Accounting for actions and omissions: a discourse analysis of student nurse accounts of responding to instances of poor care

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ACCOUNTING FOR ACTIONS AND OMISSIONS: A DISCOURSE ANALYSIS OF STUDENT NURSE ACCOUNTS OF RESPONDING TO INSTANCES OF POOR CARE

Introduction

This paper is the second from a study which explored the reporting of poor clinical practice witnessed by student nurses on placement. The first (Ion *et al*. 2015), provided a thematic analysis of factors students identified as influencing their decisions to report poor care. This paper examines the data from a different perspective - social constructionism (Burr 2003, Gergen 2009) - in order to explore the discursive strategies used by students to justify their decisions to report or not report concerns about poor practice.

The primacy of ensuring patient safety and by extension reporting concerns about care is explicit in nursing guidance from across the world, which make it clear that nurses must take action when patients are at risk or where quality of care is compromised (International Council of Nurses 2012, Nursing Council New Zealand 2012, Nursing and Midwifery Board of Australia 2008, Nursing and Midwifery Council 2015a & 2015b, American Nurses Association 2015).

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Concerns in this context might refer to mistakes and errors, as well as cases where care or professional behaviour falls below an acceptable standard as a result of conscious action, neglect, incompetence or abuse. The focus of this paper is on the latter.

The question of poor care; why it occurs and what should be done about it, was brought sharply into relief in the UK in the recent enquiry into care at Mid-Staffordshire NHS Trust (Corlett 2014, Hayter 2013, Nolan 2013, Tingle 2014). Here systemic failures led to the unnecessary deaths of hundreds of patients. One of the many issues subsequently raised was the apparent failure on the part of some health workers to voice their concerns about standards of care before it was too late (Francis 2013). Two explanations have been put forward to account for this. Paley (2013 & 2014) has argued that the failure to report poor practice is less a failure of compassion and more, as a possible consequence of heavy workloads and staffing issues, a failure to notice that a problem existed. Taking a different tack, Roberts and Ion (2015) have argued that problems of the type seen in the UK are indicative of a culture in which health care staff are conditioned to think in an instrumental manner which privileges conformity over the kind of critical self-awareness which mitigates against systemic failure.

Background

The international literature on whistleblowing indicates that the issue of poor care is a potential problem for health workers across the world (Atree 2007, Davis and Konishi 2007,

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Public Concern at Work Survey 2008, Onishi *et al.* 2008, Jackson *et al.* 2010, Mansbach & Bachner 2010, Moore & McAuliffe 2012, Mansbach *et al*). In a recent literature review, Jackson and colleagues (2014) concluded that reporting was difficult, that it carried significant personal and professional risks and that, as a consequence, it did not always take place.

The role of the student nurse in reporting poor care has also begun to attract interest (Duffy *et al*. 2012). Workhas focused on samples of students from a number of countries including; Ireland (Begley 2002), the UK (Ion *et al.* 2015, Rees, Monrouxe & McDonald 2015, Monrouxe *et al.* 2014, Belafontaine 2010, Cornish & Jones 2010, Ward 2010, Bradbury Jones *et al*. 2007a, Randall 2003, the UK and Australia (Levitt-Jones & Lathlean 2009), the UK and Japan (Bradbury Jones *et al.* 2007b and Israel (Mansbach et al 2013). Findings indicate that, like their registered colleagues, students understand the requirement to report and are aware of how to do this. There is, however, evidence that those who witness poor care carefully consider the potential negative consequences of reporting when deciding how to respond to it. These include; psychological distress, fears about being ostracized, or failing placement and fear that reporting may have a negative impact on future employment. Unsurprisingly the outcome of this is again that some poor care goes unreported in some cases.

Along with the recently published Freedom to Speak (Francis 2015), this literature is helpful in highlighting some of the issues that educators and others should consider when preparing

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students to practice in a way which is in line with regulatory body expectations. There remains, however, much about the matter of how to address the failure to raise concerns that is unclear. One such area relates to accountability and, more specifically, how students both account for their actions in relation to reporting poor practice and the purpose or function of these accounts. We explore these issues in detail, noting that while accountability is a professional expectation (Milton 2008), it remains a difficult concept for many to grasp (Krautscheid 2014). This may, in turn, be a factor in the reporting of poor care. This paper examines the discursive strategies employed by students when explaining their decisions about whether to report concerns, and the function of these. The aim is to move beyond the identification of barriers to reporting in order to better understand how students account for their actions, thereby providing an opportunity to reflect on how those accounts associated with reporting might be fostered, while considering how those which are drawn upon to excuse non-reporting might be undermined.

