to the university in some ways means you can't sort it out. Sometimes you won't ever change people's perception in respect of whatever explanation is given however right we feel we are, and we do try to explain that. But if you can do it on a one-to-one basis and it gets sorted it is a lot easier rather than bringing in third parties and fourth parties. Just more toing and froing (Zara, nurse mentor)

It's hurtful you know if somebody can't speak to you about it but then maybe it's just because they don't know you or how you are going to react. So, it's totally understandable. (Michelle, nurse mentor)

Zara and Sian make a valid point about the importance of discussing concerns promptly and collaboratively. However, this is a narrow view that does not consider students reasoning for doing so. Informing staff in the university provides several functions. Firstly, there is an official record of the issue, which can instigate the process. Furthermore, as Helen's earlier data demonstrates, it can promote feelings of safety in reassuring the student that they are being supported by staff from practice and the university.

Conversely, when I asked Brett (nurse mentor) about student nurses discussing concerns with university staff, he felt that students might have an ulterior motive for doing so.

Perhaps they think they're some kind of martyr, um I use the term loosely but 'snitching' to the university. Maybe they think they are going to get some kind of brownie points for doing these things. Points like 'oh I've seen an error in practice. If I raise that with the university, they are going to give the clinical area a bollocking'. It might be that they don't get on with their mentor or something like that. (Brett, nurse mentor)

Brett's viewpoint of the students 'snitching' to the university was in stark contrast to the other mentors I interviewed. However, there seemed to be an underlying consensus by the mentors that students should approach the mentor and clinical staff first with concerns. However, students will only approach clinical staff if they feel it is safe to do so. In this study, even if students felt it was safe to discuss concerns with clinical staff, they often approached their personal tutor as well as a safety net.

4.4.4. Seeing the university as a safety net

Most of the students in this study chose to escalate their concerns to university staff as well as clinical staff. This builds on findings from the last section which highlighted the fact that students will speak up when they perceive it is safe to do so and will select a staff member who will support them. Analysis of the students' interviews provides an insight into why students took this action. For example, Faye, a second-year student, did not develop a rapport with her mentor and felt unable to broach her concerns with her on placement. Instead, she approached a member of staff from the university who listened to her concerns and provided support.

I went to the uni at quarter to five on a Friday evening not expecting to find anyone. I knocked on this person's door and she was there and kept me for an hour. I felt so bad on a Friday night, but she didn't mind so she said don't you worry we'll put you somewhere else and you will be fine' she said. (Faye student nurse)

Similarly...

My personal tutor is fantastic, and I really think it is luck of the draw who you get and how you get on with them and how that relationship goes. She listened to me non-judgmentally; she didn't know where my placement was. I didn't give her my mentors name, she was very familiar with the link tutor for that ward so she just said 'she needs to get involved and we will sort it out don't worry (Carys, student nurse)

Cath initially remained silent after witnessing poor behaviour on placement. However, after finishing her placement she reflected on this decision.

After placement it was still bugging me. I remember thinking I wish I had said something. But I didn't. So, I went to speak to the lecturer and explained to her what I'd seen, and she said 'I think you need to raise concerns' and told me how to do it um so I did. (Cath, student nurse)

All the personal tutors interviewed had been involved in supporting students to raise concerns. Charlotte (personal tutor) provided an explanation for why students might choose to speak to their personal tutor rather than their mentor which echoes earlier findings.

Whether they see the personal tutor role as a person they can talk to without any fear of breach of confidentiality. We all know that people know each other and talk. So maybe they feel that they might be told it's confidential and then find out the next day it been repeated. That might concern them.., it's very rare that students will go to their mentor first. (Charlotte, personal tutor)

Several of the personal tutors discussed the importance of providing advice and reassurance in a safe environment, thereby enabling students to securely express concerns about their clinical experiences. In the data extract below, Barbara (personal tutor) refers to herself as a 'sounding board' for students to explore their feelings about clinical practice.

Students if they have any issues, they can come to me first... They don't know how to complain or how to raise a concern if something is bothering them. Sometimes they might just need a sounding board and I think it's good to be the personal tutor because then they can come to you. My student this morning did ask. 'Is this appropriate?', 'should I be feeling this way?' 'Am I over-reacting to this?' or 'what shall I do?' So, it's someone else bouncing back and giving their opinion really and supporting and reassuring" (Barbara, personal tutor)

Barbara illuminates the key role that the personal tutor appears to play in managing student expectations and preparing and socialising the student nurse for the realities of clinical practice. Furthermore, personal tutors believed that they provided a safe environment for students to discuss their concerns with them. The nature of their relationship also meant that they developed a rapport with their students, which facilitated trust and openness. Chapter five focuses on the relationship between student nurses and the personal tutor. Once students had escalated their concern to either a university staff member or clinician, the next stage within the process was for that person to respond to the concern and take appropriate action.

4.5 Reacting and responding

The over-arching category of reacting and responding to concerns encompasses the sub-categories of, *needing feedback and closure* and *the fall out*. These include the physical and emotional effects of the raising concerns process and the outcome of raising the concern. The students in this study who raised concerns, made their decision after assessing the clinical landscape as a favourable environment in which to speak up. Despite going through this process of sensemaking, the concerns raised were met with varying responses. After escalating concerns post-placement, Cath (student nurse) was the only participant who was asked to submit a formal written statement and attend a meeting with senior staff from the NHS health board to discuss her concerns in more detail. Cath was also advised to bring union representation with her to the meeting which exemplified the formality of the proceedings.

Cath: Well, they said who each of them were and introduced themselves and then they said that they had received my statement and read through it and had a few questions to ask. Um you know things like what times of day things had happened and did I remember what bed these patients were in and the date.... I did feel they were trying to catch me out, because they were asking me things again as if they were trying to make sure that what I put in the statement was accurate.

PB: So, towards the end of that meeting was there any indication of what action would be taken following that?

Cath: Well, they said I was right to raise concerns and the HR and the head nurse said that. My union rep said, 'do we need to think about approaching other people?' you know other members of staff and see if anyone else has concerns. The ward manager said, 'no, I think we've got enough'. By the end of the meeting, I got the impression that I wasn't the only person who had complained.

Despite being reassured that raising concerns was justified, participating in this formal and rather intimidating process, with human resources and a union representative present, appeared more like a form of disciplinary action rather than raising a concern. However, the information provided by Cath enabled the ward manager to address the concerns raised and subsequently improve patient care.

Unfortunately, not all students received a positive reaction after escalating a concern. Ryan voiced his concerns to the ward manager, within earshot of the health worker who was responsible for the wrongdoing who reacted angrily.

At that point she jumped at me and told me she didn't like my attitude and that it wasn't going to cause any harm... I just felt like we came into like a heated discussion.... it actually brought me to tears. (Ryan, student nurse)

Ryan was clearly upset by this encounter, although the reaction from the healthcare worker also raises questions about how the concerns were articulated by Ryan. At this point, Ryan left the ward and met with the senior nurse to discuss his concerns. After returning to the clinical area, he was met with this response.

I'd gone down to the nurse's station where everybody was and nobody would make eye contact with me and nobody spoke to me, so I stood there, and I felt like a spare part. just once again felt (pause) not part of their team anymore (pause) and isolated from the team. (Ryan, student nurse).

Ryan's data extract provides an example of the negative repercussions that can arise when students' raise concerns. In a similar example, Carys (student nurse) approached her mentor directly after observing incorrect medicine administration.

I went and tracked down my mentor and told her the situation that he (patient) hadn't taken any of the incorrect meds, his drug chart needs to be changed and she was not very happy. (Carys, student nurse)

Following a number of issues involving medicines management and a hostile response from her mentor, Carys re-evaluated who would be the most suitable person to discuss her concerns with. She selected the most approachable of the clinical managers on the ward. After informing the manager of the mentor's practice, he revealingly responded with, 'oh no not again'. Similarly, other students who had expressed concerns were under the impression that they were not a surprise to the clinical manager.

Yes, she did write some bits down, but she didn't seem too surprised, so I don't know, maybe something had been said before and I was just clarifying. (Jess, student nurse)

I was cautious in interpreting the data extracts above as they offered a one-sided perception of manager responses to concerns raised. However, the following quote presents a manager's perspective in responding to student concerns. This reinforced the point that students sometimes raised concerns that were previously known to clinical colleagues and were in the process of being dealt with.

I know all my nurses and how they work and that quite often when things happen, they are not a surprise to me. It's a disappointment, but it is not a surprise. But I

have to be careful though because I can't say anything negative about the nurse, because that's for me to deal with (Georgie, nurse mentor)

Georgie is clearly promoting an open and facilitative environment in her response to the student's concerns. As a manager, she is clearly listening and has taken in the gravity of what is being said. The expression, 'this is not the ethics we stand for' is also supportive and demonstrates further that the message has been understood and signals to the student that the concern is being dealt with. In doing so, Georgie promotes a favourable context in which to raise concerns.

Students also described positive examples where supportive staff facilitated a favourable environment in which to raise concerns. Helen approached her clinical manager as she was fairly confident that she would be supportive. Although the manager was genuinely shocked by the concerns raised, she was willing to listen and act.

The manager was very supportive and sort of opened up a discussion about it and was willing to hear from my side but didn't just take my side but said she would speak to the person involved...she looked physically upset and quite shocked by what I had told her and said, 'it's not the ethics that they stand for'. After that I spoke to the link practice facilitator who came in and we had a discussion... and then she went and spoke to the manager herself (Helen, student nurse)

In the extracts below, Donna and Jess were thanked for raising their concerns and there was an acknowledgement that speaking up is not easy to do. Donna received a letter of thanks from the clinical team which was appreciated.

I remember it said 'thank you for your support on this placement it really helped us'. It was so nice. (Donna, student nurse)

I ended up going back a few months after to see the ward manager and she filled in my portfolio then. she said to me then 'thank you for reporting what you did because not a lot of people would have done that, so I appreciate it' (Jess, student nurse)

PB: *So how was the relationship with your mentor after you raised the concern?*

Donna: *We got on so well. I loved that mentor she was so nice. It was absolutely the same. It was fab.*

As discussed earlier in this chapter, Sally raised several concerns about a vulnerable patient in the community. Her mentor listened to her concerns and encouraged Sally to speak to the wider team and the manager. This resulted in a Protection of Vulnerable Adults (POVA) process being instigated which Sally participated in.

I was invited to the POVA meeting, they called all the disciplines and invited him (son) and it did turn out that he had to allow them [staff] in and the palliative team went in and set up a [syringe] driver (Sally, student nurse).

Sally was involved in the escalating concerns process from start to finish and was invited to attend meetings relating to the lady's care. As a result of Sally raising this concern, the palliative care team were able to properly assess the patient and implement appropriate pain relief.

During the interviews nurse mentors were asked how they would respond to students who raised a concern. All the mentors discussed the importance of finding a quiet area to sit down with the student and explore the concern in more detail. Once they had collated the information, in most cases the concern would be escalated by the mentor to the manager of the clinical area. However, as Georgie had a dual role as a mentor and a team manager in a community setting, she was able to respond directly to a student who identified concerns about her mentor's practice.

I said I was glad that she had come to speak to me. I reassured the student that I investigate it and speak to the nurse, student, and patient. I was glad she was first and foremost concerned about the patient and about her reputation as a nurse really. I thought that was quite commendable. I asked her if she could suggest anything where improvements could be made and how we could have stopped that situation from happening. She had a think about it and said that she felt that it was done in a rush and maybe that was because of workload. (Georgie, nurse mentor)

Here, Georgie demonstrates a supportive approach and commends the student for speaking up. Furthermore, she enables the student to reflect and consider the factors that led to the incident. I was keen to find out how mentors would respond to a concern raised about a close colleague. The majority of the mentors suggested that they would escalate the concern regardless of who the perpetrator was. However, two of the mentors admitted that they might take alternative action in this scenario.

Oh, gosh if I'm speaking brutally honestly now, I would probably speak to my friend on the way out of work and tell her that the student told me about whatever. I'd like to think that I would speak to the manager about it, but I would probably speak to the person first. Saying that and being so honest makes me feel awful because I know that is probably what does happen you know... But my god, the realisation that I would probably go to that nurse first rather than take it higher (pause). That student obviously had that faith in me to come to me first. Ah, I'm ruining your project because this is not what you want. (Ellie, nurse mentor)

Hmm it's hard, isn't it? I am just trying to think what I would really do, not what you want to hear (pause). I would say to the student 'thanks for bringing it to my attention' and maybe ask for a bit of detail. It may be a misunderstanding. Then I would probably speak to that person, and I would say..... (pause). Oh, it's hard, as I wouldn't want to put my student in a difficult place by mentioning her name. I might say, 'someone said you were a bit abrupt to the patients' and I know that ... If they were one of my friends, they wouldn't be nasty to a patient anyway. I'd say 'I know you didn't mean it, but it looks quite bad in front of the student, and they might have got the wrong end of the stick, but I'm sure if you were stressed out that day. (Nicola, nurse mentor)

These candid accounts are significant and bring recognition to the precarious position that mentors could find themselves in if concerns about a close colleague's professional practice were raised. Furthermore, Ellie and Nicola concede that they would speak informally to the person, rather than escalate through the appropriate channels. Of course, this strategy in some cases may be enough to halt the wrongdoing. More concerning is the possibility of the mentor brushing the concern aside, because of a misplaced loyalty to their friend, rather than ensuring the highest standard of patient care. However, Nicola's response illustrates her trying to protect the student's identity, which is in contrast to students' perceptions of negative consequences if concerns were voiced to their mentor (see box 8 below).

Box 8 - Memo Protecting friends. [18/1/17]

Analysing the data from Ellie and Nicola is raising lots of questions for me. Wow, they have both acknowledged that if a student raised a concern about a close friend, they would speak to their friend rather than escalating to the managers. Ellie seemed shocked at her response and had not considered this before. Nicola's comment of, 'If they were one of my friends, they wouldn't be nasty to a patient anyway', makes me wonder if the concern would be taken seriously? The students have told me that they are aware of the team dynamics and cliques, so perhaps they wouldn't choose to disclose concerns to staff who are friends. Nicola suggests that she would try to maintain the student's anonymity, but this could be difficult. If the student was identified as the person raising a concern, would the issue be resolved, or could it cause more repercussions? Concerns not being escalated – Is being good friends an excuse for not reporting??

Also interesting about their comments regarding not what I want to hear!!

Personal tutors also recounted how they responded to students who raised concerns. For Olwyn, she felt it was important to explore the nature of the concerns in more detail before responding.

I think that's where the personal tutor role comes in for me, because they come to me, and we have a chat about what it is that's bothering them. You are able at that point to weed out whether there's anything major or whether it is just a bad day, personality clash.... Normally after a chat they can see and will say things like, 'oh well I know it's busy there and they were short staffed. And you just think well that's okay you're learning along the way. (Olwyn, personal tutor)

Here Olwyn attempts to 'weed out' the serious concerns, as opposed to other issues which may be caused by personality clashes or poor staffing. She reframes the issues by encouraging students to consider the factors accounting for their concerns. This extract also demonstrates that despite earlier comments regarding the chasm between theory and practice within the university, some personal tutors are aware of the realities of clinical practice.

Barbara and Mia had only recently joined the university when they were contacted by their students with concerns. Mia (personal tutor) received an email from a student who was unhappy on placement and raised a number of issues. At this point, Mia was unsure of the responding to concerns procedure, a point also echoed by Barbara.

I actually found it very difficult. I did find an algorithm that had, well first they should go to their mentor or the ward manager and take it from there. So, I felt we stumbled at the first hurdle because I was advising that she needed to tell the mentor and she didn't feel able.... I didn't really know what to do or who to turn to. (Mia, personal tutor)

It's a bit of a minefield I have to say. I had to find my way around. When I first started, I didn't have a mentor or anything, so I didn't really know what to do when students came with a concern and who to go to. Was it programme manager? Was it the head of adult nursing? So, I had to just ask people and trial and error. Which is a worry because sometimes you end up disclosing information to people who don't really need to know that information and so I don't want that either. (Barbara, personal tutor)

The personal tutors highlight the challenges in supporting and managing the concerns that students escalate to them. A lack of knowledge of the process, coupled with being new to the organisation appeared to compound the situation for Mia and Barbara. This identifies a need for personal tutor induction programmes to include information on how to

effectively support and manage student concerns. In addition to the personal tutor role, all the participants were link lecturers which involves undertaking educational audits in their own clinical areas and monitoring the quality of the learning environment (Grant et al. 2007; NMC 2008) Two of the participants also held leadership roles, including investigating concerns raised by healthcare students. Having more than one role within the university led to a blurring of boundaries in relation to supporting students who raise concerns. Mia described wearing 'different hats' to signify this role ambiguity.

I'm not sure that roles are defined, and that people can perform different functions under different hats. Because everybody has got a different hat for different occasions. (Mia, personal tutor)

The idea of different hats is also evident in Kim's description of having a 'couple of hats on' to fulfil her responsibility as a personal tutor within the university, but also as an NMC registrant. This dual responsibility highlights a potentially conflicted role, particularly when responding to students who have raised a concern. The personal tutor role as a confidante for the student must be balanced alongside a professional obligation to protect the public.

I think I'd have to go and speak to the people on the wards, because I think both as a registrant if anybody would report anything to you, I'd have to do something about it because that's what our role is. But equally, you know, students tell me something I've got to act on it. It could mean the patients are at risk, or it could mean the NMC may have to withdraw students from that area, if it's not a particularly good learning experience. So, all of those. I guess I've got a couple of hats on in that situation. (Kim, personal tutor).

The personal tutor data extracts outline a wide remit in relation to supporting students who raise concerns. There appears to be some inconsistencies in how this role is to be enacted and different perceptions around whether personal tutors should be visiting practice areas to support students in addressing concerns.

The discussion around wearing many hats, highlights the blurring of boundaries between the personal tutor role as a professional registrant and the desire to protect students and maintain confidentiality. In addition, many of the personal tutor participants held other leadership roles which required their involvement in the raising concerns process from different perspectives which at times became complex.

Once students disclosed their concerns to either a mentor, clinical manager, or personal tutor, they were keen to receive feedback on what action had been taken to address the concerns raised.

4.5.1 Needing feedback and closure

As discussed earlier in this chapter, many student nurses in this study did raise concerns. However, there were variable accounts on the feedback that was received from clinical practice staff or from the university. Michelle was the only nurse mentor who discussed the importance of keeping students informed throughout the investigation of concerns and providing feedback as to the outcome of the concerns raised.

So, I suppose it's making the student feel as comfortable as possible and making sure that they know that we're not going to push it to the side and say 'oh no that didn't happen'. We will believe them, investigate it and then obviously feedback to them with regards to what we are going to do. I think it's important that even though you lose track of them once they leave the ward, via the clinical tutor or the personal tutors we keep that link really to give them feedback. (Michelle, nurse mentor)

There were positive examples where students were given ongoing feedback regarding the concerns they had identified and were proactively involved in quality improvement. For example, after Sarah raised concerns on her placement, the clinical manager made significant improvements in standards of care. Sarah was involved in new ways of working on the ward and was given the opportunity to visit the ward post-placement to see the impact of the changes that had been made.

They invited me back to see if any of their new stuff had worked and they were supportive of me in the process of improvement which I appreciated as I am just a student. (Sarah, student nurse)

Sally (student nurse) was also kept abreast of developments after escalating a serious concern whilst on her community placement.

I was invited to the POVA meeting... the main lady said 'you are more than welcome to come in and find out' but I spoke to my mentor, and she told me the outcome and I've spoken to her since as well (Sally, student nurse)

However, for other students, there was a lack of information on how the concern was addressed and the outcome.

They did say that I would be kept informed as to what happened. However, I never did hear anything after that or find out what happened. (Cath, student nurse)

She [university staff member] said she would take it further. I didn't hear any more about it. She said it would be investigated, but I didn't hear whether they would stop students going there... I would have like to have known maybe what they had done in the end and whether they sent other students or not (Faye, student nurse).

Mel (student nurse) raised concerns to her personal tutor who visited the clinical area to discuss the concerns raised with the ward manager and the nurse mentor. Mel was given the opportunity to attend the meeting but declined due to her fear of hostile reactions from the clinical staff.

My personal tutor called me back to let me know what had gone on ... there was a meeting with my mentor and ward manager, and they were very shocked that there was any problem and that normally students there are very happy, and they get really good feedback. Then they said 'well Mel is always turning up late and she is always changing her shifts and did not work with her mentor enough to meet the quota and blah blah blah. But obviously I wasn't there to defend myself,... I was quite upset by that and didn't want them to think badly of me. They tried to paint me as a really bad student.... But my personal tutor was very understanding, and she was like 'I know you and you are not the type to be unreliable 'we are on your side here, which was really nice as I did feel like it's me versus them. (Mel, student nurse)

Mel was unable to defend the accusations made to her personal tutor about her conduct on the placement. The focus of the meeting appeared to be centred on undermining Mel's accounts and instead focusing on alleged timekeeping issues. Although the ward manager agreed to investigate the concerns raised by Mel, no further feedback was received.

The data excerpts above suggest that student nurses were keen to establish what remedial action, if any, was instigated after escalating their concerns. However, a variety of factors may have hindered the feedback process, such as complex disciplinary procedures and the need to maintain confidentiality. Investigating and resolving concerns in clinical practice can be a lengthy process, it is possible that in some cases the student who raised the concern may have left the placement which creates further challenges in ongoing communication.

Kim (personal tutor) recognised the difficulties in providing feedback to students who raise concerns and suggested the use of a template to provide an indication of actions taken by the university and clinical practice settings.

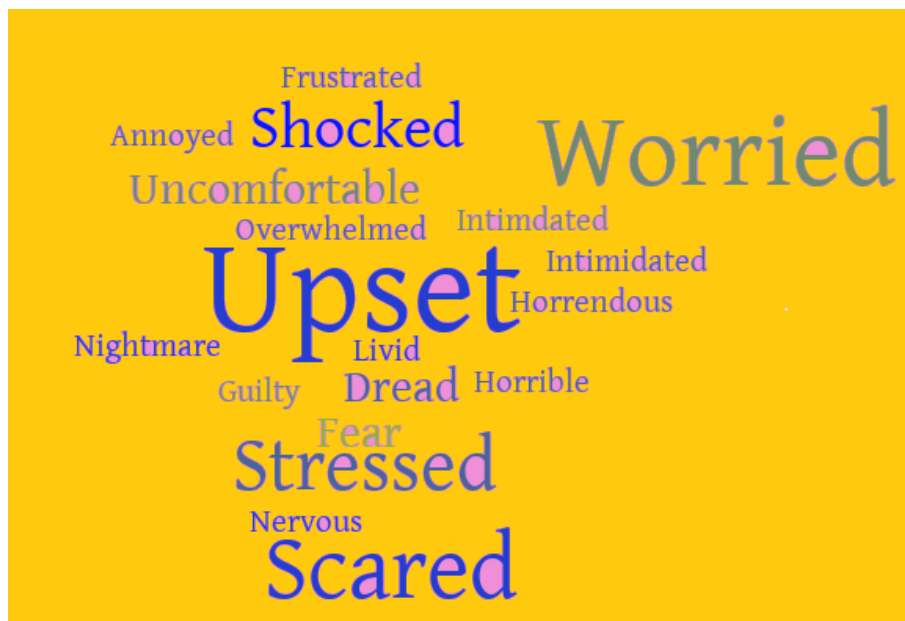
A bit, 'you said, we did', that works quite well with patients. It could be anonymised, you know. (Kim, personal tutor)

Feeding back to students more broadly would not provide detail on individual cases but would demonstrate that concerns were listened to and could highlight improvements that were made as a result of students' speaking up. In addition, the actions taken to improve patient safety and enhance standards of care could be communicated without breaching confidentiality.

4.5.2 The Fall out

This section describes the 'fall out' from raising concerns and encompasses the range of emotions, decisions, actions, and outcomes that the student nurses' experienced during the process of raising concerns, The 'word cloud' below captures student nurse data that reflects the fearful or negative effect on students which were evoked after students witnessed wrongdoing. For junior students in particular, they were shocked to witness poor nursing care and unprofessional behaviour in their placement. Other students felt angry and dismayed that patients were not being treated with dignity and respect. These reactions were clearly emotive and ranged from shock, upset, guilt and anger.

Box 9 – Emotional impact of raising concerns



At the time I got very upset over it and some of it you feel it's your fault, maybe I'm not a good student. I was also exhausted, you know and ended up having a load of health problems related to that stress you know. So, it was a bit of a mess at the time. (Mel, student nurse)

It actually brought me to tears and in all the years that I've worked for the NHS I have never been brought to tears by a member of staff (Ryan, student nurse)

Every day I dreaded going in. I just know I couldn't.... I know 4 or 5 weeks doesn't seem very long, but I couldn't have stayed there. I thought I either go and talk to someone or I'm going to drop out. That's the way I was thinking you know. (Faye, student nurse)

The emotional impact experienced by students began after they identified poor care and appeared to be exacerbated by the uncertainty of how to respond to the wrongdoing. For some students, emotional effects such as anxiety, isolation, insomnia and experiencing self-doubt about whether they had done the right thing continued throughout the process of raising concerns. For Ryan, his poor placement experience and stress of speaking up led to him questioning his career choice.

I seriously contemplated ... I've worked for the NHS for five years and that ward made me seriously contemplate my career choice and I thought to myself 'why am I doing this?' (Ryan, student nurse)

However, the emotional impact of raising concerns is not only confined to student nurses. Ellie (nurse mentor) also alluded to the stress she experienced after a student raised concerns about her.

I had been really worried about it and it had affected me in work and outside work. Before the meeting and yeh (sigh) because I felt like it was a personal attack (Ellie, nurse mentor)

Mel and Fay identified safety concerns in their placements and experienced a number of negative emotional effects as a consequence of speaking up. Both students, were moved to different placements after they escalated their concerns, which was met with joy and relief.

My personal tutor was there, and she called me in and said, 'have you looked at your email as we have moved you and got you a new placement to start on Monday'. So, I was so overjoyed because I had just had enough with all the stuff going on with placement. (Mel, student nurse)

I felt like a huge weight had been lifted and I slept so well that night. (Faye, student nurse)

The unusual step of moving students to a new placement was a necessary step in order to address the issues that they identified and enhance the learning environment for student nurses in the clinical areas concerned. Although Mel and Faye both described the physical and emotional burden of raising concerns, they recognised the importance of speaking up and acknowledged that they would raise concerns again in the future if required.

In relation to the outcomes of raising concerns, positive changes to patient care were recounted by students. For example, Sally's (student nurse) experience of identifying a safeguarding issue in a community setting was addressed and culminated in the patient receiving relevant palliative care and passing away peacefully. For other patients who were on the receiving end of poor nursing care or staff attitudes, a number of student nurses intervened at that point or escalated their concerns to halt sub-optimal practices.

The impact on the staff responsible for displaying poor practice was also evident in some of the data extracts. For example, Carys's mentor was booked to undergo mentor retraining and a medicines management update. New guidelines for mentors and students were also developed as a result. Cath and Becky reported healthcare workers who displayed inappropriate attitudes towards their patients. As a result of investigations, one staff member was moved to a different clinical area, and another faced disciplinary action. These examples and others have been the result of students' escalating concerns in clinical practice and demonstrate the valuable role that students play in maintaining patient safety and care quality.

Although a small number of students experienced negativity because of raising concerns, most conceded that although they had worried about negative consequences, they had not actually experienced any fall out:

Well personally, I've not heard of being outcasted for whistleblowing away or anything like that, but for me it was more of a worry than a reality because the staff did still speak to me. If anything, I think, they were more appreciative that I did speak out and it was seen as more of a good thing than you are going to break up our teams. (Helen, student nurse)

Mia (personal tutor) below also makes this distinction of perception versus reality.

I think it's the fear. I don't think there has been a repercussion as far as I'm aware, but I think people worry about their reputations and are they going to be known as a difficult student. (Mia, personal tutor)

The data from this study suggests that a fear of repercussions continues to exist, with a small number of students in this study experiencing negative consequences such as being ostracised or verbally attacked for speaking up. In response to these experiences, the emotional burden of raising concerns appeared to intensify when students were placed in hostile clinical settings where poor care was evident and staff unsupportive. On the other hand, students who developed positive relationships with staff and felt safe to raise concerns to mentors and clinical managers did not appear to suffer the emotional impact that students in this section experienced

However, a fear of repercussions appears to persist, despite the fact that such fear is contradictory to most students' experiences. This raises questions about whether the university and clinical staff could do more to disrupt this narrative and highlight the positive impact of speaking up and raising concerns.

4.6 Chapter summary

This chapter has explored each phase of the raising concerns process – from the initial observation of concerning practices, through to the responses and learning (or not) resulting from concerns being raised. However, mentors and personal tutors contend that inexperience and a misinterpretation of events could lead to students inadvertently identifying practice as concerning. There was also a strong feeling that the way that student nurses were taught in university did not always reflect the clinical workplace, which could potentially lead to concerns being raised needlessly. It is possible that this could be due to teaching strategies, content of clinical skills sessions or indeed the extent to which academic staff are clinically credible or out of touch with contemporary practice?

Student nurses were aware of their responsibility in reporting poor practice, but at times felt unable to voice their concerns. Decision-making was influenced by the severity and frequency of the wrongdoing and initially the relationship with the nurse mentor, the personal tutor and the wider clinical team. The safety of the personal tutor was sought when the clinical areas were deemed too risky to raise concerns.

The potential repercussions of speaking up were a major factor in the student's reluctance to raise a concern. Student nurses stressed the importance of being accepted by the clinical staff and 'fitting in' to the culture of clinical practice. Repercussions such as being labelled

and staff treating them negatively were uppermost in the student's mind and they were keen to avoid conflict. The overriding decision on whether to raise concerns was determined by the perceived favourability of the environment and the staff within it. This included the manager's relationship with other staff, the dynamics of the team, the approachability of the mentor and an assessment of the context in which the students found themselves.

An important finding of this study was the significance of the personal tutor role in the process of raising concerns. The majority of the student participants discussed their concerns with their personal tutor rather than to their mentor or clinical colleagues. The practice learning environment was often deemed to be an unfavourable landscape for voicing concerns and students sought the safety of the university instead. The personal tutors acknowledged their role in managing student expectations and providing a safe space for students to discuss their worries and concerns. However, it was clear that personal tutor's who were new to the university did not receive any preparation on how to manage student concerns and as a result found the process challenging. The action taken by the personal tutor varied from providing advice, escalating to the professional head, or encouraging students to document their concerns and write reflections. These actions did not appear to be consistent, but perhaps were tailored to the individual student's needs.

Responses to the concerns were variable, with a small number of students who were involved in all stages of the process and received feedback on the outcome of the concern. For others, no feedback was received which left them wondering whether any action had been taken to address the concern. In some cases, there was a sense of not having closure, particularly when they were unsure whether any improvements in patient safety or nursing care was implemented. Several students experienced effects such as anxiety, stress and negative reactions from staff, although very few experienced repercussions as a result of raising the concern.

The impact of raising a concern was positive for most of the student nurses. Their confidence increased as a result of speaking up and they all agreed they would do so again, if required. However, they would only voice concerns to the clinical team or mentor if the culture was conducive to raising concerns and if staff were approachable and receptive to

listening. Therefore, the prospect of students remaining silent remains a distinct possibility in the clinical placements where voicing concerns is most needed.

Within this chapter the nurse mentor participants have provided insight into their perceptions and experiences of supporting students as they navigate the journey of raising concerns. Within Chapter five, the factors affecting the participants' experiences of the mentor-student relationship and the influence of this dynamic on the student's propensity to escalate concerns will now be explored.

CHAPTER FIVE – Balancing the mentor-student dynamic

5.1 Introduction to the chapter

The previous chapter explored the process of raising concerns from the perspective of the student nurse, nurse mentor and personal tutor. Student nurse participants gave an insight into their experiences of witnessing sub-standard nursing care or unprofessional behaviour whilst on clinical placement. There were several factors that influenced the student nurse's decision making in relation to raising concerns. Contextual factors, such as the workplace culture and the perceived support and approachability of the health care team, contributed to either a conducive or an unfavourable environment in which to voice concerns. The relationship between the student and mentor was also identified as a significant factor in student decision-making to raise concerns.

Within this chapter, attention now turns to the exploration of the mentor-student relationship. In the course of analysing data, it became clear that the dynamic between the student and mentor was an important factor in the decisions made around raising concerns. This led to the theoretical category, '*balancing the mentor-student dynamic*', which provides novel insights into the dynamic between these individuals and how this influenced the student's propensity to escalate concerns. At the time of data collection, student nurse participants were supported in practice by nurse mentors who were responsible for facilitating learning experiences and assessing the clinical component of pre-registration nurse education programmes. Professional regulation within the United Kingdom required nursing students, and mentors, to spend at least 40% of the placement time working together directly or indirectly (NMC, 2008).

Within this chapter the phrase 'relational dynamic' is used to signify the relationship between the student and their mentor and how they respond to each other. Moreover, related terms such as 'interplay' and 'interpersonal dynamics' are used interchangeably to describe the interaction between a student and mentor and how this affects actions, behaviours and ultimately the nature of the relationship between them.

Before examining how the relational dynamic between the mentor and student influences speaking up behaviours, it is important to understand how these relationships are

developed and maintained. Providing this contextual backdrop will illustrate the nature of these relationships and how they contribute to students' decisions on voicing their concerns.

The interplay between the nurse mentor and student nurse is explored through the sub-categories of; *first impressions count, developing rapport within the mentor-student relationship, perceptions of influence, status, and power dynamics and bypassing the mentor and accessing the personal tutor* (see figure 11 below).

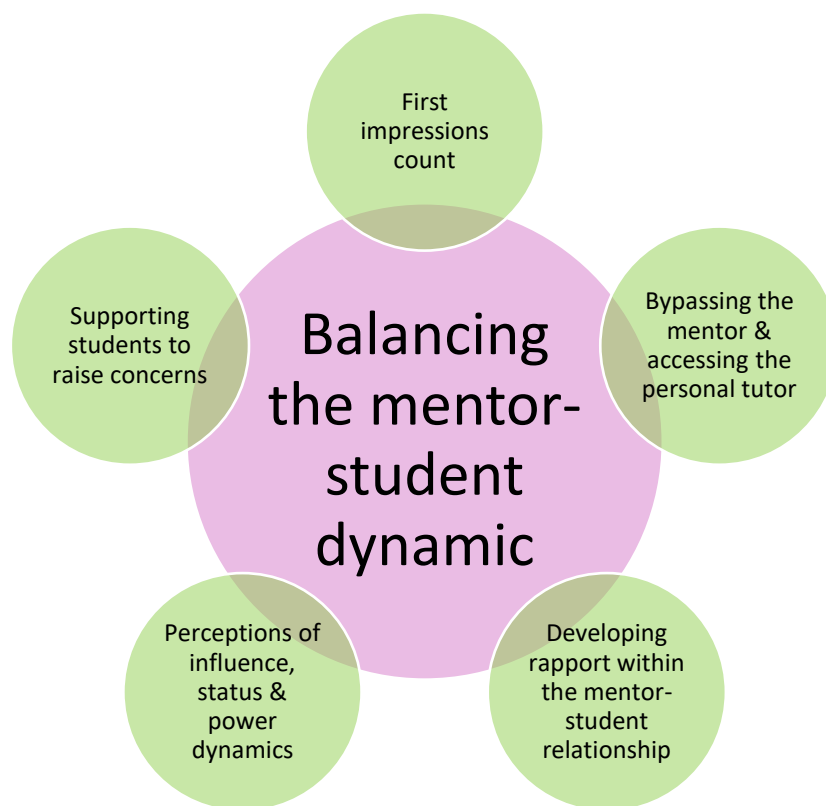


Figure 11 – Sub-categories of balancing the mentor-student dynamic

The first two sections of this chapter focus on the students' initial impressions of their mentor and members of the clinical team. The impact that these initial experiences had on establishing and maintaining relationship are also explored. Students and mentors described a variety of mentoring styles which led to differences in the interpersonal dynamics and rapport between students and mentors, all of which were consequential for student decision-making. Perceptions of influence, status and power dynamics between

mentor and student are examined to ascertain how these affect the dynamic of relationships and voicing concerns.

Finally, within the sub-category, *supporting students to raise concerns*, the student nurses discussed how their relationships within the practice setting and the university, influenced who they approached to support them in raising and addressing concerns. Nurse mentors, personal tutors and clinical managers provided support and guidance to students in managing the concern. In some instances, the students discussed their concerns with the mentor, but most of the student participants were *bypassing the mentor and accessing the personal tutor* for support instead.

Before progressing into a discussion of each sub-category, it is worth recalling that developing an effective mentor-student relationship was essential, not only for the student's professional socialisation in understanding the norms, values, and culture of the practice environment, but also for practice learning and achievement of clinical outcomes. The importance that students place on the mentor-student relationship was captured in the following data extract.

Every placement you go on you wonder 'what's my mentor going to be like'? So the relationship you have with that person is important, because I think that while the outcomes of the placement are down to your competence and what you do and demonstrate, a lot of it does come down to the relationship with the mentor. (Owen, student nurse)

Here Owen (student nurse) acknowledges the apprehension felt before starting on a placement in relation to the nurse mentor. As the following section demonstrates, first impressions were very important in establishing relationships.

5.2 First impressions count

Starting a new clinical placement was a daunting experience for student nurses. Receiving a warm welcome from the mentor and clinical staff was fundamental in reducing a student's anxiety and enabling them to feel part of the team.

Yes, he [the mentor] was very warm and welcoming and he really loved having students on the ward, so it was really nice. He wasn't scary at all. (Sarah, student nurse).

Well yes if I go back to my first day on the ward and things like that, yes, it is nerve wracking. So, you want to see a nice smiley face, you know you walk into the staff

room, and you want to feel welcome. Yes, I try to do my best for them. They spend a lot of time with us don't they and we teach them because they are the future. (Claire, nurse mentor)

Nurse mentors in this study were aware of how 'nerve-wracking' it was for students to start a new clinical placement. Making an effort to be 'smiley' and helpful created a positive first impression that was appreciated by students. Orientating students to the clinical area, discussing mutual expectations and interacting with the students all served to set the tone of the placement and to help students to integrate into the practice environment.

Well first it's important that they [students] get shown around the area they are working in with you and identify at the beginning of the placement what they expect to achieve from the placement. Their expectations, but also, it's important you are able to explain what your expectations are as well. (Michelle, nurse mentor)

Providing a warm and friendly welcome and orientating students to the new clinical placement all contributed to a favourable first impression. Unfortunately, student nurse participants described instances where the clinical team or mentor did not set a welcoming tone for the placement.

My mentor was not there, but I didn't know she was on sick leave... For three days I walked around, and I didn't ask anything, nothing is happening... they all looked busy but with no smile. Some of the staff you know... I was actually shocked. Four of them, two key workers and one main staff and I was standing there between them, and this lady came and said, 'do you want a cup of tea' and asked everyone but me. Well, I just looked at her and thought 'why didn't she ask me?' (Gareth, student nurse)

The absence of Gareth's mentor meant that he was not welcomed or orientated to the new clinical environment. Gareth clearly felt shocked by the way he was overlooked and ignored which added to his sense of isolation. Other students described instances where their first impression of their mentor was not conducive to developing an effective working relationship.

We didn't really have a particularly close relationship... I did meet her on the first day, but she didn't really introduce herself to me or anything. They say first impressions are important and she didn't seem interested in me. It's a horrible feeling. (Sarah, student nurse)

I think the worst experience I've had with a mentor on a placement is where a mentor didn't want to be my mentor. On my first day, they said, 'this person is going to be your mentor' and then the next day that person hadn't spoken to me all day apart from saying like 'hello'..... I didn't get another mentor until about a week and

that was on a placement where I didn't find my feet... I think that first week is so important to fit in and. I just felt as if I was not wanted. (Owen student nurse)

Sarah and Owen's mentors appeared to be disinterested and uncommunicative which impeded their ability to 'fit in'. Owen's quote illustrates his feelings of rejection. Despite being assigned a new mentor, those initial thoughts of feeling unwanted, clearly left a lasting negative impression. Neil (student nurse) witnessed a very unorthodox method of allocating mentors to students which made him feel very uncomfortable.

They hadn't pre-allocated the mentors and it was myself and a young student in her twenties. We got there and they decided to flip a coin to decide who was looking after whom... Well, I thought it was a bit odd, they could have sorted it out first as it was a bit awkward. (Neil, student nurse)

Neil's experience led to a poor first impression of the placement and a perception that the staff were unprepared for the students. This sense of thoughtlessness extended to their insensitive approach to mentor allocation.

The data extracts above, highlight the importance that students place on having a mentor who is approachable and invested in facilitating their learning. At the very start of the placement, students were already sensing whether the mentor was displaying positive, open communication, or was disengaged. Some students were allocated to nurse mentors who lacked enthusiasm and were unwelcoming, which in some instances led to an ineffective relationship that adversely affected their placement experience.

5.3 Developing rapport within the mentor-student relationship

Developing rapport is defined as the "feeling of interconnectedness and closeness to another person" (Leitner et al. 2018 p.2) and is particularly important when establishing new working relationships. Student nurses and nurse mentors described how getting to know each other enabled them to build trusting relationships and foster emotional connections. Understanding each other's life experiences, bonding over common interests and being able to laugh together strengthened the mentor-student relationship.

We sit down and chat. I try to have a bit of a laugh with them and find out about them as well, so it's not just work and serious. I try to be open with them.. and hopefully they talk openly about themselves. (Nicola, nurse mentor)

Um yes, my mentors were really nice. I clicked with my first mentor and was sat in the car with her for long periods and we got to know each other. Then we just

connected and had things in common. I knew people that she knew, and I wasn't uncomfortable going out alone in her car. (Ryan, student nurse)

Being open and honest and feeling comfortable with each other led to a mutual respect and friendship. The student nurses who established a positive rapport with their mentor, described the attributes that they felt these mentors displayed (figure 12 below).



Figure 12 – Mentor attributes that contribute to positive support

Nurse mentors who exhibited these traits enabled the students to feel more at ease in the clinical environment and described a genuine desire to help students to learn.

So, if I'm expecting somebody, I always make sure that I'm there and put aside about an hour at the beginning so we can have a chat about what they expect, where they are in their training and the experiences they've had. I always like to explain what I expect from them as well. Then we have a general chat because it can be a bit overwhelming. (Leanne, nurse mentor)

Early in the first week I try and meet with them and find out what they want to gain from the placement as that's always a good place to start. Then see what we can actually offer them on the ward that's feasible. We just try and work together really and try and build up that rapport (Ellie, nurse mentor)

Nurse mentors discussed how establishing rapport with their student helped to create a positive learning environment, it facilitated open lines of communication and encouraged students to broach concerns to their mentor.

I feel that they should feel comfortable and should be able to approach me with anything or my colleagues if they have a worry about something. A bit like your therapeutic relationship, to be open and honest and if there's something not quite right or something that's not quite expected then you're able to bring it up. (Leanne, nurse mentor)

I think it's important to have a good relationship with your student. Fundamentally I want them to have a good experience on the ward. I think the relationship should be honest and open and be able to come and speak to their mentor if they are concerned about anything (Nicola, nurse mentor)

Encouraging and facilitating an environment conducive to discussing concerns was built into the student's induction in some clinical areas.

Initially we do an induction day... we make sure that they know if they are experiencing difficulties then they can talk to their mentors or find one of the lead mentors. There are always people to talk to and we encourage them not to bottle it up but express it in some way and discuss things with someone. (Zara, nurse mentor)

Having open lines of communication and encouraging students to query practice normalises speaking up behaviours. Here, mentors are creating a safe environment for students to communicate openly which is reminiscent of the concept of psychological safety (Edmondson 1999). Such a positive learning environment takes away the need for students to try and evaluate whether speaking up will be welcomed or discouraged. However, not all mentors specifically mentioned raising concerns during the placement. Ellie (nurse mentor) questions why this may be the case.

Do you think it's partly fear of that we don't let them know that they can raise concerns because it feels like it's a negative thing on us if the student has a concern to raise? (Ellie, nurse mentor)

This is an insightful quote that opens up the possibility that mentors may deliberately refrain from mentioning concerns in case it reflects badly on the mentor. Here, the tone is in direct contrast to Zara's data which encourages students to be open and not bottle things up, whereas Ellie's data implies closure and silence.

Other influences on developing rapport were discussed by Neil, when he reflected on how an age gap between himself and his mentor had an adverse effect on the relationship.

The dynamics weren't great. She was the youngest mentor I have had so far, early mid-twenties and not long qualified.... I felt like sometimes she [mentor] didn't know how to take me.... I don't fit that mould [student nurse]. I was probably the first person she mentored that was significantly older than her. (Neil, student nurse)

Neil felt that being assigned to a much younger mentor had a direct effect on the mentor-student dynamic. His comment of, 'she didn't know how to take me' speaks directly about rapport and the difficulties in establishing an interpersonal connection because of an age gap. Furthermore, Neil's statement of '*I don't fit that mould*' is interesting in relation to his perceptions of identity and being a student nurse. In contrast to Neil's experience, other students experienced good relationships with mentors who were nearer to them in age.

My first mentor was a young girl in her 20's and she was lovely. It was nice because she was not that long out of her training, so she still understood what it was like to be a student and she was encouraging. I felt because I was a lot younger going in that she was more approachable to go to as a young mentor rather than someone who is a lot older. (Faye, student nurse)

I think sometimes it [relationship] can depend on your ages as well, so sometimes you can have a more teacher/pupil relationship and then other times like on my last placement my mentor and me were similar in age, and we had quite a lot in common.... So, I would say it was less like a teacher relationship and more working in partnership with her. I think the age can make a difference to the type of relationship. I think the mentor I had stuff in common with, I would be more likely to raise a concern to her I think, because your more open talking with them than someone who is a bit more authoritative. (Emma, student nurse)

Faye and Emma suggested that they found younger mentors easier to approach. This was explained in terms of personal connections and shared interests, but also because of the mentor's recent experience as a student which enhanced empathic understanding. These factors rebalanced the mentor-student dynamic from the authoritative or hierarchical stance (teacher-pupil) experienced with older mentors, to a relationship based on reciprocity and partnership working. These findings also highlight the fact that the students were more likely to raise a concern to a mentor who was of a similar age. However, as mentor allocation is wholly based on the availability of staff who meet NMC requirements, allocation according to age may not be a relevant consideration when assigning mentor to student.

Box 10 Memo – mentor-student dynamic and age - [19/7/16]

The influence of age on the mentor relationship is an interesting one. The data here suggests that these students found mentors who are nearer in age more approachable, and they were more likely to talk to them about concerns. I wonder if students perceive older mentors to be more authoritative. Are the students more likely to speak up to a nurse because of the similarity in age? Or is the fact that they are more recently trained more relevant? Faye refers to this. In my experience as a clinical teacher, students did tell me that they enjoyed working with newly qualified mentors as they still understood what it was like to be a student. So, it could be that the mentors understood the content of the course, were familiar with the portfolio and could identify with the student? Either way, being able to articulate exactly what made these mentors more approachable should be captured, so that mentors of all ages can promote open communication and support for students.

From a nurse mentor perspective, age did not feature as a factor in developing relationships and rapport with students. Instead, mentors considered different facets of the student-mentor relationship as important. For example, Ann focused on the teaching element of the role, whereas Zara described the multi-faceted nature of the mentor relationship which involved being an educator as well as looking after the student's wellbeing.

We are teachers mainly; we need to teach them, and they need to learn... we need to promote nursing to get them to have a good experience of nursing. (Ann, nurse mentor).

It is really important, and it is not just about learning but you've kind of got to look after them as well, so it is also about a buddy system. They've got to look after their whole wellbeing, so their learning needs and however they learn best. They're not going to learn if they've got other issues outside of work, so we have to bear that in mind. It is a bit of a mixture of all roles really -you've got to be an educator and you've got to be a buddy. I think in some cases you got to be um... not a mother that's too strong, but more protective as it is quite a harsh environment anyway. (Zara, nurse mentor)

Here the mentor role encompasses a holistic approach to mentoring where nurturing, supporting, and facilitating learning are important facets of the mentoring relationship. Claire and Fran took the nurturing aspect one step further and described adopting a mothering style. This approach focuses on caring for the student's physiological needs and going into 'mummy mode'.

I don't know, I do go into mummy mode. I make sure they are fed and watered, and they have proper breaks, and you know things like that. Some of them are kids aren't they bless them. And I always think it could be my children, so I like to treat them like the way I'd like someone to treat my children. You know if they are just out of school or whatever it's a big step for them. (Claire, nurse mentor).

I am a bit mothering as well. It might annoy some, but you know. They call me mamma. (Fran, nurse mentor)

Other nurse mentors emphasised the importance of fostering educational and professional development. Within this facilitative approach, students were encouraged to identify their objectives for the placement and to take ownership of their own learning.

I try and get the student to structure their placement when they are here you know. It tends to be, 'what do you want to learn? What are your competencies? What do you need to achieve on this placement? and how can we facilitate it? There're the numbers for you to go and call and structure it yourself'. (Brett, nurse mentor)

To identify at the beginning of the placement what they expect to achieve from the placement. Their expectations, but also, it's important you can explain what your expectations are as well... They need to take a bit of ownership about what they want as you will get out of the placement what you put into it really" (Michelle, nurse mentor)

Participants in this study highlighted the benefits of developing a positive mentor-student relationship, but also alluded to the importance of maintaining boundaries.

I think there should be professional boundaries still. I wouldn't go over their house for tea or anything but um I would say obviously get to know them personally and professionally and find out what interests they have so you can have that conversation with them. But I also think that you should have that professional boundary with students as well and if they are doing something that they shouldn't be then they can still have the opportunity to say, 'maybe you shouldn't be doing that way, let's do this way' without making a conflict. (Helen, student nurse)

Helen (student nurse) highlights that being friendly and having a rapport had to be balanced with upholding professional boundaries and the relational distance between students and mentors. This was crucial in order to raise concerns or challenge practice. Yvonne (mentor) explains the importance of mentors maintaining objectivity about a student's performance.

It is difficult because you want to be friendly with them but obviously you can't be overly friendly because you have to be objective in the end. (Yvonne, nurse mentor)

Professional boundaries between mentor and student are linked to roles and responsibilities, accountability, and the status of the mentor as a professional registrant and student as a supernumerary learner. Student nurses are under the direct supervision of the nurse mentor and there should be clear demarcation between both roles. However, boundaries can be successfully managed and should not impede rapport building between mentor and student. Professional boundaries offer legitimate control to the mentor and student, which if broken, can affect the relational dynamic between them. The blurring of boundaries could present challenges for the student in identifying and discussing concerns and for the mentor in supporting and managing the concern.

Several study participants discussed experiencing challenging mentor-student relationships. Nurse mentors Ellie and Zara acknowledged that building connections with students was difficult if the student was unreceptive to learning in clinical practice.

So, I've had students I've been really friendly with and it's like having a friend in work if that makes sense. So, some of my management students have been like that and you spend the whole thirteen weeks, and you enjoy it, and they really blossom as they get on so well with you. I have had the other end of the spectrum where the student is either very standoffish or very difficult and that is really hard because it's like coming in to work every day and having to work with the person you wouldn't choose to work with. So, it's a very important relationship and if you can build a relationship and have it then it's fantastic and you have a really enjoyable experience and if you haven't got it from the offset, it just stands the rest of the placement then. (Ellie, nurse mentor)

Relationships have been variable really. Some students are enthusiastic and want to learn and that's okay, some people are quite shy, so you have to coax them out of it. The difficult ones are the ones that you offer, and you try to work out how they want to learn and how best to do it, but they give nothing back. So, that's a difficult relationship because you are trying to develop one but there is nothing forthcoming (Zara, nurse mentor)

The excerpts above, demonstrate the challenges in supporting students who appear unmotivated and disinterested. The lack of enthusiasm described by Zara clearly affects the dynamic between mentor and student with the relationship becoming one-sided. Here, the student's lack of effort and engagement prevents the formation of an effective mentor-student relationship. Conversely, mentors who developed a friendly relationship with their students enjoyed working with them and watching their confidence and skills developing during the placement.

A number of student attributes contribute to rapport building between mentor and student. There are similarities and overlap between these and the mentor attributes which were outlined earlier in this chapter. Characteristics such as being friendly and building connections were highlighted by both mentors and students as important in developing relationships. There were also overlaps between mentors wanting students to be enthusiastic and proactive in their learning and students wanting a mentor who was interested in facilitating their learning. It appears that reciprocity is the key, with both parties needing to demonstrate motivation and interest.

However, there were differences noted in desirable attributes with mentors expecting student nurses to be proactive and take ownership of their learning. However, student nurses emphasised the importance of having a mentor who was approachable, supportive, open, and honest and willing to listen. These mentor and student characteristics collectively contributed to a favourable context in which to raise concerns (see figure 13)

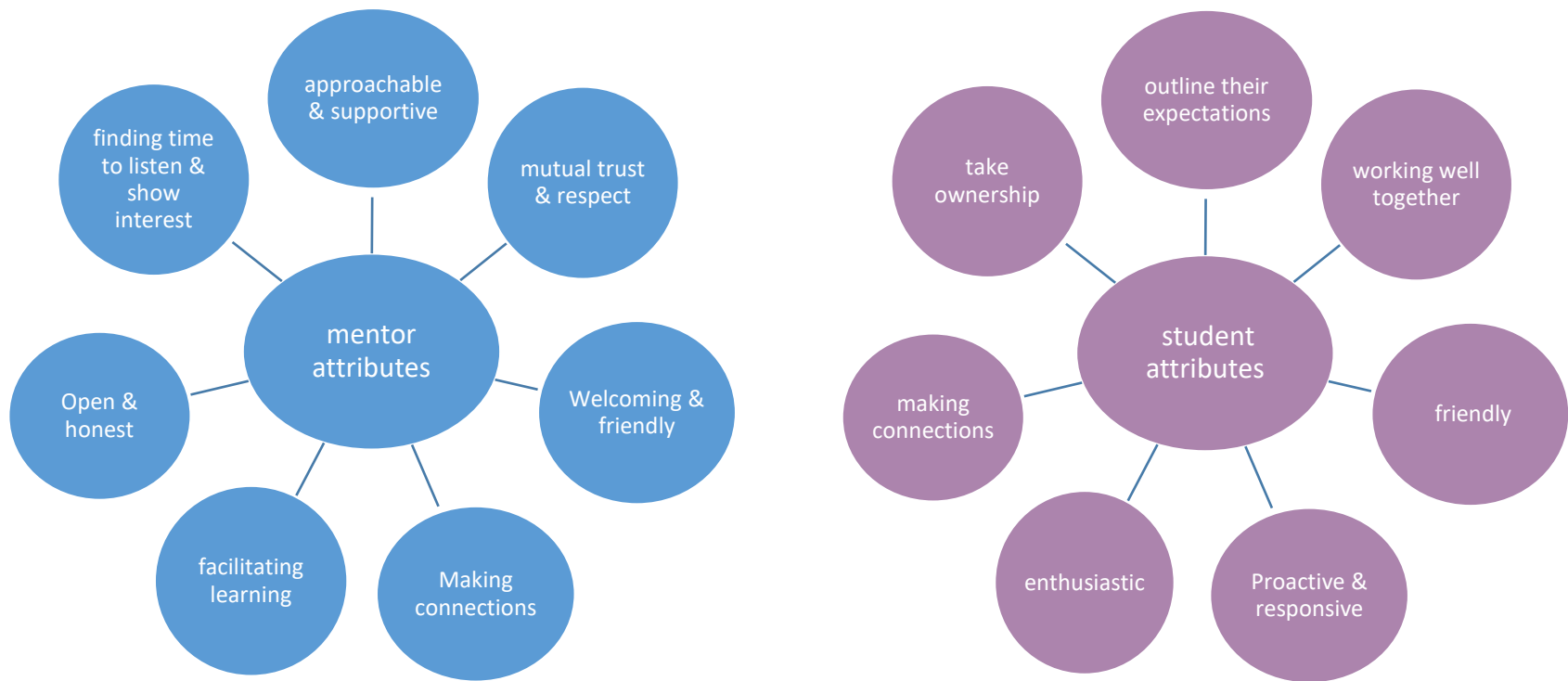


Figure 13 – A comparison of mentor and student attributes that contribute to building rapport

A small number of student nurses in this study also described challenges in building a rapport with their mentor. Building on the findings from the previous chapter, students cited examples where their mentor was hostile, unhelpful, or indifferent, which had a deleterious effect on their learning experience. Carys struggled with a mentor whose non-verbal communication was antagonistic and unfriendly and inhibited the development of an effective working and learning relationship.

My mentor, she spoke very quickly, and she'd often be running down the ward and I'd be kind of running after her going, 'I didn't catch any of that, please can you slow down?' She got very irritated with that, and I thought, "well I'm not here to make friends, I'm here to learn and it's got to be professional. I can't go getting upset about the fact there's no sort of friendship building here. Break time I would go off on my own as sitting with her was really uncomfortable so it kind of got to the stage where I was like I don't know what to do, who do I talk to? (Carys, student nurse).

After half an hour he [mentor] came to introduce himself so I went with him, but... He didn't show me anything I was just doing washes, turns. He didn't involve me in medication rounds. I felt he was kind of condescending and laughing at me a little bit. It had gotten to the stage where I didn't know who to turn to. A lot of it was down to the way the mentor made me feel on that placement. (Faye, student nurse)

Both mentors were unwilling to engage with their students. Here non-verbal cues, and more overt negative signals, led to the students sensing a non-supportive environment in which to broach concerns. The poor relational dynamic impeded the student's ability to discuss concerns directly with their mentor. Therefore, Carys and Faye chose to raise concerns with other staff who were deemed to be more approachable.

This section has provided an insight into nurse mentor and student nurse perceptions and experiences of mentor-student relationships. Having a functioning relationship where students are welcomed, shown basic respect, and valued as a member of the team are positive conditions in which open communication can facilitate speaking up behaviours.

Conversely, in instances where students were ignored or undermined, the mentor-student relationship failed to flourish, which impeded the student's ability and confidence to approach mentors with concerns. Several participants commented on how age and mentoring style influenced rapport building. A more collegial mentoring relationship developed when student and mentor were of a similar age. The next section builds on the findings of the mentor-student relationship, but attention turns to explore how influence,

status and power dynamics affect the mentor-student relationship and speaking up behaviours.

5.4 Perceptions of influence, status, and power dynamics

Study participants' perceptions of status, influence and power during interviews will now be explored in relation to how these concepts affect the mentor-student dynamic. Student nurses in this study recognised that promoting patient safety within the clinical environment was everyone's responsibility, regardless of status and role. As also exemplified in chapter four and in the data extracts below, identifying and reporting concerns was a crucial element of maintaining safety, and took courage to escalate.

I think it's a role everybody should have. To look out for something wrong and if it is you tell someone and escalate it. (Donna, student nurse)

If anything is a concern it has to be raised. A concern is a concern and if you think, something is not right you just have to do it. You know there is enough bad stories in the NHS with all these reports and failings and it's because somebody wasn't brave enough to say what is happening. (Sally, student nurse).

However, despite identifying that speaking up was everyone's business, students acknowledged the existence of a hierarchy within the practice environment. Statements such as, "I am just a student" (Sarah, student nurse) and "I am not in a position to question things as a student" (Jess, student nurse), illustrate students' perceptions of occupying a lowly position within the hierarchy and the impact of their student status on the use of voice.

Even the students who had established positive relationships with their mentor acknowledged the status differential, but they did not feel that this affected the working dynamic in a negative way. On the contrary, students described how reciprocal relationships with their mentor resulted in partnership working rather than the student feeling 'inferior'.

They [mentors] never made me feel inferior to them. Like they always offer me knowledge, but not in a patronising way. They all explained that they have been there before and everyone has to learn so never patronising, always helpful. (Sally, student nurse)

She [mentor] is brilliant and lets me have my own patients and I can see she is enthusiastic with my learning which helps me. She doesn't speak to me as a student but on par as an equal. (Faye, student nurse)

The extracts above emphasise student-centred and facilitative educational strategies where mentors successfully narrow perceptions of difference, or seniority between students and mentors. In Faye's data the mentor demonstrates trust in the student by relinquishing control which appears to reduce the asymmetry of power to a more equal relational dynamic.

For Becky (student nurse) the unequal power balance was recognised but deemed to be less so if students were supervised by a newly qualified nurse mentor.

There is a power imbalance but a lot of the mentors I've had, haven't long been in my shoes. I've had two or three mentors that were more newly qualified. (Becky, student nurse)

It was nice because she was not that long out of her training, so she still understood what it was like to be a student and she was really encouraging. (Faye, student nurse)

Mentors who were recent graduates were considered to be more attuned and empathic to the needs of the student and appeared to enhance the mentor-student relationship. It is possible that the students' impressions of the clinical hierarchy would see a newly registered nurse as occupying a lower status and having less managerial responsibilities than more established senior colleagues. Therefore, being mentored by a recent nurse graduate, diminishes the power differential between mentor and student. Here, power dynamics are strongly linked to the perceived status of the mentor within the hierarchy of the clinical team.

In the following data extract, Sarah (student nurse) discusses how the relationship with her mentor influenced her decision-making in relation to raising concerns.

The relationship wasn't that good anyway but that [speaking up] would have scuppered any sort of relationship. I feared she would have, not shunned me (laughs), but not been interested at all in doing anything with me.. I would have worried about that definitely about her not engaging with me. I think she would see it as me threatening her or challenging her care and thinking 'I've been doing this for years, who does this student think she is' sort of thing. (Sarah, student nurse).

Sarah's perception, of the way her mentor would react if concerns were raised, led to a decision to bypass her mentor, and instead discuss concerns with her personal tutor. It was clear that the relational dynamic was poor and that voicing concerns could potentially have damaged the relationship even further. Perceptions of an unequal power dynamic is

implicit within the quote, *'I've been doing it for years'* and positions the mentor as having significantly more experience and expertise of nursing than the student. Furthermore, the statement *"who does the student think she is"* alludes to this experience and status differential between mentor and student. Here the perception is that students would be pushing established boundary norms relating to experience and status if concerns were raised, or the mentor's practice was challenged

Students clearly perceived the dynamics of hierarchy to be unequal with Carys stating during her interview that *'the power balance is with the mentor'*. A notable finding in this regard was the mentor's role as the assessor of the student's clinical competence. The attainment of clinical competency outcomes is a requirement for students' successful progression through the nursing undergraduate programme. Whether these outcomes are achieved or not is dependent not only on the competence of the student nurse, but also the nurse mentor's judgement of competence and willingness to sign practice outcomes. Carys again, in the extract below, perceives the student as occupying a subservient position in the relationship with the mentor.

We feel like Oliver Twist going around saying 'please can you sign' You are at the mercy of your mentor (Carys, nursing student)

When you go onto clinical placement you are by yourself and if you don't get on with your mentor... If they score you below a 3 on your attitude scale, you fail that placement... You do feel like you're walking on eggshells and trying to please them so that you pass. (Faye, student nurse).

Kim's (personal tutor) data below further echoes the student's concerns regarding the assessment of clinical competencies by their mentor and claims that power is considerably balanced towards the mentor.

The mentor has got the power essentially to fail you and to fail the course. So, the relationship is a very tricky one to negotiate, because they've got the power to make or break you and I think we have to be cognisant of the fact that in some areas there is a bullying culture. So, there could be an opportunity for somebody then to bully you. I'm not saying that happens but if you are a student and you think 'actually I'm not sure I want to upset her. I know I've got to report something... but just as a patient is vulnerable, I will report it afterwards so that I am not a hostage to however they treat me. (Kim, personal tutor)

Kim emphasises the vulnerability of the student in reporting concerns and is clearly concerned about retribution and suffering detriment. Telling also is how she relates this

process to patients who may also be reluctant to complain in case their care is compromised. Instead, she suggests that students (like patients) may decide to wait until the placement (or their care) is over. However, it is worth reinforcing that as disturbing as this is, it was only Kim's perception. There was no evidence on this placement (or in this study) of bullying whilst students were undertaking clinical placements, or indeed of poor patient care on this ward.

Neil's (student nurse) data extract below highlights the pressure on students to achieve all elements of the clinical portfolio. Similarly, to Kim, he believed that failing to do so could halt career progression. He acknowledged the sacrifices he made to undertake nurse training and felt these may be in jeopardy if raising concerns to mentors resulted in the portfolio not being signed.

I think we are beholden to that portfolio and those competencies. That portfolio owns us (laughs) because if it's not all signed off, you're not getting registered. Getting to do your training is a big commitment and you can't let stuff stand in the way of it. There have been a lot of sacrifices made to get to here and you go into a placement thinking of all the hoops and hurdles you jump through; you don't want not getting a few competencies signed off to be the thing that stops your career path because that would be a crying shame. (Neil, student nurse)

The data here emphasised Neil's perception of raising concerns as a high risk/low reward activity. Neil admitted that "this is the biggest thing that would stop me from speaking up, it's the assessment"

This is an interesting perspective that appeared to be a common perception amongst student nurses that is largely ungrounded in reality. Hypothetically, a mentor could refuse to sign clinical outcomes, although they would be expected to provide evidence to support this decision. In most cases, this would not result in a student being discontinued from the programme, unless there was also non-achievement of theoretical outcomes. However, the stress of having outstanding clinical competencies should not be underestimated. The fear of not progressing on clinical placement was also a significant factor in Cath's decision not to speak up whilst she was on placement.

you do have that pressure on you to get competencies signed so that you can progress on to the next year. This was my final placement of the first year, so I had to get all my remaining competencies signed off in order to move on. So yes, there is that and that does make you feel like if I complain are they going to try and get

*one back on me by not signing my competencies and prevent me going forward.
(Cath, student nurse)*

The nurse mentor data highlighted variable responses in relation to their assessment role and perceived power over students. Georgie and Nicola's data illustrates the power imbalance between mentor and student and clearly demonstrates that they are fully aware of this powerful position. Both mentors seemed to suggest that students put in extra effort and ingratiated themselves with their mentors to get the documentation signed off.

As far as the [students] are concerned what they need from you is to complete their portfolio and if they give you any reason not to complete their portfolio you are suddenly making their lives very difficult. They view the portfolio as another essay, and you are what they need to pass that essay. Therefore, they have to keep you on side and have to keep your mentor sweet (Georgie, nurse mentor)

*I definitely feel like students might feel like they've got a bit of a gun to their head. You know like 'oh god if I say anything they are not going to sign me off' Yes definitely. I remember saying to one of them 'right that's it you can behave normally now, it's all sorted, and I've signed you off' so you can go away now (laughing).
(Nicola, nurse mentor)*

The emotive language seen below (figure 14) describes the influential role of the mentor as assessor.

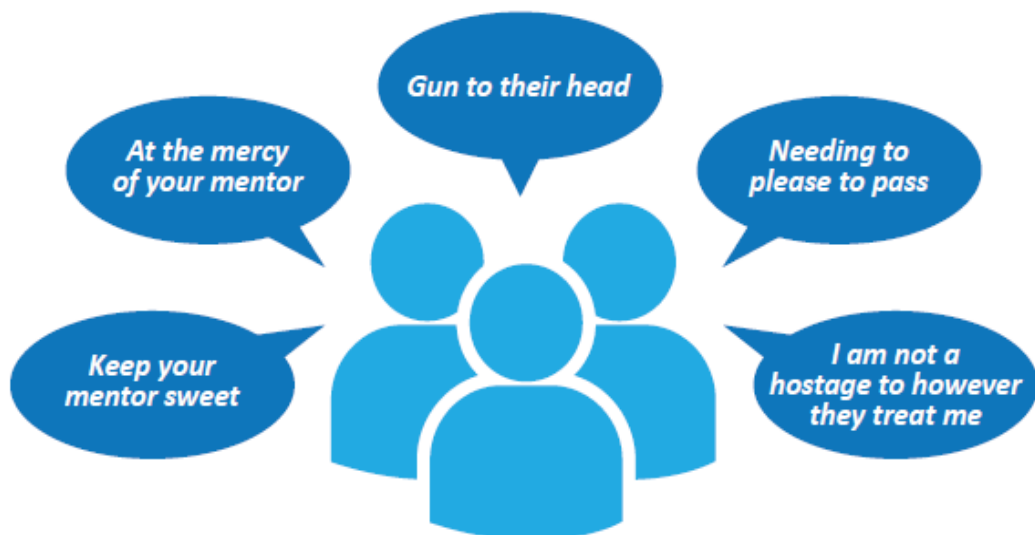


Figure 14 – Emotive language associated with power dynamics

The quotes within the figure above, illustrate the tensions underlying the mentor-student relationship. Student nurse participants describe 'walking on eggshells' and needing to

'keep the mentor sweet' to pass the clinical element of the programme. The inherent power and influence of the mentor was evident when students discussed the need to ingratiate themselves with their mentor in order to pass the placement. This power imbalance had practical consequences as it influenced speaking up behaviours and resulted in students bypassing their mentor to raise concerns.

However, having the clinical portfolio signed off was not the primary concern for all students who escalated concerns. When analysing the data, about half of the student nurse participants were concerned about the implications of speaking up on the clinical assessment. However, for others, decisions were based on the impact for the patient.

I honestly didn't think about my portfolio. I thought about what would have happened if I hadn't spoken out and the patient. At the time, I was thinking more about that rather than my portfolio. (Helen, student nurse).

Yes, I can see why people would be worried {about getting portfolio signed off}, but I think if it is something really serious you know I think I would put that over getting my portfolio signed, because I will get it signed somehow and if that's the reason, I haven't got my competencies signed then there is something wrong there you know (Paula, student nurse).

Paula reasoned that voicing concerns should hold higher priority than the portfolio. Here she acknowledged that there would be other opportunities to complete competencies but believed that refusing to sign the portfolio because a student had raised concerns was wrong.

Within this section the findings have pointed to a mentor-student dynamic which positions an inherent power balance towards the nurse mentor, due to their assessor role and professional standing. However, the following data extracts provide a contrasting perspective on the students' perceptions of power and influence. Sarah (student nurse) identified care that was outdated and task-focused and raised her concerns about elderly patients being routinely woken early to be washed.

She [ward manager] was really lovely and very good about it so I was lucky in that sense as she had the power basically to ruin my placement if she wanted to and had taken it personally. But she took my feedback on board and was going to implement gradual waking rather than waking everyone up at the same time. They invited me back about six months later to see if any of their new stuff had worked and they were supportive of me in the process of improvement which I appreciated as I am just a student. (Sarah, student nurse)

Sarah alludes to the power held by the ward manager and the potential for repercussions to occur. However, by voicing her concerns she was influential in instigating a positive change to nursing practice. In this instance, Sarah was able to draw on her knowledge of current evidence-based practice on which to base her concern.

In terms of relational dynamics, mentors have status as experienced nurses who also undertake an assessor role. This status and power have influenced students' perceptions and behaviour in relation to raising concerns and challenging practice. However, the student can be perceived as a knowledgeable individual with access to evidence-based practice.

The information that they [students] bring is fresh, it's up to date, researched. We had a student a while back here and he was excellent, and he was pointing things out. He was very knowledgeable, and it does make you think 'ooh, why are we doing things like that' so I think they do bring things to us as well you know (Yvonne, nurse mentor)

I learn quite a lot from students as they might have recently been on another placement that I don't know much about. Say someone's been to vascular surgery recently and I'll go 'how do they do this on vascular'? I like having students as it always makes me think about things before I do them and it keeps me on my toes (Nicola, nurse mentor)

These examples illustrate how the student's knowledge and placement experience may supersede mentor knowledge and potentially lead to the student influencing mentor's practice. In this way a two-way dynamic exists which is not static but contextual.

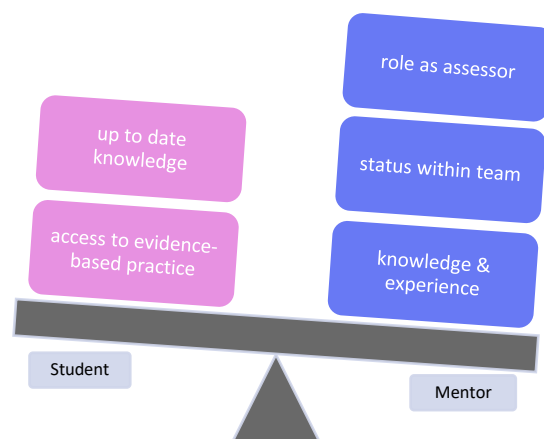


Figure 15 – The mentor-student dynamic

This dynamic is illustrated in figure 15 above. Having outlined students, mentors and academics perceptions of the dynamics and influence of status and power, the next section further explores how students are supported to raise concerns in practice settings.

5.5 Supporting students to raise concerns

Previous sections have demonstrated that the relationship between the mentor and student is a significant factor in a student's learning experience, achievement of practice learning outcomes and their enculturation into the clinical environment. Furthermore, the student nurse participants who were assigned to an approachable and supportive mentor developed a rapport that facilitated speaking up behaviour. For example, Sally identified several concerns on her community placement, these were outlined in the previous chapter (section 7.1). The data extract below illustrates the support given to Sally by her mentor in raising her concerns.

My mentor brought it up for me in handover knowing I was concerned about it and then offered me the chance to say what I felt, and she backed me up. But yes, it could have been awkward, because she might have felt that I pushed her in to doing it and when you're on the community it's just you and your mentor all day. You have to get on with people and I was worried whether it would affect the mentor-student relationship, but it never did. She was lovely about it and understanding and said 'you know you've done the right thing, don't worry about it. (Sally, student nurse)

Sally's mentor supported speaking up in a number of ways. For example, the mentor raised the issue during the team handover, which provided an opportunity for Sally to voice her concerns to the rest of the team. The support and encouragement displayed by her mentor also signalled legitimacy to the other staff members, that Sally's concern was valid and needed to be taken seriously. Initially, there was agreement from the nursing team that the issues raised needed to be addressed urgently. However, the complexity of the concerns and a discussion about a possible POVA referral, divided the staff on whether this was warranted.

It was like everyone got scared ... the way everyone was acting was making me feel worse as if I shouldn't have raised this concern um and it didn't need to go to POVA because she was fine, but she wasn't fine. We did do the referral and my mentor signed it and I witnessed it and it went off. Then my mentor was worried all weekend about what was going to happen... I felt from other members of staff there was no support or thought for my mentor (Sally, student nurse)

The data extract above highlights tension within the team and demonstrates that mentors can also be subjected to some of the fears and risks experienced by the student. Regardless of the tension the mentor continued to be supportive throughout the process, even out of hours.

All weekend I was 'oh my god have I done the right thing?' My mentor rang me and said, 'I know your worrying, please don't worry' She said 'you haven't made anyone do anything they didn't want to do. You've only raised your concerns, please don't worry, and enjoy your weekend. (Sally, student nurse)

Sally's mentor provided emotional support, even though she experienced a lack of support and some resistance from her colleagues. Although Sally acknowledged the potential for the mentor-student dynamic to change after speaking up, the strength of their relationship was able to withstand pressure and disapproval from other team members. The way in which the mentor reacts to students and their concerns, may be a reflection of the broader team dynamics which mentors have to negotiate. In a sense, this is a 'hidden dynamic' in that the mentor's relationship within the team may also influence the mentor's dynamic with the student. The nature of the mentor's relationship with the team more generally is unclear. However, friction within the staff and a sense of 'us versus them' became more apparent in Sally's data extract.

The example provided by Sally demonstrate how a collegial, interpersonal mentor-student relationship created a conducive landscape in which to voice concerns, resulting in reduced patient harm and suffering. The influence of the mentor-student relationship in speaking up is summarised by Donna.

I think you just have to have a really good mentor to be able to escalate concerns. (Donna, student nurse)

However, within this study the majority of the student nurses made the decision to bypass the mentor when raising concerns.

5.5.1 Bypassing the mentor and accessing the personal tutor

In this section the nature and dynamic of the mentor-student relationship, and the personal tutor-student relationship, will be examined to further explore the students' decisions to circumvent the mentor. Study participants were asked to consider why students might be reluctant to discuss concerns with their mentor.

Maybe because they wouldn't want their relationship with their mentor to be affected. (Nicola, nurse mentor)

Perhaps they don't feel comfortable with their mentor maybe? Either that or it could be an issue with the mentor that they need to raise so they can't speak to their mentor (Ellie, nurse mentor)

The problem might be with the mentor or with the ward. They might not trust the mentor (Barbara, personal tutor)

The data extracts above identify that nurse mentors and personal tutors recognised that raising concerns to the mentor could have a detrimental effect on the mentor-student relationship. The difficulty in broaching concerns that were specifically about the student's allocated mentor was also recognised. This was the case for Sarah and Mel who felt uncomfortable challenging their mentor and chose not to speak to them.

I didn't feel comfortable enough to speak to my mentor about it. I had seen her doing some of the things I was unhappy with, so it was difficult. (Sarah student nurse).

She [mentor] was also the one who at times did not lock things away, you know the trollies being left open. I always felt if I was to speak to her about things, she would play it down. (Mel, student nurse)

The challenges for students in directly confronting mentors about their own practice were previously highlighted in chapter four. For students who were reluctant to challenge their mentor's practice, or who struggled to build an effective relationship with their mentor, raising concerns with someone outside the healthcare environment was deemed to be preferable. The university was viewed by some participants as a separate entity to the clinical environment and was described as a 'safety net' for students to raise concerns. In particular, the personal tutor was positioned as the most appropriate person to raise concerns to within the university and was commonly approached as an alternative source of support to the student.

if you don't get on with [mentor] then you're only going to tell your personal tutor (Donna, student nurse)

Particularly in cases where the dynamic between student and mentor was not conducive to raising concerns, the personal tutor was often the first point of contact for students:

So, I put in an incident form about it so that was all documented and I informed my personal tutor. She was supportive and she told me that I did the right thing and I still believe that I did the right thing. (Ryan, student nurse)

I just thought I'll go to my personal tutor, and I told him all of this and he said to go and tell the ward manager. The next day I went in and told the ward sister and she said that she would have a look into it and go from there. (Jess student nurse)

The data extracts illustrate the role that the personal tutor plays in supporting students to raise concerns by reinforcing policy, providing reassurance, and advising on next steps and action required. In the data extract below, Simon (personal tutor) provides his perspective on the reason why students report concerns to the personal tutor, rather than their mentor in practice.

I think because we probably say what they want to hear. It's all going to be alright and it's all okay. I'm isolated from that. I don't have to go out there and face up to that... So why do students tell personal tutors? I think it's easier, softer more gentle. (Simon, personal tutor)

Simon suggests that voicing concerns to personal tutors may be seen as a softer approach for students. This may be connected to his ability to consider the concern with some detachment. He recognises that he can advise the student but is not actively involved in addressing the concern within the clinical environment. Perhaps this enables the personal tutor to provide an outsider perspective and consider the concern with fresh eyes. Pastoral care is central to the personal tutor role and focuses on the wellbeing of the student. This may also account for the 'softer approach' which focuses on support and reassurance for students when concerns are disclosed. This point is exemplified in the following quotes.

I'd like to think it's because I have got such a good relationship with my students. They feel they can trust me and have that conversation in confidence and maybe just articulate what they feel is wrong and get it off their chest...you need that bolster person where you can just knock on the door and come in and have a chat with, regardless of what you say, you can say it comfortably and safely. There has to be that one person. (Olwyn, personal tutor)

My personal tutor I think I have very open communication with her and can confidently raise concerns with her, so I think it's just about developing good relationships with people. (Helen, student nurse).

I will say to them 'do you feel happy to put it into writing. I can support with that?' We talk about statement writing and support... but you can't make them write anything official. They see the personal tutor role as a person they can talk to without any fear of breach of confidentiality. (Charlotte, personal tutor)

Here, the importance of trust in the relationship between personal student and tutor is highlighted. Olwyn emphasises the importance of making the students feel comfortable and providing a safe place to discuss concerns confidentially. This also links to earlier

discussions on sensemaking and provides an opportunity to use the safe space to gather thoughts and attempt to make sense of the situation. This is echoed by Charlotte who discusses confidentiality and suggests that she can assist students in writing statements, only if they are willing to do so. However, the professional accountability for educators in relation to raising concerns is explicit within the NMC (2018c) Standards Framework for Nursing and Midwifery Education who state that all educators and assessors,

“are expected to respond effectively to concerns and complaints about public protection and student performance in learning environments and are supported in doing so” (NMC, 2018c, section 4.8, p. 11)

Nurse educators have a professional duty to ‘act without delay’, if information received, from any source identifies a risk to patient safety (NMC 2019a, p.4). If concerns raised by students violated the NMC Code (2018a), then the personal tutor would be duty-bound to escalate the concern and advise the student to write an official statement (with support from a union representative). The responsibility to raise concerns provides a legitimate reason for personal tutors to disclose and escalate information that may be in the public interest (NMC 2018a, 2019a). However, maintaining professional and personal accountability alongside pastoral support for student nurses can be challenging for personal tutors to balance. In this study, it is unclear whether relationships would be affected if confidentiality could not be maintained. Nevertheless, the data illustrates the availability and approachability of the personal tutor, and an open-door policy is evident:

If they need me, they come and find me, and I respond quickly to emails. Because they fret, they worry and if there is a concern about anything, they need to know so that they sleep well, so they go into practice the next day fresh not concerned that type of thing. (Olwyn, personal tutor)

The personal tutor’s pastoral role, in some cases, focuses heavily on caring for the student’s emotional well-being. Olwyn’s data demonstrates her role in nurturing and caring for her personal students. Although nurse mentors also alluded to the importance of being nurturing and ‘motherly’ towards their students, the mentor relationship is short-term in comparison to the personal tutor relationship which continues throughout the duration of the undergraduate nursing programme. This continuity in personal tutor support provides an opportunity for trust and mutual respect to be established, and for effective interpersonal relationships to develop between student nurse and personal tutor.

I know now with my students who I've known for two years that things maybe aren't quite right. So, um reading between the lines I know if one of them sent me an email, which was uncharacteristic, that's somethings wrong.... Whereas a mentor may not pick up on that particularly due to busyness. (Charlotte, personal tutor)

Charlotte's data outlines the subtle nuances in students' patterns of behaviour, or even the tone of emails that may be picked up by the personal tutor. Mentors may not have the time to develop this kind of relationship or may not recognise when something is wrong due to their busy role. This quote illustrates that personal tutors who have well-established relationships with their students, may detect subtle changes in the student that might indicate a concern on their mind.

Providing emotional support featured as an integral part of the personal tutor role. Simon's (personal tutor) earlier quote of, "*It's all going to be alright and it's all okay*" highlighted the reassurance and supportive approach utilised by some personal tutors when students raised a concern. However, it is possible that the nature of the personal tutor-student dynamic may influence the approach used to address the issues raised. For example, two students escalated concerns to their tutor which led to them being moved to a different placement, rather than being supported to raise concerns within the placement area.

Although this was viewed as a positive outcome from the students' perspective, protecting the students from the potentially emotional fallout of raising concerns prevented them from being actively involved in the process. In terms of enabling students to raise concerns confidently, removing them from placement in some instances may be counterproductive and does little to prepare them for voicing concerns. However, in cases where clinical environments are deemed to be unsafe, removing students from clinical placements is appropriate.

It is possible that a student-personal tutor relationship which focuses primarily on emotional support, may inadvertently encourage an over-reliance on the personal tutor to deal with the concern and make it go away. However, balancing the pastoral function of the personal tutor role and maintaining professional accountability by escalating concerns promptly can be a challenge for the personal tutor. Strategies to develop knowledge and confidence in managing student concerns are required and will be discussed further in chapter seven. Therefore, increasing the support in the placement area when a concern is

raised would be more beneficial. Nevertheless, the potential critique of the pastoral element of the personal tutor role is an interesting and important finding.

A further supportive mechanism was that several personal tutors incorporated reflection into their personal tutor meetings which provided a safe space for students to discuss and learn from concerns and consider how they might deal with it next time.

I talked to my personal tutor, and she went, 'okay but let's sort of unpack that' and I said 'a couple of things have happened'... So, I'd written all these reflections" (Carys, student nurse).

A lot of them said they wished they had said something at the time. And I always say to them 'would you say something next time?' and they always say, 'yes I would' and we talk about what that looks like. how they would address it, what do they feel comfortable with saying and sometimes tips around, for example if it's manual handling, you might just say, 'oh in university this is how we've been taught to do it, would you mind if I use a slide sheet? Using evidence as well so we might go through that". (Charlotte, personal tutor)

These discussions were used to aid professional development and appeared to focus on assertive communication techniques and reflection on how students could alter their behaviour and strategies if concerns needed to be raised in the future. The opportunity to reflect was often used by students who had disclosed concerns to their mentors, as well as by students who accessed support from their personal tutor instead of the mentor.

In relation to this study, Mia was the only personal tutor who actually met with her student's mentor in clinical practice to discuss the concerns raised. Her student was invited to accompany her, but due to a fear of repercussions she declined. The meeting was challenging for the personal tutor, as the mentor did not agree with the concerns raised by the student. Although it was understandable that the personal tutor protected the student who did not want to meet with a potentially hostile mentor, meeting collaboratively may have helped the student's learning and enabled the student to present her perspective on the situation. Simon (personal tutor) acknowledged the importance of having more open communication with mentors when concerns are raised by students:

I think we as academics have a role to play in terms of supporting and informing mentors and being on the same page as mentors. Having that conversation is invaluable to getting that insight and perspective. (Simon, personal tutor)

Mentors and personal tutors working more collaboratively to support students in addressing concerns would enhance the concerns process as a learning opportunity for

both the student and the clinical area. At times it is not always clear that the concern is addressed by the clinical area, or fully translated into a learning opportunity for students. Communication between the practice placement and academia would also ensure that there are no delays in escalating concerns. The mentor-student relationship is a significant factor in the student's decision to raise concerns in clinical practice. However, the student's relationship with the personal tutor is more established, and in this study resulted in many students choosing to speak to their tutor about concerns either alongside speaking to the mentor or instead of.

There were no reports of students having a challenging relationship with their personal tutors in this study. It would be interesting to know how a poor student-personal tutor dynamic might influence decision-making and speaking up behaviours for those students. The ideal situation would be that the student approaches the mentor first, so that issues are addressed immediately, and that the student is involved in all parts of the process. Meeting with the personal tutor would enable the student to have emotional support and an opportunity to reflect on the process in a safe and familiar environment.

5.6 Chapter summary

The focus of this chapter was to explore how the mentor-student relationship facilitated or inhibited students' propensity to raise concerns in clinical practice. The students' first impressions of the clinical placement and their mentor saw the student assessing the receptiveness of the mentor and the friendliness of the clinical team. These initial impressions either enabled students to feel secure and to experience a sense of belonging or conversely a sense of rejection and uncertainty.

There were a number of personal attributes and factors that were perceived to influence the dynamic within the relationship including age, professional boundaries, experience of the mentor and the mentoring approach. However, status and influence affected the relational dynamic depending on how this was perceived by both parties. Power was inextricably linked to the dynamic of the relationship, particularly in relation to the mentor's role as the primary assessor. An unfounded but real fear of failing the placement appeared to be a barrier to students escalating concerns directly to the mentor. This is interesting, particularly as the clinical portfolio is designed to be an ongoing record of

achievement for each year. If a mentor did not sign off all of the practice learning outcomes, then in most cases the student could carry them on to the next placement or to the next year.

It could be argued that there is an inherent power imbalance due to the mentor's professional position and assessor role. Within this study the data showed how a student can present themselves as having knowledge of current, evidence-based practice, which sees a two-way dynamic existing, and introduces a counterbalance to an extent, which is not static but contextual.