The Study

Aim

To explore how nursing students accounted for their decisions to report or not report poor care witnessed on placement, and to propose the potential functions of these accounts.

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Design

Discourse analysis refers to a range of approaches that examine the way in which people draw upon discursive resources to construct matters in a particular way as part of everyday social practice and in the performance of various actions (McKinlay & McVittie 2008, Georgaca 2014). It offers an approach to the analysis of textual and interview data (Traynor 2006). The version of discourse analysis drawn on here was developed by Potter and Wetherall (1987) for whom talk and text are not simply the mechanism by which we transmit an objective reality; rather they are the means by which versions of reality are created. It proposes that there are multiple ways in which we might describe a given event or situation. The one chosen privileges a specific version, which, in turn, achieves particular functions for the speaker. Here, language is 'action orientated' in that it is not simply a conduit through which information travels, instead it is constructive in that it creates the reality we occupy. As such the ability to explain or justify actions is not simply a matter of disinterestedly representing an event and associated choices. Rather, it requires the deployment of discursive strategy and involves the purposeful construction of meaning. The approach has been used in a range of fields, for example, understanding identity construction in student nurses with dyslexia (Evans 2013), as a way of understanding how women account for smoking during pregnancy (Wiggington & Lafrance 2014) and as a means of unpicking public arguments for and against the development of a community mental health facility (Cowan 2003). A further

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example can be found in the work of Robertson (2010) who explored the way in which nurses accounted for their actions in relation to a patient suicide.

Sample

A purposive sample was recruited from a UK university by placing an advert on the university website and by contacting individuals known to have an interest in the area. Thirteen students agreed to participate and all were interviewed. Their ages ranged from twenty to forty seven with nine females and four males. Participants included both adult and mental health nursing students , with representation from all years of the programme. One participant had withdrawn from study at the time of the interview.

Table 1: Participants

Name	Gender	Age	Field of study	Status
Joan	F	25	Adult	Second year
Ann	F	21	Adult	Third year
Cath	F	25	Adult	Second year
Ritchie	M	41	Adult	First year
Katie	F	34	Mental Health	Third year
Ronan	M	24	Mental Health	Second Year
Tammy	F	40	Mental Health	Third year
Nicola	F	47	Adult	Fourth Year
Hester	F	24	Mental Health	Withdrawn
Julie	F	35	Mental Health	Second year
Trudy	F	47	Mental Health	Third Year
Connor	M	22	Mental Health	Third year
Mitch	M	26	Mental Health	First Year

Data Collection

This was via semi- structured interview carried out in the summer of 2013. Questions were developed using guidance provided by Ross (1997). Full details of the data collection process and the rationale for this can be found in Ion et al. (2015).

Ethical issues

Ethical approval was granted by the University Ethics Committee. All participants gave their written informed consent and were reminded that, in the event of a report of a concern, which had previously not been reported, University guidance on reporting concerns should be followed.

Data Analysis

Interviews were transcribed and read by three researchers to find cases where students had encountered poor practice and had reported this, along with those where they had seen poor practice and not reported. Each researcher independently examined the resultant data to identify the discursive strategies used by participants to account for their actions, as well as the function of these. The aim was not only to identify and describe how individuals explained their actions and omissions, but also to consider both how these explanations were

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constructed and the function they served. In doing this we were mindful of the strategic and action oriented way in which explanations are assembled in order to address issues such as accountability and blame. Put simply, participants do not simply describe their actions in an objective manner, rather they do so while attending to the range of potential consequences which might arise from their account. Consequences include issues such as the negative evaluation of the audience as well as the possibility of negative self-evaluation.

Individual analyses were presented to the research group, after which, researchers again revised and developed their analysis. A final cycle of analysis and presentation was undertaken before analytic consensus was reached.

Rigour

The use of a consensus-building methodology (Sheilke, 2009) enhanced rigour by allowing for a range of interpretations and views, while ultimately providing an arena in which a shared understanding of data could be reached. The integrity of the final analysis was checked and agreed by all team members.