Students who had a good relationship with their mentor, were treated as an equal. This was due to a facilitative mentoring approach which encouraged partnership working, in doing so it relinquished control and power to the student. These relational dynamics influenced the likelihood of students engaging in dialogue with the mentor regarding concerns. One mentor who supported a student in raising a concern was subjected to resistance from colleagues.

In cases where the dynamic between student and mentor was not conducive to raising concerns, the personal tutor was often the first point of contact. The long duration of the personal tutor-student relationship provided a safe haven for students to broach concerns, without the fear of repercussions that were identified in chapter four. However, bypassing the mentor is a worrying finding if this results in a delay to reporting and subsequent action. This could have an adverse effect on the patient.

In conclusion, the mentor-student dynamic is certainly a significant factor in the student's decision to raise concerns or to bypass the mentor. However, other factors within the sub-culture of the clinical environment appear to be equally significant. The students appeared to weigh up a number of contextual factors within the environment. This included the mentor-student relationship and rapport, the team dynamics, leadership, and the perceived risk of repercussions if students chose to speak up. This 'context favourability' was assessed by students within the placement and a decision was made, based on how 'favourable' or 'unfavourable' these contextual factors were. The findings of this chapter suggest that a positive relationship, with a nurse mentor and personal tutor, adds to the favourable context for speaking up behaviours to occur. When students raise concerns to

their mentor and personal tutor, these roles can complement each other and provide the support and psychological safety required for students to raise concerns confidently whilst on placement.

CHAPTER SIX – Equipping with the right toolkit

6.1 Introduction to the chapter

The previous chapter explored the nature of the mentor-student dynamic and revealed that an effective relationship with the mentor facilitated a learning environment which was conducive for students to raise concerns. Conversely, students were reluctant to raise concerns if their interpersonal relationships with the mentor or clinical team were perceived as unfavourable. The personal tutor was found to be a consistent source of support for students who wished to raise a concern. The majority of students in this study contacted their personal tutor after witnessing poor care, as an alternative course of action to raising concerns with their mentor. Furthermore, the personal tutor played a key role in exploring the nature of concerns, providing an opportunity for reflection, and discussing strategies for raising concerns in the future.

This chapter builds on the preceding findings and presents the main category of *equipping with the right toolkit*. This category was constructed from the insights of the study participants regarding the knowledge, skills and support that students, mentors and personal tutors require to raise concerns or support students through this process. The sub-categories of; *preparing students and mentors to raise concerns, utilising policies and guidance, accessing support, and developing confidence in speaking up* were generated from the data. Figure 16 provides an overview of these subcategories.

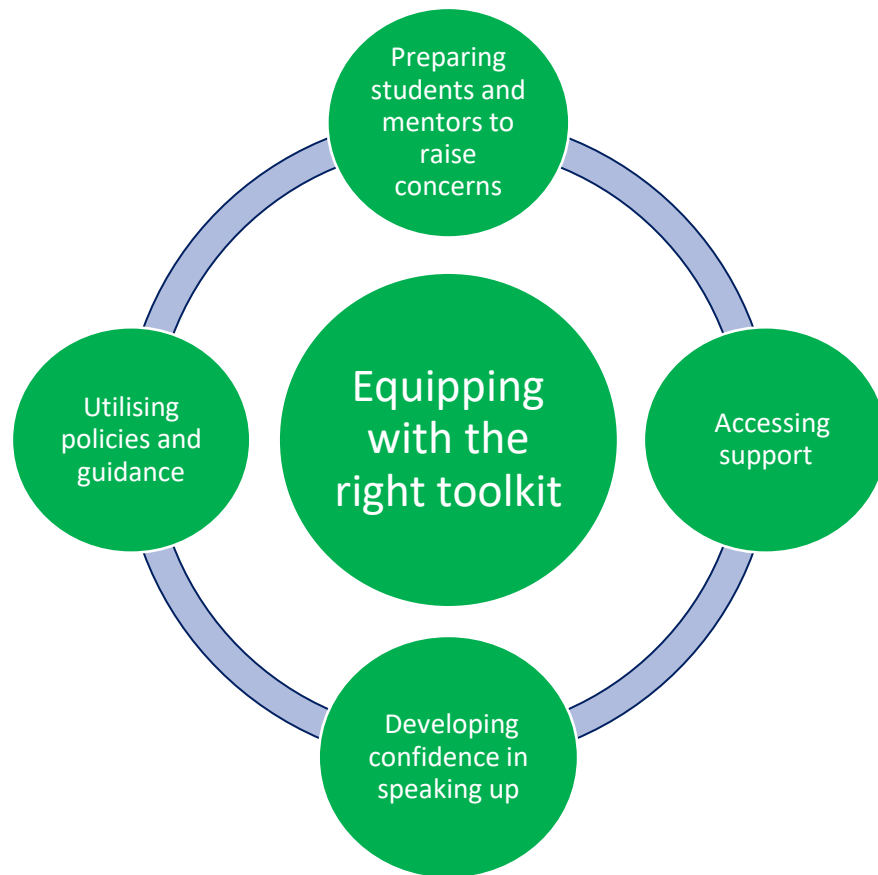


Figure 16 – Sub-categories of equipping with the right toolkit

Firstly, *preparing students and mentors to raise concerns*, explores the formal preparation that student nurses receive within the university setting. Here, students reflect on the efficacy of the teaching sessions as well as suggestions to enhance their understanding of the raising concerns process. This sub-category also provides insights and perceptions on the preparation of nurse mentors and personal tutors in relation to responding and managing student concerns.

Secondly, the study participants awareness of the university and local health board policies on raising and escalating concerns are explored within the sub-category *utilising policies and guidance*. The perceived accessibility and utilisation of the policy is explored in relation to student nurse decision-making. It will reveal whether nurse mentors and personal tutors refer to policy when responding to and supporting student concerns.

Thirdly, *accessing support* draws on participants' perspectives and experiences of accessing wider support from staff within the clinical setting and the university. Students, mentors,

and personal tutors present their ideas for enhancing current support structures for raising concerns.

Within the final section, the sub-category *developing confidence in speaking up*, student nurse participants reflect on how their experiences of raising a concern have influenced their willingness to speak up in the future. Nurse mentors and personal tutors discuss their perception of student nurses raising concerns and contributing to the wider role of enhancing safety and driving quality improvement in clinical practice.

6.2 Preparing students and mentors to raise concerns

This sub-category begins by exploring how students were prepared, in university, for raising and escalating concerns. A 'preparation for practice' lecture was timetabled for all student nurses before embarking on each practice learning experience and included information on raising and escalating concerns. However, student recollections of what information was provided on raising concerns varied.

We have had a few lectures on it... I think we had a PowerPoint and info on learning central about where to go if you want to escalate concerns and how to do it and that kind of thing. I haven't read that much into it I got to be honest. (Donna, student nurse).

They didn't really tell us how to escalate concerns. It is online and you have the forms to escalate any concerns, but they don't tell you who to talk to... who to contact or how to deal with things. (Carys, student nurse).

Oh, yes, it's drilled into us from day one. The Nursing and Midwifery Code of conduct and patient safety. How to report and who to speak to..., that patient safety is key in practice and if you see anything then it should be reported because you're just as bad as the one doing it if you don't report them (Helen, student nurse).

Helen recalled that the importance of raising concerns was emphasised and clearly linked to patient safety and the NMC Code. In contrast, Carys felt that there was a lack of practical guidance provided and Donna appeared uncertain as to the content covered. Helen's quote "you're just as bad as the one doing it if you don't report them", highlights the seriousness of remaining silent if wrongdoing is identified. This underpins the expectation for students to raise concerns if patient safety is compromised and attempts to appeal to the student's own moral compass of doing the right thing.

Perceptions on the frequency and efficacy of these sessions also differed between students. For example, Owen found the lecture to be repetitive and overly focused on the process of reporting concerns.

We have preparation for placement sessions which we have before every placement which I find a bit much, a bit overkill. Especially as it is very much focused on 'if you see something that's not very good then here is the flowchart showing what to do and how to report it'. So yes, I am aware, speak to your mentor, speak to your ward manager or if you are not comfortable with doing that then you have your link lecturer, your personal tutor (Owen, student nurse).

We are told about the procedure and how to go through it but that was probably the beginning of the first year and it's not really reinforced (Becky, student nurse)

In contrast Becky (student nurse), recalled the lecture being conducted at the beginning of the year but felt that this was not revisited on a regular basis. Information on raising concerns was provided before every placement, this equates to at least two to three preparation sessions a year.

The data extracts above demonstrate how student needs and expectations differ in relation to the content covered in preparation sessions and how often the information needed to be reinforced. Sally's quote below acknowledges the practical guidance provided within the lecture, but also recalled how an example of a serious clinical error was shared.

They tell us about raising concerns, the process to go through if we have any concerns and who to talk to and gave us examples of things that happen when people didn't raise concerns. A gentleman actually died because a student nurse noticed that an x-ray was back to front on the board, and they were operating, and they took out the wrong kidney. But the student nurse was too scared to say anything. So, they make sure that you feel confident to be able to speak up. (Sally, student nurse).

Recounting the tragic outcome of not speaking up clearly struck a chord with Sally. The message portrayed to students was that disastrous consequences could have been avoided if the student had been confident enough to voice their concern. However, it is not clear how these sessions alone would necessarily promote confidence. In fact, the findings identified that many of the student participants did not feel confident to raise concerns, particularly in the early stage of their undergraduate programme. The data extracts above also demonstrate that the content of preparation sessions does not meet all the student's needs.

Box 11- Memo Perpetuating the fear of speaking up [29/5/17]

*The session that Sally described on raising concerns, outlines the consequences of failing to speak up when safety is breached. Sharing these horror stories are remembered and recounted by students. However, in relation to speaking up, several students are telling me that they would like to know what happens when students **do** escalate concerns and report unsafe practice, rather than just hearing about the consequences of **not** speaking up.*

I wonder why the positive impact of raising concerns is not discussed in these 'preparation for practice' sessions at the university. A fear of the unknown is cropping up frequently in my data and this appears to be reinforced in lectures.

The students taking part in this study identified the need to understand more about the entire trajectory of raising concerns, and the positive impact of speaking up, rather than only focussing on the consequences of remaining silent.

I feel like the only thing that will encourage students to escalate concerns would be actual student stories and have students actually saying what they've done and what happened and stuff because it's all well and good lecturers telling us to do this but that would probably be a good idea. (Donna, student nurse)

Maybe a lecture that goes over the process and tells you what happens when you raise concerns, because I was really scared and was thinking what is going to happen? Am I going to have to testify in court or something? If you see something horrendous, I guess it could get to that stage. If maybe a student who has raised a concern came to talk to us about their experience and said you know, 'I was scared but I don't regret doing it', it would encourage people to do it, to speak up. Knowing what to expect I think, because I know some people haven't spoken up because they are scared of the unknown, I suppose. (Mel, student nurse)

Mel's data extract captured the heightened anxiety she experienced after raising a concern. Her fear of the unknown led to her imagining worst-case scenarios, such as having to 'testify in court'. Relaying positive cases and student stories could help to demystify fear of the unknown, which appears to provoke uncertainty and a reticence when students make decisions around raising concerns. Similarly, Donna (student nurse), suggested that lectures on this topic would be more effective if they included learning from fellow students. This may be due to a perception that lecturers, and lecture content, are not sufficiently embedded in the realities of clinical practice and are unable to provide a student nurse's perspective of raising a concern. This resonates with earlier chapter findings on the teaching-practice gap and provides one solution which may help to bridge this chasm.

The students in this study suggested that hearing first-hand accounts from peers who had raised a concern would provide useful insights into the reality of escalating concerns on clinical placement. However, as illustrated in the data extract by Neil, caution should be applied to negative experiences, which, when shared within student cohorts, appear to deter students from raising concerns.

One of my friends in the cohort raised concerns about standards of care in a placement and regrets it because of the amount of aggravation. It ended up she had to be interviewed and statements... A really long process and she just wanted to put it behind her and move on. I think it may have influenced some people in my group of friends. (Neil, student nurse)

Student-led sessions could provide advice on how to manage potential repercussions, as well as celebrating the positive impact of raising concerns. The importance of sharing positive accounts of students raising concerns was echoed by Kim (personal tutor).

I think we need positive examples of where students have raised concerns, and something has been done. ...when you're preparing for practice, to say, 'this is part of your role now'. ... Because it's like any other skill. Raising a concern is a skill and you need to be able to give people the tools to do that job. I don't think we prepare students for that role necessarily. (Kim, personal tutor)

Kim makes an interesting point in that if students are expected to raise concerns effectively whilst on placement, then they need to be specifically prepared to do this. Personal tutors also suggested that students needed the 'tools' and specific skills in order to confidently raise concerns.

Maybe more resilience and boosting confidence and empowerment, that kind of thing. (Barbara, personal tutor)

The debriefing sessions that we have post-placement are really important so that people have a chat, discuss things, and have time to mull things over. Enable them to develop a toolkit or skills set of, 'okay, how did I feel last time I went through this? ... it unsettled me but I recognise it this time around and I know if I chat to somebody I might feel better or who do I need to raise that concern with? So maybe there's an opportunity for us as academics, as a HEI to put something in place to help those students to develop themselves, to enable them to be able to articulate better, to advocate for them better. I don't think they have a problem advocating for patients, I think they've got a problem advocating for themselves. But I think reflection is key... Dealing with the emotional turmoil that comes with professional practice. (Olwyn, personal tutor)

Providing students with the opportunity to critically reflect on their clinical placement, to focus on building resilience, articulating better and with more confidence, were highlighted

as key elements of a toolkit needed to empower students to speak up. Claire (nurse mentor) also stressed the importance of developing communication skills by using scenarios within the undergraduate programme.

Well, they need to do scenario learning as one of the first things. I think sometimes and I don't mean this rude, there is a fine line between cockiness and confidence isn't there? Some of them [students] do come across quite cocky. I haven't got a problem with people being confident but sometimes they just tip over into the cockiness. So yes, there is a way of saying things, I think. So maybe they ought to be a little bit more aware of this. I mean you can get peoples backs up if you are cocky. (Claire, nurse mentor)

Similar to Olwyn's view that students need to 'articulate better', Claire identified over-confident communication approaches. Attempts to raise concerns or challenge practice have the potential to be interpreted as the student being 'cocky'. Moreover, this over-confidence may influence the mentor's interpretation of the message and in turn how they respond. There appears to be a fine line between demonstrating assertive communication and being perceived as over-confident. When I asked student nurses about the skills required to communicate concerns effectively in practice, Emma identified the need for further training on managing conflict.

I was wondering if this year we might get some conflict management lectures anyway or just managing difficult situations? In the second year going into the third year, you need to learn how to manage people and delegate, manage conflict, so I feel like we would need some guidance. I've taken out books in the library on conflict management. I know it's an area I will need to work on, so I do feel like we need maybe more knowledge on it. (Emma, student nurse)

Interestingly, in chapter four Emma discussed that her decision to remain silent after witnessing poor practice was due to a lack of confidence in approaching staff with her concerns. Her past experience may have influenced Emma's need for knowledge and skills in conflict resolution to manage challenging situations including raising concerns.

Preparing student nurses in the university to raise concerns can be challenging. The data extracts above identify differing expectations and learning needs which may well be dependent on experiences of different types of practice, norms, and cultures. One issue that many seemed to agree on is that peer to peer learning (students), and an injection of reality into classroom learning, might better prepare them to raise concerns in clinical

practice. This may also reduce the fear of negative consequences associated with speaking up.

The university's mentor preparation programme included information on the mentor's role in responding and managing student concerns. A consistent message, within the data generated by mentors, was that more information on the theory and clinical skills content of the undergraduate nursing programme should be included within the mentor preparation programme.

The findings in this study have illustrated that mentors who were unapproachable, or responded negatively to concerns, perpetuated an unfavourable context in which to raise concerns. Liz (nurse mentor) discussed the need for more emphasis within mentorship training on how mentors respond to student concerns.

There is scope for more focus on dealing with concerns in the mentorship training. I'm just thinking about some of the colleagues I work with. If they were challenged, I don't think they would act. It needs to be addressed because people are encouraged to speak up now aren't they. They raise concerns but I don't think with some people it would go down very well. I think it would be quite a shock to some mentors if a student challenged them. I don't think they would know how to react to it but would take offence. (Liz, nurse mentor).

The extract above indicates that a change was being detected by the mentors and that raising concerns has previously been considered as counter to the norm. Liz's quote above highlights how communication encounters are dependent on the nature of interactions between student and mentor. Mentors could potentially feel threatened by a student and take umbrage if concerns or questions were raised by students in an over-confident manner. Equally, mentors also need to consider how they respond to concerns constructively and appreciate the significance of their role as a support and conduit for concerns. Effective communication skills are required on both sides and the mentor-student dynamic will influence the relational interplay between student and mentor. To this point, what is becoming clear is that sensitive two-way communication is required on both sides and genuine inter-action.

The data extracts from Carys and Sarah (student nurses) give credence to Liz's perception of mentors not wanting to be questioned or challenged by student nurses.

I think the thing that I've become aware of is that I'm a very curious person and ask lots of questions, but that can be perceived as picking holes in practice. So, I never ever thought of it like that. I thought people would like questions, but they don't. Like you ask, 'what are you doing, why are you doing that for?' in a nice way not kind of 'what did you do that for it's not evidence based?' (Carys, student nurse)

I think she [mentor] would see it as me threatening her or challenging her care and thinking I've been doing this for years, who does this student think she is sort of thing (Sarah, student nurse)

Contrary to Liz's observations of a student's over-confident communication, Carys discussed her emerging awareness that posing questions and challenging practice needs to be carefully worded. Questioning and challenging the mentor can potentially contribute to improvements in patient care and can be utilised as a precursor to formally raising concerns. Therefore, a mentor's discouragement of questioning is concerning from the perspective of raising concerns. Students can be over-confident, but also can be over-curious when not aware that questioning can be considered threatening. Carys's awareness of this has grown, and sometimes only experience can lead to this. Perhaps this is an aspect of raising concerns that could be discussed in class via 'real life' accounts of students raising concerns.

These study findings indicate that formal mentor preparation could provide more information on the theoretical aspects of the undergraduate nursing programme. This would provide mentors with more insight into the theory being taught and help to bridge the gaps. More importantly, it could enable mentors to manage student expectations and in turn reduce concerns that arise from misunderstandings of care.

The nursing undergraduate programme and mentor preparation, needs to emphasise the importance of interaction and relating to each other in a positive way that will facilitate learning and promote mutual respect. There also needs to be sensitivity to context, for both speaker and listener, and the importance of bridging the gap by introducing these realities into the students' classroom and training of mentors. The next sub-category will focus on the participants' awareness of relevant policies and guidelines on raising and escalating concerns.

6.3 Utilising policies and guidelines

The university's Raising and Escalating concerns Policy (2016) provides guidance to student nurses who wish to raise concerns that are identified within the clinical placement. The policy also provides guidance for academics and clinical staff (such as personal tutors and nurse mentors) who may need to respond to these concerns. One feature of the guidance is a flowchart which provides the steps to follow when a concern has been identified. In addition, examples of concerns are provided to guide students in their decision-making. The terminology used within this policy is deliberately broad as it needs to reflect all roles in use within the School of Healthcare Sciences. The concern should then be escalated to the professional head of nursing who is based within the university.

Student nurses and academics can access the policy via the university's virtual learning environment (known as learning central) and mentors via the local health board intranet. However, accessing the policy was an issue identified by student nurses who could not recall how to locate the policy and found the intranet difficult to navigate.

I was aware of them [policy] but I think they could have been a lot more clearly presented, because they are not easy to find especially on learning central. I think there needs to be a place where you can find the policies (Becky, student nurse)

I just look at it online, but then you have to trawl through. I couldn't tell you now when we had the concerns lecture. I know we've had one and we would have had one at the beginning of this year. I guess if it was there in front of you in your portfolio then it's there 24/7 to have it in your portfolio written... like have a flow chart or something. (Jess, student nurse).

Jess makes a valid point that students would benefit from having a simple flowchart of the raising concerns process serving as an aide memoir within their portfolio. The data extracts above, stand in direct contrast to Neil who was not aware of the content of the policy.

I don't know the proper guidelines or policy, but I would treat it informally and just go and default to whoever I was comfortable with. (Neil student nurse)

Neil acknowledged that he would rather approach someone he felt comfortable with, which could potentially be a clinical or university staff member, a point reinforced by Sian.

The policy is very clear into my mind. The student sees something that they feel is wrong and it does guide them to raise it locally first. However, if they can't or that hasn't had a good effect, then obviously they bring it to the school. It can come into the school in many ways. It can come in via a personal tutor, programme leader,

cohort lead, placement lead, a link lecturer, someone who happens to be teaching them that day and they got the courage to say it or someone else's personal teacher ...You'll never control that or stop that happening, because the key issue is that the student feels confident to speak out. (Sian, Senior Academic)

Sian recognised the importance of students having the courage to raise their concern with someone. For two of the students, the fear of speaking up prevented them from following the guidance of the raising and escalating concerns policy.

Yes, we were told how to raise concerns and I think online on the shared drive there's a raising concerns thing that tells you what to do. So, you could access that if you needed to. Um I just didn't, too scared I think (Cath, student nurse, page 10)

PB: *Have you been given any guidance from the university in relation to raising concerns?*

Emma: *Yes, they did, but again I just didn't feel like I could. I know there were other students who had concerns but didn't raise them*

Cath and Emma's data extracts highlight the emotive nature of raising concerns. If the student feels 'too scared' to voice their concerns, then having access to the policy is futile. The data here illustrates that the immediate context of the organisational culture and the staff within it, or at least the students' perceptions of this and how it could result in detriment to their learning could influence whether students raise concerns or not. In this sense the policy is only as effective as the culture allows it to be.

The nurse mentors had access to the local health board policy on raising and escalating concerns as well as the university policy. However, only a small number of mentors were aware that the university policy was available on the nursing intranet. In the quote by Fran (nurse mentor) she refers to accessing the 'whistleblowing policy' which was the health board policy.

Well, you can pull off the whistleblowing policy and that's what I went by (Fran, nurse mentor)

I'm sure there is stuff on the intranet. The practice facilitator would point me in the right direction anyway so I could always get advice. . I'm confident I could find it. (Ann, nurse mentor)

Ann suggested that she would ask the practice facilitator for advice on raising concerns guidance and this was echoed by other nurse mentors.

The practice facilitator told me what to do. (Ellie, nurse mentor)

Yes, my first point of contact would be with the clinical teacher [practice facilitator]. In my lead mentor box, there's an escalation policy for raising concerns, so I would tend to pull that and dust it off and have a look or just contact the practice facilitator who'd be able to pass it on to the right person to speak to. So, yes just a phone call away. (Michelle, nurse mentor)

In fact, the majority of the nurse mentors described their reliance on advice from the practice facilitator, rather than referring to the escalating concerns policy. Nurse mentors often developed collegial relationships with their practice facilitator which provided an ideal forum to discuss issues related to concerns. Furthermore, the practice facilitator team were easily accessible and on hand to respond promptly to mentor queries. These factors provide a rationale for the mentor's decision to contact practice facilitators as opposed to accessing policy. This is not captured within the formal university policy but could be interpreted as the informal sensemaking and "work" that goes on to practically respond to students' concerns. An example of this informal sensemaking is described in Brett's data extract below.

***PB:** Are you aware of any policies or guidelines that are in place to help you as a mentor if students have any concerns?*

***Brett:** Well, you got fitness to practice and the NMC Code of conduct. I've got my own hierarchy here and I often say to my colleagues, 'I don't know what to do about this so give me your opinion'*

Brett also referred to the NMC Code (2015) and the 'Fitness to Practice' procedure (2012) to guide him through the raising concerns process. Referrals can be made to a fitness to practice panel if students fail to adhere to university requirements during their studies. The nurse mentor is more likely to instigate this procedure if they have concerns about the student's conduct in placement, rather than when students raise a concern. The NMC Code provides clear guidance on the need to raise concerns immediately if patient or public safety is at risk (NMC 2018a) but does not include specific procedures for escalating concerns.

The personal tutors appeared to have varying levels of knowledge in relation to the Raising and Escalating concerns Policy (2016). Barbara was not sure if there was a policy and Kim had not accessed the policy.

Do we have the whistleblowing policy as such here? I don't know. (Barbara, personal tutor)

I found it very difficult to work out what to do. I did find like an algorithm [flow chart] that had first of all they should go to their mentor or the ward manager and take it there. So, I felt like we stumbled at the first hurdle because I was advising that she needed to tell the mentor and she didn't feel able. I spoke to the link lecturer who helped to resolve the situation and as far as I'm aware that wasn't on the algorithm at all. I didn't really know what to do or who to turn to. (Mia, personal tutor)

Mia also described her uncertainty about the raising concerns process. Referring to the flow chart in the policy as 'an algorithm', she felt that they 'stumbled at the first hurdle' as the student was unable to broach concerns with her mentor. However, the guidance indicates that students, as a first step, can inform a named practice link or academic support (such as a personal tutor). As Mia was the personal tutor, she fulfilled the appropriate first line contact for her student to raise concerns to, although she clearly required further support in escalating the issues raised by her student and seemed to find the guidance incomplete and unhelpful. Kim was aware of the policy but acknowledged that she would only consult it when she needed to.

There is a policy and things, but I can't say I'm particularly familiar with it. The first thing I would do is look to see what the actual policy would say about it because I always find it's like any policy, until you need it you don't really look at it. (Kim, personal tutor).

Despite having supported a personal student who escalated a concern in practice, Kim had not referred to the raising and escalating concerns policy. However, in this instance the concern was managed by the nurse mentor and escalated appropriately, which may explain why additional guidance was not required. On the other hand, Olwyn was very familiar with the raising concerns policy and found it a useful tool to structure managing concerns, in conjunction with additional support.

I think they are guidelines, and they will never cover what you really want them to cover, but if you take the stance that more heads are better than one and just call on people that you need and you know can help. You are dealing with such grey areas sometimes. Complaints can be raised on all sorts of issues, and they are grey because they are due to human factors the vast majority and how can you address all with a policy? So, they are very useful tools, but I don't think they are the be all and end all. (Olwyn, personal tutor)

Olwyn acknowledged the benefits of having policy guidance, but also referred to the 'grey areas' or complex nature of concerns that are impossible to capture within the policy. Interestingly, the term 'complaints' is used rather than concerns. The interchangeable use

of these terms was noted throughout this research study, although they differ and are addressed using different channels. For example, complaints should be addressed via a complaints or grievance procedure (NMC 2019a). Accessing help and support from other staff was identified as a useful strategy alongside accessing policy. These informal networks were similar to those accessed by the nurse mentors. Support was available for students, mentors, and personal tutors in relation to raising concerns. However, findings from this study suggested that students needed more clarity on the nature of the support roles available within clinical practice and academia.

6.4 Accessing support

Most of the participants in this study identified that support, for students and nurse mentors, was available in clinical practice from practice facilitators or from link lecturers. However, there appeared to be uncertainty amongst the student participants of the nature of these clinical support roles when raising concerns.

I hear different titles mentioned, but they are just names, so I don't know who they are or what they all do. (Emma, student nurse).

I think there should be a bit in there [mentorship programme] to say who supports who as our mentors get confused by what the PF does, the link lecturer and personal tutor. (Tina, nurse mentor)

I guess a clarification of those roles because I'm still not entirely sure what I should talk to the PF about and the link lecturer. (Sarah, student nurse).

Although the overall roles and responsibilities of the link lecturer and the practice facilitator (PF) were outlined during the preparation for practice lectures, it was unclear whether their role extended to supporting students and/or mentors in the process of raising concerns. More clarity was needed on whether this was specifically discussed within these sessions. Student nurses shared their experiences of being visited by these staff whilst on placement.

On the placement I've just been, someone actually came out from the university and asked me how things were going along which I really liked and I feel like if that had happened on that ward [where the student had concerns] I think I would have said straight to her look this is going on and I hate it can you sort me out... on my last placement they had someone come out to do mentor stuff sort of a recap which was really good so then obviously they were up to date and knew what needed to be signed (Mel, student nurse)

Mel discussed the benefits of practice facilitators providing mentor updates in clinical practice. She also suggested that placement visits from academic staff could encourage and help students to raise concerns on placement. Faye (student nurse) made a similar point:

I feel that there need to be more links. I saw a practice facilitator on my first placement, and I haven't seen anybody since until this placement and that's the difference of seven placements. So, I do feel that in the nursing home situation if someone had popped in, I could have raised my concerns. But I didn't know who to turn to. (Faye student nurse).

Unsurprisingly perhaps, students wished to see academic staff more regularly on placements. Although contact details for practice facilitators and link lecturers are available in all clinical areas for students, a more regular clinical presence was required. This could facilitate the discussion of concerns and resolve problems at an early stage if there was someone to speak to. However clinical visits which provide support for students, work best when the surrounding clinical environment is conducive to discuss concerns.

I was in the corridor on this one day and this incident had already happened, and I was unhappy. I remember this link lecturer coming around and saying, 'how are you finding placement and have you got any concerns?' but she asked me in the corridor with lots of people around and I wasn't about to say 'well yes actually....' So maybe on a placement just make themselves known and this is my office or email... if they could have one day in a week where we could have a meet and greet and say has anyone got any concerns. I might have been more inclined to stay behind and say well actually this and this have happened, rather than waiting to go into uni at the end. But asking me in the corridor, I'm not going to rattle off my concerns. (Cath, student nurse)

This resonates with the findings discussed in chapter four which identified students reluctance to upset the status quo by speaking up. In this instance, it was clear that Cath's awareness of staff being within earshot acted as a barrier to voicing her concerns. This data extract is significant as it illustrates how perceptions of an unfavourable context inhibit concerns being voiced. Cath's practical suggestion of having the opportunity of a timetabled meeting, in a private location, would have provided a favourable environment to raise concerns and facilitate open communication.

Additional support roles were suggested by the study participants in relation to raising concerns. Nicola (nurse mentor) reflected on the traditional clinical teacher role whereby

university staff would undertake patient care with students in clinical practice. This model was suggested as a useful way of facilitating the discussion of concerns.

How about clinical tutors? Someone who comes around in uniform and maybe goes 'ok we are going to do a wash with a student'. I think someone like that would be quite appropriate who they know their face well. Someone who looks after the student in the whole hospital and that's their job to go around teaching and then after they've done the wash the student might feel comfortable to say, 'I'm a bit concerned about something that's happened and they trust someone that they know. Just someone they can approach and then maybe that person could approach the ward. Someone who is in-between the hospital and the university. (Nicola, nurse mentor)

Here Nicola alluded to a model of clinical education that is no longer in place locally. The relationship between student and clinical tutor was described by Nicola as being underpinned by trust, familiarity, and approachability, which mirrors the features required for an effective mentor-student relationship. This model appears to position the clinical tutor as a conduit between the student and staff working within that clinical area. In this instance the clinical tutor acts as a "buffer" who could escalate concerns on the student's behalf. This practice education model outlines several features that facilitate a favourable landscape for speaking up and raising concerns. Here, the clinical tutor would be ideally placed to role model positive speaking up behaviours. However, to optimise learning the clinical tutor would be required to involve the student in all aspects of the raising concerns process. This point was reiterated by Sian (senior academic):

I'm very keen for students to take responsibility for their actions. So, if a student can hand it over, that may separate them from the process [raising concerns]. I quite like to see them very much part of that process. (Sian, Senior Academic)

The importance of student nurses taking and maintaining ownership of raising concerns was discussed within the previous findings chapter, where personal tutors' well-intentioned support occasionally over-shielded students to the extent they were removed from having any further dealings with the concerns process. Handing over concerns to be dealt with by someone else may similarly prevent students from developing their knowledge and skills in raising concerns and fail to prepare them for dealing with concerns in the future. I asked the student nurse participants about their perceptions of specific roles that have been created in England to assist raising concerns.

PB: *In England, some health boards have a speaking up champion or ambassador for raising concerns. What are your thoughts on that?*

Jess: *I think that would be really good actually. But then does it not take away the fact that you should be challenging the person you are working with. I don't know.*

Jess's response echoes Sian's earlier point about students taking responsibility for raising concerns. It is unclear whether having a dedicated role for staff raising concerns would inhibit or enhance open discussions as part of everyday clinical practice. However, concerns should ideally be raised locally by the person who has identified the concern. A speaking up ambassador role may only come into play if the response is inadequate. Owen (student nurse) shared his insights on an alternative source of support when raising concerns.

I think what would be really helpful is a system of pastoral support where it wasn't being provided by a registered nurse. You can go to student support services for counselling or whatever, but they don't necessarily understand what you're talking about. So, they can't help you work through a situation and learn from it... I can't go to my personal tutor and work through something that I've seen or done on placement, because she will ask me did you report it? I think you need that support to help you learn. How do you work out whether to report something? I don't think current nurses who work to the code are able to do that. If I sat here and told you on this ward on this date, I saw this and this happen and I didn't report it, you would have to do something about it, irrespective of whether its research or a personal tutor meeting or a piece of academic writing. I couldn't have that conversation with a registered nurse because they have a professional obligation to do something about that (Owen, student nurse)

Owen's thoughtful data extract above, illustrates the complexity of disclosure within a regulated workforce who have statutory obligations to respond and be open about concerns in the workplace. This highlights the conflicting nature of the personal tutor as a registrant who also undertakes a pastoral role. There may be advantages to having a dedicated confidante who is not a registrant. However, having the opportunity to discuss concerns with staff, who have a healthcare background, is also beneficial in relation to decision-making.

It could be argued that specific roles dedicated to supporting speaking up have benefits and barriers in relation to encouraging healthcare staff to communicate concerns as they arise. However, ultimately, all of healthcare needs to develop an open culture where staff can discuss concerns freely and as a normal part of day-to-day practice. The next section explores how students experienced and reflected on their experiences of escalating concerns.

6.5 Developing confidence in speaking up

This sub-category discusses how students' experiences of raising concerns influenced their propensity to raise concerns again in the future. For many students, a surge in confidence as a result of experiencing the process of raising a concern appeared to be a factor in their willingness to speak up again.

Scary but so worth it, so (emphasises so) worth it. Also gave me confidence that if I don't think something's right in future, I will speak up about it. (Sally, student nurse).

I would definitely do it again and maybe I would be confident enough to not go via the tutor route. It's hard to say and all depends on the scenario, the team and of course your mentor. It has made me a lot more confident in my professional integrity ... So, it was nice to have done it and proved to myself that I can do it and that's what we are supposed to do if we see things, we are not happy with. I am confident I could do it again and maybe care less about the ramifications because I was nervous to do it the first time, but now I know the process I would do it again. (Sarah, student nurse)

Raising concerns for the first time appeared, understandably, to be an emotive experience for student nurse participants. Despite this, raising a concern on placement increased confidence and the willingness to speak up in future. In particular, Sarah acknowledged that fearing the repercussions of speaking up would not feature as strongly in subsequent decision-making. This was due to a greater understanding of the process but may also have been influenced by the positive response she received after raising concerns, and her involvement in changing practice on her placement. However, deciding who to approach with concerns in the future, remained dependent on Sarah's assessment of the mentor and clinical team. The ongoing appraisal of clinical staff also appears to influence whether concerns would also be discussed with her personal tutor prior to voicing concerns in clinical practice.

Other student nurses described how their responsibility to speak up and advocate for their patients became more apparent as they progressed through their undergraduate programme.

Because I'm in my third year and I know a bit more and I'm due to qualify so it's kind of my responsibility now. But I guess because I was in my first year, I felt a bit unsure about the whole situation. So, I would do things differently now and definitely speak up. (Jess, student nurse)

Yes, I would say something, and I don't know if that's to do with confidence or more aware now of my role as a nurse. You have to speak up for patients, whereas I think as a student nurse you're a bit protected, but now I'm getting closer [to registration] and I think you know why they want you to raise concerns. It's not just about that one patient it's about every patient that person looks after (Cath, student nurse).

Cath suggested that student nurses may be protected from having to raise concerns. However, this statement is ambiguous and open to interpretation. Cath could be referring to being protected by a lack of expectation that they should raise a concern, or perhaps protected by having a personal tutor to rely on. However, Cath described her growing sense of responsibility and confidence as she neared registration, suggesting more awareness and knowledge of the raising concerns process which alters the students' mindset.

Mel also discussed how her confidence to speak up had increased since she raised concerns in her first year of nurse training. Over time, she also accrued knowledge and experience, and this increased her confidence in recognising poor practice and raising concerns.

Well, I definitely would have more confidence to say that's not right. Because I was only in my first year when it happened, and I had never worked in a hospital before... I didn't really know. But now I've had more placements to compare it to and I would know now 'that's not normal practice' so I would have more confidence to speak up. (Mel, student nurse)

The quote above highlights Mel's uncertainty as a novice student in identifying concerns and care that deviated from 'normal practice'. In her first year she describes the adage of 'you don't know what you don't know', a sense of naivety which made her question whether the nursing practice she observed was a concern or not. However, knowledge and skills were developed as placement experience increased and this boosted her confidence to differentiate between acceptable standards of care and areas of concern.

The importance of student nurses identifying and raising concerns was emphasised by personal tutors.

I think they [students] are absolutely vital. They can raise red flags at an early stage, and I think that's vital to the organisations [health board and university] and I think we should value their feedback. (Kim, personal tutor).

They've got fresh eyes that come into clinical placement, and the previous placement may have had some really good ideas that they can then bring to the current area. I appreciate it's difficult because people are entrenched in their own areas. You've been working somewhere for a very long time, and you don't see

things the same. You see the barriers rather than the enablers. I think they [students] are vital to make those changes. That makes them a stronger practitioner when they qualify, so that they are ready. (Olwyn, personal tutor)

Student nurses' experience care giving in a number of diverse placement areas that allows them to experience healthcare in a variety of contexts. Entering new clinical environments enables students to see care being delivered with 'fresh eyes' and to pick up on deviations from the expected standards of care which may have gradually eroded over time to become normalised. Olwyn suggests that staff who have worked in a clinical area for a long time may become accustomed to or 'entrenched' within these ways of working, as a result they may find it challenging to change established and normalised practices. In this sense students may contribute to quality assurance by providing positive or constructive feedback on how clinical teams and individuals perform. Perceptions of students' informing practices and facilitating change were also discussed by nurse mentor participants.

you get a fresh pair of eyes coming in and maybe they question why we do something this way or 'we were taught this way in college so why are you doing it like this?' Because we do get stuck in our ways don't, we and I think it's really good. (Liz, nurse mentor)

I love having students myself because they have the most up to date knowledge, up to date research. They bring fresh ideas and all kind of new things to the table. (Leanne, nurse mentor)

However, the points above need to be considered alongside the need for both students and mentors to be open and responsive to productive dialogue and not be cocky or dismissive of good ideas. There was also some doubt about the student's role in quality improvement and changing practice. Simon (personal tutor) believed that making changes in the practice setting was not the role of a student nurse.

I don't think students are the right people to be making those changes as they are not empowered to do so. Their priority is getting their portfolio signed and getting on with people (Simon, personal tutor)

Simon's views reflect some of the students' earlier views that their priority at all times is to get the portfolio signed. Simon seems to suggest or reinforce the idea that these two things cannot exist simultaneously. This begs the question of whether student nurses pick up on this premise from personal tutors.

This study has found that in raising concerns, students were not only capable of halting poor care but in some cases were driving quality improvements and making a valuable contribution to positive change in nursing practice. However, personal tutors alluded to the need to focus more on empowering students to confidently raise concerns in practice. Concerns about the student's role in maintaining care quality and patient safety were echoed by Sian, who alluded to the ethics behind the expectation of student nurses acting as change agents.

Well, it's the whole issue isn't it and the ethics of using students as change agents which really we're sort of talking about and actually registrants should be vigilant as to what other registrants are doing, so this isn't only an issue for students, I think this is an issue for all in this whole post Francis culture. If a student notices poor practice, I would be confident that registrants on that placement has also seen it so what's stopping them from speaking up and speaking out? (Sian, Senior Academic)

The issue of students' 'fresh eyes' leading to practice change is important, but as the data shows here it can be potentially contentious and risky for students. Admittedly, as this chapter's findings have demonstrated, students are well positioned to inform and generate changes.

6.6 Chapter summary

This category of 'equipping with the right toolkit' has explored how student nurses develop the knowledge, skills and experience that they require in order to confidently raise concerns in clinical practice. Information on raising concerns was provided to students within the raising and escalating concerns policy (2016) and formal lectures. However, the frequency and content of preparation for practice sessions varied amongst the student nurse participants, with some requiring more guidance on the practicalities of raising concerns. Hearing from students who had direct experience of raising concerns was suggested by many participants as a useful way to gain a real insight into the trajectory of raising concerns. It could potentially lessen the fear of the unknown and the often-unfounded negative consequences so often associated with speaking up.

A key insight within this category was the limitation of the Raising and Escalating Concerns Policy (2016). Participants demonstrated unfamiliarity or no awareness of this policy with poor utilisation of the guidance on occasions. The process of raising concerns was also problematic at times and many students felt unable to bridge the gap between identifying

concerns and speaking up. If students cannot or do not know how to raise concerns, then this largely renders the policy as useless. The policy is also ineffective if the student deems the mentor or the clinical environment to be unfavourable. One might question whether this is a problem with the policy itself or whether this topic is one that needs to be addressed in teaching and support. Perhaps a combination of strategies is required to encourage speaking up. Furthermore, it is questionable whether educators and staff can truly eradicate this fear of repercussion.

A few strategies, which could potentially increase the likelihood of students moving from identifying to speaking up about concerns, were identified. These include enhancing assertive communication, conflict management training and the use of scenarios to role play difficult conversations between students and nurse mentors. A need to focus on harnessing emotions and developing resilience and coping strategies were also advocated by personal tutors. Within mentorship preparation programmes, more attention should be given to how mentors respond to concerns, challenges, and questions. This is relevant, given that students use questioning as an alternative strategy to raising a concern.

Nurse mentors were reliant on the practice facilitator, as a bridge between the HEI and NHS, to provide guidance on managing concerns. Informal sensemaking and networking with colleagues was a powerful presence which informed decision-making by mentors, personal tutors, and students at various points of the raising concerns process. This method of exchanging opinions and seeking support and advice were favoured as an alternative to utilising policy and guidance.

Therefore, these informal sensemaking networks are important, as they reduce the need to use the policy. The policy is viewed as a last resort, to be accessed only if all else fails. Researchers and all those responsible for education should think about these networks/spaces as opportunities e.g., using information to drive what is actually discussed in these spaces.

Students welcomed the opportunity to discuss concerns with support staff in placement areas but argued that a private and safe space would optimise the likelihood of voicing concerns. Discussions regarding the introduction of a designated person to discuss concerns with was met with mixed results. One student nurse favoured a designated role

for managing concerns, whereas others felt that that this might disengage the person from the process and inhibit learning. In addition, the benefits of disclosing to a registrant were offset by the potential conflicts of interest that a registrant might have in dealing with concerns. However, this issue could be managed by outlining expectations around the discussion of concerns.

Importantly, length of time and experience on the nursing programme appeared to influence a student's ability and confidence to raise concerns. Many students who had raised a concern, acknowledged that they would do so again. Growing confidence and clinical placement experience appeared to be a significant factor in their willingness to speak up again in the future. There was also an overriding sense of increasing accountability and responsibility to raise concerns as they approached the latter stage of nurse training.

Despite placement preparation, access to policy and the benefit of direct experience of raising concerns, assessing the clinical landscape as a favourable or unfavourable environment to raise concerns, continues to be the significant factor in student nurse decision-making. The findings of this chapter suggest that students would raise concerns in the future, but to whom will be dependent on the perceived approachability of staff in clinical and academic settings.

6.7 Presentation of the grounded theory

As a result of the theoretical analysis, the core category of 'reading the context' has been generated from this study. The student nurse continually evaluates the context of the organisation (clinical placement) by interpreting signals and cues. These provide an indication as to whether raising a concern is likely to be met with a positive response (favourable) or considered to be a risky endeavour (unfavourable). Box 12 presents the proposed grounded theory.