Results

Participants included those who reported their concerns and those who did not. Students who reported issues described events including assaults and perceived omissions of care. Those

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who did not report were more cautious in their discussions and descriptions of the index incident.

Action taken

Moral and professional duty

Students accounted for their decision to report by reference to both moral and professional duty, usually attributing their action to internal aspects of character. This position is summed up below in the statement by Ritchie who, having described a concern, goes on to say:

'I'm not the kind of person who sits back and ignores these things' (Ritchie 617)

Ritchie is clear that the decision to report is firmly tied to something intrinsic – in this case …the 'kind of person' they are. While not made explicit, it is difficult to avoid the conclusion that the 'kind of person' this is, is someone who is driven by a clear sense of right and wrong. A contrast is therefore drawn between inaction and active reporting in the face of 'these things'. This general descriptor ('these things') also functions to generalize wrongdoing or poor practice thereby strengthening the claim that such reporting of these practices covers a range of non-specific instances and as such strengthens the claim that this derives from a general personal disposition.

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Implicit in this discourse of 'kind of person', is the idea that reporting is not done for personal gain, but because it is the right thing to do:

'…. I was told 'thank-you' for bringing that to my attention and I'm sorry that that impacted on your placement' and I thought as long as it doesn't impact on the patient (Ronan .110).

For Joan the discomfort of reporting was outweighed by a personal commitment which could not be overridden

"You don't want to be labeled as the girl who grasses, but if you see something bad you have to do something." (Joan 228)

A related discourse was put forward which positioned the student as a professional, albeit a trainee. Here the interviewee makes explicit their commitment to the regulatory body's requirements in the form of the 'The Code', to which they align themselves

'…as a student I have to follow my NMC guidelines about risk management and patient safety' (Ritchie .124)

Referring to the professional regulations again, this participant reiterates their view:

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'Well for me if someone had highlighted to you that something is important (The Code) to begin with…..then that shouldn't be getting ignored' (Ritchie .235)

Here the student makes it clear that their decision to report was driven by a commitment to a professional requirement. In this respect they associate themselves with the identity of the 'professional nurse'.

Positive personal attributes

Personal qualities were also used as justifications for reporting. These related to discourses around strength, confidence, ambition and determination to succeed:

'I came to nursing determined to achieve something and I thought somebody's unwillingness to cope is not going to stand between me and what I want to achieve' (Julie .124)

'I was quite confident that what I was doing was justified, what I was doing was right..' (Ritchie. 367)

This was echoed by Tammy who noted:

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I wouldn't have done it like that, I have the confidence to ask why they did it that way (Tammy. 25)

Regardless of this clarity of vision, the decision to report was presented as being far from straightforward and often involving a degree of internal struggle. As Joan noted in relation to her decision to report :

'I felt like I had done something wrong. I felt horrendous…. but then there was another part of me that was like if you don't report this then something even worse could happen and you have known about this and haven't said anything' (Joan. 234)

Reflecting back on an occasion when they had raised a concern another student explained how self –doubt had begun to erode her initial sense of certainty regarding the need to report:

"As time passed between the incident happening and me reporting, I began to wonder if I was overreacting … cos it's not like she beat her (the patient) up or anything , it was a slap which is still terrible, but because she just brushed it off and got on with things I wondered if I was overacting"   (Hester. 52)

These accounts draw attention to the notion of reporting as deriving from attributes that are inherent in personal dispositions. The action to report therefore is located within the

personality of the student and the attendant metaphor of strength of character. The implication is that this quality is required in the face of what may be unpleasant outcomes for the reporter, including internal psychological dissonance. Adding difficulty to the account of reporting, also serves to enhance the potential for seeing the student in a positive light.

Exonerations for delayed action or inaction

Exonerations, arguments and justifications for inaction were more complex than justifications for action. This may be because the participants are in a position where they are accounting for actions which do not meet the requirements of the profession.

The hopelessness of the situation

In this discourse action is portrayed as futile in the face of an established structure that the individual feels cannot be broken down. One participant stated:

'…I spoke to my sister who is a nurse and she says you will never overcome the way that unit is run…' This is a unit that's run its own way by a Senior Charge Nurse who is laughable. There's no point taking it any further because people have done it in the past and she is still there (Trudy. 52)

Presenting an account about their perceived powerlessness in the face of what they felt were inadequate staffing levels Mitch said:

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"… I could see that they were understaffed and there was a danger to some of the patients but it's not something that I am going to be able to change. I am not going to be able to go to the NHS management … and go 'this is understaffed' and them say 'the student says we are understaffed, let's put another two or three nurses on'. That's not going to happen." (Mitch. 84)

These kinds of account construct professional and organisational hierarchies as something to be reckoned with, and suggest that the individual is pitted against powerful forces. The implication being that there is little point in taking on these, given that to do so would be at best hopeless and possibly foolhardy.

Negative personal impact

A second exoneration concerns the personal and professional impact of reporting:

For Katie, reporting was very difficult:

I was worried that it would get back to them… that it would be an even worse environment for me if they found out what I had been saying… (Kate. 391)

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Hester summed up the potential consequences of reporting stating:

"Becoming an outcast, that's what happens. If you see somebody doing something wrong and you do the right thing and you report it, you can't work there anymore, because you are never going to be accepted (Hester. 312)

Others provided similar cautionary stories:

'… and I mean people are often left in placements that they have raised concerns and that isn't a pleasant situation to be in' (Nicola. 548)

'The biggest thing is people worry about making a name for themselves by reporting' (Connor. 47)

These constructions emphasise the potential personal difficulties that are likely to be faced by reporters. They serve to situate the person who considers reporting as facing a dilemma where the axis of action/inaction is set against the benefits of doing the right thing - confronting the poor practice - versus the potential unpleasant consequences of taking this

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course of action. This balancing of the costs and benefits of reporting allows the presentation of an account where, given the circumstances, doing nothing is reasonable

Theory practice gap

Here the gap between the idealized world of official guidance and the real world of practice is highlighted .The challenges of the latter are given as reasons for inaction:

'I think everyone wants to say that they put the patient first, but it is harder to do that in reality' (Connor. 725)

'You think you are going to look like you are totally out of touch with reality just expecting everything to be textbook when that's not possible always' (Nicola .410)

Here participants contrast the abstract world of theory with 'on the ground' reality or at the level of broad principle (e.g. putting the patient first) versus the reality of the situation. In either case 'reality' trumps principle given that it is presented as being what actually transpires or is the case. Confronted with actual practice, what should or ought to happen is presented as literally unrealistic, or as a desired outcome that is in some way an untenable position or impossible stance.

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Displacement of responsibility

Exoneration is also claimed by situating the responsibility for action or decision making away from the student. Referring to an earlier episode in which she had taken an academic issue to a faculty member, Ann explained a reluctance to report a concern in the following way:

'She doesn't seem interested in my grade problem so is she really going to be interested in this (concern), so it was a lack of trust I suppose' (Ann. 480)

A range of exonerations which were also deployed throughout the text that seemed to act as 'further support' arguments, for example, that communication is difficult:

'it doesn't help either that once we are out on the placements we can't really access our emails.' (Julie 532)

'I found it quite difficult to mention it on the ward because the Senior Charge Nurse hadn't introduced herself' (Ann .453)

Further to this participants talked of the placement context as not being conducive to enabling reporting to occur in terms of shifted perspective ('it's normal here to do this'), fatigue and over-work:

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… I wasn't introduced to anyone, I wasn't made to feel welcome (Cath. 123)

'…but it is really difficult, I mean especially as there are still places like where I am where you are on 12 hour shifts, and you know if you have family or pets or other things it does get, you know, at the end of the day you are exhausted …'(Nicola .461)

'…sometimes you don't think, you think that is what happens here and then when you leave you go actually 'no'' (Ann .63)

A similar view was expressed by Cath:

… so I was thinking, is this just what happens in a care home … is it normal? (Cath. 179)

These accounts offer what can be considered as the traditional means of constructing excuses (Scott and Lyman, 1968). This relies upon making a case for not reporting by pointing to something that prevented the person from acting at the time. In extract P8.461 above, fatigue is presented as overcoming the person thereby preventing them from acting there and then. In extracts P2.63 a more subtle form of excuse is constructed; that of being unaware at the time, but that after time and consideration the issue became apparent. Not 'thinking' or 'realising' is presented in a general way as something that is excusable given that the implication is that many, if not most, people in these circumstances would also exhibit this lack of awareness.