Box 12 – Proposed grounded theory of - ‘Reading the context’

After identifying poor care or wrongdoing, student nurses navigate their way through the trajectory of raising concerns, by continually ‘**reading the context**’ of the placement as either favourable or unfavourable to receiving concerns.

Although the mentor-student relationship is a significant contextual factor which is taken into account, this dynamic process of sensemaking sees other mediating signals and cues also contributing to student assessment of favourability. Making sense of these cues, which are fluid rather than fixed, provide an ongoing evaluation of whether the practice context is a safe environment in which to raise concerns, or too risky.

The assessment of the organisational context is not a static process but is dynamic and fluid. Contextual sensemaking begins as soon as the student identifies a concern. At this point, the student deciphers the perceived severity of the action or behaviour that they have witnessed. They look to the subject of the wrongdoing and to bystanders to monitor reactions to the event (a process referred to in the data as ‘suss out’) Here, the student undergoes a metacognitive process to think carefully about what they have witnessed and make sense of their observations before considering what the next step should be.

Signals and cues regarding the supportiveness of the organisational culture, including the clinical team, clinical manager and in particular the nurse mentor, are crucial in students sensemaking and provide an overarching assessment of a speaking up culture, favourability, and responsiveness. If a student perceives the nurse mentor to be supportive then this provides a favourable environment to potentially voice concerns. The appraisal of interpersonal relationships is integral to decisions regarding context favourability and is dependent on the contextual signals or mediators that influence decision-making, actions, and outcomes in relation to whether concerns are raised. The cues can include verbal interactions that may directly involve the student or can be observed encounters between team members. Signals can also be non-verbal such as facial expressions, body posture or avoidance. However, these cues can also be ‘fluid’ in that students’ assessments of contexts for speaking up can switch from favourable to unfavourable, or result in overall uncertainty.

If the contextual cues signal an uncertain or unfavourable environment, where the risk is perceived to be too great, students will bypass the mentor and clinical team and seek a more conducive environment. The university can be perceived as a 'safety net' for student nurses, providing a more favourable and consistent context to discuss concerns. In particular the longer-term relationship between personal tutor and student nurse positions them as a suitable person to broach concerns with and promotes psychological safety in discussing concerns. The personal tutor role in providing support, reassurance and an opportunity for reflection and debriefing enables a favourable context for raising concerns and professional development in this area.

Figure 17 illustrates the process of context favourability, which has been adapted from Dutton et al. (2002) who explored organisational contexts for issue selling. The contextual cues of the mentor-student relationship, organisational culture and the team dynamics are the areas that potentially influence students' decision-making in relation to raising a concern. The student nurses' made sense of these contextual cues which prompted evaluative appraisals or mediators which helped decision-making.

As a result of this contextual sensemaking, students anticipate whether it is safe to raise concerns, and if so, to whom. Most of the students in this study raised concerns to the personal tutor. A small number of students chose to discuss concerns with their mentor and some to the clinical manager. However, in most cases the personal tutor was also involved, even if the student had raised the concern in clinical practice. This process is illustrated by the dotted arrows in the diagram (figure 17). Remaining silent in this study, occurred when the student believed that the whole team were providing care that lacked compassion. In this sense, the team dynamic resulted in social exclusion and the student's decision to remain silent. However, in most cases the outcome was an identification of the wrongdoing and highlighting concerns to university staff, which resulted in an improvement in patient care and reports of learning from the process of speaking up.

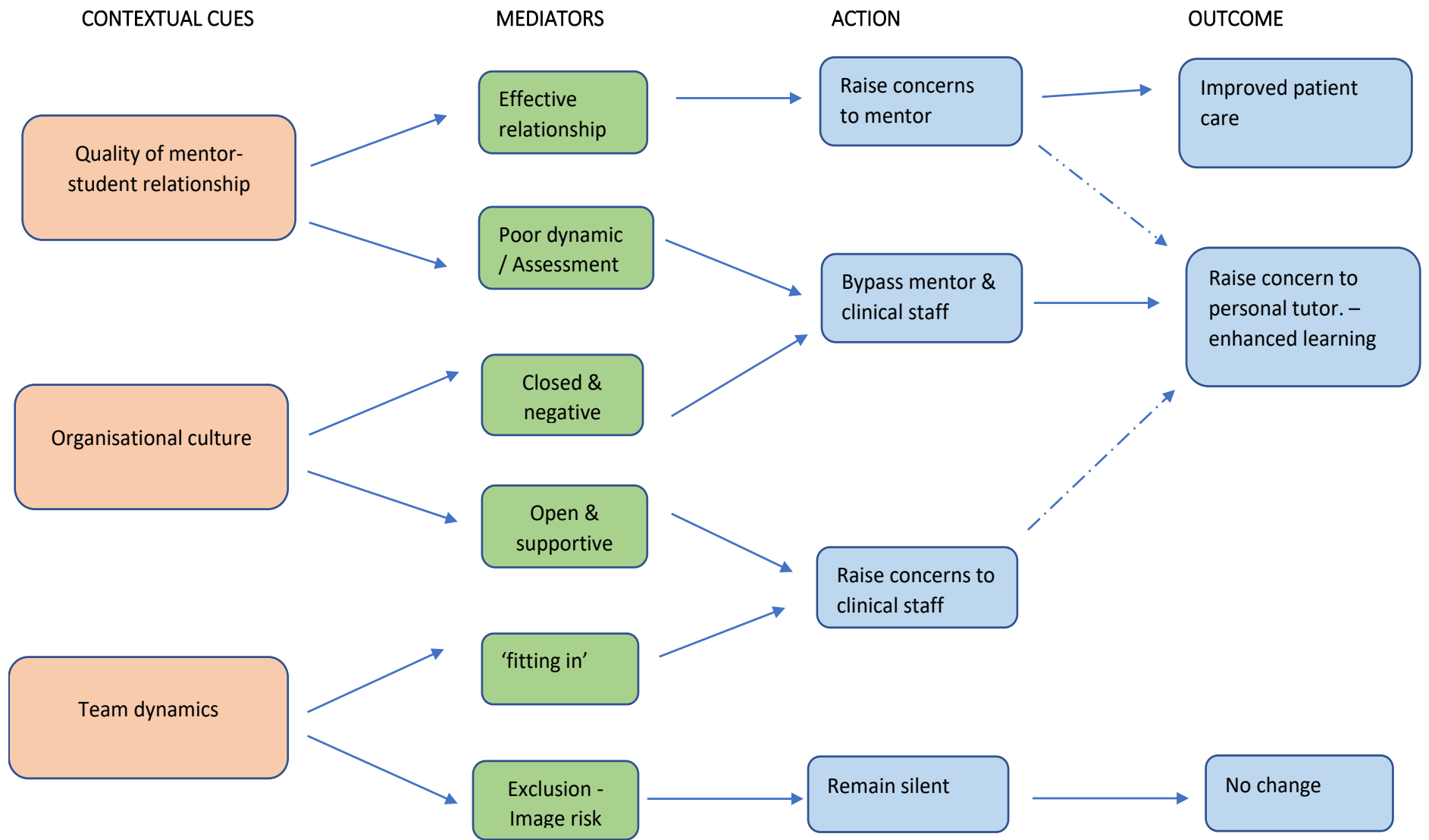


Figure 17 – Process of context favourability (adapted from Dutton et al. 2002)

CHAPTER SEVEN - Discussion

7.1 Introduction to chapter

The aim of this study was to explore the dynamics of raising concerns by student nurses, from the perspective of the student nurse and nurse mentor. As data analysis progressed, the significance of the personal tutor role within raising concerns was identified and they were also included in data collection. A constructivist grounded theory approach was utilised which facilitated the development of three theoretical categories and twelve sub-categories through analysis and interpretation of interviews with nurse mentors, student nurses and personal tutors.

These theoretical categories led to the development of the core category, 'reading the context' which underpins the proposed grounded theory for this study. This chapter presents the concept of context favourability and critically examines the development of the grounded theory. This extends existing knowledge of the complex dynamics involved when a student nurse navigates the trajectory of raising concerns via a dynamic process of sensemaking. It sees the student interpreting signals and cues to determine whether the clinical context is a favourable and safe environment in which to raise concerns.

In developing a deeper and more critical understanding of context favourability, this chapter's first section will explain in more detail the process of 'contextual sensemaking' (Dutton et al. 2002, p.355). This involves the student evaluating the organisational culture, the perceived supportiveness of the clinical manager and team relationships. These cues can all potentially contribute to the student's perception of context favourability and will be critically discussed in light of the study findings.

Thereafter the influence of the mentor-student dynamic on context favourability will be examined and will consider how the concept of power contributes to the relational dynamic and student decision-making on raising concerns. The implications of the mentor-student relationship are also examined considering the recent changes in nurse education within the UK. New education standards of proficiency for registered nurses were introduced during this study which resulted in the development of new roles to support practice learning (NMC 2018b).

An examination of the role of the personal tutor in supporting student concerns will be discussed in section 7.6 and the implications of the academic assessor role in supporting student nurses in practice settings will be debated.

This discussion will be underpinned with reference to contemporary literature, as well as influential research, which has been adapted to underpin the grounded theory of reading the context to establish context favourability. Furthermore, the political and professional drivers which underpin the raising concerns and speaking up agenda will be integrated into this discussion. The following section introduces the concept of context favourability.

7.2 Context favourability

The premise of this grounded theory is that student nurses continually interpret and respond to a number of contextual cues within the clinical placement, and these influence their perception of 'context favourability'. Within this section the origin and development of 'context favourability' will be discussed in relation to its original use within studies, focusing on the concept of 'issue selling' within the business literature. Reading the context to determine whether issue selling can occur, resonates with student nurses' decision-making on raising concerns and speaking up in clinical settings. These concepts can, therefore, be usefully applied to generate a better understanding of the ways in which students respond when confronted with poor care.

Issue selling is an important mechanism in business, whereby employees have an opportunity to bring ideas, information, or issues to the attention of senior management (Dutton and Ashford 1993; Dutton et al. 1997). In this sense, Ashford et al. (1998) suggest that issue selling has a wider remit than raising concerns or whistleblowing and includes the communication of any information that can influence the company agenda or improve the strategic position of the organisation. In comparison, raising concerns in healthcare is focused on bringing safety breaches or substandard care to the attention of someone who can halt the behaviour. However, despite the differing motivations and outcomes that may instigate issue selling or voicing concerns, both are relevant as they involve upward communication (Ashford et al.1998).

The concept of 'context favourability' originates from Dutton et al. (1997) and can be defined as the process of sensemaking. This can be used to evaluate a range of signals and

cues to determine whether a context is favourable or not to act (Dutton et al. 1997; 2002). A study undertaken by Dutton et al. (1997) examined the factors that influenced whether middle managers sold strategic issues to those in senior positions. Thirty managers from a telecommunications company were interviewed to ascertain the features that contributed to a favourable or unfavourable context in which to undertake issue selling. The results indicated that a supportive culture and a manager's willingness to listen, contributed to 'context favourability' or a favourable environment to speak up. Conversely, a fear of consequences or perceived risk to image was evaluated as an unfavourable context to sell issues.

In an attempt to explain the nuances of how context is appraised, Dutton et al. (1997) described how sailors 'read the wind' in order to ascertain safe conditions to sail. This metaphor was usefully applied to explain how middle managers 'read the context' of the organisation to gain a sense of whether the context is favourable (tail wind) or unsafe (head wind) for issue selling (sailing). This dynamic process uses contextual cues to decipher the likelihood of success in bringing ideas and concerns to managers. These contextual cues include; manager characteristics, organisational culture, relationships and cultural exclusivity which is determined by the extent to which employees feel included or disregarded within dominant groups (Dutton et al. 1997, Ashford et al. 1998).

These contextual cues clearly resonate with the findings of this study. Whether it is safe to raise concerns is determined by the student's perception of the organisational culture and leadership, as well as their ability to integrate into the team and establish a rapport with their nurse mentor. The process of assessing these factors amounts to a student 'reading the context' and deciding whether to raise a concern, in a similar way to the sailor assessing whether it is safe to sail or not. Moreover, the sailing metaphor in this study is extended as context favourability continues throughout the whole sailing journey. For example, was the assessment of reading the wind correct in ensuring a smooth passage or does the ship need to change course due to unpredictable weather changes? This study highlights how shifting contexts and conditions alter the student's contextual sensemaking and underpin the entire trajectory of the raising concerns process.

The aim of this study was to explore the dynamics of raising clinical concerns by student nurses, from the perspective of the student nurse and nurse mentor. The nature and

influence of the mentor-student relationship was a significant element of context favourability. Students read signals and contextual cues in appraising the likelihood of being able to establish an interpersonal connection with their mentor. Developing an effective relationship with the nurse mentor was important, not only for a successful placement experience, but also to enhance the context favourability if concerns were identified and needed to be raised.

Ashford et al. (1998) noted the importance of effective relationships when they examined conditions that enhanced or inhibited selling gender equity issues. A trusting, warm relationship between middle managers and critical decision makers decreased image risk and enhanced psychological safety. Milliken et al. (2003) extended this work further in their research which explored the factors that influenced employee silence in organisations. They found that the fear of damaging relationships was a significant deterrent to speaking up and emphasised the 'relational implications' of upward communication. This study noted similar findings in relation to the mentor-student relationship. A friendly camaraderie, rapport and reciprocity between the student and mentor contributed to a favourable context for student nurses to raise concerns. On the other hand, challenging relationships deterred students from speaking to their mentor and saw them 'reading the context' by metaphorically 'changing the direction of sailing' and seeking alternative routes to raise concerns.

Nursing research has also identified how organisational factors facilitate or inhibit raising concerns and speaking up behaviours (Attree 2007; Moore and McAuliffe 2010). More contemporary research studies have begun to focus on the influence of contextual factors on student nurses' ability to raise concerns. Fagan et al. (2016; 2021) identified the significance of organisational factors within their concept analysis of undergraduate students speaking up for patient safety. They provide a useful updated version of Morrison's (2011) employee voice behaviour model and apply this to students speaking up. The model incorporates contextual factors such as workplace culture, supervision and support, organisational structure and professional requirements and position these as antecedents of speaking up.

Within this thesis, the contextual factors highlighted by Fagan et al (2016) are also viewed as important elements that students utilise in 'reading the context' to ascertain a

favourable or unfavourable context in which to raise concerns. This grounded theory adds more life to these concepts and explains how the process of assessing these contextual issues is active and dynamic. Furthermore, this study also further extends understanding of the supervision and support suggested within Fagan's model, through exploring the influence of the mentor-student relationship and the role of the personal tutor.

7.2.1 Context favourability and psychological safety

In this study, the features of an effective relationship with a mentor, personal tutor, manager, and clinical team were all underpinned by the positive traits of approachability, inclusiveness, empathy, and openness. These attributes all contribute to feelings of psychological safety (Ashford et al. 1998; Aranzamendez et al. 2015). This clear link between psychological safety and context favourability deserves further attention. Edmondson (1999) defines psychological safety as a shared belief that the working environment is a safe place to speak up and take interpersonal risks. Applying this definition to student nurses in practice settings, it could be argued that students do not automatically experience psychological safety in clinical settings, but they undergo initial sensemaking to ascertain whether the conditions underpinning psychological safety are present. The notion of initial sensemaking by student nurses, therefore, is crucial in further understanding Edmondson's view of 'shared belief' suggesting that prior to shared belief, students' undergo a process of establishing their own singular views of the clinical context.

To summarise, therefore, this study suggests that sensemaking is a dynamic process of reading the context, where students initially assess context favourability. This strongly suggests that psychological safety is highly conditional and fluid and needs to be generated and signalled by staff working in clinical areas rather than assuming it is a given. For example, nurse mentors have to demonstrate and reinforce these key attributes as students are initially wary and unconvinced that psychological safety actually exists. Uncertainty prevails in relation to whether the environment is conducive to raising concerns. In an attempt to read the context, they undertake contextual sensemaking and look for signs that the culture and staff within it are supportive and open. If the context is deemed to be favourable, then it is likely that the student also feels psychologically safe. Here, psychological safety is considered to be an antecedent to context favourability (see figure 18 below).

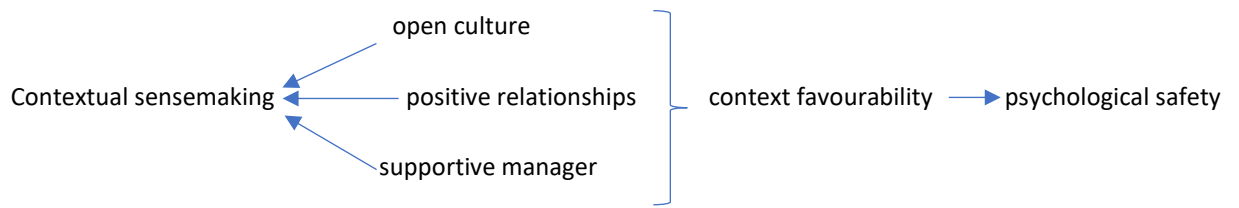


Figure 18 – Link between context favourability and psychological safety

7.3 The influence of contextual factors on raising concerns

Up to this point the chapter has discussed the origins of context favourability and how contextual sensemaking is used by employees to evaluate features of the organisational context (Dutton et al. 1997; 2002). This process forms the basis of early decision-making in issue selling and student nurses adopt a similar approach when they witness wrongdoing in practice and consider raising concerns. In this situation, the student searches for signals that give some indication of the context’s favourability or otherwise. However, in adapting this concept to a student nurse concept, I argue that reading the context through contextual sensemaking is not only utilised as a reasoning process for early decision-making, but actively continues throughout the whole trajectory of raising concerns. In this way, student nurses continue to evaluate the reactions, responses and actions of key individuals and team as the process of raising concerns unfold. The culture of the clinical placement also provides the student with significant clues as to the normative standards of care provided, the leadership and openness of the clinical manager and the underlying favourability in raising concerns. Figure 19 provides an overview of this process.

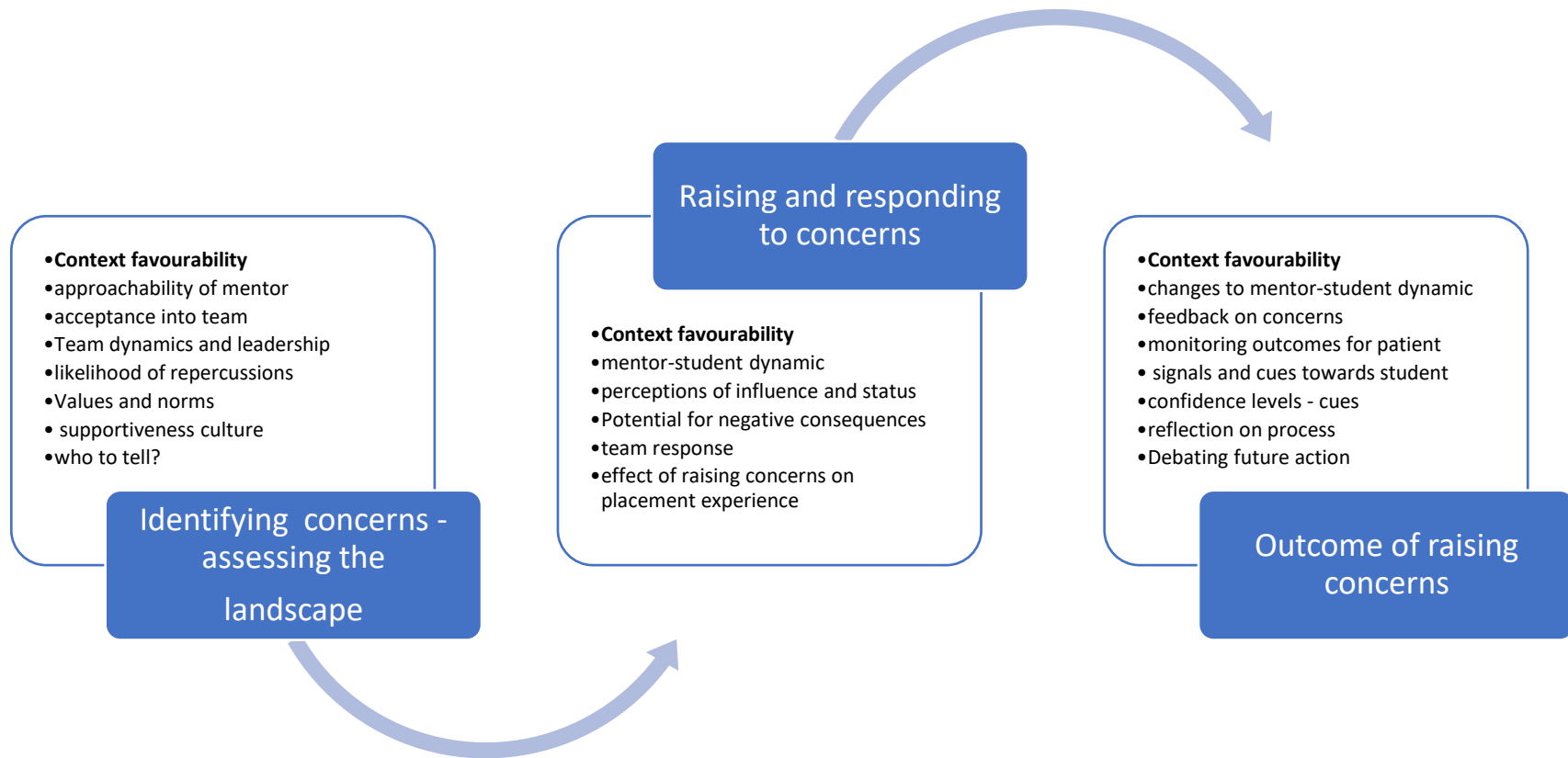


Figure 19 – Context favourability and raising concerns

It is clear that sensemaking underpins the process of assessing context favourability. Weick et al. (2005) explored the concept of sensemaking in organisations and identified some key features that can be related to student nurse sensemaking. For example, sensemaking is described as an ongoing sequence where cues extract “meanings that inform and constrain identity and action” (Weick et al. 2005, p.409). Students in this study were often compelled to act or constrained by the cues and signals received through the social context of sensemaking, and this impacted on behaviours and decisions.

Furthermore, the role of sensemaking in a healthcare context has been acknowledged by Blenkinsopp and Edwards (2008) who examined the role of emotions in the whistleblowing decision of ‘inaction’. Decisions around speaking up are positioned as an ongoing, iterative process that is underpinned by “affect-influenced sensemaking” (Blenkinsopp and Edwards, 2008, p.186). In this study, the obligation to protect patients alongside the risks of raising concerns led to “cues for inaction” whereby sensemaking accounts for staff remaining silent. These findings, resonate with the findings of a later study by Ion et al. (2016) where student nurses justified their decision to not raise concerns by suggesting that any ‘reasonable’ person would come to a similar conclusion. The next section will continue the sensemaking theme but will now consider the influence of the organisational culture on student nurses’ propensity to raise concerns.

7.3.1 Organisational culture (clinical placement)

Whilst undertaking practical placements, students enter the complex and multifaceted world of clinical practice (Jessee 2016). Here, they attempt to adapt to a dynamic and evolving culture which is characterised by the behaviour of the group (Davies et al. 2000; Braithwaite et al. 2017). For the purposes of this study, the organisational culture refers specifically to the culture of the clinical placement in which the student undertakes workplace learning. Schein (1985 p. 18) defines culture in organisations as,

a pattern of shared assumptions learned by a group as it solved its problems of external adaptation and internal integration, which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel (Schein 1985 p.18 cited in Manley et al. 2011)

Organisational culture, therefore, encompasses the ‘taken for granted’ values, attitudes and beliefs which are fundamental and often entrenched in practice (Davies et al.2000).

Adapting to new practice placements can be challenging for students as they attempt to integrate into established teams and sub-cultures. Reading the context of the day-to-day routines of staff and patients, provides some indication of the workplace culture (Manley et al. 2011) and a sense of the “way things are done around here” (Deal and Kennedy 1982 p.4) is established.

A student nurse participant provided an example of ‘reading the context’ of the placement, where the signals and cues indicated a lack of compassionate care which appeared to be insidious within the team culture. She described feeling unable to speak up due to the widespread pervasiveness of this issue, *‘it wasn’t just one member of staff it seemed like it was the ward ethic... you do begin to think that’s the norm’*. This shows that although sensemaking is driven by first impressions, there is also a sense of gradual or progressive realisation. The culture was evaluated as an unfavourable context in which to raise concerns and she remained silent. The team culture, values, norms, and behaviours conflicted with the student’s own values and created dissonance, confusion and discomfort.

The Mid Staffordshire Inquiry (Department of Health 2013) identified ‘a negative uncaring culture’ within the NHS including acceptance of poor behaviours, low staff morale and a lack of candour. However, similar reports dating back decades, have also said much the same about an NHS workplace culture which inhibits raising concerns and fails to learn from these events (Jones and Kelly 2014).

The Freedom to Speak Up Review (Francis 2015), provided further evidence of how some cultures within the NHS deterred staff and student nurses from raising concerns. Recommendations focused on fostering a culture of safety and learning and encouraging visible and open leadership to facilitate speaking up behaviours (Francis 2015). The review also positioned students at the forefront of patient safety, with an important role to play in identifying poor care and contributing to quality improvement. As discussed in earlier chapters, putting this responsibility on students may be perceived as slightly contentious. However, as future leaders of healthcare, student nurses are key to the culture change required to normalise raising concerns into day-to-day practice. A national strategy to enable culture change within the NHS England was launched by the Department of Health

(2015) to support safe, effective, and compassionate care and learn lessons from the Mid-Staffordshire inquiry.

In this study, most nurse mentors and students described working in clinical cultures that were supportive, inclusive, and proactive when dealing with concerns. Students considered the context to be favourable when staff were open, honest, willing to reflect on errors and motivated to undertake quality improvement. These characteristics align with the principles of a 'just culture', where staff and students can openly discuss concerns without fear of retribution or blame (NHS England 2018).

In promoting a just culture, the NMC (2021b) acknowledge the need to understand how contextual factors such as workload pressures, social norms, staffing levels and team culture affect safety and the ability of organisations to adapt to a culture of openness and learning. Enabling students to promote patient safety within organisational culture gives them "permission" to be open and provides an opportunity for them to act as a 'safety barometer' in highlighting risks and concerns (Lidster and Wakefield 2018). The next section will discuss how the characteristics of the clinical manager contribute to student perceptions of the organisational context.

7.3.2 Characteristics of the manager

The qualities displayed by managers in Dutton et al's (2002) study were cited as a contextual variable in assessing context favourability. The attitude of the manager was a 'diagnostic' indicator used to assess the predicted level of understanding and openness required to raise issues. Similarly, clinical managers' approachability, accessibility, and willingness to listen, provide contextual clues as to the likely success of students raising concerns (Milliken et al. 2003). These management qualities align to 'compassionate leadership', the key ingredients of compassion including attending, understanding, empathising, and helping behaviours (West et al. 2017). Empowering staff in the NHS to be innovative, take risks and feel safe in speaking up is a key role within compassionate leadership and aims to promote a culture where speaking up is the norm (West et al. 2017).

These positive leadership qualities were observed and detected by students within their placement experience. This was especially pertinent for those students who experienced challenging relationships with their mentor. In these instances, the mentor was bypassed

and the manager was assessed by students to determine if they were amenable to discussing concerns. Managers who took an interest in the student and were approachable and proactive in promoting a speaking up culture, enabled the students to appraise the context as a favourable environment to voice concerns. In table 18 below, two examples are provided of how manager characteristics influence student nurse decision-making.

Table 18 – Influence of manager characteristics on context favourability

Contextual factors	Data extracts to support sensemaking	Assessment of context
Characteristics of deputy ward manager	'I had to pick which person [manager] to speak to. He was the one who welcomed us and was the approachable one' (Carys)	Favourable
Characteristics of the ward sister	"Well, I was scared of the ward manager, and I felt incredibly intimidated any time I walked onto that ward. I felt like I was being watched and people were waiting for me to slip up" (Mel)	Unfavourable

The first example illustrates the significance of a friendly welcome from a particular manager when embarking on a new clinical placement. This positive signal coupled with his approachability and openness led to an overarching assessment of a favourable landscape in which to raise concerns. The second example clearly identifies how Mel was scared and intimidated by the manager. In contrast to the first example, the manager's characteristics were negative and associated with strong emotions such as fear and intimidation. In this instance, psychological safety was absent and an unfavourable context for raising concerns was evaluated.

Contextual sensemaking continued as students monitored the manager's response to their concerns and observed how the concern and action plan was communicated to the rest of the team. In one example, a student nurse raised a concern which resulted in a positive change to nursing practice. The manager encouraged the student to be actively involved in the change and was supportive, despite the reluctance of some team members to adapt to this new way of working. Enabling the student to contribute to quality improvement enhances psychological safety and empowerment and demonstrates the principles of compassionate leadership (West et al. 2017).

However, in this study there were also examples where student nurses assessed the manager as being intimidating, unprofessional or “too friendly” with particular members of staff. This raised doubts in students’ minds about discretion and confidentiality and resulted in an absence of psychological safety. These negative characteristics inhibited student nurses from approaching the manager with concerns as the context was deemed to be too risky to speak up. Within the next section, the influence of the team and the group dynamic on student’s assessment of the context favourability is discussed.

7.3.3 Team culture and relationships

Effective teamwork and open communication are vital in healthcare settings where patient safety is paramount. Supportive relationships are characterised by trust, dependability and shared values and beliefs (Edmondson 1999; Gu et al. 2013). Team relationships, and in particular the group dynamic, can provide useful clues for students as to the norms and values that underpin their membership and culture. These positive characteristics further enhance feelings of security and psychological safety and facilitate a climate of openness and opportunity to discuss concerns freely (Kahn 1990; Aranzamendez et al. 2015). However, when student nurses enter the clinical setting, they are stepping into the unknown as “outsiders” as they are joining a social network of pre-existing relationships (Jessee 2016). For a variety of social and educational reasons, students are keen to integrate into the clinical team culture and feel a sense of belonging (Levett-Jones et al. 2007; Bickoff et al. 2016).

In this study, the receptiveness of the wider team influenced the student’s ability to integrate into the culture of the workplace. Dutton et al. (2002), described ‘cultural exclusivity’ as a cue to assess context favourability, which refers to the extent to which individuals believe they are encouraged or excluded from interacting with a dominant group. This idea has resonance with this study, where students who established their place in the clinical environment were keen to maintain the status quo and wary of jeopardising their position by ‘rocking the boat’ (Levett-Jones and Lathlean 2009; Bickoff et al. 2016). This phrase describes a conscious strategy used by employees to withhold information that could be interpreted as dissent and opposes group practices (Redding 1985).

In some instances, student nurses in this study witnessed unprofessional behaviour and 'gossip' which made them feel uncomfortable. One student recalled overhearing the team criticising a student colleague who had recently left the placement. This cast doubt on the trustworthiness of the team which is a key aspect of team psychological safety (Aranzamendez et al 2015). This example reinforces negative perceptions of the team and validates the assessment of the team culture as an unfavourable context. Many of the students in this study, worried about the potential for negative repercussions to occur, even if they had established collegial relationships within the team.

These and other examples demonstrate the complexity of sensemaking. Although positive interpersonal interactions point towards a favourable context, the student's ability to make definitive assessments from reading the context may be inconclusive. It could be argued that although the team display positive attributes, a lack of specific cues that predict how they might react to concerns results in a cautionary residue of doubt. Furthermore, worries about the potential for negative consequences circulate amongst student nursing peer groups, despite relatively little evidence of actual repercussions occurring. This collective sensemaking is described as 'social contagion' by Milliken et al. (2003) and can be a powerful negative influence on context favourability if other factors are ambiguous. Conversely, students who receive specific advice and encouragement to raise concerns or queries, appear to be less anxious about negative repercussions and evaluate the context as favourable.

In Dutton et al. (2002) study, the importance of managers creating and maintaining a positive impression with others within the workplace was emphasised. How the team perceived the manager was an influential indicator of whether or not to initiate issue selling. Similarly, student nurses exhibited similar anxieties about presenting a positive image to other team members. The desire to be liked and to be accepted as a member of the placement team was an enduring theme throughout this study. The fear of being labelled as a 'troublemaker' or 'complainer' by permanent members of the team appeared to act as a powerful deterrent to raising concerns.

The study by Dutton et al (2002) found that a strong likelihood of image risk resulted in an unfavourable context and a decision being made not to initiate issue selling. Likewise, being excluded and ignored by the clinical team was also identified, in this study, as a potential

or actual consequence of speaking up and cited as a barrier to raising concerns in other research studies (Ion et al. 2016; Fisher and Kiernan 2019; Fagan et al. 2020). In table 19 below the influence of the team culture on students’ assessments of context favourability is illustrated below.

Table 19 – Influence of team culture on context favourability

Contextual factors	Data extracts to support sensemaking	Assessment of context
Team relationships & culture	“They all agreed and said yes this has been going on for too long now” (Sally)	Favourable
	“It was just the lack of support from everybody else and like everyone backed away a bit! (Sally)	Unfavourable
	“I had gone down to the nurses station where everybody was and nobody would make eye contact with me and nobody spoke to me” (Ryan)	Unfavourable

The table above highlights how the context of team relationships may be perceived in different ways, as students make sense of signals and cues within team interactions. The quotes illustrate how a perceived lack of support from the team or being ignored leads to the student’s perception of an unfavourable context. Conversely, shared goals and ideas can provide reassurance to the student and promote a supportive and favourable context. However, in some instances, cues and signals from the team may conflict with signals received from other staff members. In this study, negative cues from some team members were counterbalanced by positive cues and support from a mentor and manager and resulted in a favourable context. This demonstrates the dynamism of this process where context favourability ebbs and flows.

In this study, the culture, manager, and the team have all been cited as influential contextual factors within the process of students raising concerns. Within the next section, attention turns to how the mentor-student dynamic specifically influences the students’ appraisal of context favourability.

7.4 The influence of the mentor-student dynamic in evaluating context favourability

The crucial role that the nurse mentor plays in supporting and assessing student nurses in clinical practice is well documented within the literature (Foster et al. 2015; Jack et al. 2020). The importance of the mentor-student relationship in the development of clinical learning and successful placement experiences has been highlighted in several nursing studies (Gunther 2011; Jack et al. 2018). However, there is a lack of research studies on how the dynamics of the mentor-student relationship influences students' raising concerns.

Student nurses interpreted contextual cues to evaluate the risk involved in speaking to the nurse mentor to raise concerns. Contextual sensemaking involved monitoring the mentor's receptiveness and interest, their approach to supervising and facilitating student learning, observing non-verbal communication and the mentor's interactions with other team members. In addition, students gained a sense of the mentor's underlying values and compassion by observing standards of nursing care and professionalism.

This section builds depth around contextual sensemaking within the mentor-student relationship. Students who developed a good rapport with their mentor, were more likely to assess the context as a favourable environment in which to raise concern. This echoes similar research findings where the ability to challenge poor practice and voice concerns were more likely if the students felt a sense of belonging and had established an effective relationship with their mentor (Levett-Jones and Lathlean 2009; Grobecker 2016; Jack et al. 2018).

Conversely, student participants in this study who were ignored by their mentors or found them to be hostile or unprofessional felt unable to establish an effective relationship. These mentors were assessed by students as being an unsuitable individual to discuss concerns with. In these circumstances, students' sensemaking evaluated the context as unfavourable and mentors were bypassed in the raising concerns process. However, students who disclosed their concerns to the mentor, monitored the context for any subtle changes in the mentor-student dynamic. Table 20 provides an example of how the relational dynamic contributes to either a favourable or unfavourable context.

Table 20 – Influence on mentor-student relationship on context favourability

Contextual factors	Data extract supporting sensemaking	assessment of context
Mentor-student dynamic	<i>'I was worried whether it would affect the mentor/student relationship but it never did and she was lovely about it and understanding' (Sally)</i>	Favourable
Mentor-student dynamic	<i>"I didn't feel comfortable enough to speak to her about it and I didn't ever speak to her about it. I'd seen her doing some of the things I was unhappy with, so it was difficult" (Sarah)</i>	Unfavourable

The next section will explore how perceptions of power and status within the mentor-student relationship affect contextual sensemaking.

7.4.1 The influence of power and status on context favourability

Healthcare settings are naturally hierarchical and authoritative (Grealish and Trevitt 2005; Levett-Jones and Lathlean 2009). Student nurses in this study frequently referred to themselves as occupying a lowly status within the clinical hierarchy. Grealish and Trevitt (2005) argue that this perception is reinforced in practice when students' opinions are not valued, and they feel marginalised (Jackson et al. 2011).

Mentoring relationships are reciprocal yet asymmetrical exchange relationships that are dynamic in nature and defined by the types of support provided by the mentor (Eby 2007, p.7).

According to Eby (2007) an inherent unequal power exists between a mentor and student. However, the relationship can be mutually beneficial for both parties. The student is ideally positioned to share current, evidence-based practice and the mentor assists the student to develop their professional identity and apply theoretical concepts to nursing practice (O'Mara et al. 2014). How the mentor-student relationship manifests in practice are, in part, determined by the students' perceptions of status and influence and the effect of these on the relational dynamic.

For example, in this study, students suggested that a mentor's higher status within the hierarchy accounted for a perceived power differential. In addition, the mentor's role as an assessor positioned them as powerful individuals who could affect students' progression on the nursing programme, if they refused to confirm student achievement of clinical

practice outcomes. Consequently, students felt under pressure to please the mentor, which meant they were reluctant to approach their mentor with concerns. These perceptions of power were an undercurrent running throughout the entire process of raising concerns and contributed to the student nurse perceptions of context favourability. French and Raven's (1959) theory on social power will be used as a framework to better understand how power within the mentor-student dynamic influenced students' perceptions of the suitability of the context in which to raise concerns.

Social psychologists French and Raven (1959) identified six bases of social power which provides an explanation of the relationship between power and influence (see table 16 below). Although this influential theory is over sixty years old, French and Raven's thinking illuminates how the power forces at play within the mentor-student relationship can be exercised to influence the dynamic between them. In this way, perceptions of power influence the way in which students interpret contextual cues and make decisions on whether to approach mentors with concerns.

Table 21 – French and Raven – The bases of social power (1959)

1. Legitimate power	Stems from the belief that there is a legitimate right to influence a person and to expect others to comply
2. Reward power	The basis here is the ability to offer a positive incentive if the person complies
3. Coercive power	This comes from the threat of punishment if there is failure to comply
4. Expert power	This is based on a perceptions of a person's specialist skills and knowledge
5. Referent power	This stems from the relationship between two people and how one person identifies with the other
6. Informational power	based on the ability to control the flow of information that is needed to get things done.

Legitimate power

According to French and Raven (1959), legitimate power is derived from the position a person holds which gives them a formal right to authority. Organisational structures and

social hierarchies all provide the basis for legitimate power. The nurse mentor, as a registered nurse occupies a position of legitimate power and authority which is underpinned by a job description which outline roles and responsibilities.

Undertaking a nurse mentor role requires additional formalised preparation and assessment. This legitimises the mentor as a person designated to supervise and assess student progress and achievement in the practice environment. In this study, however, a number of students felt vulnerable and subservient because of mentors' legitimate power, which appeared to confirm students' assumptions of their subordinate status within the clinical hierarchy. A feeling of powerlessness also created tensions which resulted in students feeling silenced and unable to exercise their voice when communicating with the mentor. Student nurses feeling disempowered and unable to advocate for patients has been a common feature in other nursing studies (Ion et al. 2015; Fagan et al. 2016).

Theoretically, all students in the study had a legitimate role in responding to poor care by raising concerns. In fact, policy and professional regulatory guidance outlines the student's obligation to do so (NMC 2019a). However, statements such as, *'I didn't feel like I could raise any concerns'*, illustrate how legitimacy is threatened by negative contextual sensemaking which may manifest itself in perceptions of powerlessness or a fear of negative repercussions.

In this study, students described how they felt 'beholden to the mentor', who they perceived to have power over them in assessing the student's clinical competencies. The mentor exercises legitimate power in their responsibility for assessing and documenting student progress and achievement in practice. However, some students feared that this legitimate power could be abused if the mentor refused to sign clinical documentation. Students perceived that raising concerns could potentially upset the mentor and result in them failing the placement. However, there were no examples of this occurring in this study.

Conversely, a positive mentor-student relationship is a dynamic of legitimate power which can be a more collaborative shared relationship, rather than subservient (Laverack 2009). Student nurse participants who reported a more egalitarian relationship with their mentor, described a partnership approach underpinned by mutual trust and a feeling of being

valued. This positive mentor-student dynamic created an environment which was conducive to speaking freely and raising concerns. A qualitative study by Bradbury-Jones et al. (2011) explored empowerment in nursing students in practice, it cited similar findings and concluded that effective mentorship enabled students to feel empowered. Therefore, legitimate power can be perceived or experienced as driving subservience and thus the students fear in speaking up.

Coercive and reward power

Coercive power can be used to punish a person if they fail to conform, whereas reward power can provide an incentive which encourages compliance (French and Raven 1959). It is useful to review these two sources of social power together as the mentor has the authority to exert the power of reward and coercion within their role (Uren and Shepherd 2016). Examples of reward power can be seen in relation to providing student nurses with access to learning opportunities, inclusion in social events and achievement of practice assessments. However, coercive power could also be manifested by obstructing students' career opportunities, excluding them from social groups or arguably the most feared form of coercive power is refusing to complete clinical assessments (Jack et al. 2020). Here, coercive, and legitimate power appear to overlap, as although the mentor has a legitimate role in assessing students' clinical proficiency, students believe that this power can be abused through the demonstration of coercive power.

In this study, a small number of students recounted examples where mentors did exercise coercive power, such as deliberately changing their shifts without informing students, ignoring them, and generally making their lives difficult. The fear of coercive power in response to raising concerns was in some cases driven by negative cues that evaluated the environment as unfavourable. Bypassing the mentor in this instance perhaps prevented the mentor from being able to exercise coercive power.

A small number of mentors were aware of the power inherent in their role as assessors, although there was no evidence of this power being enacted inappropriately. However, French and Raven (1959) do highlight the negative effects of coercive power which over time can lead to negativity and resentment within relationships.

Expert power

Expert power is based on an individual's perception of another person's expertise and credentials. Students were aware of the mentor's legitimate power, although legitimacy could also be occasionally undermined by a mentor's lack of expert power. This was clearly illustrated when a mentor in this study displayed poor knowledge and skill in relation to medicines management and led to a student raising concerns to her clinical manager.

According to Polifroni (2010) expert power can be held by an individual irrespective of their positioning in an organisation. Despite student nurses in this study viewing themselves as occupying low status, there were examples where their expert power was enacted through discussion with mentors. This dialogue displayed the students knowledge of contemporary research and a more current evidence-based approach to nursing care. However, Polifroni (2010) argued that informational power resides alongside expert power and refers to knowing how and when to exercise expert power. Yet, these two distinct concepts do not automatically operate in tandem as having insider knowledge of an organisation and knowing how the systems work are relevant in ensuring receptiveness to expert power. This may explain why nursing students in this study were able to identify outdated or unsafe care, but a lack of informational power regarding the organisational context and navigating the raising concerns process made it difficult to exercise their expert power. On a positive note, there were examples of mentors learning from students and encouraging them to enact expert power. However, at times expertise was overridden by a student's perception of the mentor's legitimate power.

Referent power

Referent power is described by French and Raven (1959) as the power inherent in a relationship between two people. How a person identifies to another and is liked, respected, valued and perceived all contribute to referent power. This concept is especially relevant to this study which has explored the dynamic between the student nurse and mentor. The nature of the mentor-student dynamic is determined by the way the mentor exerts power. In turn this influences how the student nurse responds to the mentor. Mentors who developed a more reciprocal relationship with their student demonstrated referent power by valuing and respecting the student's contribution. In addition, nurse

mentors who enacted referent power displayed positive role-modelling behaviours that students identified with and emulated. This promoted a strong interpersonal connection which promoted psychological safety and a favourable context in which to raise concerns. Conversely, mentors who displayed negative behaviours in this study were also identified by students as modelling behaviours, but in this instance as examples of 'learning how not to do things' which reinforced the context as being a risky environment in which to raise concerns.