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Functions of discourses of inaction

The function of these discourses is to excuse inaction while at the same time enabling participants to maintain a positive identity. This is done by either drawing attention to the risks of reporting, explaining that action would result in no obvious benefits; or illustrating that any other reasonable person would behave in the same way in similar circumstances.

Discussion

None of the participants claimed that they unaware of the need to report or that they did not know how to do this. This stands in contrast to Paley's (2013) argument that nurses may fail to report concerns because they are too busy to notice them in the first instance - a position already questioned by Rolfe & Gardener (2014) and by Darbyshire (2014).

While this may be comforting for faculty staff insofar as they can rightly claim that they have made students aware of both the need to report and how to do so, it should, noting Darbyshire, Ralph & Caudle's (2015) notion of 'sentinel events', also create some concern in relation to those cases where students were aware of problems, but chose not to raise these.

We have examined the ways in which students account for this using a range of discursive actions. One of the functions of discursive arguments in situations where there is the potential for blame or a requirement to account for a particular course of action is the management of

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the situation from the informant's perspective (Benson et al 2003). The presentation of self was key for both those who reported and those who did not. In the case of the former, participants explained their actions by referring to their own moral position, strength of character and / or a clear commitment to professional regulations and guidance. Edgar and Pattison (2011) have previously noted that a strong sense of personal integrity may be an important characteristic for the would-be whistle-blower, noting also that this may need to be tempered by the ability to reflect and operate in the challenging environment of clinical practice. The function of these discourses appears to be to present the self as a nascent professional, essentially good and driven by an appreciation of the difference between right and wrong and the need to put patients first. Here action was undertaken because of internal attributes such as personal morality, or goodness, and despite internal psychological struggle or external challenges. Positive self-identity is therefore achieved and is in fact reinforced by drawing attention to the difficulty of the task of reporting.

Non-reporters also took care to present themselves in the best possible light – a finding which is consistent with work on excuse making (Bagsall & Snyder 1988). In contrast to their peers those who decided against raising concerns, explained their choice by reference to external factors over which they had little if any control, for example, the futility of reporting, or the gap between the simple world of theory and the complex domain of practice. In doing this they also managed to maintain a positive self-identity through implicitly suggesting that inaction was the only realistic option available to them. Blame or moral censure is

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consequently avoided in a situation where any other reasonable person would have made the same decision.

These results indicate that justifying or explaining reporting presents an individual and positive affirmation of self-identity, while not reporting is presented as an excusable activity, grounded in the context in which the index incident occurs, which serves to maintain a positive sense of self. In contrast with the explicit guidance of the regulatory body (NMC 2015a), participants rarely indicated that reporting concerns was a duty. Instead, in many cases it was presented as an option, which might be chosen, but could be legitimately rejected under certain circumstances. Given the key role of the nurse in advocating for patients and the professional expectation that patient safety is paramount (NMC 2015b), this notion of choice should be of concern to regulators, educators and above all to patients and their families. While not reporting may be explainable, given the vulnerability of patients and the trust placed in nurses by the public, it is not excusable.

Roberts and Ion (2015) suggested that explanations for a failure to report concerns lies in the educational and professional context. This paper supports their ideas in two respects. The first being the active engagement of participants in discourses which allow responsibility for action to ultimately be inconsequential to nursing students positive self-perception, and the second that it seems possible for the legitimate use of a passive 'I am only a student' stance. The former discourse is evidenced by the apparent ability of some students to distance themselves from action, or to claim that potential negative consequences outweigh the gains

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to be made from reporting, the latter allows the transfer of responsibility on to staff and the university.

Becoming a nurse involves not only gaining theoretical knowledge and the development of technical competence, but also assimilation and socialization into the profession. Taking on stories about how practice is in reality, and how it is allowable for reality to be different from theory, while maintaining a positive self-image may be part of this acculturation. The 'principle versus practice' discourse (Wetherall *et al*., 1987) sits alongside this as both an ideological dilemma (Billig *et al.,* 1988) and as a practical means by which nurses can at one and the same time espouse a moral and duty-bound commitment to report poor practice as well as pointing to the realities of the job and the consequences that may arise if this course of action is taken. As a result practice undermines principle and the normative position arises that reporting is not considered an option or is taken up only as a last resort.