Students who developed a supportive relationship with their mentor did raise concerns directly to the nurse mentor. However, for other students, the perceived power of the mentor in assessing the student's clinical outcomes was a barrier to speaking up. Power is largely attributable to the mentors role as assessors of clinical outcomes. However, the sections above have outlined reasons why mentors hold power and to a much lesser extent how students in some instances may also have power. What French and Raven's (1959) work illustrates is that power is complex, interrelated, and multidimensional and these concepts can be applied to the mentor-student relationship, although further research on this relational dynamic may further enhance understanding.

The development of the NMC Standards for Student Supervision and Assessment (2018) may have implications for the future development of power dynamics within practice learning and is examined in the following section.

7.5 Potential Implications of the NMC Standards (SSSA, 2018) for students' raising concerns

The introduction of the NMC standards for Student Supervision and Assessment (SSSA, 2018) signified a shift in the nature of practice-based learning. The previous mentorship model was all-encompassing, with the nurse mentor providing support and guidance, facilitating learning, and assessing student competence (NMC 2008; Lidster and Wakefield 2018).

There has been a long-standing concern that the conflicting nurturing and assessment functions of the mentor role were unsustainable because they challenged the mentor's ability to maintain objectivity in assessment decisions (Bray and Nettleton 2007; Brown et al. 2012). This was brought into sharp focus with Duffy's (2003) research on 'failing to fail',

which illustrated the tension for nurse mentor's in developing collegial relationships with student nurses alongside undertaking robust assessments.

The SSSA (NMC 2018b) addresses these issues through the implementation of the practice supervisor role which involves facilitating learning experiences and providing student support and the practice assessor who focuses on the progression and achievement of clinical proficiencies.

The rationale for the separation of these roles was primarily to increase the consistency of assessment judgements and widen staff involvement in supporting practice learning. However, these new roles may have a positive impact on students raising concerns. In this study, students alluded to a fear of failing their placement or halting their progression within the nursing programme if they escalated concerns to the mentor. This influenced student nurse decision-making and led to students bypassing the mentor to raise concerns to the personal tutor, or on occasion, resulted in students remaining silent.

It is possible that this model of practice learning may re-balance the power dynamics discussed within the last section. Student nurses undergoing sensemaking about the practice context will evaluate the practice supervisor's role of facilitating and supporting learning, rather than summative assessment of the student's competence which is no longer the main focus of the role. This demarcation between assessment and learning roles may increase psychological safety, reducing the risk of repercussions and encouraging students to voice their concerns. However, students who struggle to establish a rapport with their practice supervisor may still be reluctant to raise concerns in this instance.

The NMC (2018b) further stipulated the requirement to have a nominated person in each practice setting to specifically support students with concerns. This role should be undertaken by an individual who is not involved in facilitating or assessing that particular student. This is a positive step in promoting a favourable context for the student to raise concerns. However, anecdotally it appears that this role is commonly undertaken by the ward manager, or educational lead. Both hold relatively powerful positions in clinical practice which could influence whether students feel able to raise concerns. For example, student nurses' sense of perceived powerlessness within the clinical hierarchy could potentially deter students from utilising these nominated persons and render the role

ineffective. The next section discusses the study findings in relation to the role of the personal tutor in the raising concerns process.

7.6 The safety net of the personal tutor

Within the UK, the personal tutor role has been situated as an essential requirement for pre-registration nurse education (NMC 2004). The role provides students with support and guidance, promotes professional development, and aims to prevent attrition within Higher Education Institutions (Braine and Parnell 2011). There are local variations in the titles and role functions of the personal tutor (McFarlane 2016). However, there is agreement that the role involves: monitoring student progress (Por and Bariball 2008); facilitating personal growth and reflection (Hughes 2004; Dobson and Harrington 2006); signposting (Por and Bariball 2008) and pastoral care (Roldan-Merino et al. 2019).

Within this study, a number of nursing students evaluated the mentor-student relationship or the team culture as being an unfavourable context in which to raise a concern. Instead, the student nurses contacted their personal tutor to either escalate the concern or to seek advice, support, and reassurance. This replicates findings in O'Mara et al. (2014) study in which student nurses looked to the university for support when they experienced challenging clinical experiences.

A nurse mentor in this study, described the university as a 'safety net' for students, a metaphor that also resonated with personal tutors' views, when they emphasised the importance of providing a safe environment for students to discuss concerns. Furthermore, research studies by Rhodes and Jinks (2005) and more recently, Roldan-Merino et al. (2019) suggest that a supportive relationship between student and personal tutor is key in providing a safety net. This relationship is of longer duration than the mentor-student partnership, spanning the undergraduate programme (Ross et al. 2014). This sustained contact provides an opportunity for the relationship to flourish but does require the personal tutor to be approachable and accessible (Dobinson-Harrington 2006) and to invest time and energy in the relationship (Por and Bariball 2008). In this study, the personal tutors' approachability was evident, with tutors advocating and enabling an open-door policy which encouraged students to access support and advice in a timely way.

There is consensus in the literature that the personal tutor-student relationship should be underpinned by a humanistic approach that reflects caring, mutual trust and respect, empathy, and honesty (Charnock 1993; Ross et al. 2014). These principles were reflected in the data with student nurses' who were effusive in their praise for their personal tutor and felt supported to raise their concerns.

In this study, it was clear that the personal tutor assisted students in their contextual sensemaking of the events witnessed within the clinical environment. This was undertaken in a number of ways including; facilitating reflection and critical thinking, and providing advice and support in dealing with concerns. Moreover, the personal tutor provides a favourable context that appears to be underpinned by psychological safety. At times, the personal tutor could become too protective of students, too efficient at removing students from the placement rather than supporting the student to learn through the conflict situation triggered by raising concerns.

There has been limited research or specific guidance for nurse educators working within academic environment's on responding and managing student concerns (Ion 2019). In this study, there is evidence to suggest that clearer processes and increased support for the personal tutor would be beneficial in responding appropriately to student nurses' raising concerns. Outlining for example, the expectations and influential nature of the personal tutor role in relation to supporting and managing student concerns should be incorporated into induction programmes for new personal tutors. The reinforcement of regulatory requirements in relation to professional accountability, public protection and promoting patient safety should also be emphasised (NMC 2018c). Clearly delineating professional responsibilities in relation to accountability, could form part of a personal tutor-student charter. This would be signed at the outset of the undergraduate programme and clearly outline expectations for both parties throughout the duration of the relationship.

The use of university policies and procedures on raising and escalating concerns should underpin induction sessions on raising concerns and include an opportunity to review case studies which will enable new staff to apply policy to real-life situations. Furthermore, regular peer support and debrief meetings with other personal tutor's would share best practice and provide a debrief for emotive decision-making. Finally, it is possible that a

designated role within the university could provide support for all nurse educators who are challenged with the expectation of supporting and managing student's with concerns.

7.6.1 A blurring of roles – the Academic Assessor

The creation of the Academic Assessor (AA) role was developed as part of the standards for student supervision and assessment that were discussed in the previous section (NMC 2018b). The academic assessor is a member of academic staff from the students Approved Education Institution (AEI) who works collaboratively with the practice assessor to monitor and confirm achievement of proficiencies and programme outcomes (Lidster and Wakefield 2018). The new academic assessor role has been developed to complement existing support roles such as the link lecturer and personal tutor (NMC 2019b).

However, the introduction of the academic assessor role now raises questions about the role of the personal tutor in supporting students through the raising concerns process. Students are still allocated a personal tutor, for the duration of their programme, to provide pastoral care. Therefore, it could be argued that the established long-term personal tutor-student relationship may continue to provide a safe avenue for students to discuss concerns.

Students will now also have the opportunity to build a relationship with an academic assessor over the course of one part of the programme (after which a new AA is assigned). They will meet with students to discuss and reflect on practice-based learning. This could provide a valuable opportunity for students to discuss concerns or challenging aspects of nursing practice as they arise. If academic assessors become more entrenched in practice learning, they may be more suitably positioned to discuss contemporary issues and concerns.

As discussed in the previous section, there were examples where students were moved to a different placement area after raising concerns to the personal tutor, which precluded student involvement and restricted learning. The AA's collaborative relationship with the practice assessor could potentially facilitate the discussion of concerns and see the AA acting as a conduit between the university/personal tutor and clinical placement to address and resolve concerns, whilst keeping students involved in the process. On the other hand, the academic assessor's closer relationship with clinical staff may be perceived as too risky,

particularly if students have already evaluated the workplace culture as unfavourable. If this is the case, then the safety net of the personal tutor may continue to be viewed as a safer option. From a local context, it is too early to speculate on how the academic assessor role will influence students raising concerns. However, there is a need for formal evaluation of this role.

7.7 Chapter summary

This chapter has critically discussed how the concept of context favourability has developed our understanding into the way that student nurses undergo sensemaking to aid decision-making on raising concerns. Similarities between speaking up in healthcare and issue selling in organisations, have identified the influence of team dynamics, the organisational culture and manager characteristic. However, the mentor-student dynamic also contributes to students' contextual sensemaking. Students already enter the clinical environment with their own sense of identity and perceptions of status and power (Ferns and Meerabeau 2009; Fisher and Kiernan 2019). Further sensemaking occurs when the mentor-student relationship is established and continues throughout the placement. The social bases of power (French and Raven 1959) provide a useful framework to explain how the mentor-student dynamic can be enacted. However, these power bases are fluid and may fluctuate depending on how mentor and student respond to each other, as well as several external factors. However, the potential for abuse of legitimate power may become less of a worry, with the demise of the mentor role and introduction of the SSSA model of practice learning (NMC 2018b). However, it is possible that practice assessors could be persuaded by other team members to fail student assessments if concerns are raised. The implications of these roles will be discussed further within the concluding chapter.

Evaluating team dynamics and the culture of the healthcare setting are appraised by observing and monitoring the signals and cues within social groups. This sensemaking can identify shared values and norms or reveal fractured relationships and low morale. However, the shifting nature of contextual sensemaking can result in a fluidity of evaluation which is interpreted differently by students looking in. The potential to be socially isolated or labelled as a troublemaker because of speaking up was frequently discussed in the data

by students (Levett-Jones and Lathlean 2009; Bickoff et al. 2016). However, this was often in the absence of any direct negative comments or observations. One could question whether students are pre-empting issues with no evidence or perhaps picking up on more subtle signals that identify the existence of an unfavourable context in which to raise concerns.

Student nurses also evaluate whether the principles of a just culture such as openness and promoting speaking up behaviours are embedded in the day-to-day business of the practice setting. Clinical placements that demonstrate a compassionate and just culture not only promote raising concerns, but also enhance psychological safety. Clinical leaders can gain useful nuanced information about what is going on in the workplace and how team dynamics and relationship impact on speaking up behaviours. Battles et al. (2006) acknowledge the role that sensemaking can play in reducing risk and learning lessons when things go wrong. However, for sensemaking to be truly effective, individuals need to utilise a retrospective and prospective approach to learning (Battles et al. 2006).

This study has identified that all students use sensemaking to determine whether clinical placements are favourable or a risky environment to raise concerns. Contextual cues can provide useful information on who is likely to take the concern seriously and support the student through this process. The use of sensemaking within the education arena has been advocated by Brandt and Popejoy (2020) who suggest that applying Weick et al. sensemaking model (2005) can enable ethical principles to be applied to practice and ethical knowledge which may influence behaviour.

A summary of context favourability is provided in Image 2 below and is presented as a traffic light system. A clear green light is indicated when students evaluate the context as favourable and feel safe to raise concerns. A red light signals an unfavourable context, and the student will remain silent or seek support. Unfortunately, some cues are ambiguous, and students will be uncertain as to whether the environment is favourable or not. In this situation, an amber light results in student's continuing to look for further cues that may indicate the risks versus benefits of speaking up.

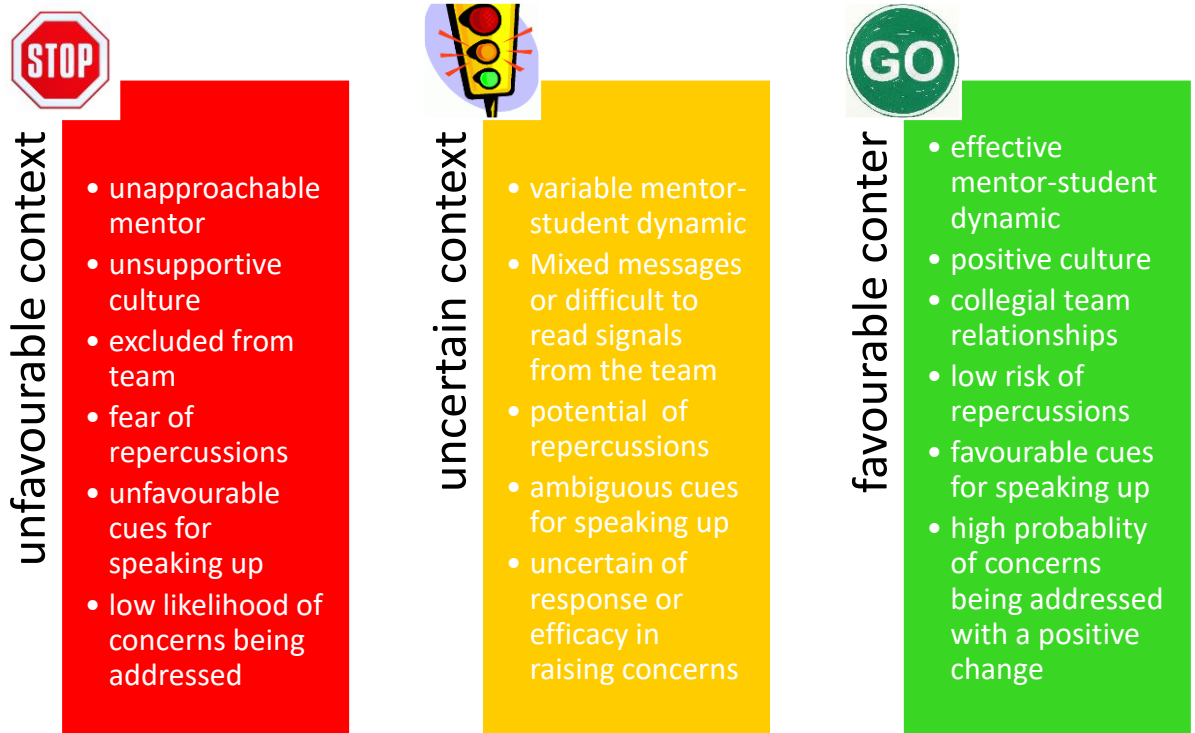


Image 2 – Traffic light system of context favourability

CHAPTER EIGHT – Implications for the study and conclusion

8.1 Chapter overview

This chapter begins with a summary of the study contributions as well as detailing how this research has addressed a gap within the literature and achieved the overall aim of this study. As a result, recommendations and the implications of the findings for practice learning, nurse education, policy and research will be discussed. The strengths and limitations of this study will be provided, before moving on to consider areas for future research. Finally, this chapter will present concluding remarks and a personal overview of my PhD journey.

The impetus for undertaking this study was the identification of a gap in knowledge on how the mentor-student dynamic might influence the process of students' raising concerns. Through a rigorous process of data analysis and theorizing, the overall aim of the study and research questions have been achieved. In addition, a valuable insight into the mentor-student relationship has identified an ongoing process of contextual sensemaking, whereby nursing students' assess whether the nurse mentor will be a favourable person to approach after witnessing poor practice.. Therefore, this study extends our understanding of how the mentor-student dynamic influences the student's propensity to raise concerns. In some cases, strong interpersonal connections promoted speaking up, or more commonly, the student was reluctant to discuss concerns due to the fear of repercussions and bypassed the mentor.

Furthermore, this work has identified for the first time, the significant role that the personal tutor undertakes in supporting students to raise concerns as well as developing their future practice through assertive communication. However, the central narrative running throughout the raising concerns trajectory, was the students' assessment of context favourability which explains how student nurse decision-making and action (or inaction) is guided by contextual sensemaking.

These findings add to the body of knowledge on raising concerns and has broader implications for nurse education and practice learning. The next section will consider how

this research study translates these important findings into recommendations for practice, education, and development.

8.2 Summary of recommendations

Practice

- **For key findings of this study to be disseminated to Practice Facilitators and fed into local Practice Assessor and Practice Supervisor training programmes.**

Discussing how the mentor can promote an open culture and normalise the process of speaking up should be included within preparation programmes. In particular, the importance of directly broaching concerns with students on their first day of placement and reassuring them that open communication is encouraged. This is now part of the induction checklist within the All-Wales Practice Assessment Document (HEIW 2020) but it is unclear how much attention is given to this topic in clinical practice.

Practice supervisor and assessor training should incorporate scenarios and role play that explore how to respond to being challenged by students. The practice dissonance between teaching and academia and learning in clinical practice could be addressed further within preparation programmes and include signposting and access to the learning materials utilised within the university setting. This would align theory to practice and identify and correct areas where teaching in the university setting does not mirror the reality of clinical practice.

Finally, the majority of nurse mentors in this study were unaware of the students use of modified voice as an alternative to formally raising concerns. A greater understanding by mentors of how this occurs and more importantly, why students utilise this strategy would be beneficial for inclusion within staff training programmes.

- **To develop an evaluation form for students to provide feedback to organisations on their perceptions of the organisational context.**

Nursing student evaluation of placements could be widened and standardised across the local NHS health board to provide an opportunity for students to share feedback on the organisational culture and ideas for enhancing the learning environment to promote psychological safety.

Education

- **As part of university placement preparation, student nurses' should receive teaching that enhances knowledge and skills on raising concerns. This should include first-hand accounts from student peers who have raised a concern in practice.**

Teaching strategies on raising concerns should include face-to-face sessions such as lectures, action learning sets, role play and the use of scenarios, as well as critical reflection, blogs, and podcasts. Participating in these sessions will enable students to develop resilience and coping mechanisms to deal with the challenges associated with speaking up (Ion et al. 2016; Fagan et al. 2020).

- **A digital tool will be developed as part of a comprehensive guide and resources for students, academics and staff to access on supporting students to raise concerns.**

A padlet is an example of a digital tool that serves as a virtual notice board to feature documents, podcasts, links and videos. The use of case studies, vignettes and new developments will provide a valuable resource for student nurses, practice-based staff, and academics. This package will be developed in co-production with student nurse representatives from all fields of nursing and will include engagement in all phases of the planning and implementation of this resource on raising concerns. This digital tool would be funded and developed via research impact funding opportunities, using a collaborative approach to complement existing policies and procedures from the university and local health boards.

- **The personal tutor role should be reviewed to provide clarity and consistency on supporting students to raise concerns.**

There is a need to clearly define the role and responsibility of the personal tutor in relation to supporting students in raising concerns.

Policy

- **The policy flowchart should be incorporated into e-pad to reinforce procedure for students and nurse mentors.**

This recommendation (suggested by a student nurse participant) will enable the procedure for raising and escalating concerns to be readily available for students and nurse mentors to access in clinical practice. This may expedite the process of speaking up and acts as a constant reminder for student nurses.

Research

- **Explore and evaluate the impact of the Standards for Student Supervision and Assessment (NMC 2018b) on the process of students' raising concern.**

There is a need to explore how separating the roles of practice supervisor and practice assessor may impact on students' raising concerns. In particular, the role of the nominated person in each practice environment to specifically support students is an area of interest that requires evaluation.

- **Undertake further research on the context favourability and raising concerns.**

Future research is needed to explore whether the educational interventions that have been recommended in this study can assist in the students decision-making and action taken after witnessing wrongdoing.

The influence of the workplace culture and organisational context could be extended to explore context favourability in other healthcare students and professional groups.

8.3 Implications for practice learning

Student nurses spend 50% of the undergraduate programme, gaining practical experience in a variety of placement settings (NMC 2010). In doing so, they gather useful intelligence on the workplace culture of the clinical placement, which in most cases is untapped by NHS organisations and placement providers. At present, there is an opportunity for students to evaluate the quality of the placement experience through a university evaluation form which is sent to all nursing students following their clinical placement.

However, there is scope to re-design the evaluation form in collaboration with clinical leaders, which could incorporate feedback on the student's appraisal of the organisational culture. Ideas for quality improvement and enhancing psychological safety in raising concerns should be included. However, this activity could induce anxiety if the student wishes to share constructive feedback, so ways to overcome this need to be considered.

Nevertheless, utilising this valuable information alongside service-user feedback would provide a more rounded picture of the workplace culture and contribute towards the culture change needed within the NHS. The ethos of compassionate leadership views clinical leaders as enablers of innovation and empowerment within clinical practice, as well as creating the optimum conditions for psychological safety (West et al. 2017). Fostering innovation through ideas and improvements is central to a compassionate culture. As the clinical leaders of the future, student nurses are pivotal to developing the cultural change that is required to promote safer care (Francis 2015). There is an opportunity for clinical managers and senior nurses to explore additional mechanisms for tapping into students contextual sensemaking of workplace cultures.

The change in the practice learning model (NMC 2018b) has seen a transition from the nurse mentor to the development of practice supervisor, practice assessor and academic assessor roles. As these roles develop, there is a need for placement providers and universities to work in partnership to deliver content within practice supervisor and assessor programmes that 'support students to raise concerns relating to the practice environment' (NMC 2018b). The potential contribution that student nurses can make in enhancing patient safety and quality improvement should be emphasised within preparation programmes. In addition, the key role that clinical staff and individuals in

supporting roles (Practice Facilitators) can play in facilitating positive environments that openly discuss concerns should be highlighted.

The perceived dissonance between teaching within academia and learning in clinical practice could be addressed further within preparation programmes and include signposting and access to the learning materials utilised within the university setting. This would align theory to practice and identify areas where teaching in the university does not mirror the reality of clinical practice.

Formal training for practice supervisors and assessors could incorporate scenarios and role play that explore how to respond to being challenged by students. This may help to develop confidence in registered nurses who may feel anxious about advocating for students (Jack et al. 2018). Developing assertive communication techniques should also take into account how power dynamics affect speaking up behaviours. The importance of adopting mentoring strategies that promote a facilitative approach and decrease asymmetry between student and registered nurse should be emphasised.

8.4 Implications for nurse education

Nurse education providers have a responsibility to ensure that students are adequately prepared to identify and escalate clinical concerns whilst working in practice settings (Ion et al. 2015; Blowers 2018). However, over-emphasising the negative consequences of speaking up appears to have perpetuated an anticipated fear of repercussions. This has led to a fear of the unknown which acts as a barrier to speaking up. It is crucial that students hear about the positive outcomes of raising concerns but are also well equipped to deal with the challenging aspects of speaking up in clinical practice.

Educators have an important role to play in facilitating teaching strategies and critical reflection that will enable students to feel safe in raising concerns. Re-balancing the structure and content of how students are prepared for raising concerns may help in this endeavour. Teaching strategies should be incremental and focus on developing assertive communication alongside the compassion and sensitivity required to advocate for patients. Ethical care should feature prominently within the undergraduate curriculum, particularly as students' motivation to speak up in this study and others, is often driven by an individual's moral and ethical principles (Ion et al. 2015).

The NMC (2018b) developed the academic assessor role to collate student achievement and work in partnership with the practice assessor in confirming student progression. It is too early to speculate on how this additional role might impact on student decision-making in communicating concerns. However, anecdotal feedback suggests that there may be overlap between the personal tutor and academic assessor role in relation to the raising concerns process. Further clarity is required.

Finally, the findings of this study have identified the need for a comprehensive and user-friendly package of resources on raising concerns which can be easily accessed by students, academics, and practice-based staff. This co-production will enable students to engage in all stages of the process from consultation, planning, development, participation and dissemination (Healey et al. 2014). Student nurses' will be invaluable in establishing whether the findings and recommendations of this study resonate with their own perceptions and to share how their own experiences can shape this resource to become a useful tool to aid decision-making in raising concerns.

As raising and escalating concerns is a requirement for all healthcare students, there is scope to develop a package that can be utilised on a wider scale within the university. The development of this resource will require input from information technology, staff and representatives from all healthcare professions. Initially, students will be invited to be part of this exciting journey by establishing a student forum on raising and escalating concerns.

8.5 Implications for policy development

Policies on raising and escalating concerns need to be clear, accessible, and easy to understand if they are to be effective. The university policy clearly outlines the sequence of events to be followed if concerns need to be raised. However, the policy needs to be more visible within the virtual learning environment to increase accessibility by students and academic staff.

However, a more pressing issue is that the process of speaking up will only be instigated if a student has the courage to inform someone about a concern. Work needs to focus on developing favourable environments that are conducive to taking the first step of speaking

up. However, as the policy is university-wide, the wording on who to speak to regarding concerns is not specific to nursing and uses generic terms such as ‘named practice link’ and ‘academic support’. This perpetuates the need to have additional guidance that is nursing specific alongside this policy. The next section considers the implications of this study for future research.

8.6 Implications for future research

This study has identified several potential areas that would benefit from evaluation and research. The new practice roles that have replaced the nurse mentor role, have resulted in changes to the way student nurses are assessed in clinical practice. A fear of failing the placement is commonly cited as a potential repercussion that appears to deter students from speaking up in placement settings. Future research could explore whether this change has an impact on the student’s propensity to raise concerns.

This study has related the concept of ‘context favourability’ to the nursing arena. Attention could now turn to undertaking research within the clinical environment that explores the variables of context favourability in more detail and research that develops our understanding of how relationships, hierarchy, and organisational context support student voice. This could be extended to exploring context favourability within other health care professional groups.

Future research could also explore whether the educational interventions, which have been recommended in this study, make any difference to student decision-making and behaviour after wrongdoing has been witnessed in clinical practice settings.

8.7 Strengths and limitations of this study

This section of the chapter considers the strengths of the study and the limitations which must be considered when appraising the overall quality of the research.

Strengths of the study

Recruiting student nurses and nurse mentors provided a rich and varied data set for this grounded theory research study. The unanticipated recruitment of personal tutors added additional insights into the supportive role of the personal tutor and demonstrated theoretical sampling in action. The key tenets of grounded theory were applied throughout

this study and ensured methodological congruence. My philosophical stance as a researcher was clearly articulated and consistently aligned to the chosen study design. The use of memos and field notes captured my insights, evolving analysis, and mistakes throughout the research journey. In addition, reflexivity, peer review and regular critical debate with academic supervisors, developed my self-awareness of the research process and highlighted areas that required further exploration. Publishing a research paper (Brown et al. 2020) during this candidature, also provided external peer review and constructive feedback.

Following the coding procedures outlined by Charmaz (2014) led to the development of categories and the resulting substantive grounded theory. The findings provide new insights on the process of students raising concerns and have enabled the aim and research questions of the study to be achieved. In doing so, the gap in the research literature on the influence of the mentor-student dynamic on raising concerns has been narrowed. Furthermore, 'reading the context' explains how the dynamic process of contextual sensemaking contributes to student decision-making and actions relating to raising concerns. The findings have been translated into realistic and practical recommendations which can be actioned within a local context.

Limitations of the study

This study was conducted within one local health board and one university, which is a limitation of the study. However, the nurse mentor participants and student nurses worked in four different healthcare settings across the region. Only one student from the field of child health, volunteered to participate in the study. In addition, there were no nurse mentors or personal tutors from the child field, which highlights an under-representation of participants from the field of paediatric nursing.

This study used a constructivist grounded theory which involved the co-construction of data. Therefore, the findings are an interpretation of the interactions between myself and the research participants. In addition, interviews do not necessarily replicate an authentic picture of reality. The students who volunteered may have had their own reasons for wanting to share their experiences. It is possible that students who had very positive experiences of speaking up did not come forward to share these.

Nevertheless, the study generated a large amount of rich data which were analysed and resulted in a grounded theory which addressed the research questions and enhanced understanding of how students utilise sensemaking to assess whether the context is favourable to raise a concern within the clinical placement.

8.8 Concluding remarks

Raising concerns within the clinical environment is a crucial element of patient safety. Despite the many reviews and recommendations implemented to enhance safety within healthcare systems, it is clear that staff and student nurses still find raising and responding to concerns challenging. This research study has identified that student nurses will speak up if the nurse mentor is approachable and the environment is conducive to do so.

There were examples of exemplary practice in this regard, where students were encouraged to discuss their concerns, remained involved until the concern was resolved and in some cases were invited back to the clinical area to see the results. However, the study findings also identify how an unfavourable organisational context deters students from speaking up, which is a concerning finding.

This thesis has enhanced our understanding of the factors influencing student nurses' propensity to raise concerns whilst on placement. Assessment of the context favourability involves the dynamic process of sensemaking in response to signals and cues. The interpersonal relationships and interactions between the student and the nurse mentor, clinical team, the manager, and personal tutor underpin this process.

The recommendations developed from this study aim to enhance student nurses' knowledge and understanding of the reality of raising a concern and to develop user-friendly resources to support students, clinical staff and nurse academics within the raising concerns process.

8.9 A personal reflection

This PhD journey has been all-consuming for the past seven years. Undertaking this thesis as a part-time student with a busy full-time job has not been without its challenges. Along the way there have been health challenges which impacted on my schedule, and times

when 'imposter syndrome' kicked in and I doubted my ability to complete this. But not once have I regretted embarking on this journey, or begrudged the hours spent working on this every weekend.

Having the opportunity to interview nursing students, nurse mentors and personal tutors has been the most enjoyable aspect of this thesis and certainly brought the research study to life. Reading about data generation in a textbook does not capture the value and joy in interacting with individuals as part of a qualitative research study. Interpreting these encounters and making sense of their perceptions and experiences of raising concerns, has been insightful and I am privileged that they agreed to share their experiences with me.

Joining an academic community is a vital element of being a PhD student and I have enjoyed the opportunity to network as well as sharing the highs and lows of undertaking this 'traumatic intellectual transition' (Philips and Pugh 2015, p.10). Disseminating my work at the RCN International Research Conference in 2018 was a particular highlight, especially when I had a queue of nursing students waiting to talk to me after my presentation. At that point, I could really see that this study resonated with their experiences.

Raising concerns continues to be a challenge for many student nurses in clinical practice settings. As an adult nursing lecturer, I am keen to utilise the knowledge I have gained from this PhD to be a 'champion', to influence and enhance student nurses' experiences of raising concerns. Maintaining close professional links with clinical staff, educators and key stakeholders within local health boards and the university, will enable me to work collaboratively in achieving the recommendations outlined within this chapter.

References

- Ahern, K. and McDonald, S. 2002. The beliefs of nurses who were involved in a whistleblowing event. *Journal of Advanced Nursing* 38 (3) pp.303-309.
- Aldiabat, K. and LeNevanec, M.C. 2018. Data Saturation: The Mysterious Step In Grounded Theory Method. *The Qualitative Report* 23(1) pp.245-261.
<https://doi.org/10.46743/2160-3715/2018.2994>
- Ali, N.A., May, R., Griffin, K.V. 2018. A systematic review of grounded theory studies in physiotherapy. *Physiotherapy Theory and practice* 35 (12) pp. 1-31
- Alingh, C.W., Wijngaarden, J.D.H., Van de Voorde, K. 2019. Speaking up about patient safety concerns: the influence of safety management approaches and climate on nurses' willingness to speak up. *BMJ Quality and Safety* 28 pp.39–48. doi.org/10.1136/ bmjqs-2017-007163
- Allan, G. 2003. A critique of using grounded theory as a research method. *Electronic Journal of Business Research Methods* 2 (1) pp. 1-10.
- Alleyne, P; Hudaib, M., Pike, R. 2013. Towards a conceptual model of whistleblowing intentions among external auditors. *British Accountant Review* 45 (1) pp.10–23.
<https://doi.org/10.1016/j.bar.2012.12.003>
- Alsaawi, A. 2014. Critical Review of Qualitative Interviews. *European Journal of Business and Social Sciences* 3 (4) <https://dx.doi.org/10.2139/ssrn.2819536>
- American Nurses Association. 2015. *Code of ethics with interpretative statements*. Available at:
<http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html> [Accessed 1 January 2022]
- Andrade, J.A. 2015. Reconceptualising Whistleblowing in a Complex World. *Journal of Business Ethics*, 128 2 pp.321–335
- Andrews, J and Butler, M. 2014. *Trusted to Care. An independent review of the Princess of Wales Hospital and Neath Port Talbot at Abertawe Bro Morgannwg, University Health Board*. Available at: <https://gov.wales/sites/default/files/publications/2019-04/trusted-to-care.pdf> [Accessed 13 Aug 2020]
- Annells, M. 1997. Grounded theory method. Part 1: within the five moments of qualitative research. *Nursing Inquiry*. 4 (2), pp. 120-129.
- Anvari, F. et al. 2019. 'The social psychology of whistleblowing: An integrated model'. *Organizational Psychology Review* 9 (1) pp. 41–67. doi: 10.1177/2041386619849085.
- Aranzamendez, G., James, D., Toms, R. 2015. Finding antecedents of psychological safety: A step towards quality improvement. *Nursing Forum*. 50 (3) pp. 171-178.

- Ashford, S. J., Rothbard, N.P., Piderit, S.K. and Dutton, J.E. 1998. *Out on a Limb: The Role of Context and Impression Management in Selling Gender-Equity Issues*. *Administrative Science Quarterly*. 43 (1) pp. 23–57. <https://doi.org/10.2307/2393590>
- Atkinson, P. and Silverman. D. 1997. Kundera’s Immortality: the interview society and the invention of the self. *Qualitative Inquiry* 3 (3) pp.304–325.
- Attree, M. 2007. Factors influencing nurses' decisions to raise concerns about care quality. *Journal of Nursing Management*. 15 pp.392-402.
- Azevedo, V. et al. 2017. Interview transcription: conceptual issues, practical guidelines and challenges. *Revista de Enfermagem Referência*. IV (14) pp. 159-168.
- Battles, J. B., Dixon, N. M., Borotkanics, R. J., Rabin-Fastmen, B., & Kaplan, H. S. 2006. Sensemaking of patient safety risks and hazards. *Health services research*, 41(4 Pt 2) pp. 1555–1575. <https://doi.org/10.1111/j.1475-6773.2006.00565.x>
- BBC News. 2013. NHS whistle-blowers in Wales ‘put off’ complaining by policy. Available at: <https://www.bbc.co.uk/news/uk-wales-24628122> [Accessed 9/11/20]
- Beauchamp, T.L., Childress, J.F. 2019. *The Principles of Biomedical Ethics*. New York: Oxford University Press.
- Beck, C. T. 1993. Qualitative research: the evaluation of its credibility, fittingness, and auditability. *Western journal of nursing research*, 15(2) pp. 263–266. <https://doi.org/10.1177/019394599301500212>
- Bellefontaine, N. 2009. Exploring whether student nurses report poor practice they have witnessed on placements. *Nursing Times*, 105 pp.28-31.
- Benzies, K.M. and Allen, M.N. 2001. Symbolic interactionism as a theoretical perspective for multiple method research. *Journal of Advanced Nursing* 33 (4) pp. 541-547.
- Berry, B. 2004. Organisational culture: A framework and strategies for facilitating employee whistleblowing. *Employee Responsibilities and Rights Journal* 16 (1) pp. 1-11.
- Bickoff, L., Levett-Jones, T. and Sinclair, P.M. 2016. Rocking the boat - nursing students' stories of moral courage: A qualitative descriptive study. *Nurse Education Today* 42 pp.35-40.
- Birks, M and Mills, J. 2011. *Grounded Theory: A Practical Guide*. Los Angeles: Sage Publications
- Bjørkelo, B., Einarsen, S., Nielsen, M. B. and Matthiesen, S.B. 2010. Predicting proactive behaviour at work: Exploring the role of personality as an antecedent of whistleblowing behaviour. *Journal of Occupational and Organizational Psychology* 83 pp.371–39.

- Bjørkelo, B., Einarsen, S., Nielsen, M.B. and Matthiesen, S.B. 2011. Silence is golden? Characteristics and experiences of self-reported whistle-blowers. *European Journal of Work and Organizational Psychology* 20 (2) pp. 206–238.
- Black, L.M. 2011. Tragedy into policy – a quantitative study of nurses’ attitudes toward patient advocacy activities. *American Journal of Nursing* 111 (6) pp.27–35.
- Blair, W., Kable, A., Palazzi, K., Courtney-Pratt, H., Doran, E., Oldmeadow, C. 2016. Nurses’ perspectives of recognising and responding to unsafe practice by their peers: A national cross-sectional survey. *Journal of Clinical Nursing*. 00 pp.1–16.
<https://doi.org/10.1111/jocn.1567>
- Blenkinsopp, J. and Edwards, M. 2008. On not blowing the whistle: Quiescent silence as an emotion episode. *Research on Emotion in Organizations* 4 (10), 1016/S1746-9791(08)04008-X.
- Blenkinsopp, J., Snowden, N., Mannion, R., Powell, M., Davies, H., Millar, R. and Michael, J. 2019. Whistleblowing over patient safety and care quality: a review of the literature. *Journal of Health and Organisational Management* 33 pp.737-756.
- Blowers, J.E. 2018. An investigation of professional integrity in pre-registration nurse education: A modified grounded theory study. *Nurse Education Today*. 68 pp. 40-44.
- Blumer, H. 1969. *Symbolic interactionism: Perspective and method*. Berkeley, CA: University of California Press Ltd.
- Boadou, M. and Sorour, K. 2015. On Utilizing Grounded Theory in Business Doctoral Research: Guidance on the Research Design, Procedures, and Challenges. *International Journal of Doctoral Studies* 10 pp. 143-166. 10.28945/2251.
- Bolsin, S., Pal, R., Wilmhurst, P. and Pena, M. 2011. “Whistleblowing and patient safety: the patient’s or the profession’s interests at stake? *Journal of the Royal Society of Medicine*. 104 (8) pp. 278-82.
- Bradbury-Jones, C., Sambrook S. and Irvin F. 2007. The meaning of empowerment for nursing students: a critical incident study. *Journal of Advanced Nursing* 59 (4) pp. 342–351.
- Bradbury-Jones, C; Irvine, F., Sambrook, S. 2010. Empowerment of nursing students in clinical practice: spheres of influence. *Journal of Advanced Nursing*. 66 pp. 2061–70.
<https://doi.org/10.1111/j.1365-2648.2010.05351.x>
- Bradbury-Jones, C., Sambrook, S., Irvine F. 2011. Nursing students and the issue of voice: a qualitative study. *Nurse Education Today* 31 (6) pp.628–32.
<https://doi.org/10.1016/j.nedt.2010.10.030>

- Bradley, E.H., Brewster, A.L., McNatt, Z. et al. 2018. How guiding coalitions promote positive culture change in hospitals: A longitudinal mixed methods interventional study. *BMJ Quality & Safety* 27 pp. 218-225.
- Braine, M.E. and Parnell, J. 2011. Exploring student's perceptions and experience of personal tutors. *Nurse Education Today* 31 pp. 904-10.
- Braithwaite, J., Herkes, J., Ludlow, K., Testa, A., Lamprell, G. 2017. Association between organisational and workplace cultures, and patient outcomes: systematic review. *BMJ Open*. 7 e017708. doi: 10.1136/bmjopen-2017-017708
- Brandt, L and Popejoy, L. 2020. Use of sensemaking as a pedagogical approach to teach clinical ethics: An integrative review. *International Journal of Ethics Education*. 5 (1) pp. 23-37
- Bray, L. and Nettleton, P. 2007. Assessor or mentor? Role confusion in professional education. *Nurse Education Today*. 27 pp. 848-55.
- Breckenridge, J.P., Jones, D., Elliot, I., Nicol, M. 2012. Choosing a Methodological Path: Reflections on the constructivist turn. *Grounded theory review. An International Journal* 1 (11) pp. 1-9.
- Brown, L., Douglas, V., Garrity, J., Kim, S.C. 2012. What influences mentors to pass or fail students. *Nursing Management* 19 (5) pp. 16-21.
<http://doi.org/10.7748/nm2012.09.19.5.1>
- Brown, P., Jones, A. and Davies, J. Shall I tell my mentor? Exploring the mentor-student relationship and its impact on students' raising concerns on clinical placement. *Journal of Clinical Nursing* 00 pp. 1-13.
- Bryant, A. and Charmaz, K. 2007. Introduction to grounded theory research: Methods and practices. In: Bryant, A and Charmaz, K. eds. *The SAGE handbook of grounded theory*. Thousand Oaks, New Delhi: SAGE Publications Ltd pp. 1-28.
- Callister, L.C., Luthy, K.E., Thompson, P. and Memmot, R.J. 2009. Ethical reasoning in Baccalaureate nursing students. *Nursing Ethics* 16 (4) pp. 500-510.
- Cambridge Dictionary. 2021.
<https://dictionary.cambridge.org/dictionary/english/manhandle?q=Manhandle>
[Accessed on 8 Aug 2021]
- Cardiff and Vale University Health Board. 2015. *Whistleblowing policy*. Cardiff: Cardiff and Vale UHB
- Cardiff University. 2015. *Confidentiality Policy*. Cardiff: Cardiff University.

Cardiff and Vale University Health Board. 2017. *Procedure for NHS staff to Raise Concerns*. Available at: <https://cavuhb.nhs.wales/files/f2su/final-procedure-for-nhs-staff-to-raise-concerns-nov-17-uhb-formatted-pdf/> [Accessed 6 Jan 2022]

Cardiff University. 2018. *Data Protection Policy*. Cardiff: Cardiff University

Cardiff University. 2017. *Research Integrity and Governance Code of Practice*. Cardiff: Cardiff University.

Care Quality Commission. 2015. *The Duty of Candour. Guidance for providers*. Available at: <https://www.cqc.org.uk/sites/default/files/20210421%20The%20duty%20of%20candour%20-%20guidance%20for%20providers.pdf> [Accessed 12 Oct 2021]

Cassematis, P. and Wortley, R. 2013. Prediction of whistleblowing or Non-reporting Observation. The Role of Personal and Situational Factors. *Journal of Business Ethics* 117 (3) pp. 615-634.

Charmaz, K. 2006. *Constructing Grounded Theory*. London: Sage

Charmaz, K. 2014 *Constructing Grounded Theory*. 2nd ed. London: SAGE.

Charmaz, K. 2016 'The Power of Constructivist Grounded Theory for Critical Inquiry'. *Qualitative Inquiry* 23 (1) pp. 34–45. doi: 10.1177/1077800416657105.

Charmaz, K. and Belgrave, L.L. 2012. Qualitative interviewing and grounded theory analysis. In: *The SAGE Handbook of Interview Research: The Complexity of the Craft*. New York: SAGE Publications pp. 347-366. <https://doi.org/10.4135/9781452218403.n25>

Charmaz, K and Bryant, A. 2010. Grounded Theory. Qualitative Research. Available at: <https://reader.elsevier.com/reader/sd/pii/B9780080448947015815?token=F52743880BF91A99E8FB869FB3B0A742C4CDD62854F6F00153501CAD423140245A6FC41D77315A4983A4CAD4358EABAA&originRegion=eu-west-1&originCreation=20220106211411> pp. 406 – 412.

Charnock, A. 1993. The personal tutor: a teacher's view. *Nursing Standard*. 7 pp.28-9.

Chen, C.P and Lai, C.T. 2014. To blow or not to blow the whistle: the effects of potential harm, social pressure and organisational commitment on whistleblowing intention and behaviour. *Business Ethics: A European Review*. 23 (3) pp. 327-342.

Chen, L. 2019. A Review of Research on Whistleblowing. *American Journal of Industrial and Business Management*, 9 pp. 295-305. doi: 10.4236/ajibm.2019.92019.

Chen, A, Treviño, L.K., Humphrey S.E. 2020. Ethical champions, emotions, framing, and team ethical decision making. *Journal of Applied Psychology* 105 (3) pp. 245-273.

- Chua, R.L.E. and Magpenty, J.C. 2019. Moral distress of undergraduate students in community health nursing. *Nursing Ethics* 26 (7-8) pp. 2340-2350.
- Cole, D.A., Bersick, E., Skarbek, A; Cummins, K., Dugan, K., Grantosa, R. 2019. The courage to speak out: A study describing nurses' attitudes to report unsafe practices in patient care. *Journal of Nursing Management* 27 pp. 1176–1181.
<https://doi.org/10.1111/jonm.1278>
- Conlon, C., Timonen, V., Elliott-O'Dare, C., O'Keeffe, S., Foley, G. 2020. Confused About Theoretical Sampling? Engaging Theoretical Sampling in Diverse Grounded Theory Studies. *Qualitative Health Research* 30 (6) pp. 947-959.
- Creswell, J.W. 2014. *Research Design. Qualitative, quantitative & Mixed Methods Approaches*. Los Angeles: Sage
- Crotty, M. 1998. *The Foundations of Social Research. Meaning and Perspective in the research process*. London: Sage.
- Culiberg, B and Mihelic, K.K. 2017. The evolution of whistleblowing studies: a critical review and research agenda. *Journal of Business Ethics* 146 pp.787–803.
<https://doi.org/10.1007/s10551-016-3237-0>
- Cusack, L., Thornton, K., Drioli-Phillips, P., Cockburn, T., Jones, L., Whitehead, M., Prior, Alderman, J. 2020. Are nurses recognised, prepared, and supported to teach nursing students: Mixed methods study. *Nurse Education Today*. 90. DO10.1016/j.nedt.2020.104434
- Dalton, D. and Radtke, R.R. 2013. The joint effects of Machiavellianism and Ethical Environment on Whistleblowing. *Journal of Business Ethics* pp.117 153-172.
- Darawsheh, W. 2014. Reflexivity in research: Promoting rigour, reliability and validity. *International Journal of Therapy and Rehabilitation*. 21 (12) pp. 560-568.
- Davies, H.T.O., Nutley, S.M., Mannion, R. 2000. Organisational culture and quality of health care. *Quality in Health Care*. 9 pp. 111-119.
- Davis, A. J. and Konishi, E. 2007. Whistleblowing in Japan. *Nursing Ethics* 14 pp.194-202.
- Deal, T.E. and Kennedy, A.A. 1982. *Corporate cultures: The rites and rituals of corporate life*. New York: Perseus.
- Deering, K. and Williams, J. 2020. Approaches to reviewing the literature in grounded theory: a framework. *Nurse Researcher* pp. 1-7. doi: 10.7748/nr.2020.e1752
- Denzin, N.K. 2009. *The research act: A theoretical introduction to sociological methods*. 3rd ed. Englewood Cliffs, NJ: Prentice Hall.

Denzin, N.K. and Lincoln, Y.S. 2013. *The Landscape of Qualitative Research*. 4th ed. Los Angeles: Sage Publications.

Department of Health. 2015. *Culture change in the NHS. Applying the lessons of the Francis Inquiries*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/403010/culture-change-nhs.pdf [Accessed 12 June 2020]

Derrington, M. 2019. *Qualitative longitudinal methods*. Los Angeles: SAGE Publications <https://dx.doi.org/10.4135/9781071814277>

Devlin, N. and Duggan, S. 2020. An evaluation of nurses' experiences of mentoring pre-registration students. *British Journal of Nursing* 29 pp.308-313.

de Vries, E.N., Ramrattan, M.A., Smorenburg, S.M., Gouma, D.J., Boermeester, M.A. 2008. The incidence and nature of in-hospital adverse events: a systematic review. *Quality and Safety in Health Care* 17 (3) pp .216–23. <http://doi.org/10.1136/qshc.2007.023622>

Dobinson-Harrington, A. 2006. Personal tutor encounters: understanding the experience. *Nursing Standard* 20 pp. 35-42.

Dhollande, S. et al. (2021) 'Conducting integrative reviews: a guide for novice nursing researchers. *Journal of Research in Nursing* 26 (5) pp. 427–438. doi: 10.1177/1744987121997907.

Donaldson, L. 2000. *An organisation with a memory. Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer*. London: TSO.

Doyle, S. 2013. Reflexivity and the Capacity to Think. *Qualitative Health Research* 23 (2) pp. 248 –255. doi: [10.1177/1049732312467854](https://doi.org/10.1177/1049732312467854).

Duffy, K. 2003. *Failing students. A qualitative Study of Factors that Influence the Decisions Regarding Assessment of Students' Competence in Practice*. PhD Thesis, Glasgow Caledonian University.

Dunne, C. 2011. The Place of the Literature Review in Grounded Theory Research. *International Journal of Social Research Methodology* 14 pp. 111-124.

Dutton, J.D and Ashford, S.J. 1993. Selling issues to top management. *The Academy of Management Review* 18 (3) pp. 397-428.

Dutton, J.D., Ashford, S.J., O'Neill, R.M., Hayes, E., Wierba, E.E. 1997. Reading the wind: How middle managers assess the context for selling issues to top managers. *Strategic Management Journal*. 18 (5) pp. 407-425.

- Dutton, J.D., Ashford, S.J., Lawrence, A., Miner-Rubino, 2002. Red Light, Green Light: Making Sense of the Organisational context for Issue Selling. *Organisational Science* 13 (4) pp. 355-369.
- Eby, M.1994. "Whistleblowing". In: Tschudin, V. ed. *Ethics: Conflicts of Interest*. London: Scutari pp. 56-84.
- Eby, L.T. 2007. Understanding problems in mentoring: A review and proposed investment model. In: Ragins, B.R and Kram, K.E. eds. *Handbook of mentoring*. Thousand Oaks CA: Sage pp. 323-344.
- Edmondson, A. (1999) 'Psychological Safety and Learning Behaviour in Work Teams', *Administrative Science Quarterly* 44 (2) pp. 350–383. doi: 10.2307/2666999.
- Elliot, N. and Higgins, A. 2012. Surviving grounded theory research method in an academic world. Proposal writing and theoretical frameworks. *Grounded Theory Review. An international Journal* 2 (11)
- Elliot, N. and Jordan, J. 2010. Practical strategies to avoid the pitfalls in grounded theory research. *Nurse Researcher*. 17, pp. 29-40.
- Elliot,N. and Lazenbatt, A. 2005. How to recognise a 'quality' grounded theory research study. *Australian Journal of Advanced Nursing* 22, pp. 48-52.
- Engward, H. 2013. Understanding grounded theory. *Nursing Standard* 28 (7) pp. 37-41.
- Engward, H. and Davis, G. 2015. Being reflexive in qualitative grounded theory: discussion and application of a model of reflexivity. *Journal of Advanced Nursing* 71, pp. 1530-8.
- Enosh, G., Ben-Ari, A. 2016. Reflexivity: The Creation of Liminal Spaces - Researchers, Participants, and Research Encounters. *Qualitative Health Research* 26 pp.578-584.
- Enterprise and Regulatory Reform Act*. 2013.Available at:
<https://www.legislation.gov.uk/ukpga/2013/24/contents/enacted> [Accessed 2 Jan 2022]
- Erdkil, F and Korkmaz, F, 2009. Ethical Problems Observed by Student Nurses. *Nursing Ethics* 16 (5) pp. 589-598.
- Espin, S. and Meikle, D. 2014. Fourth-year nursing student perceptions of incidents and incident reporting. *Journal of Nurse Education*. 53 pp. 238–43.
<https://doi.org/10.3928/01484834-20140217-04>
- Evans, G.L. 2013. A Novice Researcher's First Walk Through the Maze of Grounded Theory: Rationalisation for Classical Grounded Theory. *The Grounded Theory Review* 12 (1) pp. 1-19

Fagan, A; Lea, J., Parker, V. 2020. Conflict, confusion and inconsistencies. Pre-registration nursing students' perceptions and experiences of speaking up for patient safety. *Nursing Inquiry*. 28:e12381. <https://doi.org/10.1111/nin.12381>

Fagan, A., Parker, V. and Jackson, D. 2016. A concept analysis of undergraduate nursing students speaking up for patient safety in the patient care environment. *Journal of Advanced Nursing*. 72 pp. 2346-57.

Farrell, D. and Petersen, J.C. 1982. Patterns of political behaviour in organizations. *Academy of Management Review*. 7 pp.403-412.

FeldmanHall, O., Mobbs, D., Evans, D., Hiscox, L., Navrady, L., Dalgleish, T. 2012. What we say and what we do: the relationship between real and hypothetical moral choices. *Cognition* 123 (3) pp. 434-41. doi: 10.1016/j.cognition.2012.02.001.

Ferns, T. and Meerabeau, E. 2009. Reporting behaviours of nursing students who have experienced verbal abuse. *Journal of Advanced Nursing*. 65 pp. 2678-88.

Finlay, L. 2002. "Outing" the researcher: The Provenance, process, and Practice of Reflexivity. *Qualitative Health Research* 12 (4) pp. 531-545.

Finlay, L. 2008. Reflecting on 'Reflective practice'. Practice-based Professional Learning Paper 52, *The Open University* pp. 1-26.

Firth-Cozens, J., Firth, R.A., Booth, S. 2003. Attitudes to and experiences of reporting poor care. *International Journal of Health Governance*. 8 (4) pp. 331-6. <https://doi.org/10.1108/14777270310499423>

Firtko, A. and Jackson, D. 2005. Do the ends justify the means? Nursing and the dilemma of whistleblowing. *Australian journal of Advanced Nursing* 23 (1) pp. 51-56

Fisher, M. and Kiernan, M. 2019. Student nurses' lived experience of patient safety and raising concerns. *Nurse Education Today*, 77 pp. 1-5.

Foley, G., Timonen, V., Conlon, C., O'Dare, C.E. 2021. Interviewing as a vehicle for theoretical sampling in grounded theory. *International Journal of Qualitative Methods* 20 pp. 1-10.

Foster, H., Ooms, A., Marks-Maran, D. 2015. Nursing students' expectations and experiences of mentorship. *Nurse Education Today*, 35, (1) pp.18-24.

Francis R. 2013. *The Mid Staffordshire NHS Foundation Trust Public Inquiry* (Chaired by Robert Francis QC) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office.

Francis R. 2015. *Freedom to Speak Up: An Independent Review into Creating an Open and Honest Reporting Culture in the NHS*. London: The Stationery Office.

French, J.R.P. and Raven, B. 1959. The bases of social power. In: Cartwright, D.D. ed. *Studies in social power*. University of Michigan. pp. 150-167.

Gagnon, M. and Perron, A. 2019. Whistleblowing: A concept analysis. *Nursing Health Science* 22 pp. 381-389.

Gallagher, A. 2010. Whistleblowing: what influences nurses' decisions on whether to report poor practice. *Nursing Times*. 106 (4) pp. 22-25.

Gao, J., Greenberg, R. and Wongon, B. 2015. Whistleblowing Intentions of Lower-Level Employees: The Effect of Reporting Channel, Bystanders, and Wrongdoer Power Status. *Journal of Business Ethics* 126 (1) pp. 85–99.

Garon, M. 2012. Speaking up, being heard: registered nurses' perceptions of workplace communication. 20 pp. 361-371.

Giles, T., King, L., de Lacey, S. 2013. The Timing of the Literature Review in Grounded Theory Research. *Advances in Nursing Science*. 36 (2) pp. E29-E40 doi: 10.1097/ANS.0b013e3182902035

Giles, T, de Lacey, S., Muir-Cochrane, E. 2016. Coding, constant comparisons and core categories. *Advances in Nursing Science* 39 (1) pp. E29–E44

Gelling, L. 2011. The Complexities of using grounded theory. *Nurse Researcher*. 18 (4) pp. 4-5.

Given, L.M. 2008. *The SAGE Encyclopedia of Qualitative Research Methods*. Thousand Oaks, CA: SAGE Publications.

Glaser B. and Strauss A.L. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine Publishing Company, New York.

Glaser, B. 1978. *Theoretical Sensitivity*. Sociological Press, Mill Valley, CA, USA.

Glaser, B. 1992 *Emergence vs. forcing: Basics of Grounded Theory Analysis*. Mill Valley, CA: Sociology Press.

Glaser, B. 1998. *Doing Grounded Theory: Issues and Discussions*. Mill Valley, CA: Sociology Press.

Glaser, B. 2001. *The Grounded Theory Perspective: Conceptualization Contrasted with Description*. Mill Valley, CA: Sociology Press.

Glaser, B. 2012. Constructivist Grounded Theory. *The Grounded Theory Review* 11 (1) pp. 28-33

- Goffman, E. 1959. *The presentation of self in everyday life*. New York: Random House Inc.
- Grant, M; Leigh, J; Murray, C; Howarth, M. 2007. *The role of the academic in clinical practice. A systematic review*. Salford Centre for Nursing, midwifery and Collaborative Research: Salford,
- Gray, D.E. 2014. *Doing Research in the real world*. 3rd edn. Los Angeles: Sage Publications
- Grealish, L. and Trevitt, C. 2005. Developing a professional identity: student nurses in the workplace. *Contemporary Nurse* 19 pp. 137-50.
- Green, J. and Thorogood, N. 2014. *Qualitative Methods for Health Research*. 3rd edn. Los Angeles: SAGE Publications
- Grobecker, P.A. 2016. "A sense of belonging and perceived stress among baccalaureate nursing students in clinical placements." *Nurse Education Today* 36, pp. 178-83.
- Grover, J.S. 2019. "Empathetic Student-Centric Decisional Mindset: A Grounded Theory Study Of Teachers' Judgment Experiences" Theses and Dissertations.
- Grube, J.A., Piliavin, J.A., Turner, J.W. 2010. The courage of one's conviction: when do nurse practitioners report unsafe practices? *Health Community* 25 (2) pp. 155-64.
<https://doi.org/10.1080/10410230903544944>
- Guba, E. and Lincoln, Y. 1985. *Naturalistic Inquiry*. CA: Sage Publications.
- Guba, E. and Lincoln, Y. 1989. *Fourth generation evaluation*. Newbury Park, CA: Sage.
- Gundlach, M.J., Douglas, S.C., Martinko, M.J. 2003. The decision to blow the whistle: a social information processing framework. *Academic Management Review* 28 (1) pp. 107-23.
- Gunther, M. 2011. Empathic anger in junior nursing students. *Journal of Nurse Education*. 50 (5) pp. 242-7. doi: 10.3928/01484834-20100930-01.
- Hall, H., Griffiths, D., McKenna, L. 2013. From Darwin to constructivism: the evolution of grounded theory. *Nurse Researcher* 20 (3) pp. 17-21.
- Hallberg, L.R.M. 2006. The "core category" of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-being* 1(3) pp.141-148. <https://doi.org/10.1080/17482620600858399>
- Halperin, O. and Bronshtein, O. 2019. The attitudes of nursing students and clinical instructors towards reporting irregular incidents in the medical clinic. *Nurse Education in Practice*. 36 pp.34-39.

- Hanson, A. Negative case analysis. 2017. In: Matthes J, Davis C.S., Potter, R.F. eds. *The International Encyclopedia of communication Research*. New Jersey: John Wiley & Sons.
- Harrison-white, K. and Owens, J. 2018. Nurse link lecturers' perceptions of the challenges facing student nurses in clinical learning environments: A qualitative study. *Nurse Education in Practice*,32 pp.78-83.
- Healey,M; Flint,A. and Harrington,C. 2014. *Engagement through partnership: students as partners in learning and teaching in higher education*. The Higher Education Academy: HEA
- Heath, H. and Cowley, S. 2004. Developing a grounded theory approach: a comparison of Glaser and Strauss. *International Journal of Nursing Studies* 41 pp.141-50.
- Health Education England. 2016. *In safe Hands. Prioritising patient safety across the UK*. Available at: https://www.hee.nhs.uk/sites/default/files/documents/HEE_Patient_Safety_Toolkit_2019_v6b.pdf [Accessed 2 Dec 2021]
- Health Education and Improvement Wales. 2020. *Once for Wales 2020*. Wales: HEIW
- Henik, E. 2008. Mad as hell or scared stiff? the effects of value conflict and emotions on potential whistle-blowers. *Journal of Business Ethics*. 8
- Hennink, M.M., Kaiser, B.N. and Marconi, V.C. 2017 'Code Saturation Versus Meaning Saturation: How Many Interviews Are Enough?' *Qualitative Health Research*, 27 (4) pp. 591–608. doi: 10.1177/1049732316665344.
- Henriksen, K. and Dayton, E. 2006, "Organizational silence and threats to patient safety" *Health Services Research* 41 (4) pp. 1539-54.
- Hersh,M.A. Whistleblowers – Heroes or traitors?: Individual and collective responsibility for ethical behaviour. *Annals Reviews in Control* 26 (2) pp.243-262
- Higginbottom, G. and Lauridsen, E.I. 2014. The roots and development of constructivist grounded theory *Nurse Researcher* 21 pp. 8-13.
- Hilton, C. 2016. Whistleblowing and the duty of candour in the National Health Service: a 'history and policy' case study of the 1960's and 2010's. *Journal of the Royal Society of Medicine*. 109 (9) pp. 327-330
- Hirschman, A.O. 1970. *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States*. Cambridge, MA: Harvard University Press.
- Hoare, K., Mills, J.E., Francis, K. 2011. Dancing with data: an example of acquiring theoretical sensitivity in a grounded theory study. *International Journal of Nursing Practice* 18 pp. 240-245

- Holden, R.R. and Passey, J. 2009. Social desirability. In: Leary, M.R and Hoyle, R. eds. *Handbook of individual differences in social behavior*. New York: Guilford. pp. 441-454.
- Hollings, J. 2013. Let the Story Go: The Role of Emotion in the Decision-Making Process of the Reluctant, Vulnerable Witness or Whistle-Blower. *Journal of Business Ethics* 114 (3) pp. 501–512.
- Holloway, I. and Galvin, K. 2016. *Qualitative Research in Nursing and Healthcare*. 4th edn. Hoboken: John Wiley and Sons.
- Holstein, J.A. and Gubrium, J.F. 1995. *The Active Interview*. Thousand Oaks, CA: SAGE.
- Holstein, J.A and Gubrium J.F. 2003. *Inside Interviewing*. Thousand Oaks, CA: SAGE Publications.
- Holt, N.L. 2016. *Doing grounded theory in sport and exercise*. In Smith, B. and Sparkes, A.C. eds. *Routledge handbook of qualitative research in sport and exercise*. London, UK: Routledge. pp. 24-36. doi:10.4324/9781315762012.ch3
- Houghton, C., Casey, D., Shaw, D., Murphy, K. 2010. Ethical challenges in qualitative research: examples from practice. *Nurse Researcher* 18 pp. 15-25.
- Hughes, S. 2004. The mentoring role of the personal tutor in the 'Fitness for practice' curriculum: An all Wales approach. *Nurse Education in Practice*. 4 pp.271-278.
- Hughes, L. J., Mitchell, M. and Johnston, A.N B. 2016. "Failure to fail" in nursing – A catch phrase or a real issue? A systematic integrative literature review. *Nurse Education in Practice*, 20 pp.54–63. <https://doi.org/10.1016/j.nepr.2016.06.009>
- Hughes, H. 2019. Freedom to speak up – the role of freedom to speak up guardians and the National guardian's office in England. *Future Healthcare Journal*. 6 (3) pp. 186-189
- Hunter, A., Murphy, K., Grealish, A., Casey, D. and Keady, J. 2011 'Navigating the grounded theory terrain. Part 1', *Nurse Researcher*, 18 (4) pp. 6 -10.
- Institute of Medicine. 1999. *To Err is Human: Building a Safer Health system*. Available at: <https://www.nap.edu/resource/9728/To-Err-is-Human-1999--report-brief.pdf> [Accessed 23 Nov 2021]
- Ion, R., Smith, K., Nimmo, S., Rice, A.M. and McMillan, L. 2015. Factors influencing student nurse decisions to report poor practice witnessed while on placement. *Nurse Education Today*, 35 pp. 900-5.
- Ion, R., Smith, K., Moir J. and Nimmo, S. 2016. Accounting for actions and omissions: a discourse analysis of student nurse accounts of responding to instances of poor care. *Journal of Advanced Nursing*, 72 pp.1054-64.

- Ion, R., Smith, K., Dickens, G..2017. Nursing and midwifery students' encounters with poor clinical practice: A systematic review, *Nurse Education in Practice*. doi: 10.1016/j.nepr.2017.02.010.
- Ion, R. 2019. *Raising concerns about poor nursing care: the moral and professional responsibility of nursing students and registered nurses*. PhD Thesis: Abertay University
- Jack, K., Hamshire, C., Harris W.E., Langan, M., Barrett, N. and Wibberley, C. 2018. "My mentor didn't speak to me for the first four weeks": Perceived Unfairness experienced by nursing students in clinical practice settings *Journal of Clinical Nursing* 27 pp. 929-938.
- Jack, K., Levett-Jones, T., Ion, R., Pich, J., Fulton, R., Ylonen, A. M. and Hamshire, C. 2020. 'She would wash the patients as if she was scrubbing a dirty plate in the sink': Exploring nursing students experiences of care delivery. *Nurse Education Today* 90 pp. 104444.
- Jackson, D., et al. 2010a. Understanding whistleblowing: qualitative insights from nurse whistle-blowers. *Journal of Advanced Nursing* 66 pp. 2194-201.
- Jackson, D. et al. 2010b. Trial and retribution: a qualitative study of whistleblowing and workplace relationships in nursing. *Contemporary Nurse* 36 pp. 34-44.
- Jackson, D., Hutchinson, M., Everett, B., Mannix, J., Peters, K. Weaver, R., Salamonson, Y. 2011. Struggling for legitimacy: nursing students' stories of organisational aggression, resilience, and resistance. *Nursing Inquiry* 18 (2) pp. 102-10.
- Jackson, D., Hickman, L. D., Hutchinson, M., Andrew, S., Smith, J., Potgieter, I., Cleary, M., & Peters, K. 2014. Whistleblowing: An integrative literature review of data-based studies involving nurses. *Contemporary Nurse* pp. 5513 -5549
<https://doi.org/10.5172/conu.2014.5495>
- James, D. 2015. How to get clear about method, methodology, epistemology and ontology, once and for all. Available at: <https://walesdtp.ac.uk/onlinematerials/how-to-get-clear-about-method-methodology-epistemology-and-ontology-once-and-for-all/> [Accessed 5 May 2020]
- Jameton, A. 1984. *Nursing Practice: The ethical issues*. New Jersey: Prentice Hall.
- Jeon, Y. 2004. The application of grounded theory and symbolic interaction. *Scandinavian Journal of Caring Sciences* 18 pp. 249-56.
- Jessee, M.A. 2016. Influences of Sociocultural Factors Within the Clinical Learning Environment on Students' Perceptions of Learning: An Integrative Review. *Journal of Professional Nursing* 32 (6) pp. 463-486.
- Jogulu, U.D. and Pansiri, J. 2011. "Mixed methods: a research design for management doctoral dissertations". *Management Research Review* 34 (6) pp. 687-701.

Jones, A. and Kelly, D. 2014. Whistleblowing and workplace culture in older peoples' care: qualitative insights from the healthcare and social care workforce. *Sociology of Health and Illness* 36 pp. 986-1002.

Kahn, W.A. 1990. Psychological Conditions of Personal Engagement and Disengagement at Work. *The Academy of Management Journal* 33 (4) pp. 692–724.
<https://doi.org/10.2307/256287>

Kaptein, M. 2011. From inaction to external whistleblowing: the influence of the ethical culture of organizations on employee responses to observed wrongdoing. *Journal of Business Ethics* 98 (3) pp. 513–30. <https://doi.org/10.1007/s10551-010-0591-1>

Keenan, J.P. 2002. Whistleblowing: A Study of Managerial Differences. *Employee Responsibilities and Rights Journal*. 14 pp. 17–32
<https://doi.org/10.1023/A:1015796528233>

Kelly, D. and Jones, A. 2013. When care is needed: the role of whistleblowing in promoting best standards from an individual and organizational perspective. *Quality of Ageing in Older Adults* 14 (3) pp. 180–91.

Kent, L; Anderson, G; Ciocca, R; Shanks,L. and Enlow,M.2015. Effects of a senior practicum course on nursing students' confidence in speaking up for patient safety. *Journal of Nursing Education* 54 (3) pp.12-5.

Keogh, B. 2013. *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*. London: NHS England.

King, N. and Horrocks, C. 2010. *Interviews in Qualitative Research*. Los Angeles: Sage

King, G. and Scudder, J.N. 2013. 'Reasons Registered Nurses Report Serious Wrongdoings in a Public Teaching Hospital', *Psychological Reports* 112 (2) pp. 626–636. doi: 10.2466/21.13.PR0.112.2.626-636.

Klaas, B.S., Olson-Buchanan, J.B., Ward, A.K. 2012. The determinants of alternative forms of workplace voice: an integrative perspective. *Journal of Management* 38 (1) pp. 314–45.

Kolb, S. 2012. Grounded theory and the constant comparative method: Valid research strategies for educators. *Journal of Emerging Trends in Educational Research and Policy Studies* 3 pp. 83-86.

Krauss, S.E. 2005. Research Paradigms and Meaning Making: A Primer. *The Qualitative Report*, 10 (4) pp. 758-770. <https://doi.org/10.46743/2160-3715/2005.1831>

Lachman,V.D. 2008a. Whistle-blowers: troublemakers or virtuous nurses? *Dermatology Nursing* 20 pp. 390-3.

- Lachman, V.D. 2008b. Whistleblowing: role of organizational culture in prevention and management. *Dermatology Nursing* 20 (5) pp. 394-396
- Laverack, G. 2009. *Public health: power, empowerment and professional practice*. 2nd ed. London: Palgrave MacMillan.
- Law, B.Y. and Chan, E.A. 2015. The experience of learning to speak up: a narrative inquiry on newly graduated registered nurses. *Journal of Clinical Nursing*. 24 pp. 1837-48.
<https://doi.org/10.1111/jocn.12805>
- Leitner, J., Ayduck, O., Boykin, M., Mendoza-Denton. 2018. Reducing negative affect and increasing rapport to improve interracial mentorship outcomes. *PLoS ONE* 13 (4) pp. e0194123. <https://doi.org/10.1371/journal>
- Lempert, L.B. 2007. Asking Questions of the Data: Memo Writing in the Grounded Theory Tradition. In: Bryant, A. and Charmaz, K. eds. *The SAGE Handbook of Grounded Theory*. Los Angeles: SAGE Publications pp. 245-264.
- Levett-Jones, T., Lathlean, J., McMillan, M. and Higgins, I. 2007. Belongingness: a montage of nursing students' stories of their clinical placement experiences. *Contemporary Nurse*. 24 pp. 162-74
- Levett-Jones, T. and Lathlean, J. 2009. 'Don't rock the boat': Nursing students' experiences of conformity and compliance. *Nurse Education Today*. 29 pp. 342-9.
- Lewis, D., D'Angelo, A. and Clarke, L. 2015. Industrial relations and the management of whistleblowing after the Francis report: what can be learned from the evidence? *Industrial Relations Journal*. 46 (4) pp. 312-327.
- Licquirish, S. and Seibold, C. 2011. Applying a contemporary grounded theory methodology. *Nurse Researcher* 18 (4) pp. 11-16.
- Lidster, J. and Wakefield, S. 2018. *Student Practice Supervision and Assessment*. London: Sage
- Lindh, I.B., Severinsson, E., Berg, A. 2008. Exploring student nurses' reflections on moral responsibility in practice. *Reflective Practice*. 9 (4) pp. 437-448.
- Mogashoa, T. 2014. Understanding Critical Discourse Analysis in Qualitative Research. *International Journal of Humanities, Social Sciences and Education* 1 (7) pp. 104-113
- Malmedal, W., Hammervold, R. and Saveman, B. I. 2009. To report or not report? Attitudes held by Norwegian nursing home staff on reporting inadequate care carried out by colleagues. *Scandinavian Journal of Public Health*. 37 pp. 744-50.

- Mansbach, A; Melzer, I and Bacher, Y.G. 2012. Blowing the whistle to protect patients: A comparison between physiotherapy students and physiotherapists. *Physiotherapy*. 98 (4) pp. 312 - 317
- Mansbach, A., Ziedenberg, H., Bachner, Y.G. 2013. Nursing students' willingness to blow the whistle. *Nurse Education Today*. 33 pp. 69-72.
- Mansbach, A., Kushnir, T., Ziedenberg, H. and Bachner, Y.G. 2014. Reporting misconduct of a co-worker to protect a patient: a comparison between experienced nurses and nursing students. *The Scientific World Journal*. 413926. Doi 10.1155/2014/413926
- Manley, K., Sanders, K., Cardiff, S., Webster, J. 2011. Effective workplace culture: the attributes, enabling factors and consequences of a new concept. *International Journal of Practice Development*. 1. Article 1.
- Mannion, R. and Davies, H. 2018. Understanding organisational culture for healthcare quality improvement. *British Medical Journal*. 363 pp. k4907.
- Mannion, R., Blenkinsopp, J, Powell, M., McHale, J., Millar, R., Snowden, N., Davies, H. 2018. *Understanding the knowledge gaps in whistleblowing and speaking up in health care: Narrative reviews of the research literature and formal inquiries, a legal analysis and stakeholder interviews*. Southampton: NIHR Journals Library; PMID: 30148582.
- Marks, V. and Richmond, C. 2008. Beverly Allitt: the nurse who killed babies. *Journal Of the Royal Society of Medicine*. 101 pp. 110-5.
- Marshall, C., Rossman, G.B. 2016. *Designing qualitative research*. 6th ed. Los Angeles: Sage.
- Marshall, J.E., Fraser, D.M., Baker, P.N. 2010. Reflexivity: the experience of undertaking an ethnographic study to explore issues of consent to intrapartum procedures. *Evidence-based Midwifery* 8 (1) pp.21-25.
- Martin, G.P., Chew, S. and Dixon-Woods, M. 2021 'Uncovering, creating or constructing problems? Enacting a new role to support staff who raise concerns about quality and safety in the English National Health Service'. *Health* 25 (6), pp. 757–774. doi: 10.1177/1363459319901296.
- Maz, J. 2013. Employing a grounded theory approach: core characteristics. *British Journal of Cardiac Nursing*. 8 (9) pp. 453-458.
- McDonald, S. and Ahern, K. 2000. The professional consequences of whistleblowing by nurses. *Journal of the Professional Nurse*, 16 pp. 313-21.
- McFarlane, K.J. 2016 'Tutoring the tutors: Supporting effective personal tutoring', *Active Learning in Higher Education*. 17 (1) pp. 77–88.

- Melia, K.M. 1996. Rediscovering Glaser. *Qualitative Health Research*. 6 (3) pp. 368–378.
- Mesmer-Magnus, J. and Viswesvaran, C. 2005. “Whistleblowing in organizations: an examination of correlates of whistleblowing intentions, actions, and retaliation”. *Journal of Business Ethics*. 62 (3) pp. 277-97.
- Miceli, M.P. and Near, J.P. 1992. *Blowing the whistle: The Organizational and Legal Implications for Companies and Employees*. Lexington, New York.
- Miceli, M.P. and Near, J.P. 2002. ‘What Makes Whistle-Blowers Effective? Three Field Studies’, *Human Relations* 55 (4) pp. 455–479. doi: 10.1177/0018726702055004463.
- Miceli, M.P., Near, J.P. and Dworkin, T.M. 2009. A Word to the Wise: How Managers and Policy-Makers can Encourage Employees to Report Wrongdoing. *Business Ethics* 86 pp. 379–396. <https://doi.org/10.1007/s10551-008-9853-6>
- Miceli, M.P, Dreyfus, S., Near, J.P. 2014. Outsider ‘Whistle-blowers’: Conceptualizing and Distinguishing ‘Bell-ringing’ Behavior. In: Brown, A.J., Lewis, D. and Moberly, R.E, eds. *International Handbook on Whistleblowing Research*. London: Edward Elgar Publishing, pp. 142–256. <https://doi.org/10.4337/9781781006795.00010>
- Milligan, F., Wareing, M., Bhandol, J., Pappas, Y., Randhawa, G., Preston-Shoot, M. 2016. *Supporting Nursing, Midwifery and Allied Health Professional Students to Raise Concerns with the Quality of Care: A Systematic Literature Review*. University of Bedfordshire, Council of Deans of Health.
- Milliken, F.J., Morrison, E.W., Hewlin, P.F. 2003. An Exploratory Study of Organisational silence: Issues that employees don’t communicate upward and why. *Journal of Management Studies*. 40 (6) pp. 1453-1476.
- Mills, J., Bonner, A. and Francis, K. 2006. Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of nursing Practice* 12 pp. 8-13
- Moher, D., Liberati and Tetzlaff, J. 2010. Preferred Reporting Items for systematic Reviews and Meta-Analyses: The PRISMA Statement. *International Journal of Surgery*. 8 (5) pp. 336-341.
- Monrouxe, L.V., Rees, C.E., Endacott, R. and Ternan, E. 2014. ‘Even now it makes me angry’: health care students’ professionalism dilemma narratives. *Medical Education*. 48 (5) pp. 502–17.
- Montgomery, P. and Bailey, P.H. 2007. Field notes and theoretical memos in grounded theory. *Western Journal of Nursing Research*. 29 pp. 65-79.

Moore, L. and McAuliffe, E. 2010. Is inadequate response to whistleblowing perpetuating a culture of silence in hospitals? *Clinical Governance International Journal*. 15 (3) pp. 166–78.

Moore, L. and McAuliffe, E. 2012. To report or not to report. Why some nurses are reluctant to whistle-blow. *Clinical Governance International Journal* 17 (4) pp.332–42.
<https://doi.org/10.1108/14777271211273215>

Morrison, E.W. 2011. Employee voice behaviour: Integration and directions for future research. *The Academy of Management Annals*. 5 (1) pp. 373-412.

Morrow, K. J., Gustavson, A. M., & Jones, J. 2016. Speaking up behaviours (safety voices) of healthcare workers: A metasynthesis of qualitative research studies. *International Journal of Nursing Studies* 64 pp.42–51. <https://doi.org/10.1016/j.ijnurstu.2016.09.014>

Morse, J.M. 2015. “Data were saturated”. *Qualitative Health Research* 25 (5) pp. 587-588.

Morse, J.M; Bowers, B.J; Charmaz, C; Corbin, J; Stern, P.J. and Clarke, A.E. 2016. *Developing grounded Theory. The Second Generation*. New York: Routledge.

Moule, P., Aveyard, H. and Goodman, M. 2017. *Nursing Research. An introduction*. Los Angeles: Sage

Munhall, P. 2012. *Nursing research: A Qualitative Perspective*. 5th ed. Florida: Jones and Bartlett Learning.

Nader, R., Petkas, P. and Blackwell, K. 1972. *Whistle Blowing: The Report of the Conference on Professional Responsibility*. New York: Grossman.

National NHS Staff Survey Co-ordination Centre. 2020. *NHS Staff Survey 2020*. Available at: <https://www.nhsstaffsurveys.com/static/afb76a44d16ee5bbc764b6382efa1dc8/ST20-national-briefing-doc.pdf> [Accessed 12 Aug 2021]

Near, J.P., Rehg, M.T., Van Scotter, J.R. and Miceli, M.P. 2004. Does Type of Wrongdoing Affect the Whistleblowing Process? *Business Ethics Quarterly* 14 (2) pp. 219–242.
<http://www.jstor.org/stable/3857908>

Near, J.P., Dworkin, T.M. and Miceli, M.P. 1993. Explaining the whistleblowing process: suggestions from power theory and justice theory. *Organisational Science*. 4 (3) pp. 393–411.

Near, J.P and Miceli, M.P. 1985. Organizational dissidence: the case of whistleblowing. *Journal of Business Ethics*. 4 pp. 1–16.

Near, J.P and Miceli, M.P. 1995. Effective whistleblowing. *Academy of Management Review* 20 (3) pp. 679-708.

NHS England. 2016. *Freedom to speak up: whistleblowing policy for the NHS*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2021/03/freedom-to-speak-up-raising-concerns-policy-for-the-nhs-april-19.pdf> [Accessed on 8 Dec 2021]

NHS England 2018. *A Just culture Guide*. Available at: <https://www.england.nhs.uk/patient-safety/a-just-culture-guide/> [Accessed 8 March 2021]

NHS England and NHS Improvement. (2019). *The NHS Patient Safety Strategy. Safer culture, safer systems, safer patients*. Available at: https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf [Accessed 9 June 2020]

NHS Wales. 2013. *All Wales Raising Concerns (whistleblowing) Policy*. Available at: [https://www2.nphs.wales.nhs.uk/PHWPapersDocs.nsf/\(\\$All\)/765D60FF0C871FE280257BE1005828F4/\\$File/27%2011b%20All%20Wales%20Raising%20Concerns%20\(Whistleblowing\)%20Policy%2021-08-2013.pdf?OpenElement](https://www2.nphs.wales.nhs.uk/PHWPapersDocs.nsf/($All)/765D60FF0C871FE280257BE1005828F4/$File/27%2011b%20All%20Wales%20Raising%20Concerns%20(Whistleblowing)%20Policy%2021-08-2013.pdf?OpenElement) [Accessed 8 Dec 2021]

Noble, H. and Heale, R. 2019. Triangulation in research, with examples. *Evidence Based Nursing* 22 (3) pp. 67-68.

Nursing and Midwifery Council. 2008. *Standards to Support Learning and Assessment in Practice*. Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-to-support-learning-assessment.pdf> [Accessed 8 November 2021]

Nursing and Midwifery Council. 2010. *Standards for Pre-registration nursing education*. Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-pre-registration-nursing-education.pdf> [Accessed: 4 December 2021]

Nursing and Midwifery Council. 2015. *The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates*. Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf> [Accessed 28 Dec 2021]

Nursing and Midwifery Council. 2018a. *The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates*. Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf> [Accessed on 28 Dec 2021]

Nursing and Midwifery Council. 2018b. *Realising professionalism: standards for education and training. Part 2: Standards for student supervision and assessment*. Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/standards-of->

[proficiency/standards-for-student-supervision-and-assessment/student-supervision-assessment.pdf](#) [Accessed on 17 October 2021].

Nursing and Midwifery Council. 2018c. Part 1 – Standards Framework for nursing and midwifery education. Available at: <https://www.nmc.org.uk/standards-for-education-and-training/standards-framework-for-nursing-and-midwifery-education/> [Accessed 28 April 2022]

Nursing and Midwifery Council. 2019a. *Raising concerns for nurses, midwives and nursing associates*. Available at: <https://www.nmc.org.uk/globalassets/blocks/media-block/raising-concerns-v2.pdf> [Accessed 4 Aug 2021]

Nursing and Midwifery Council. 2019b. *Who are academic assessors and how are they prepared?* Available at: <https://www.nmc.org.uk/supporting-information-on-standards-for-student-supervision-and-assessment/academic-assessment/who-are-academic-assessors-and-how-are-they-prepared/> [Accessed 5 Jan 2021]

Nursing and Midwifery Council. 2021a *Whistleblowing to the NMC*. Available at: <https://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives/whistleblowing/> [Accessed 5 Jan 2021]

Nursing and Midwifery Council. 2021b. *Promote a just culture*. Available at: <https://www.nmc.org.uk/employer-resource/local-investigation/guiding-principles/just-culture/> [Accessed 5 Jan 2021]

O’Conner, A., Carpenter, B. and Coughlan, B. 2018. An Exploration of the key issues in the Debate between Classic and Constructivist Grounded Theory. *The Grounded Theory Review*. 17 (1) pp. 90-103.

Ohnishi, K., Hayama, Y., Asai, A. and Kosugi, S. 2008. The process of whistleblowing in a Japanese psychiatric hospital. *Nursing Ethics* 15 pp. 631-42.

Okuyama, A., Wagner, C. and Bijnen, B. 2014. Speaking up for patient safety by hospital-based health care professionals: A literature review. *BMC Health Service Research*. 14, 61.

Olsen, W. 2011. *Data Collection: Key Debates and Methods in Social Research*. Los Angeles: Sage

O’Mara, L., McDonald, J., Gillespie, M., Brown, H. and Miles, L. (2014). Challenging clinical learning environments: Experiences of undergraduate nursing students. *Nurse Education in Practice* 14 (2) pp. 208-213. <https://doi.org/10.1016/nepr2013.08.012>

Orbe, M.P. and King, G. III. 2000. Negotiating the tension between policy and reality: exploring nurses’ communication about organizational wrongdoing. *Health Communication* 12 (1) pp. 41–61. https://doi.org/10.1207/S15327027HC1201_03

- O'Reilly, M. and Kiyimba, N. 2015. *Advanced Qualitative Research. A Guide to using Theory*. London: Sage.
- Panagioti, M., Khan, K., Keers, R.N., Abuzour, A., Phipps, D. and Kontopantelis, E. 2019. Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis. *BMJ*. 366, pp.14185
- Parahoo, K. 2014. *Nursing Research. Principles, Process and Issues*. London: Palgrave Macmillan.
- Parlese, A. et al. 2018. Multi-level analysis of national students' disclosure of patient safety concerns. *Medical Education*. 52, pp. 1156-1166.
- Park,H; Blenkinsopp,J and Park,M. 2014. The influence of an Observer's value Orientation and personality type on Attitudes towards whistleblowing. *Journal of Business Ethics* 120 pp. 121-129
- Pauly, B., Varcoe, C., Storch, J. and Newton, L. 2009. Registered nurses' perceptions of moral distress and ethical climate. *Nurse Ethics* 16 (5) pp. 561-73. doi: 10.1177/0969733009106649.
- Peters, K., Luck, L., Hutchinson, M., Wilkes, L., Andrew, S. and Jackson, D. 2011. The emotional sequelae of whistleblowing: findings from a qualitative study. *Journal of Clinical Nursing* 20 pp. 2907-14.
- Phillippi, J. and Lauderdale, J. 2018. A Guide to Field Notes for Qualitative Research: Context and Conversation. *Qualitative Health Research*. 28 (3) pp. 381-388. doi: 10.1177/1049732317697102.
- Phillips, E. and Pugh, D.S. 2015. *How to get a PhD: A handbook for students and their supervisors*. 6th ed. London: Open University Press
- Polifroni, E.C. 2010 'Power, Right, and Truth: Foucault's Triangle as a Model for Clinical Power', *Nursing Science Quarterly*. 23 (1) pp. 8–12. doi: 10.1177/0894318409353811.
- Pohjanoksa, J., Stolt, M., Leino-Kilpi, H., Suhonen, R. and Löyttyniemi, E. 2018 Whistleblowing process in healthcare: From suspicion to action. *Nursing Ethics*. pp. 1-15. <https://doi.org/10.1177/0969733017705005>
- Polit, D.F. and Beck, C.T. 2014. *Essentials of Nursing Research: Appraising Evidence for Nursing Practice*. 8th ed. Philadelphia: Lippincott Williams and Wilkins.
- Prang, I.W. and Jelsness-Jorgensen, L.P. 2014. Should I report? A qualitative study of barriers to incident reporting among nurses working in nursing homes. *Geriatric Nurse* 35 (6) pp. 441–7. <https://doi.org/10.1016/j.gerinurse.2014.07.003>

Public Concern at Work. 2013. *The Whistleblowing Commission, Report on the Effectiveness of Existing Arrangements for Workplace Whistleblowing in the UK*. London: PCAW.

Public Health Wales 2018. All Wales Procedure for NHS staff to raise concerns. Available at: <https://phw.nhs.wales/about-us/policies-and-procedures/policies-and-procedures-documents/human-resources-policies/procedure-for-nhs-staff-to-raise-concerns/> [Accessed 8 December 2021]

Public Interest Disclosure Act. 1998. Available at: <https://www.legislation.gov.uk/ukpga/1998/23/contents> [Accessed 15 December 2021]

Redding, W.C. 1985. Rocking boats, blowing whistles, and teaching speech communication. *Communication Education* 34 pp. 245-258.