Our focus is on the accounts provided by students in relation to their decisions to report or not report instances of poor care. The aim was not to evaluate the severity or nature of these concerns and, as such, students did not always describe the index incidents in detail. Where this did occur, it was in cases where students had reported. In contrast those who did not report often chose to talk about their decisions without providing details about the incident. It may be that in describing the nature of their concerns reporters bolstered their self-image by providing an example of the severity of the issues they encountered, while those non-reporters minimised the potential for criticism by choosing not to describe. As Potter (1996)

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notes, the provision, and by association, absence of detail in accounts can play a crucial part in how they are received by others. One view of it may be that participants made strategic choices around the provision of detail.

Limitations

While there are limits to the generalisability of the findings of a small scale study of this type, this work sheds further light on an aspect of the literature that has, to date, been overlooked, namely how students account for their actions and omissions.

We make no claim that the accounts given by a self-selecting group of thirteen students represent the full gamut of accounts available nor do we argue that this is the only possible interpretation of the data . In place of this certainty readers are left to judge the value of the findings for themselves based on fit with their experience of the world and on our account of the research process.

The work makes no judgement on whether students made the correct decision about whether or not to report. This was not our aim. Instead we sought to analyse the issue of accountability by examining how participants justified their decisions

Conclusions

It is essential that students not only understand the process of reporting concerns, but that they are also prepared to do so on both a personal and a professional level. In focusing on

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accounts, this study suggests a number of approaches educators might use to encourage reporting.

Care should be taken to emphasise the extent to which the action of reporting is aligned with the values of the profession, specifically in relation to the maintenance of patient safety and promotion of a culture of openness. Reporting concerns can be encouraged by making the point that there is both an expectation and professional requirement to do so. Suggestions that reporting is a pointless endeavour can be countered by examples of change brought about in cases where concerns have been raised, while fears about negative personal impact might be addressed by assurances of protection, along with examples where there have been no negative consequences. The perceived gulf between theory and practice can be explicitly discussed, with students encouraged to explore the potential consequences for vulnerable patients of not reporting.

Finally what seems particularly important is to ensure that students understand that reporting concerns about care is not a case of personal choice, rather responsibility lies with the individual who is answerable to the profession, and to patients. Bearing in mind that the purpose of the nursing profession is the care of vulnerable others, and in contrast with those who raised concerns, non-reporters were largely silent in relation to the potential impact of inaction on patients. Transferring priority of care from the self to patients may be a further shift needed to re-balance the arguments for and against reporting.

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References

American Nurses Association Code of Ethics: Revised Version 2015 Retrieved from http://www.nursingworld.org/Mobile/Code-of-Ethic (05/92/15)

Atree, M. 2007. Factors influencing nurses' decisions about care quality. Journal of Nursing Management. 15: pp.392 -402.

Basgall, J. A. and Snyder, C. R. 1988. Excuses in waiting: External locus of control and reactions to success-failure feedback. Journal of Personality and Social Psychology. 54(4): pp.656-662.

Begley, C. 2002. 'Great fleas have little fleas': Irish students midwives' views of the hierarchy in midwifery. Journal of Advanced Nursing. 38(3): pp.210-317.

Bellefontaine, N.2009. Exploring whether student nurses report poor practice they have witnessed on placements. 105(35) Nursing Times.

Benson, A. et al. 2003. Discourses of blame: accounting for aggression and violence on an acute mental health inpatient unit. Social Science & Medicine. 57(5): pp.917-926

Billig, M., Condor, S., Edwards, D., Gane, M., Middleton, D.J. and Radley, A.R. (1988). Ideological Dilemmas: A Social Psychology of Everyday Thinking. London: Sage.

26

Bradbury-Jones, C., Irvine, F. and Sambrook, S. 2007. Empowerment of nursing students in the United Kingdom and Japan: a cross-cultural study. Journal of Advanced Nursing. 59(4): pp.379-387.

Bradbury-Jones, C., Sambrook, S. and Irvine, F. 2007. The meaning of empowerment for nursing students: a critical incident study. Journal of Advanced Nursing. 59(4): pp.342-351.

Burr, V. 2003. Social constructionism. 2nd ed. London: Routledge.

Corlett, S. 2014. Francis, Berwick and culture change - an opportunity to engage patients and increase transparency in mental health. Mental Health and Social Inclusion. 18(1): pp.13-16.

Cornish, J. and Jones, A. 2010. Factors affecting compliance with moving and handling policy: Student nurses' views and experiences. Nurse Education in Practice. 10(2): pp.96-100

Cowan, S. 2003. NIMBY syndrome and public consultation policy: the implications of a discourse analysis of local responses to the establishment of a community mental health facility. Health & Social Care in the Community. 11(5): pp.379-386.

Darbyshire, P. 2013. Nursing's crisis of care: What part does education own. Nurse Education Today. 33(4): pp.305-307.

Darbyshire, P., Ralph, N. and Caudle, H. 2015. Editorial: Nursing's mandate to redefine the sentinel event. Journal of Clinical Nursing. : pp.n/a-n/a.

27

Darbyshire, P. 2014. Character assassination? Response to John Paley, "social psychology and the compassion deficit". Nurse Education Today. 34(6): pp.887-889.

Davis, A. J. and Konishi, E. 2007. Whistleblowing in Japan. Nursing Ethics 14(2) pp. 194-202.

Duffy, K. et al. 2012. Whistleblowing and student nurses - Are we asking too much? Nurse Education in Practice. 12(4): pp.177-178.

Edgar A and Pattison S 2011. Integrity and the moral complexity of professional practice. 12(2) pp. 94-106. Nursing Philosophy.

Evans, W. 2014. I am not a dyslexic person I'm a person with dyslexia: identity constructions of dyslexia among student

Francis, R.2013. The Mid-Staffordshire NHS Foundation Trust Public Inquiry. pp. http://www.midstaffspublicinquiry.com/report.

Francis R 2015 Freedom to speak up: an independent review into creating an open an honest reporting culture in the NHS. https://freedomtospeakup.org.uk/wpcontent/uploads/2014/07/F2SU_web.pdf (11/05/15)

Georgaca, E. 2014. Discourse analytic research on mental distress: A critical overview. Journal of Mental Health. 23(2): pp.55.

Gergen, K. J. 2009. An invitation to social construction. 2nd ed. London: Sage.

Hayter, M. 2013. The UK Francis Report: the key messages for nursing. Journal of Advanced Nursing. 69(8): pp.e1-3.

International Council of Nurses ICN Code of conduct for nurses 2012 Retrieved from http://www.icn.ch/images/stories/documents/about/icncode_english.pdf (06/02/15)

Ion, R. et al. 2015. Factors influencing student nurse decisions to report poor practice witnessed while on placement. Nurse Education Today.

Jackson, D. et al. 2014. Whistleblowing: An integrative literature review of data-based studies involving nurses. Contemporary Nurse. 48(2): pp.240-252.

Krautscheid, L. 2014. Defining professional nursing accountability: a literature review . Journal of Professional Nursing. 30(1) : pp.43.

Levett-Jones, T. and Lathlean, J. 2009. 'Don't rock the boat': Nursing students' experiences of conformity and compliance. Nurse Education Today. 29(3): pp.342-349

Mansbach A and Bachner YG 2010. Internal or external whistleblowing: nurses' willingness to report wrongdoing. 17(4) pp. 483-90. Nursing Ethics.

29

Mansbach, A. et al. 2014. Reporting misconduct of a coworker to protect a patient: a comparison between experienced nurses and nursing students. The Scientific World Journal. 2014: pp.413926.

Mansbach, A., Ziedenberg, H. and Bachner, Y. 2013. Nursing students' willingness to blow the whistle. Nurse Education Today. 33(1): pp.69-72.

McKinlay, A. and McVittie, C. 2008. Social psychology and discourse. Oxford: Wiley-Blackwell Pub.

Milton, C. L. 2008. Accountability in Nursing: Reflecting on Ethical Codes and Professional Standards of Nursing Practice from a Global Perspective. Nursing Science Quarterly. 21(4): pp.300-303.

Monrouxe, L. V. et al. 2014. 'Even now it makes me angry': health care students' professionalism dilemma narratives. Medical Education. 48(5): pp.502-517.