Rees, C., Monrouxe, L. and McDonald, L. (2014). 'My mentor kicked a dying woman's bed': Analysing UK nursing students 'more memorable' professional dilemmas. *Journal of Advanced Nursing*. 71 (1) pp. 169-180. <https://doi.org/10.1111/jan.12457>

Rees, C.E., Monrouxe, L.V., Ternan, E. and Endacott, R. 2015. Workplace abuse narratives from dentistry, nursing, pharmacy and physiotherapy students: a multi-school qualitative study. *European Journal of Dental Education* 19 pp. 95-106.

Reeves, S., Kuper, A. and Hodges, B.D. 2008. Qualitative research methodologies: ethnography. *BMJ*. 337, a1020. doi: 10.1136/bmj.a1020.

Rest, J.R. 1986. *Moral Development: Advances in Research and Theory*. New York: Praeger

Rhodes, S. and Jinks, A. 2005. Personal tutors' views of their role with pre-registration nursing students: an exploratory study. *Nurse Education Today* 25 pp. 390-7.

Richards, L. and Morse, J.M. (2007) *Readme First for a User's Guide to Qualitative Methods*. Thousand Oaks: Sage Publications.

Rieger, K. 2018. Discriminating among grounded theory approaches. *Nursing Inquiry* 26, pp. e12261. <https://doi.org/10.1111/nin.12261>

Ross, J., Head, K., King, L., Perry, P., Smith, S. 2014. The personal development tutor role: An exploration of student and lecturer experiences and perceptions of that relationship. *Nurse Education Today* 34, (9) pp. 1207-1213

Rowley, J. 2012, "Conducting research interviews". *Management Research Review*, Vol. (35 ¾), pp. 260-271. <https://doi.org/10.1108/01409171211210154>

Royal College of Nursing. 2011. *Informed consent in Health and social Care Research*. RCN *Guidance for Nurses*. 2nd ed. London: RCN.

- Royal College of Nursing. 2010. *Principles of Nursing Practice*. London: RCN.
- Royal College of Nursing. 2018. RCN International nursing Research conference. RCN: Birmingham.
- Royal College of Nursing. 2019. *Standing up for patient and public safety*. London: RCN
- Royal College of Nursing. 2020. *Raising and Escalating Concerns*. Available at: <https://www.rcn.org.uk/professional-development/publications/rcn-raising-and-escalating-concerns-uk-pub-009425> Accessed 8/12/21
- Roldan-Merino, J., Migel-Ruez, D., Roco-Capara, N. and Rodrigo-Pedrosa, O. 2019. Personal tutoring in nursing studies: A supportive relationship experience aimed at integrating, curricular theory and professional practice. *Nurse Education in Practice*. 37 pp. 81-87.
- Sandelowski, M. 1986. The problem of rigor in qualitative research. *Advances in Nursing Science* 8 pp. 27-37.
- Sayre, M.M., McNeese-Smith, D., Phillips, L.R. and Leach, L.S. 2012. A strategy to improve nurses speaking up and collaborating for patient safety. *Journal of Nursing Administration* 42 (10) pp. 458-60. doi: 10.1097/NNA.0b013e31826a1e8a.
- Schiff, G. and Shojania, K.G. 2021. Looking back on the history of patient safety: an opportunity to reflect and ponder future challenges. *BMJ Quality and Safety*. 0 pp. 1-5
- Schwappach, D.L. and Gehring, K. 2014a. Trade-offs between voice and silence: a qualitative exploration of oncology staff's decisions to speak up about safety concerns. *BMC Health Service Research*. 14, 303. pp.
- Schwappach, D.L. and Gehring, K. 2014b. 'Saying it without words': a qualitative study of oncology staff's experiences with speaking up about safety concerns. *BMJ Open*. 4, e004740.
- Schwandt, T.A. 2001. *Dictionary of Qualitative Inquiry*. 2nd ed. Thousand Oaks, CA: Sage.
- Silverman, D. 2017. How was it for you? The interview society and the rise of the (poorly analyzed) interview. *Qualitative Research*. 17 (2) pp. 144-158.
- Slawomirski, L., Aaraaen, A. and Klazinga, N. 2017. *The Economics of Patient Safety. Strengthening a value-based approach to reducing patient harm at national level*. Organisation for Economic Co-operation and Development. Available at: <https://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf> [Accessed 8/10/21]
- Smith J. 2002-2004. The Shipman Inquiry. Six Volumes. London: Her Majesty's Stationery

- Solum, E.M., Maluwa, V.M. and Severinsson, E. 2012. Ethical problems in practice as experienced by Malawian student nurses *Nursing Ethics* 19 pp. 128-138.
- Somers, M. and Casal, J.C. 2011. 'Type of Wrongdoing and Whistleblowing: Further Evidence That Type of Wrongdoing Affects the Whistleblowing Process'. *Public Personnel Management*, 40 (2) pp. 151–163. doi: 10.1177/009102601104000205.
- Starks, H. and Trinidad, S.B. 2007. Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Quality Health Research*. 17 pp. 1372-80.
- Stern, P.N. 1994. Eroding grounded theory. In *Critical issues in Qualitative Researcher Methods*. Morse, J.M. ed. Thousand Oaks CA: Sage Publications, pp. 212–233.
- Stuart, C.C. 2013. *Mentoring, Learning and Assessment in clinical Practice. A Guide for Nurses*. 3rd ed. Philadelphia: Churchill Livingstone Elsevier
- Strauss, A. and Corbin J. 1990. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage Publications
- Swanson, R.A. and Holton, E.F. 2005. *Research in Organisations. Foundations and Methods of Inquiry*. San Francisco: Berrett : Koehler Publishers
- Tarrant, C., Leslie, M., Bion, J. and Dixon-Woods, M. 2017. A qualitative study of speaking out about patient safety concerns in intensive care units. *Society of Science and Medicine*. 193 pp. 8-15.
- Taylor, E.Z. and Curtis, M.B. 2010. An Examination of the Layers of Workplace Influences in Ethical Judgments: Whistleblowing Likelihood and Perseverance in Public Accounting. *Journal of Business Ethics*. 93 pp. 21–37. <https://doi.org/10.1007/s10551-009-0179-9>
- Teo, H. and Casperz, D. 2011. Dissenting Discourse: Exploring alternatives to the Whistleblowing/Silence Dichotomy. *Journal of Business Ethics*. 104 pp. 237-249.
- Thistoll, T., Hooper, V. and Pauleen, D. 2015. Acquiring and developing theoretical sensitivity through undertaking a grounded preliminary literature review. *Quality and Quantity*. 50. 10.1007/s11135-015-0167-3.
- Thomas, S.P. and Burk, R. Junior nursing students' experiences of vertical violence during clinical rotations. 2009. *Nursing Outlook*. 57 (4) pp. 226-31. doi:10.1016/j.outlook.2008.08.004.
- Thornberg, R and Charmaz, K. 2014. *Grounded Theory and theoretical coding*. 10.4135/9781446282243.n11
- The Shipman Inquiry. 2004. "Fifth report – safeguarding patients: lessons from the past – proposals for the future". Available at: www.shipman-inquiry.org.uk/fifthreport.asp [Accessed 2/4/20]

Tie, C.Y., Birks, M. and Francis, K. 2019. Grounded Theory Research. A design framework for novice researchers. *SAGE Open Medicine*. 7 pp. 1-8.

Trevino, L.K., Weaver, G.R. and Reynolds, S.J. 2006. Behavioral ethics in organizations: a review. *Journal of Management*. 32 pp. 951–90.

Tueby, R.J., Rotich, J.K. and Bengat, J.K. 2015. Research paradigms: Theory and Practice. *Research on Humanities and Social Sciences*. 5 (5) pp. 224-228.

Uren, C and Shepherd, P. 2016. Valuing the student contribution to practice. Nursingtimes.net

Vadera, A., Aguilera, R. and Caza, B. 2009. “Making sense of whistleblowing’s antecedents: learning from research on identity and ethics programs”. *Business Ethics Quarterly*. 19 (4) pp. 553-86.

Vale of Leven Hospital Inquiry. 2014. *The Vale of Leven Hospital Inquiry Report*. (Scottish Government Publication No. DPPAS10898). Edinburgh, Scotland: APS Group.

Vancell, J. 2018. The use of grounded theory in Educational Research: Exploring the application of the methodology in an investigation on E-Learning in Maltese SME’s. Available at:

<https://www.um.edu.mt/library/oar/bitstream/123456789/38166/1/Joseph%20Vancell.pdf> [Accessed 10/12/21]

Vandekerckhove, W. 2006. *Whistleblowing and Organizational Social Responsibility: A Global Assessment*. Hampshire: Ashgate Publishing Ltd.

Vinales, J.J. 2015. Exploring failure to fail in pre-registration nursing. *British Journal of Nursing*. 24 pp. 284-8.

Vollstedt, M. and Rezat, S. 2019. *An Introduction to Grounded Theory with a Special Focus on Axial Coding and the Coding Paradigm*. In: Kaiser G. and Presmeg, N. eds. Compendium for Early Career Researchers in Mathematics Education. ICME-13 Monographs. Springer, Cham: https://doi.org/10.1007/978-3-030-15636-7_4

Walker, D. and Myrick, F. 2006. Grounded theory: an exploration of process and procedure. *Qualitative Health Research*. 16 pp. 547-59.

Weaver, K.D. and Olson, J. 2006. Understanding paradigms used for nursing research. *Journal of Advanced Nursing*. 53 ,4 pp. 459-69.

Weick, K.E., Sutcliffe, K.M. and Obstfeld, D. 2005. Organizing and the process of sensemaking. *Organisational Science*. 16 (4) pp. 409–21. <https://doi.org/10.1287/orsc.1050.0133>

- Weingart, S.N., McL Wilson, R; Gibberd, R.W. and Harrison, B. 2000. Epidemiology of medical error. *The Western Journal of Medicine*. 172 (6) pp. 390–393.
<https://doi.org/10.1136/ewjm.172.6.390>
- Welsh Assembly Government. 2009. *Research Governance Framework for Health and social Care in Wales*. 2nd ed. Available at:
<http://www.wales.nhs.uk/sites3/Documents/952/Research%20Governance%20Framework%202009%20%28English%291.pdf> [Accessed 18 March 2020]
- Welsh Government. 2019. *Review of maternity services at Cwm Taf Health Board*. Available at: [REPORT OF RCOG REVIEW \(gov.wales\)](#) (accessed on 15/11/21)
- Welsh Government. 2021 Quality and Safety Framework. Available at:
<https://gov.wales/publication-quality-and-safety-framework-whc2021022>
 [Accessed 1 Feb 2022]
- West, M., Eckert, R., Collins, B. and Chowla, R. 2017. Caring for change. How compassionate leadership can stimulate innovation in health care. King's Fund. Available at:
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf [Accessed 27 Oct 2021]
- Whittemore, R. and Knafl, K. 2005. The integrative review: updated methodology. *Journal of Advanced Nursing*. 52 (5) pp. 546 – 553.
- World Health Organization. 2011. Patient Safety Curriculum guide: Multi-professional Edition. Available at: <https://www.who.int/publications/i/item/9789241501958>
 [Accessed on 28/10/21]
- World Health Organization. 2019. Patient Safety. Available at:
<https://www.who.int/news-room/fact-sheets/detail/patient-safety> [Accessed on 28/10/21]
- Wilkes, L., Peters, K., Weaver, R. and Jackson, D. (2011). Nurses involved in whistleblowing incidents: Sequelae for their families. *Collegian*. 18 pp. 101-106.
<https://doi.org/10.1016/j.colegn.2011.05.001>.
- Wojtowicz, B., Hagen, B. and Van Daalen-Smith, C. 2014. No place to turn: nursing students' experiences of moral distress in mental health settings. *International Journal of Mental Health Nursing*. 23 (3) pp. 257-64. doi: 10.1111/inm.12043.
- Yeh, M.Y., Wu, S.M. and Che, H.L. 2010. Cultural and hierarchical influences: ethical issues faced by Taiwanese nursing students. *Medical Education*. 44 pp. 475-484.
- Zhang, J., Chui, R. and Wei, L.Q. 2009. On whistleblowing judgement and intent. The roles of positive mood and organisational ethical culture. *Journal of Managerial Psychology*. 24 (7) pp. 627-649.

Appendix 1 – Key search terms

<ul style="list-style-type: none">❖ Whistleblowing❖ Whistleblowing❖ Whistle blow❖ Blowing the whistle❖ Raising concerns❖ Raise concerns❖ Reporting❖ Incident reporting❖ Speak up❖ Speak out❖ Voice❖ Poor care❖ Poor standards	<ul style="list-style-type: none">❖ Misconduct❖ Ethical dilemma❖ Ethical issues❖ Student nurse❖ Undergraduate nurse❖ Nursing student❖ Pre-registration❖ Nurse❖ Healthcare❖ Nurse mentor❖ Mentor❖ Clinical placement❖ Patient safety
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Appendix 2 : Data extraction of research studies on whistleblowing and raising concerns in registered nurses

Author of study, date and country	Aim of study	Methodology data collection data analysis	Sample and context	Findings/Recommendations
McDonald & Ahern (2000) Australia	aims to examine the professional effects of whistleblowing and non-whistleblowing in nursing	Quantitative - A descriptive survey design Data analysed by using SPSS	Questionnaires were posted to 250 general nurses and 250 mental health nurses. Return envelopes were enclosed.100 were returned 20% response rate.	70 self-identified as whistle-blowers and 25 as non-whistle-blowers. There were severe professional reprisals if the nurse reported misconduct, but few professional consequences if the nurse remained silent. Reprisals included; demotion (4%), reprimand (11%) and referral to a psychiatrist (9%), threats (16%), rejection by peers (14%), pressure to resign (7%) and being treated as a traitor (14%). 10% reported that their career had been halted.
Orbe & King (2000) USA	To explore the way nurses communicate wrongdoing	Quantitative survey including question on critical incidents	1,900 nurses sent survey. 202 responded	5 themes emerged as central to responses of policy violations and personal ethics in the workplace: (a) perceptions of wrongdoing, (b) upholding the ideals of the profession, (c) clarity and evidence of wrongdoing, (d) consequences of reporting, and (e) workplace dynamics.
Ahern & McDonald (2002) Australia	To identify beliefs from the literature which may act as motivational factors to blow the whistle	A descriptive survey design Questionnaire – five point Likert scale	Sent to 500 nurses. 95 (20%)responses from an equal number of general and MH nurses aged between 36-50.	
Firth-Cozens et al. (2003) UK	To consider experiences and attitudes of nurses and doctors to reporting		1704 questionnaires sent out and 624 (37%) returned.	For those who returned the questionnaire, about a quarter have actually reported poor care, while 16% had a concern but did not report. Most would report again and had no negative outcome. However, 10% Dr's and 27% nurses experienced stress
Attree (2007) UK	To explore factors that influence nurses' decisions about care quality	Qualitative grounded theory Constant comparative analysis used	142 Registered Nurses made up the sample practicing in medicine (n=66), surgical (n=55) and older people's (n=21). 3 acute NHS trusts in England	Reporting was perceived as a high risk low benefit action. Fear of repercussions, labelling and blame for raising concerns, they predicted nothing would be done, were identified as disincentives Nurses lacked confidence in reporting systems. Factors influencing nurses raising concerns; -Organizational reporting system and culture – closed and concealing (pressure to keep quiet) or open (blame-free and confidence in system)
Davis & Konishi (2007) Japan	explores the meaning of and the experiences with whistleblowing in a	questionnaire focused on advocacy with a section on WB. It contained forced-choice and open-	A total of 24 nurses, Master's students and clinical teachers at a nursing college in Japan, responded to a	Of these respondents, similar in age, educational level and clinical experience, 10 had previously reported another nurse and 12 had reported a physician for a wrongful act.

	group of Japanese nurses	ended questions written in English and translated Japanese	questionnaire on advocacy that included a section on whistleblowing.	
Ohnishi et al. (2008)	study aims to unveil the process of whistleblowing	A qualitative design with a modified grounded theory approach In-depth interviews	2 participant took part	Findings revealed three chronological phases that evolved during the whistleblowing process: suspicion of wrongdoing, awareness of wrongdoing and conviction of wrongdoing (diagram to illustrate this). In contrast there was a driving force to continue to work, which impeded whistleblowing: appreciation, affection and a sense of duty. Immediately following the WB the participants experienced guilty conscience, fear of retribution and pride. Over time a sense of relief and regret were the overriding emotions.
Malmedal et al (2009) Norway	Attitudes of nursing home staff to report inadequate care	Cross-sectional design	616 N home staff (79% response rate)	Reporting was influenced by the severity of the act, perceived support from employer and peers, potential repercussions and response received from perpetrator
Grube et al (2010) USA	To explore when and why nurses report unsafe practice	Questionnaires with quantitative analysis	330 questionnaires	Likelihood of reporting increases as the frequency of unsafe practice increases and when nurses have a strong role identity and strong organisational identity.
Moore & McAuliffe (2010) Ireland (2012)	the experiences of those who have observed poor care and what they experience if they report an incident is the aim of this paper. Explore why some health-care professionals report incidents and others fail to do so	A quantitative exploratory design. Questionnaires were utilized and adapted tool used to evaluate the experience and attitudes of nurses, doctors and GP's to report care in the UK As above	A cluster random sample. Data from 8 acute hospitals in the HSE regions in Ireland. nursing staff on 3 wards within each hospital provided sample. A total of 575 questionnaire distributed to all grades of nurses on the 24 wards As above	The response rate 26%. 88% of nurses working in acute hospitals have observed an incident of poor care in the past six months, but only 70% of those reported it. Non-reporters more likely to cite "not wanting to cause trouble" and "not being sure if it is the right thing to do" as reasons for their reluctance to report. "Fear of retribution" was the most common reason given for reluctance to report and is a barrier to reporting poor care Only one in four nurses who reported poor care were satisfied with the way the organization handled their concerns. The key driver for reporting was acting in the best interest fir the patient
Jackson et al. (2010a) Australia	To explore the reasons behind the decision to blow the whistle and provide insights into nurses' experiences of being whistle-blowers	Qualitative narrative inquiry Semi-structured interviews	18 nurses with first- hand experience of WB – recruited via magazine	Participants experienced WB as highly stressful. 3 themes emerged:- -reasons for WB (I just couldn't advocate) -Feeling silenced (nobody speaks out -Climate of fear (you are just not safe The WB nurses believed they were acting in accordance of a duty of care

Jackson et al (2010b) Australia	To present and describe the effects of whistleblowing episodes on nurses' workplace relationships.	Qualitative narrative inquiry	convenience sampling strategy recruited 18 participants. 11 whistle-blowers, 4 bystanders and 3 subjects of whistleblowing complaints.	Whistleblowing had a profoundly negative effect on working relationships. The most distressing aspect of their experience was the loss of collegial relationships, which for many was damaged beyond repair. The whistle-blower and subjects of whistleblowing experienced retribution in the form of hostility from other staff, bullying and a loss of trust from co-workers
Peters et al. (2011) Australia	To highlight and illuminate the emotional sequelae of whistleblowing from subjects of whistleblowing complaints	A qualitative narrative inquiry research design In-depth face to face or telephone interview taking 40mins-2 hours	This purposive sample yielded 18 nurses from several Australian states who had been a whistle-blower, bystander or the subject of a WB episode	The findings revealed that the participant's emotional health was considerably compromised as a result of the WB incident. Three themes capture the emotional experiences of the participants:-overwhelming and persistent distress, acute anxiety and flashbacks
Wilkes et al (2011) Australia	This paper reports on a study on the effects of WB on family life from the perspective of the nurses.	Qualitative, narrative inquiry approach	14 nurses directly involved in WB complaints	Findings drew out three themes which demonstrate the negative effects of WB on nurses families and include: strained relationships with family members, dislocation of family life, and exposing family to public scrutiny.
Black (2011) USA	To examine nurses' experiences with workplace attitudes towards patient advocacy activities	Questionnaires to analyse quantitative responses	564 responses from Nevada state RN's	Potentially harmful scenarios not reported by a third of respondents due to a fear of retaliation. Also futility and the fear that nothing would be done if reporting the wrongdoing
Garon (2012) USA	to explore nurses perceptions of their ability to speak up and be heard in the workplace.	Qualitative approach. Focus group interviews Thematic content analysis used	33 nurses from a variety of HC settings in California	Findings categorised as; influences on speaking up, transmission and reception of a message and outcomes or results. The study supported the importance of the manager in setting the culture of open communication.
King and scudder (2013) USA	To examine reasons a registered nurse would report a wrongdoing within a public teaching hospital.	A survey instrument 10 items was used to address why a nurse would engage in reporting and reasons nurses chose not to report.	A 400-bed,public teaching hospital, located in Midwest was asked to participate in this study. e-mail notification sent to Approximately 1,000 RN workers . 238 nurses responded.	30% reported they had observed a wrongdoing in the past year, with 68 nurses indicating they had reported a wrongdoing in the past year -incidents threatening the well-being of patients and their professional ethics were more likely to be reported within their organizations. - Observer anonymity was perceived to have a small, but important effect on nurses reporting a wrongdoing in this sample. Results reveal a strong tendency for nurses to overlook a serious mistake by a close peer who had a reputation of being a "competent" nurse.

Mansbach et al (2014) Israel	Comparing nurses willingness to blow the whistle compared to nursing students	Quantitative. Survey questionnaires given to students at the end of a mandatory course. nurses in worktime at medical center. differences between groups were assessed using t-test The internal reliability of questions assessed using Cronbach's alpha coefficient. SPSS software used	Convenience sample of 165 participants. 82 students from 2 nursing schools 83 nurses in 4 med centers in Israel. two vignettes describe ethical dilemmas. respondent had to choose between responsibility to the patient and loyalty to a colleague.	Both groups rated the two vignettes as very serious. The nursing students perceived the severity of the misconduct of the colleague and the manager significantly lower compared to the nurses. The students reported that they were more likely to approach parties within the organization and external to it in order to change the situation compared to the nurses.
Jones & Kelly (2014) UK	to explore perceptions of WB in staff in care settings for older people. to explore strategies to WB and views on barriers enhancers	Qualitative study Individual interviews & focus groups	60 participants RN – 12, police – 4, student nurses – 16, care assistants 23 Nursing & residential homes & hospital,	Whistleblowing was perceived as a negative term. Whistleblowing was considered risky, and this led to staff creating informal channels through which to raise concerns. Those who witnessed wrongdoing were aware that support was available from external agencies but preferred local solutions and drew upon personal ethics rather than regulatory edicts to shape their responses
Schwappach & Gehring (2014a) Switzerland	Motivations and barriers to speaking up amongst doctors and nurses were investigated.	A qualitative study using Interviews inductive, thematic content	32 doctors and nurses from Six hospitals participated with seven oncology departments in Switzerland.	-Preventing patients from serious harm was strongest motivator to speak up but competes with anticipated negative outcomes. Decision whether and how to voice concerns involved reflecting on whether level of risk for a patient “justifies” the costs of speaking up. -Barriers for voicing concerns reported - damaging relationships and presence of patients and co-workers in the situation affect likelihood of anticipated negative outcomes.
Schwappach & Gehring (2014b) Switzerland	To explore the experiences of oncology staff with communicating safety concerns and the situational factors surrounding speaking up.	A qualitative study using Interviews inductive, thematic content	32 doctors and nurses from Six hospitals participated with seven oncology departments in Switzerland.	Participants likely to speak up to discuss concerns related to medicines -Other hygiene or safety violations were deemed harder to voice. Instead non-verbal gestures and facial expressions were used to signal to the wrongdoer without exposing them in front of the patient or co-workers. -Diplomacy and strategies for ‘voice tactics’ were carefully considered and differed depending on who the wrongdoer was -Staff in lower hierarchy used ‘naïve questions’ to raise concerns. -Speaking up responded to with apology and rectifying error. Sometimes silence or individual ignored.

Prang and Jelsness-Jorgensen (2014) Norway	To explore the barriers to incident reporting in nursing homes as compared to hospitals	Qualitative thematic analysis of semi-structured interviews	13 nurses working in nursing homes	Lack of support and poor culture were cited as barriers to reporting, as well as unclear routines and outcomes. Individual barriers were a fear of conflict, time issues, lack of technological confidence and knowledge and the nurses assessment of the severity of wrongdoing.
Tarrant et al. (2017) UK	Speaking out about patient safety concerns in intensive care units	Qualitative ethnographic study 900 hours of observations and interviews	98 interviews -34 consultants, 14 trainee doctors,28 senior nurses,8 staff nurses and 14 infection prevention personnel. In 19 ICU's in 9 hospital trusts	Low level social control occurred frequently – challenges and sanctions used to prevent or address norm violations. Pre-emptions used to intervene when patients at immediate risk – gentle reminders, humour and sharp words. Corrective interventions such as education and arguments underpinned with evidence. Sanctions applied – bantering, ‘a quiet word’, public exposure or humiliation. These strategies not consistently effective. A more in-depth understanding of social control is required
Alingh et al. (2017) Netherlands	To explore relationships between safety management, climate for safety, psychological safety and willingness to speak up.	cross-sectional survey study, To test hypotheses, hierarchical regression analyses and multilevel regression analyses were conducted	of 980 nurses and 93 nurse managers working in Dutch clinical hospital wards.	Significantly positive associations were found between nurses’ perceptions of control-based safety management and climate for safety and between the perceived levels of commitment-based management and team psychological safety. team psychological safety is found to be positively related to nurses’ speaking up attitudes . The relationship between nurse-rated commitment-based safety management and nurses’ willingness to speak up is fully mediated by team psychological safety
Law & Chan (2015) Hong Kong	To explore the process of learning to speak up in practice among NGN.	Qualitative study – narrative inquiry Repeated interviews	3 nurses from ICU	(1) learning to speak up requires more than one-off training and safety tools, (2) mentoring speaking up in the midst of educative a to see new possibilities for sustaining their professional identities and continuing to speak up in the future. and (3) making public spaces safe for telling secret stories.
Cole et al (2019) USA	To identify workplace factors that influence patient advocacy among RNs and willingness to report unsafe practice	Descriptive study. Replication of Black (2011)study on RN patient advocacy and use of Black’s survey instrument to determine attitudes.	convenience sample of 362 hospital-based RNs in North-East region of USA	259 (71.5%) participants reported unsafe patient care conditions to individuals they deemed were able to rectify the issue nurse's experiences and working environment are prime factors in their willingness to report patient care issues. Although RNs may not have personally experienced workplace retaliation, fear of retaliation when reporting unsafe patient care practices still exists.
Pohjanoska et al. (2018) Finland	To describe HCP experiences of observed wrongdoing and potential whistleblowing acts regarding it	A descriptive cross-sectional survey Inductive content analysis	Participants recruited from union membership Finland .226 HCPs provided a response to opequestion. Most 226 participants were female (95%) and over half were registered nurses 54%	Three themes were identified: wrongdoing related to patients, healthcare professionals, and HC managers. Whistleblowing acts were performed internally, externally, or left undone. Three main paths: internal, external, and no whistleblowing, between an observation of wrongdoing and whistleblowing act were identified

Appendix 2 (cont) - Literature data extraction of research studies on whistleblowing and raising concerns with students

Author of study, date and country	Aim of study	Methodology data collection Data analysis	Sample and context	Findings/ recommendations
Bellefontaine (2009) UK	Exploring what influences student nurses ability to report poor practice they have witnessed on placements	Qualitative – interpretative phenomenology Semi-structured interviews Content data analysis	6 Nurses (4 2 nd years, 2 3 rd years) purposive sampling	Unsafe practice not always reported. The students’ relationship with the mentor impact on their decision on whether to report poor practice.. students’ confidence of nursing as well as the fear of failing the placement were all identified as influencing factors in reporting . students would report poor practice if the ‘environmental factors were conducive’
Erdil & Korkmaz (2009) Turkey	to determine nursing students’ observation of ethical problems encountered in their clinical practice.	Descriptive study Questionnaire – 5 open questions about violation of ethical principles and observed decision-making Thematic analysis of data	153 volunteer nursing students at a university based nursing school in Ankara Purposive sample included third and fourth year student nurses who received this ethics training	some patients are physically or psychologically mistreated by doctors and nurse and were not given appropriate info and subjected to discrimination according to their socio-economic situation; privacy was ignored. The findings reveal that nurses’ own unethical behaviours contribute to a rise in ethical problems.
Ferns & Meerabeau (2009) UK	To explore the reporting behaviours of nursing students who experienced verbal abuse while gaining clinical experience	Quantitative study Questionnaires	convenience sample of 156 3 rd year nursing students from one pre-reg nursing programme in England. 114 questionnaires returned response rate of 73% .	Thirty-two students (62% of those reporting verbal abuse) stated that they had reported the incident and 19 (37Æ3%) of respondents stated that they had not. Only four incidents resulted in formal documentation. Feedback following the reporting of the concern was lacking in some cases. Students discussed their powerlessness and lack of voice within the clinical hierarchy.
Callister et al. 2009 USA	To describe and analyse ethical reasoning in student nurses	A descriptive qualitative study. Clinical journals were analyzed	70 student nurses participated – 66 female and 4 male who were on an ethics course	-some students lacked confidence to take an ethical stand -Experienced moral conflict and felt unable to challenge due to; not knowing enough about the rules; -reflective practice provides an opportunity for students to examine their own caring beliefs and stimulate critical thinking
Levett-Jones and Lathlean (2009) Australia	To present findings that focus on the relationship between belongingness,	A mixed-methods case study. Qualitative phase discussed in this paper.	18 third year students from 2 universities in Australia and one from UK.	Findings categorised into three sub-themes. -Don’t rock the boat – students conformed to practices they knew were incorrect to enhance inclusion into the group and avoid alienation. -getting RN’s offside – standing up for patient safety could jeopardise relationships.

	conformity and compliance.	Interviews		Speaking up – influenced by confidence and perception of secure position within the team
Thomas & Burke (2009) USA	To explore the phenomenon of vertical violence against junior student nurses	Qualitative Written narratives Content analysis	221 junior nursing stories from one South-eastern university	Main cause of SN anger in clinicals was perceived injustice. Students reported being ignored, feeling unwanted and a lack of eye contact, patronised or experiencing vertical violence from RN's. Assessment were redone, which belittled SN knowledge. Exerted dominance by shouting, chastising. SNs did not believe they could challenge the RNs due to power differential. Example of clinical instructor failing to confront RN although were generally empathetic
Yeh et al. (2010) Taiwan	aim of this study was to describe and explore the ethical issues and dilemmas faced by student nurses in their clinical work	Qualitative In-depth focus group 60-100mins	Participants were purposively sampled from student nurses on a 2 year course in Northern Taiwan. Following a nurse ethics course, 190 students were invited to participate and 44 agreed	Analysis revealed five themes: frustration at inability to help some patients; oppression caused by lower status; lack of honesty and ethical courage; powerlessness and self-encouragement in adversity. participants had witnessed patients being mistreated by senior staff, but did nothing as they were afraid of 'not being accepted by senior nurses' Taiwanese nursing students had a lack of appropriate role models.
Bradbury-Jones et al. (2011) UK	The extent to which nursing students are able to exercise voice during clinical practice experiences	Qualitative longitudinal study. Annual semi-structured interviews and FG	13 first-year nursing students (11 female 2 male) were recruited using purposive sampling	When students needed to speak up they either chose 'exit' (perceptions of student status, wanting to be liked) 'voice' (more as they progress through the course, confidence) or negotiated voice which is a bridge between the two such as apologising for querying and finding the right moment).
Bradbury-Jones et al (2010) UK	To explore the concept of empowerment in nursing students in clinical practice	Qualitative longitudinal study. Annual semi-structured interviews and FG	13 first-year nursing students (11 female 2 male) were recruited using purposive sampling	The process of nurse education enhanced empowerment. External spheres such as increase knowledge and confidence which also increases feelings of empowerment. Nursing students use strategies such as to feel more empowered.
Gunther (2011) USA	To explore empathic anger experienced by student nurses during clinical rotations	Qualitative Content analysis of written narratives	221 narratives from 90 second year students	-watching patients receiving uncaring treatment was distressing for students and resulted in 'empathic distress' -some RNs and instructors did not take action regarding the concerns and students met with anger or dismissal -most students avoided direct confrontation with RNs. some regretted this decision. Feeling guilty, troubled and angry were residual emotions
Solum et al. (2012) Malawi	to explore Malawian students' experiences of ethical problems	phenomenological design comprising interviews and	purposive sampling used to recruit 10 student nurse (2 nd & 3 rd yr). interviews took	Three main themes emerged: 1) Conflict between patient rights and the guardians' presence in the hospital; 2) Conflict between violation of

	during their clinical placement.	qualitative content analysis was used	place in 4 nursing Colleges across Malawi.	professional values and patient rights caused by unethical behaviour; and 3) Conflict between moral awareness and the ideal course of action.
Mansbach et al. (2013) Israel	To examine nursing student perceptions of their own readiness to blow the whistle internally/ externally, when a colleague is involved in conduct that may detrimental to a patient	A quantitative approach utilising a questionnaire containing two vignettes was administered to prospective students	Convenience sample of 82 first year nursing students from two nursing schools (one in the central region of Israel and the other in the southern part of the country).	The students considered acts that are detrimental to the patient to be very serious. The participants gave high and similar scores to their own willingness to take action to change the situation for both vignettes. The score of the internal index was found to be significantly higher than the external index
O'Mara et al (2014) Canada	to explore students' perceptions of a challenging clinical learning environment (CCLE)	Interpretive, qualitative design Focus groups	52 nursing students from two Canadian sites	-Students defined a CCLE as affected by relationships in the clinical area and by the context of their learning experiences. CCLE decreased students' learning opportunities and impacted on them as persons. Students accessed other resources when relationships were poor -strategies to rebuilt, reframe, redirect and/or retreat were utilised Relationships also acted as buffers to unsupportive practice cultures. Implications for practice and research are addressed
Wojowitz et al. (2014) Canada	To explore nursing students' experience of moral distress on an in-patient psychiatric unit	Qualitative – naturalistic inquiry Semi-structured interviews	Seven student nurses	Student highlighted the powerlessness that they and the nurses felt in relation to the doctors and psychiatrists. Students felt alone with their moral distress. Instructors, due to their inability to address the concerns on the unit. Instructors were also perceived as powerless and did not want to step on toes. They did not exhibit positive role modelling in relation to dealing with moral distress
Monrouxe et al (2014) UK	To examine dental, nursing, pharmacy and physiotherapy students' narratives of professionalism dilemmas	qualitative cross-sectional study was undertaken and a qualitative narrative interviewing design was used	Eleven group and three individual interviews were held across universities (49 females and 20 males). Dentistry=29, nursing=13, pharmacy=12 and physio=15.	The thematic analysis resulted in nine main themes. Within the professionalism dilemmas most commonly reported were; 'student abuse' dilemmas; 'patient safety and dignity breaches', 'challenging and whistleblowing dilemmas' Reasons for not challenging including; fear of being marked down, not their place, they might be wrong, fearing seniors and beliefs that nothing will change if they do. 'Habituation' described how students became less distressed with increasing exposure.
Rees et al. (2014) UK	to provide depth and breadth in the analysis of nursing students' written narratives of 'most memorable' professionalism dilemmas	online survey questionnaire and written narrative were completed.	Healthcare students N=1399) participated with 456 narratives. majority of respondents were nursing students (N=756 54%). They were from English (9), Scottish (2), Welsh (2) and Northern Irish (2) schools	79.3% of students reported acting in the face of their dilemma. Most common types of action included direct verbal challenges of perpetrators, reporting perpetrators secondary) showing concern for wronged people, typically patients (n=72), debriefing after incidents (n=39 primary; n=7 secondary, indirect verbal challenges of perpetrators (n=30 primary, n=1 secondary) and bodily acts of resistance such as leaving the room (n=23

Epsin & Meikle (2014) Canada	To explore how fourth year nursing students perceived incident as potentially harmful to patients, as well as incident reporting.	Qualitative descriptive study using five scenarios interview Thematic analysis	10 fourth year nursing students were recruited on a voluntary basis advertised on a flyer.	Of the 50 events participants identified 37 events were seen as incidents. Three themes emerged regarding how participants identified an incident: scope of practice, professional roles, and harm to the patient. Regarding 48 of the 50 events, participants said they would report these incidents informally or formally
Rees et al. (2015) UK	To explore workplace abuse amongst healthcare students	Qualitative – narrative style interviews	Healthcare students (n=69) 29 dentistry, 13 nursing, 12 pharmacy, 15 physio.	79 abuse narratives were discussed. Only 10 reported the wrongdoer, although 44 took some action – Relationship with perpetrator and concern about assessment were negative impacts that influenced students decisions
Ion et al. (2015) UK	To explore influences on student decisions on whether or not to report poor clinical practice.	Qualitative study. SS interviews thematic analysis with good detail provided	All pre-reg students (n=276) on nursing prog invited to take part. 13 took part	Four themes -‘I had no choice’ and ‘consequences for self’ discussed personal & ethical influencing factors. ‘living with ambiguity captured the uncertainty of reporting and ‘being prepared’ discusses the pros and cons of reporting concerns Role of educational institutions – Development of strategies –
Kent et al. (2015) USA	To examine the effects of a senior practicum course on nursing students’ speaking up	Quantitative study with pre and post-test survey	63 senior student nurses during a module on leadership	Students level of confidence in relation to patient safety was tested in the survey and results found that confidence in speaking up increased ($p=0.001$) after the course although no change noted in students confidence in speaking to staff in authority. Activities like simulation may help students to develop confidence in raising concerns in the workplace. Supervisors should also encourage speaking up.
Ion et al. (2016) UK	To explore how nursing students account for decisions to report or not report poor care witnessed on placement and to examine implications	Qualitative study using discourse analysis Semi-structured interviews	13 undergraduate students at a UK university during 2013. They were asked to consider their response to episodes of poor practice witnessed on placement.	Those who report justify their actions with reference to positive internal characteristics like strength of character and I commitment to professional regulation. In doing so they maintain a positive self-image strongly associated with the nascent nurse. Non-reporters attribute decisions to external factors beyond their control and to which any other reasonable person would do.
Bickoff et al (2016) Australia	To examine how UG nursing students demonstrate moral courage and factors that influence willingness to speak up	Qualitative descriptive study Data thematically analysed	Nine nursing students and one nursing graduate from one semi-metropolitan university in Australia were interviewed	Four key themes emerged: (1) patient advocate identity, which had two sub-themes of knowing one's own moral code and previous life experiences; (2) consequences to the patient and to the participant; (3) the impact of key individuals; and (4) picking your battles. consequences students face when questioning the practice of a registered nurse, and the influence supervising nurses have on a student's decisions to intervene to protect patients

Blowers (2018) UK	Explored students, mentors and lecturers experiences of professional integrity in pre-reg education	Qualitative GT approach SS interviews and focus group Thematic analysis of data using constant comparison	12 student nurses 5 mentors 6 lecturers UK uni – 4 fields nursing	Meanings of integrity– pts at centre of care & concept embedded in practice. Doing the right thing – complex. And courage needed Speaking up – influenced by confidence & novice status. Students negotiated a fine balance. Mentors & lecturers – setting the scene important for encouraging speaking up.
Jack et al (2018)	To explore the perceived unfairness experienced by student nurses during their UG nursing placements	A descriptive narrative approach Survey conducted with 1425 students	Unstructured interviews with 22 student nurses from 9 institutions in the North England	Students described being treated unfairly by clinical staff. This involved being unsupported, ignored or used in the staffing numbers as a pair of hands. Students want to feel they belong and all agreed that a supportive mentor was essential to guide learning. Ineffective mentorship had a negative impact on placement learning. The importance of having a strong mentor because of the hostile environment was alluded to
Parlese et al. (2018) Italy	To describe students opportunities to report errors, near misses or safety issues that emerged during clinical learning	A national cross-sectional design. Questionnaire SPSS data package .descriptive & inferential analyses	9607 nursing students from 43 Italian universities invited to complete a survey. Response rate (41.7%) 4004 students..	Safety issues always reported by 1603, very often by 3204 and sometimes by 3904.800 students did not report or discuss. Students who were supervised by a nurse teacher prevented disclosure in comparison with working with a nurse. Having independence and increased learning opportunities in practice increased disclosure and discussion of patient safety issues.
Harrison-White & Owens (2018) UK	To explore link lecturers views on the challenges facing student nurses in CLE's	Qualitative approach based on principles of grounded theory	10 link lecturers took part in focus groups (2 groups of 5). Purposive sampling	LL reported that students find themselves in the polarised position of either 'fitting in' and having access to learning opportunities or 'falling out' and learning to get through. The mentor has a significant influence on students negotiation of learning. Assessment by mentors contributes to vulnerability of students and may prevent students raising concerns
Fisher & Kiernan (2019) UK	to provide an insight into the factors that influence student nurses to speak up or remain silent when witnessing sub-optimal care.	An interpretive phenomenological study using the principles of hermeneutics.	The study took place university in North of England twelve adult nursing students	Four key themes identified: context of exposure, fear of punitive action, team culture and hierarchy. students recognised there was a professional obligation to raise concerns if they witnessed sub-optimal practice, willingness to do so was influenced by intrinsic (moral courage, identity)and extrinsic factors (team culture, fear of retribution)
Halperin & Bronshtein (2019)	This study examined why nursing students and clinical instructors underreport medical events.	Quantitative questionnaire. examined attitudes	103 third- and fourth-year nursing students and 55 clinical instructors completed a validated questionnaire.	one-third of the instructors and one-half of the nursing students believed that lack of awareness and fear of consequences, lead to underreporting. nursing students and clinical instructors ranked "fear of consequences" as the main reason for not reporting, yet students ranked this higher than instructors.