Moore, L. and McAuliffe, E. 2010. Is inadequate response to whistleblowing perpetuating a culture of silence in hospitals? United Kingdom: Emerald Group Publishing Ltd., Bradford UK 15 (3) pp. 166-178. Clinical Governance: An International Journal.

Nursing and Midwifery Board of Australia Code of ethics for nurses 2008 Retrieved from http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#codesofethics (05/02/15)

30

Nursing and Midwifery Council 2015a Raising concerns: guidance for nurses and midwives. NMC; London. Retrieved from http://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/raising-concerns-30-march-2015-rebrand.pdf (11/05/15)

Nursing and Midwifery Council 2015b. The code: professional standards of practice and behaviour for nurses and midwives. NMC; London Retrieved from http://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/revised-new-nmc-code.pdf (11/05/15)

Nursing Council of New Zealand Code of conduct 2012 Retrieved from http://www.nursingcouncil.org.nz/Nurses/Code-of-Conduct (05/02/15)

Nolan, P. 2013. (2) The Francis Report: Implications and consequences. Nursing Ethics. 20(7): pp.840-2.

Ohnishi, K. et al. 2008. The Process of Whistleblowing in a Japanese Psychiatric Hospital. Nursing Ethics. 15(5): pp.631-42

Paley, J. 2013. Social psychology and the compassion deficit. Nurse Education Today. 33(12): pp.1451-1452.

31

Paley, J. 2014. Cognition and the compassion deficit: the social psychology of helping behaviour in nursing. Nursing Philosophy. 15(4): pp.274-287.

Potter , J. 1996. Representing reality: Discourse, rhetoric and social construction. Sage.

Potter, J. and Wetherell, M. 1987. Discourse and social psychology: Beyond attitudes and behaviour. London: Sage.

Public Concern at Work Public Concern at Work/Nursing Standard Whistleblowing Survey 2008 Retrieved from http://www.pcaw.co.uk/files/WBsurvey_summary.pdf (on 07/01/15)

Rees, C. E., Monrouxe, L. V. and McDonald, L. A. 2015. ?My mentor kicked a dying woman's bed?? Analysing UK nursing students? ?most memorable? professionalism dilemmas. Journal of Advanced Nursing. 71(1): pp.169-180.

Roberts, M. and Ion, R. 2015. Thinking critically about the occurrence of widespread participation in poor nursing care. Journal of Advanced Nursing. 71(4): pp.768-776

Robertson, M. 2010. Accounting for Accountability: A Discourse Analysis of Psychiatric Nurses' Experience of a Patient Suicide. The Open Nursing Journal. 4: pp.1.

Rolfe, G. and Gardner, L. 2014. Invisible gorillas and red herrings: a response to Paley (2013). Nurse Education Today. 34(6): pp.954-957.

Ross, E. (1997) in Carter, Y., Thomas, C. (eds) Qualitative Research Methods – Data Collection and analysis in Research Methods in Primary Care. Radcliffe Medical Press, Abingdon.

Schielke, H. J., Fishman, J. L., Osatuke, K., Stiles, W. B. Creative consensus on interpretations of qualitative data: The ward method. Psychotherapy. 2009;19:558-565

Scott, M. B., & Lyman, S. M. (1968). Accounts. American Sociological Review 33 (1), 46-62.

Tingle, J. 2014. Francis Report: the Government accepts recommendations. British Journal of Nursing. 23(2): pp.108-109.

Traynor, M. 2006. Discourse analysis: theoretical and historical overview and review of papers in the Journal of Advanced Nursing 1996?2004. Journal of Advanced Nursing. 54(1): pp.62-72.

Ward, D. J. 07. Infection control in clinical placements: experiences of nursing and midwifery students. Journal of Advanced Nursing. 66(7): pp.1533; 1533-1542; 1542.

Wetherell, M., Stiven, H., & Potter, J. (1987). Unequal egalitarianism: A preliminary study of discourses concerning gender and employment opportunities. British Journal of Social Psychology 26(1), 59-71.

33

Wigginton, B. 2014. 'I think he is immune to all the smoke I gave him': how women account for the harm of smoking during pregnancy. Health, Risk & Society. 16(6): pp.530.