Chua & Magpanty (2019)	To explore the moral distress experiences encountered by UG nursing students in community nursing.	A descriptive qualitative design was employed	14 senior nursing students who had their course in Community Health Nursing in their sophomore year	Student nurses encounter situations which make them question their own values and ideals and those around them. Findings surfaced three central themes; moral distress emanating from the unprofessional behaviour of some healthcare workers, the resulting sense of powerlessness, and the differing values and mindsets of the people they serve in the community.
Jack et al. (2020) UK & Australia	To explore nursing students' experiences of care delivery practices witnessed during clinical placement	A survey design using self-report instrument containing open and closed questions	265 students from across 3 universities Site 1 – Scotland (n=63) Site 2 – NSW Australia (n=105) Site 3 – North England (n=98)	Although results were mainly positive, there were examples of poor nursing care, poor communication and cases where compassion was lacking and patient safety issues. Reporting poor care was acknowledged as being difficult, with potential repercussions being cited as an outcome if concerns were raised. 13 – 16% of participants indicated that reporting could have an impact on passing the placement.
Brown et al (2020) UK	To explore student nurses' and mentors' perceptions and experiences of raising concerns placement	Qualitative approach Semi-structured interviews Thematic analysis undertaken	16 student nurses – adult, mental health & child fields and 14 nurse mentors	The findings - three themes “developing a mentor-student relationship,” “keeping your mentor sweet” and “the mentor role in the raising concerns process. Student nurses and most mentors believed students should be encouraged and supported to raise concerns, but students' decisions were strongly influenced by their perceptions of the interpersonal context
Fagan et al (2020) Australia	To explore pre-reg students perceptions and experiences of speaking up for patient safety	Qualitative two stage study using interpretive description	Phase one – interviews with 12 student nurses Phase 2 – 3 focus groups (n=41)	Student's distress arises when observing nurses taking short cuts, justifying such actions and making excuses about poor practice. Students report experiencing dissonance, bewilderment and confusion and at times, anger when observing poor practice. The clinical environment culture influences students' decisions to speak up or remain silent

Appendix 2 : Data extraction of literature reviews on whistleblowing / raising concerns with nurses and or student nurses

Author of study, date and country	Type of review and overall aim	Methodology data collection Data analysis	Themes/ recommendations
<p>Kelly and Jones (2013) UK</p>	<p>Narrative review To scan the evidence and to make sense of the processes underpinning the maintenance of care standard and the significance of whistleblowing in the available literature. The paper focusses on the actions of employees within organizations (such as hospitals or domiciliary care organizations) or professional groups (such as nurses and doctors)</p>	<p>Published literature concerning whistleblowing in the UK and internationally was considered. Health and social care databases were searched (including PubMed, MEDLINE, CINAHL, BNI, PsychLit, ERIC) and a wide variety of opinion pieces, research and theoretical explorations were accessed. Additionally, databases in the humanities, law and business were also searched.</p>	<p>-There is no widely accepted theoretical framework or universally accepted conceptual underpinning for whistleblowing in the literature. -This paper reveals various associated meanings, but all sources agree that whistleblowing is an imposed, rather than a chosen, situation and that whistle-blowers are usually ordinary people who become aware of negative situations forcing them into a decision to remain silent, or to speak out. Another area of agreement within the literature is that the term whistleblowing has attracted overwhelmingly negative connotations</p>
<p>Jackson et al (2014) Australia</p>	<p>An integrative review To summarise and critique the research literature about whistleblowing and nurses</p>	<p>An integrative literature review approach was used to summarise and critique the research literature. A comprehensive search of five databases including Medline, CINAHL, PubMed and Health Science: Nursing/Academic Edition, and Google, : Fifteen papers were identified, capturing data from nurses in seven countries.</p>	<p>This review demonstrate a growing body of research for the nursing profession to engage and respond appropriately to issues involving suboptimal patient care or organisational wrongdoing. - whistleblowing and how it influences the individual, their family, work colleagues, nursing practice and policy overall, requires further national and international research attention.</p>
<p>Milligan et al (2016) UK</p>	<p>A systematic literature review commissioned by the Council of Deans of Health to to systematically gather and synthesise the evidence around raising concerns with regard to poor quality care by students on pre-registration healthcare programmes.</p>	<p>CINAHL, Medline, ERIC, BEI, ASSIA, PsychInfo, British Nursing Index, Education Research Complete and a search made for relevant grey literature search was completed on material made available from the year 2009 onwards. 52 publications included in this review.</p>	<p>-students often express a desire to raise concerns and can provide valuable insight into the delivery of care -various complexities and challenges act as a barrier and impede reporting. - Raising a concern carries an emotional burden for students as they may be fearful of potential adverse consequences. Whilst students are now expected to report concerns, professional guidance suggests that the organisational culture within universities and practice environments remains a strong influence.</p>

<p>Blair et al (2016) New Zealand</p>	<p>Mixed method integrative review. The aim of the review was to determine how nurses recognize and respond to unsafe practice.</p>	<p>A comprehensive search of literature exploring the identification and response to unsafe practice, was undertaken in CINAHL, Medline, Embase and PsycINFO databases for the period 2004–2014. Nineteen articles from 15 studies were included in the review.</p>	<p>-Behaviours and cues that indicate unsafe practice are influenced by organizational and individual characteristics. - Individual nurses responses are variable and there are professional and personal costs associated with being reported or reporting unsafe practice. -Nurses need awareness training and strategies to respond to unsafe practice and reporting systems that protect reporters from repercussions. -Further research investigating organizational factors and individual factors that contribute to a shift in practice across safety boundaries is required.</p>
<p>Morrow et al (2016) USA</p>	<p>A meta synthesis of qualitative research studies. To develop an understanding of how nurses and other healthcare workers relate to safety voice behaviours and how this might influence clinical practice.</p>	<p>A search of the PubMed, CINAHL, and Academic Search Premier databases was conducted. 11 qualitative articles published from 2005 to 2015 were reviewed using a social constructivist approach with thematic analysis.</p>	<p>The four themes identified hierarchies and power dynamics negatively affect safety voice, 2) open communication is unsafe and ineffective, 3) embedded expectations of nurse behaviour affect safety voice 4) nurse managers have a powerful positive or negative affect on safety voice.</p>
<p>Okayuma et al (2016) Japan</p>	<p>This review focused on HCP speaking-up behaviour for patient safety and aimed at (1) assessing the effectiveness of speaking up, (2) evaluating the effectiveness of speaking-up training, (3) identifying the factors influencing speaking-up behaviour, and (4) developing a model for speaking-up behaviour.</p>	<p>Five databases (PubMed, MEDLINE, CINAHL, Web of Science, and the Cochrane Library) were searched 26 studies were included in this review</p>	<p>Influencing factors such as motivation to speak up and contextual factors such as organisational support, leader attitude, team relationships and individual factors such as confidence, experience, communication skills and education. Perceived efficacy and perceived safety of voice were also considered and the fear of others response was significant A model helps to understand how HCP consider speaking up..</p>
<p>Ion et al (2017) UK</p>	<p>Systematic review To review evidence about nursing and midwifery students' encounters with poor clinical care.</p>	<p>British Nursing Index, CINAHL, Proquest Central, Science Direct, Taylor and Francis online, Web of Science (including Medline). Google and the OpenGrey database were used to identify relevant grey literature. 14 published articles included in the review</p>	<p>-Student do witness poor practice whilst working in clinical settings -hypothetical scenario responses may not mirror action taken in the real situation -A number of factors influence reporting -Consequences of being exposed to poor practice and action taken can be long lasting for students More research is required on students' encounters with poor practice, their response to it and support required.</p>

<p>Blenkinsopp et al. (2019) UK</p>	<p>A narrative review to review existing research on whistleblowing in healthcare in order to develop an evidence base for policy and research.</p>	<p>A systematic literature review protocol to select the papers to be reviewed, and the selected papers were then subject to a conventional narrative literature review using SCOPUS and EBSCO databases .A total of 55 studies for review.</p>	<p>-Provides valuable insights on the factors that influence healthcare whistleblowing, and how organizations respond - also substantial gaps in the coverage of the literature, which is overly focused on nursing, has been largely carried out in the UK and Australia, and concentrates on the earlier stages of the whistleblowing process</p>
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Appendix 3 – Approval from School Research Ethics committee



School of Health Care Sciences



Ysgol Gwyddorau Gofal Iechyd



11 January 2016



Dear Ms Brown

The mentor-student dynamic in raising concerns in clinical practice. A grounded theory

The School's PGT Research Review and Ethics Committee Chair has considered your re-submitted research proposal. The decision of the Chair is that your work should:

Pass –and that you proceed with your Research

Please note that if there are any subsequent major amendments to the project made following this approval you will be required to submit a revised proposal form. You are advised to contact me if this situation arises. In addition, in line with the University requirements, the project will be monitored on an annual basis by the Committee and an annual monitoring form will be despatched to you in approximately 11 months' time. If the project is completed before this time you should contact me to obtain a form for completion.

Please do not hesitate to contact me if you have any questions.

Yours sincerely



Appendix 4 – Appendix from NHS Research and Development (page 1)



GIG
NHS

Tel: [REDACTED]
[REDACTED]

From: [REDACTED]

13 October 2016

[REDACTED]

Dear [REDACTED]
[REDACTED]

IRAS Project ID: 193697

Title: The Mentor-Student Dynamic In Raising Concerns In Clinical Practice. A Grounded Theory Approach

Clinical Research Portfolio Ref: 193697

The above project was forwarded to [REDACTED] R&D Office by the Health and Care Research Wales Permissions Service. A Governance Review has now been completed on the project.

Documents approved for use in this study are:

Document	Version	Date
NHS R&D Form	5.3.1	27/06/2016
SSI Form	5.3.1	27/06/2016
Protocol	2.2	27/08/2016
Participant Information Sheet for Mentors	1.1	August 2016
Poster	1	June 2016
Participant Consent Form	1.2	August 2016



Appendix 4 – Appendix from NHS Research and Development (page 2)

I am pleased to inform you that the UHB has no objection to your proposal.

You have informed us that [REDACTED] is willing to act as Sponsor under the Research Governance Framework for Health and Social Care. Please accept this letter as confirmation of permission for the project to begin within this UHB.

I note that Health and Care Research Wales has determined that this study is ineligible for adoption onto the Clinical Research Portfolio. The only cost identified as being incurred by the UHB relates to releasing nurse mentors to take part in study interviews. The Directorate R&D Lead for Adult Mental Health has confirmed support for this study on the basis that nurse mentors can be released for interviews as part of their clinical time and states that any costs cannot be supported from the R&D Activity Based Funding allocation. Confirmation of support has also been received from Corporate Nursing.

Please note that nurse mentors must not be recruited until their managers have been approached and have agreed to release them for the purpose of the study.

May I take this opportunity to wish you success with the project and remind you that as Chief / Principal Investigator you are required to:

- Inform the R&D Office of the date which this study opens to recruitment. If this project has not opened within 12 months of the date of this letter. Failure to do so may invalidate R&D approval,
- Inform the Health and Care Research Wales Permissions Service and the UHB R&D Office if any external or additional funding is awarded for this project in the future.
- Ensure that all study amendments are submitted to the Health and Care Research Wales Permissions Service,
- Ensure the Health and Care Research Wales Permissions Service is notified of the study's closure,
- Ensure that the study is conducted in accordance with all relevant policies, procedures and legislation,
- Provide information on the project to the UHB R&D Office as requested from time to time, to include participant recruitment figures.

Appendix 4 – Appendix from NHS Research and Development (page 3)

Yours sincerely,



Appendix 5 – Permission to access student nurses

Re: request for permission to recruit student nurses

From: [REDACTED]
Sent: 03 April 2016 21:41
To: Patricia Brown; [REDACTED]
Subject: Re: request for permission to recruit student nurses

Apologies for the late response Tricia. As this has been approved by our ethics committee I am content for you to approach our students and commence recruitment. I think the people you have identified to inform is fine, you might want to touch base with Programme Support as they manage a lot of LC resources.

Best wishes

[REDACTED]

[REDACTED]
Senior Lecturer
Uwch Ddarlithydd

Deputy Head of School for Education and Students
Dirprwy Bennaeth yr Ysgol am Addysg a Myfyrwyr

Associate Lead for Student Conduct
Arweinydd Cyswllt ar gyfer Ymddygiad Myfyrwyr

Appendix 6 – Student information sheet on research study

Study: The mentor-student dynamic in raising concerns in clinical practice. A grounded theory.

My name is Tricia Brown and I am a part-time PhD student at Cardiff University. I would like to invite you to take part in this research study. Please read the following information before deciding if you would like to participate. If you have any questions at all, then please feel free to contact me. My contact details are provided at the bottom of the page.

What is the purpose of the study?

The purpose of this research study is to explore the experiences of raising concerns in clinical practice from a student nurse and mentor perspective. This will include looking at what factors influence speaking up and the strategies that may be used to raise a concern in clinical practice.

Why have you been chosen?

You are being invited to take part because you are a student nurse and you have undertaken at least one clinical placement since commencing your undergraduate nurse training programme.

What would be your role?

I would like to invite you to participate in an interview to discuss your views and experience of this topic. The interview would take between 45 mins -1 hour. You will not have committed yourself to the study at this stage as I will also ask you to sign a consent form on the day of data collection.

Where will the research be undertaken?

I will conduct the interview away from the clinical placement setting. A room in Cardiff University will be booked at a convenient time for you. With your consent, the interview will be digitally recorded.

Do I have to take part?

You do not have to take part in the study and you are free to withdraw from participating at any stage of the research and will not be penalised in any way from doing so.

If you do decide to withdraw from the study and you have already participated in an interview(s), you have the right to decide if the data can be used, or if you wish it to be destroyed.

Confidentiality and anonymity

All of the data collected from participants during the course of this research study will be anonymised and remain confidential. Data will only be analysed by myself and reviewed by my research supervisor. However, the data will be anonymised, before being viewed by research supervisor. The collected data will be stored securely. With your permission, anonymised data may be used for my research, publications or teaching purposes, but no student or mentor will be identified.

During the interviews confidentiality will be maintained and you will be advised not to name specific individuals or clinical areas or organisations as outlined in the 'Guidance on Professional Conduct for Nursing and Midwifery Students (NMC 2009).

If information during the interview suggests that harm or malpractice has occurred to patients or service users, then I will be obliged to act in accordance with the NMC (2015) Code of Conduct and disclose these details to others who may wish to take further action.

What are the potential benefits of the research?

This research may not benefit you personally. I hope that this research will enhance the support and training for staff and student nurses in raising concerns whilst working in clinical environments.

Is there any risk of harm from the research?

I do not anticipate any harm from participating in this research. Discussing your views and experiences of raising concerns could potentially be distressing. If this is the case you will be referred to a designated person within Cardiff University who will support you further.

Ethical Approval

This research has been reviewed by the School of Healthcare sciences Research Ethics Committee and has been approved

Contact details

If you would like to participate in this study or would like further information please contact:



Appendix 7 – Nurse mentor information sheet on study

Study: The mentor-student dynamic in raising concerns in clinical practice. A grounded theory.

My name is Tricia Brown and I am a part-time PhD student at Cardiff University. I would like to invite you to take part in this research study. Please read the following information before deciding if you would like to participate. If you have any questions at all, then please feel free to contact me. My contact details are provided at the bottom of the page.

What is the purpose of the study?

The purpose of this research study is to explore the process of raising concerns in clinical practice from a student nurse and mentor perspective. This will include looking at what factors influence speaking up and the strategies that may be used to raise a concern in clinical practice.

Why have you been chosen?

You are being invited to take part because you are a mentor who meets all NMC standards for mentorship (2008). You also have had experience at supervising and assessing student nurses when they are out in clinical placements.

What would be your role?

I would like to invite you to participate in an interview to discuss your views and experience of this topic. The interview would take between 30-45mins. You will not have committed yourself to the study at this stage as I will also ask you to sign a consent form on the day of data collection.

Where will the research be undertaken?

I will conduct the interview away from the clinical placement setting. A room in Cardiff University or in local health board will be booked at a convenient time for you. With your consent, the interview will be digitally recorded.

Do I have to take part?

You do not have to take part in the study and you are free to withdraw from participating at any stage of the research.

Confidentiality and anonymity

All of the data collected from participants during the course of this research study will be anonymised and remain confidential. Data will only be analysed by myself and reviewed by my research supervisor. The collected data will be stored securely. With your permission, anonymised data may be used for my research, publications or teaching purposes, but no student or mentor will be identified.

During the interviews confidentiality will be maintained and you will be advised not to name specific individuals or clinical areas or organisations.

If information during the interview suggests that harm or malpractice has occurred to patients or service users, then I will be obliged to act in accordance with the NMC (2015) Code of Conduct and disclose these details to others who may wish to take further action.

What are the potential benefits of the research?

This research may not benefit you personally. I hope that this research will enhance the support and training for mentors and student nurses in raising concerns whilst working in clinical environments.

Is there any risk of harm from the research?

I do not anticipate any harm from participating in this research. Discussing your views and experiences of raising concerns could potentially be distressing. If this is the case you will be referred to a designated person within the local health board who will support you further.

Ethical Approval

This research has been reviewed by the School of Healthcare sciences Research Ethics Committee and has been approved.

Contact details

If you would like to participate in this study or would like further information please contact:



CALLING ALL MENTORS



Are you interested in taking part in a research study?

I am recruiting mentors to participate in interviews for a PhD.

The aim of the study is to explore the process of raising concerns (whistleblowing) in clinical practice.

Who: Nurse mentors who have completed an NMC approved mentorship programme and have had experience of supporting student nurses in practice settings

Where: A private room near to your hospital site will be booked.

What: An interview taking a maximum of 1 hour

*For more information please contact
Tricia Brown (PhD student)*

Appendix 9 – Information sheet for personal tutors

Study: The mentor-student dynamic in raising concerns in clinical practice. A grounded theory.

My name is Tricia Brown and I am a part-time PhD student at Cardiff University. I would like to invite you to take part in this research study. Please read the following information before deciding if you would like to participate. If you have any questions at all, then please feel free to contact me. My contact details are provided at the bottom of the page.

What is the purpose of the study?

The purpose of this research study is to explore the process of raising concerns in clinical practice from a student nurse and mentor perspective. This will include looking at what factors influence speaking up, the strategies that may be used to raise a concern in clinical practice and the outcome of escalating the concern.

Why have you been chosen?

You are being invited to take part because of your role as a personal tutor to a student nurse currently undertaking the BN Nursing programme.

What would be your role?

I would like to invite you to participate in an interview to discuss your views and experience on the escalating concerns process in clinical practice. The interview would take no longer than 40 minutes. You will not have committed yourself to the study at this stage as I will also ask you to sign a consent form on the day of data collection.

Where will the research be undertaken?

A private room in the local university will be booked at a convenient time for you. With your consent, the interview will be digitally recorded.

Do I have to take part?

You do not have to take part in the study and you are free to withdraw from participating at any stage of the research. If you decide that you no longer wish to participate or be a part of this study then any data collected from you will not be used as part of the study and will be destroyed.

Confidentiality and anonymity

All of the data collected from participants during the course of this research study will be anonymised and remain confidential. Data will only be analysed by myself and reviewed by my research supervisor. The collected data will be stored securely and retained for 5 years. With your permission, anonymised data including the use of direct quotes may be used for my research, publications or teaching purposes.

During the interviews confidentiality will be maintained and you will be advised not to name specific individuals or clinical areas or organisations. If information during the

interview suggests that harm or malpractice has occurred to patients or service users or that harm or malpractice or bullying has occurred to staff, then I will be obliged to act in accordance with the NMC (2015) Code of Conduct and disclose these details to others who may wish to take further action.

The data will be stored for five years (including 2 years post completion of study) which is in accordance with the Research Governance Framework for Cardiff University (2011)

What are the potential benefits of the research?

This research may not benefit you personally. I hope that this research will enhance support and training for mentors and contribute to strategies that enable student nurses to confidently escalate concerns whilst on placement.

Is there any risk of harm from the research?

I do not anticipate any harm from participating in this research. Discussing your views and experiences of raising concerns could potentially be distressing. If this is the case you will be referred to a designated person within the local university who will support you further.

Ethical Approval

This research has been reviewed and favourably approved by the School of Healthcare sciences Research Ethics Committee and the NHS Research & Development Offices.

Contact details

If you would like to participate in this study or would like further information please contact:



Appendix 10 – Interview guide for student nurse

1. Can you tell me how long you have been a student nurse?

What year of training are you now?

2. Can you tell me about your experience of being in clinical placement so far?

How many clinical placements have you had?

What have they been like?

3. How about the mentors that you have had on placement?

How did they maintain standards of good practice?

How did they help to facilitate your learning?

What are your thoughts about the mentor acting as a 'role model' for student nurses?

4. Can you tell me about any situation in practice where the standards of care were not so good?

5. If so, can you say how this made you feel?

6. What factors influenced your thinking on whether to raise a concern or to do something about it?

7. Can you tell me what actually happened when you raised the concern or took some action?

Describe actions/strategies used?

What was the process or sequence of events that took place? And at what stage of the placement did this occur (did you speak up as soon as it happened or did you reflect/think about things first?)

Did anyone (from practice or university setting) support or help you through this process?

How did the staff in the clinical area react once you had raised the concern?

8. Was your mentor aware of you raising the concern or taking action?

If yes can you tell me more about the role of your mentor within this process?

If no can you talk me through the decision not to involve your mentor?

9. What was the outcome of the process?

Was the concern resolved or practice changed in any way?

10. How was the relationship with your mentor after you raised the concern?

11. What about policies or guidelines around raising concerns?

If so, can you tell me if you used them or considered using them?

12. Can you tell me about any sessions or lectures that you may have had in University on what to do if you see something in practice that concerns you?

13. If you were to come across something in a future clinical placement that concerned you, what do you think you might do?

Have your past experiences of raising a concern influenced what you might do (or not do) next time?

14. What support would you find helpful when raising a concern in clinical practice?

Appendix 11 – Interview guide for nurse mentors

1. Can you tell me about your experience of being a mentor so far?

How long have you been a mentor?

Where have you been a mentor? (Clinical speciality, health boards, country)

2. Can you describe your mentor role to me?

What do you actually do when you are working with your student nurse?

3. How about the relationship between a mentor and student? How important is this relationship from your perspective? How important do you think it is from a student's perspective?

4. Can you tell me about the relationship you have had with the students you have mentored?

5. Student nurses are a fresh pair of eyes when they are out on placement. How do you view their role in promoting safety and quality when they are working in clinical practice?

6. If students witness care which is not as good as it should be, what factors do you think influence their decision on whether they speak up or not?

7. Can you tell me about any situation where you have been mentoring a student nurse who has raised a concern whilst they have been on placement in your clinical area?

If so can you describe what happened?

Did the student nurse approach you with the concern first or go to another member of staff (either in practice or university?).

What was the outcome of this? How was the concern resolved?

8. Can you tell me about any situation where a student nurse has raised a concern in the clinical area you worked in?

If so can you describe what happened?

Use of strategies (formal/informal)?

What was the outcome of this? Was the concern resolved?

7. If you have not experienced a student nurse raising a concern, can you tell me what you would do if a student was to approach you with an issue that they were concerned about

8. Students are increasingly encouraged to raise concerns on placements. What do you think is the mentor's role within this process?

What can mentors do to help to facilitate raising concerns?

9. Student nurses have been known to bypass their mentor when they have a concern and report it to the university instead. What is your view on that?

Any thoughts on why they might choose to disclose to the university rather than a mentor?

10 Rather than formally reporting poor practice, some students may choose to use more informal strategies to signal discontent. What are your thoughts on this and any examples that you have seen?

11. In some cases, student nurses have raised concerns on placement that have negatively impacted on the students learning experience and assessment. What are your thoughts about that? Examples include:-

- be treated differently or ostracised by staff if they speak up

- mentor may not sign practice outcomes or provide a good report in the portfolio

11. Are you aware of any policies or guidelines that might be useful for students raising concerns or to help you in supporting this process?

Is there any staff working within your clinical area or organisation that you might approach to help?

12. Can you tell me about any training or support that you think might help you and other mentors in your mentor role in supporting students who wish to raise concerns?

13. Any other experiences around raising concerns that you would like to share?

Student name

Has participated in a research interview for a PhD study. This has provided an opportunity to discuss perceptions and experiences of raising concerns and to reflect on how the process could be enhanced for students.

Date:

Signed:

Mentor/PT name

Has participated in a research interview for a PhD study. This has provided an opportunity for discussion and critical reflection on the process of raising concerns in clinical practice.

Date:

Signed:

Appendix 14 – Grounded theory approaches to interviewing

Grounded theory approach	Underpinning philosophy of GT approach	Interview style
Classic Grounded Theory (Glaser & Strauss 1967, Glaser 1978)	Objectivist grounded theorists neutral analysts with an aim to ‘discover’ theory which is uncontaminated by preconceived notions and theories	a neutral, passive interview style in which the researcher and participant are detached
Straussian Grounded Theory (Strauss and Corbin 1990)	Post-positivist grounded theorists have objective assumptions about inquiry but acknowledge that participants meanings may be interpreted differently.	The interplay between researcher and participant is acknowledged. Researcher has active relationship with participants but co-ordinates conversation in a systematic way
Constructivist Grounded Theory (Charmaz 2006, 2014) (Charmaz and Belmont 2012)	Constructivist grounded theorists view the world as socially constructed. Both researcher and participant bring their build on the principles of interactionism that multiple realities exist and actions and meanings are constructed.	Intensive interview where researcher and participant co-construct the data . Reality is (re)created by the mutual relationship between the researcher and participant according to the interpretation at that time and place.

Appendix 15 – Memo on power

Memo – Power

The concept of power is coming through within the data. Some of the students describe the mentor as being in a powerful position in relation to their assessor role. They have the sole responsibility in completing the clinical portfolio and students felt that this could prevent the student nurse from progressing or even entering the professional register. The student nurses I interviewed also highlighted the influence that the mentor may have over other members of the team and are often friendly with the management staff. sussing out whom the mentor is friendly with appears to be important in making decisions around reporting. It also appears to be relevant in the student's ability to fit in. The power dynamic between students and mentors is an area to explore further in phase two of this study.

- Are mentors aware of this perceived power imbalance?*
- How do the student's perceive power and how does it influence their relationship with their mentor?*
- Do other members of the team influence power?*
- How does the concept of power relate to students contributing to patient safety and quality improvement?*

Appendix 16 – Amendment to School Research Ethics Committee



Eich eyf/Your ref
Ein eif/Our ref
Welsh Health Telephone Network 1872
Direct Line/Llinell unibonyddol

30th October, 2017

|

The mentor-student dynamic in raising concerns in clinical practice. A grounded theory.

Dear Chair

I am writing to request a minor amendment to my research proposal to include another group of participants. My research has revealed that student nurses frequently involve their personal tutor when they raise concerns. Therefore, I am keen to interview a small number of personal tutors (nursing) and interview the [redacted] all of whom are [redacted] staff.

Personal tutors and the [redacted] would be recruited via email which would briefly outline my study. Staff who respond and express an interest in participating will be sent the Participant Information Sheet to read and to then make an informed decision on whether to participate in the study. The interviews will be focused and will take a maximum of 40 minutes.

I attach new participant information sheets, consent form and interview schedules for your perusal.

Yours sincerely

T. Brown

Mrs Tricia Brown
Clinical Teacher

Appendix 17 – Interview guide personal tutor

1. Can you tell me about your role as a personal tutor?

How long have you been a personal tutor?

2 . How do you perceive your role as a personal tutor in relation to raising concerns?

3. What do you think is the role of the student in promoting safety and quality when they are working in clinical practice?

4. Can you share with me any experience you have had where one of your students has escalated a concern whilst they have been out on clinical placement? (or perhaps has debated raising an issue)

-If so can you describe what happened?

-If this has not happened, how might you deal with this scenario?

5. Can you tell me about any situation where a student has raised a concern to you, but does not want to tell anyone else?

- If not how do you feel about this

- How might you respond to this scenario?

6. My research findings so far have revealed that students do not always speak up when they witness poor practice. I am interested to hear your thoughts on this?

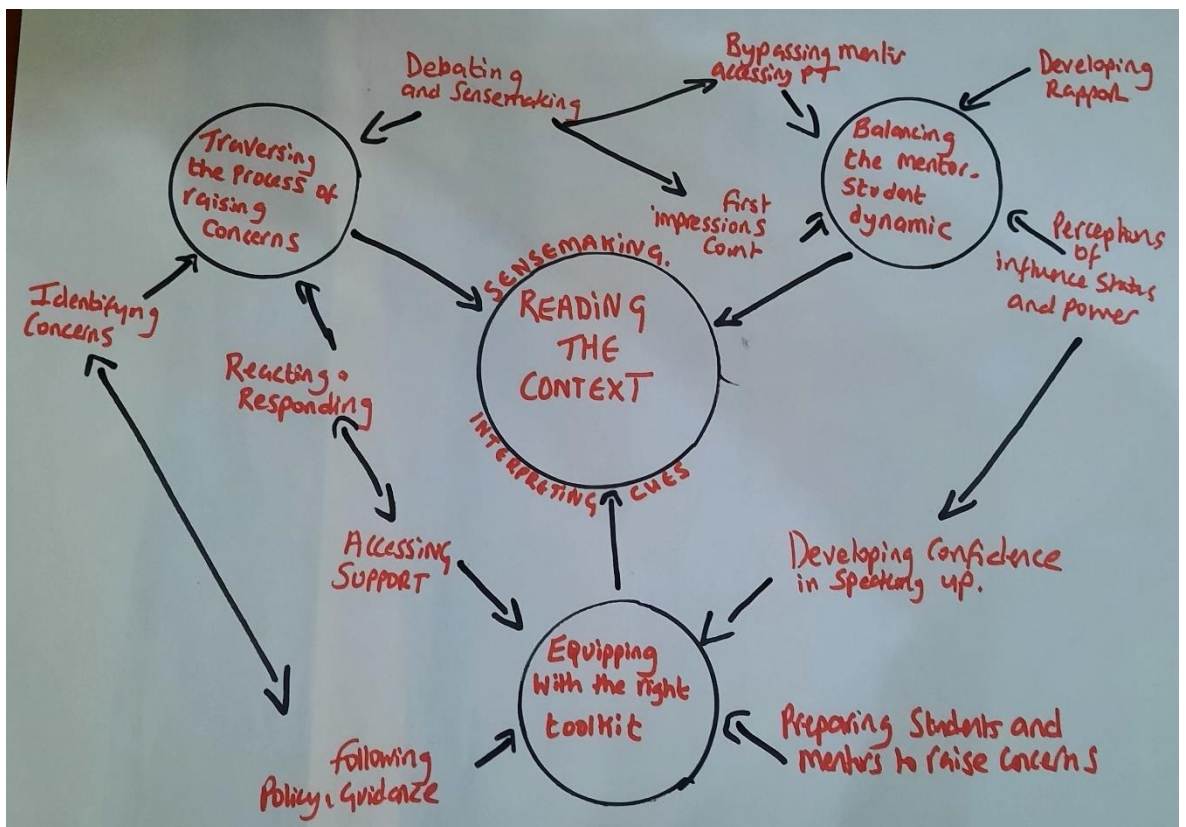
7. How can we enable students to raise concerns confidently whilst they are in practice settings?

-from a university perspective/ practice perspective

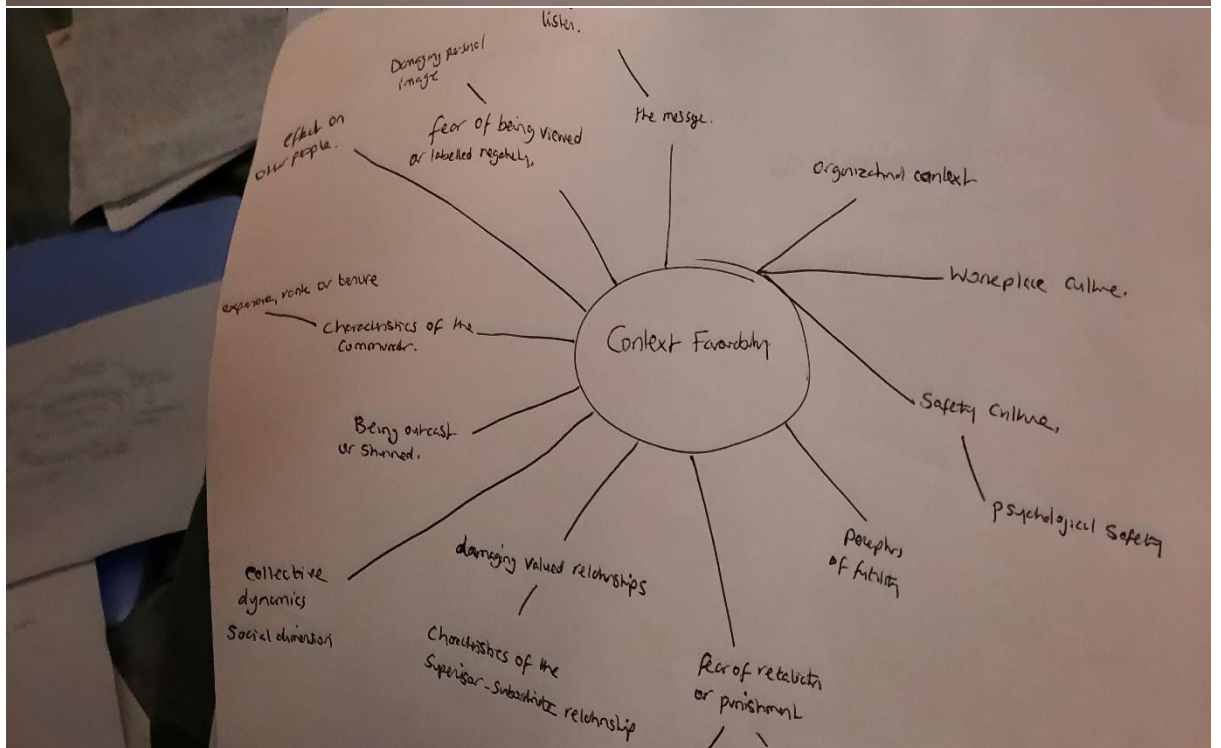
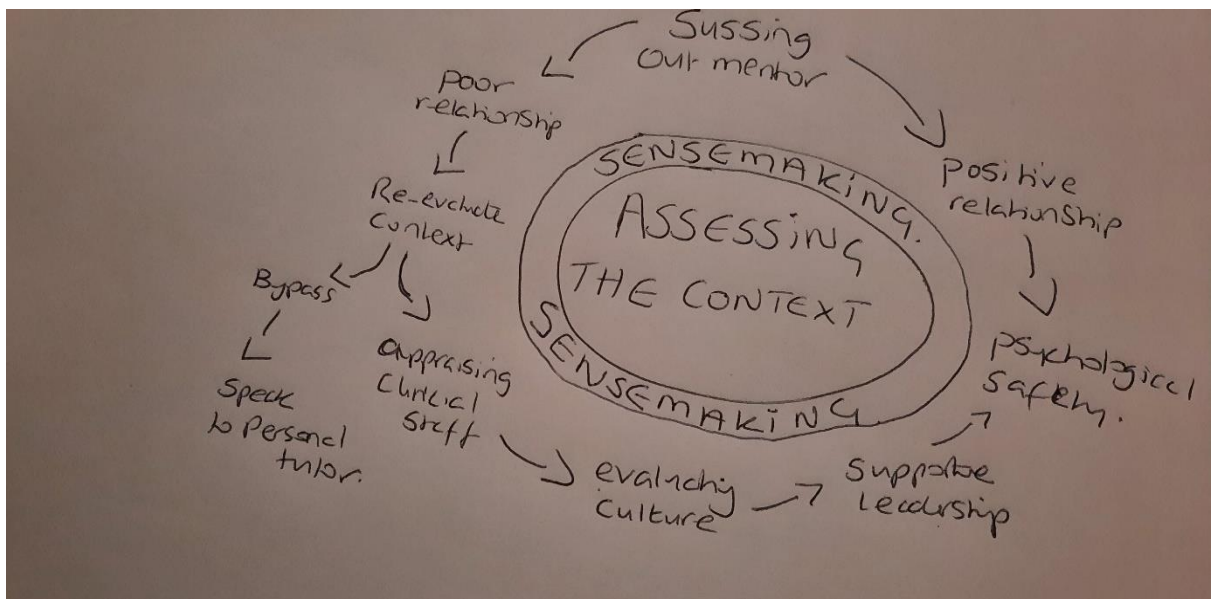
8. Can you share your thoughts on the Raising and Escalating Concerns Policy?

- how helpful is it , any comments

Appendix 18 – Patterns in the data



Appendix 19 – interpreting student sensemaking and context



Appendix 20 – Consent form for research participants

Study Title: The mentor-student dynamic in raising concerns in clinical practice. A grounded theory.

Please initial the box alongside each statement below to signify your consent.

I confirm that I have read the information for the above study and I
Have understood the purpose of the study. I have had the opportunity
to consider the information, ask questions and have them all answered
Satisfactorily.

I agree to take part in the above study as a participant in an interview.
I understand that my participation is voluntary and that I am free to
Withdraw at any time without giving any reason.

I understand that my interview will be recorded on a digital recording
device. I give permission for this.

I understand that the information gathered during the course of
this study will be confidential and anonymised

I agree to data being used for research purposes and publication
(in whole or in part) in peer-reviewed academic journals

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Appendix 21 – Raising and Escalating Concerns Policy (2016)

Raising and Escalating Concerns Policy, Codi a Cynyddol Polisi Pryderon

STUDENTS ARE REQUIRED TO READ THIS POLICY PRIOR TO ATTENDING PLACEMENT LEARNING OPPORTUNITIES.

The Francis Inquiry (2013) identified the principles of openness, transparency and candour as the “cornerstone of healthcare” and that “every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public”.

STUDENTS: Raising and Escalating Concerns in Clinical Practice

Raising concerns is defined as the disclosure by an individual to the public, or those in authority, of mismanagement, corruption, illegality or some other form of wrong doing in the work place. Other terms that you may hear that have a similar meaning include: whistleblowing, whistleblowers, incident reporting.

This policy provides students with guidance to be followed in the event that they have concerns about the delivery of care in practice. The guidance will enable students to access the necessary support whilst protecting confidentiality where appropriate. For example, when patient safety is at immediate risk confidentiality cannot always be guaranteed. However, this is rare and nevertheless the School will always support you with reference to your disclosure.

It is recognised that different terminology is used to describe support systems in place for students. For the purpose of this School policy the term **Academic Support** will be used, to include Link Lecturer, Personal Tutor, Visiting Lecturer, Academic Liaison, Practice Education team, Clinical Education team.

In placement learning environments the term **Named Practice Link** will be used to identify student support including Mentor, Educator, Manager, Clinician, Clinical Teacher, Practice Educator or Practice Facilitator.

What is an issue of concern?

Anything you are aware of, witness or are involved in that you feel is inappropriate can constitute an issue of concern.

Examples might include:

- Witnessing a danger or risk to health and safety e.g. the use of inappropriate equipment;
- Witnessing or being aware that someone is verbally or physically abusive towards a patient, relative or staff member;
- An instance of unsafe or poor practice regarding care delivery involving health care professionals or other staff members;
- Anything you believe breaches a duty of care;
- Where fraud or theft is suspected;

- Substance and alcohol misuse affecting a staff member or student's ability to work;
- Ill-health affecting a staff member or student's ability to work.

These examples are not exhaustive. When you consider you have witnessed something inappropriate then you are strongly encouraged to raise the matter immediately. You can raise your concern with a number of people, including: Practice Link or the person in charge and/or your Academic Support. This ensures that all issues of concerns are dealt with promptly and effectively.

Reporting inappropriate practice can be difficult and you may be concerned about reprisals from fellow students or clinical/placement staff. You may also be concerned about the reporting process, making a statement and being called to give evidence as a witness. We realise that this is a difficult process, however the School will fully support you. In addition, you may find it useful to refer to key guidance on raising and escalating concerns. Documents can be downloaded from the following websites and it is strongly recommended that you read this guidance. You can access the documents via the following links

www.nmc-uk.org/Nurses-and-midwives/Raising-and-escalating-concerns/

www.hcpc-uk.org/registrants/raisingconcerns

www.hcpc-uk.org/registrants/raisingconcerns/whistleblowing

www.hpc-uk.org/assets/documents/10002C16Guidanceonconductandethicsforstudents.pdf

www.cot.co.uk/briefings/professionalism-and-raising-concerns

www.csp.org.uk/professional-union/professionalism?csp-expectations-members/code-professionalvalues-behaviour

www.qaa.ac.uk/Publications/InformationAndGuidance/Documents/OperatingDeptPractice.pdf

www.codp.org.uk/documents/HPC%20Standards%20of%20Proficiency%20ODPs.pdf

www.sor.org/learning/document-library/code-conduct-and-ethics

Further information and support about raising concerns is provided by the charity 'Public Concern at Work'. They have an excellent website and telephone helpline – for further information see <http://www.pcaaw.co.uk>

Who can I turn to for support?

There are a number of people who can provide you with support at all stages of the process. The Academic Team and the Practice Link and/ or the person in charge can all give support. Additionally the School's Professional Heads for each programme are available for advice. You can contact the University's Student Support centre, the Students' Union, the appropriate professional and/or regulatory body or trade union for confidential advice. Please remember that confidentiality must be maintained at all times from the initial raising of the concern and throughout the whole process. It is essential that you do not discuss your concerns with parties not directly involved but maintain your professionalism and use the identified mechanisms to report your concerns and seek support at all stages of the process. This will ensure confidentiality is maintained for all involved.

What is vitally important is that you report the concern immediately and do not wait until after you complete the placement learning opportunity.

Additional Advice

Once you have reported an issue of concern you are protected by the Public Interest Disclosure Act 1998 which covers reporting the following activities:

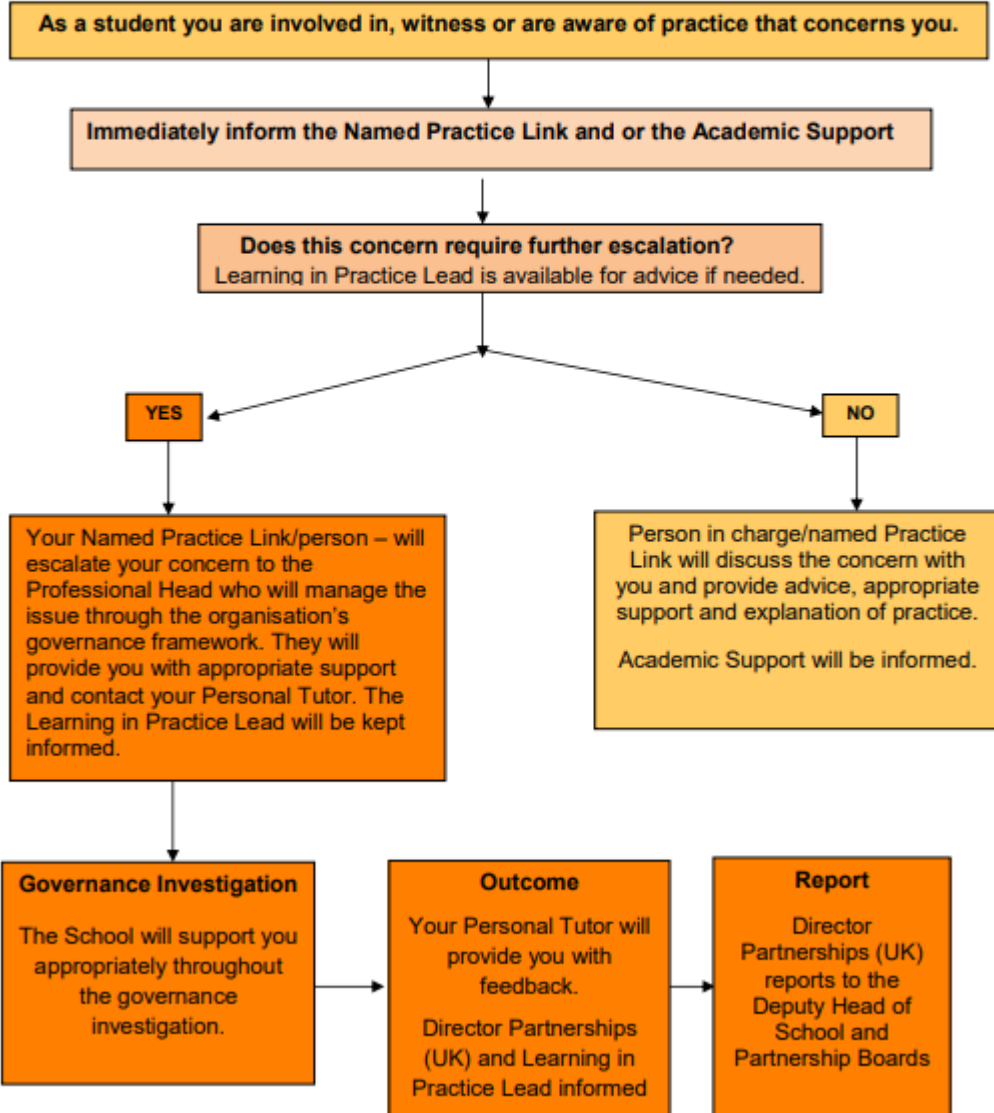
- A criminal offence
- Failure to comply with legal obligations
- A miscarriage of justice
- Endangering the health and safety of an individual
- Causing environmental damage
- Deliberate concealment of information that would constitute evidence of any of the above.

Once an issue of concern has been reported, the named Practice Link you have informed will follow the organisation's procedure. (Remember you can access support from all the people noted above during this time)

For non-NHS placements the process is the same. You raise the issue of concern with your named Practice Link or the person in charge and your Academic Support in the University. For students of the School of Healthcare Sciences who are also employees of the NHS, for example Operating Department Practitioners students, please follow the organisation's procedure and inform a member of academic staff (as listed above) to ensure support can be provided.

**Student guidance for Raising and Escalating Concerns in Practice
Flow Chart (B)**

Advice can be sought from the Practice/clinical Educator, Personal Tutor, Professional Heads and/or Learning in Practice Lead / Director Partnerships (UK) at any time during this process.





Placement Link / Personal Tutor: Procedure for Raising and Escalating Concerns about Students. FLOW CHART (C)

Advice can be sought from the Professional Heads and/or Learning in Practice Lead / Director Partnerships (UK) at any time during this process.

