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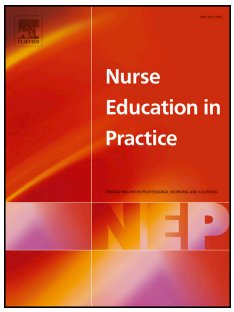

Nursing and midwifery students' encounters with poor clinical practice: A systematic review

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ABSTRACT

The aim of this paper was to systematically review evidence about nursing and midwifery students' encounters with poor clinical care.

We undertook a systematic review of English language empirical research using multiple databases from inception to April 2016. Hand searching was also undertaken. Included papers contained accounts of empirical research which reported on students' encounters with poor care. These were quality-assessed, information was extracted into tables, and study results were synthesized using thematic analysis.

N=14 papers met inclusion criteria; study quality was moderate to good. Study synthesis revealed four themes: i) encounters with poor practice: students encounter poor practice that is likely to be worthy of professional sanction; ii) while intention to report is high in hypothetical scenarios, this appears not always to translate to actual practice; iii) a range of influencing factors impact the likelihood of reporting; iv) the consequences of encountering and subsequently reporting poor practice appeared to have a lasting effect on students.

Research is required to determine the frequency and nature of students' encounters with poor care, when and where they encounter it, how to increase the likelihood that they will report it, and how they can be supported in doing so.

Key words

Student, Poor Care, Reporting Concerns, Whistle blowing, Placement, Clinical Rotation

INTRODUCTION

Across the world, professional guidance enshrines nurses' duty to provide the best possible care in a manner which is grounded in a commitment to core human needs including respect, to maximise personal dignity, to promote choice, and value cultural diversity (International Council of Nurses 2012, Nursing and Midwifery Council 2015, American Nurses Association 2015, Nursing Council New Zealand 2012). While most nursing care meets these expectations there is now a broad range of evidence to suggest that poor care is both widespread and significant (Reader & Gillespie, 2013; Jogerst et al., 2008; Jackson et al., 2014; Castle, Ferguson-Rome & Terisi, 2015; Albina, 2016; Jonson, 2016; Francis 2013; Chockwe & Wright, 2011). While understanding of the prevalence and nature of care failure has developed there is still much to learn, including how healthcare workers themselves experience and respond when they witness or encounter it. A recent review (Jackson et al., 2014) examined the responses of registered nurses to care failure and their experiences of whistle blowing. Notable issues included participants' reluctance to report concerns, the contextual and situational factors impacting on reporting intent, and the negative consequences of raising concerns including victimisation by colleagues or management, job loss, and impact on relationships. Relatively little is known about pre-registration students' experience of poor care despite the expectation, at least in the UK (NMC, 2013) that they report it. Clinical placement learning is a central part of preparatory nursing and midwifery programmes globally, providing opportunities for practical skills training, socialisation into the profession, and a means by which students can make decisions about future career options. Positive placement experiences are associated with future career choices (Carlson & Idvall 2014), enhanced professionalism, and the acquisition of caring skills (Ma et al. 2013). Conversely, negative experiences are associated with increased stress and attrition from

training programmes (Gilbert & Brown 2015; Hamshire et al 2013). The potential of students to contribute to monitoring care standards has also been raised (Duffy et al, 2012; Francis, 2015). Whilst pre-registration students may, due to inexperience or status, have added vulnerability as whistle blowers, they do have a potentially unique perspective as newcomers to an established culture of care who could view a situation with a degree of detachment. Bickhoff, et al. (2015) have explored qualitative literature specifically focused on the display of moral courage in undergraduate nursing students confronted by poor care. However, we aimed to use a systematic approach to identify, appraise, and synthesise all the relevant empirical literature which focuses on nursing and midwifery students' encounters with poor care in the broadest sense during their clinical practice placements.

METHODS

Review protocol

The review was conducted in accordance with the relevant sections of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009).

Search strategy

The aim of the search, which took place between August 2015 and January 2016, was to identify all empirical studies which reported on nursing or midwifery students' encounters with poor clinical practice during practice placement. The following databases were searched: 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. Using wildcard truncation where appropriate, population keywords (student nurse, student midwife) were paired with the keywords related to the study focus (raising concerns, concerns, poor practice, poor care, abuse, neglect, whistleblowing, moral dilemma, distress), and setting (clinical: practice, placement,

rotation). Hand searches of reference lists from included papers were also undertaken. Titles and abstracts were reviewed by the first author and the full text version of any paper that described a potentially relevant empirical study was retrieved. Full text papers were reviewed independently by all authors.

Table 1 Search example (CINAHL) goes here

Study selection

Titles and abstracts of papers identified by the search were reviewed by the first author and full text versions of potentially relevant studies obtained. Elimination of papers at the full text review stage was achieved by consensus among all three authors following independent review. See *Figure 1* for details of the process by which papers were excluded

Figure 1 Goes here

Inclusion/exclusion criteria

To be included a paper needed to describe an empirical study which reported on nursing or midwifery students' encounters with poor care while on clinical placement. Studies which reported on other groups in addition were included, but the findings as they related to the other groups were not addressed. The actual physical setting of studies was not limited though only those related to experiences of poor care during clinical practice placement were included. Non-English language studies were excluded, as were papers in which poor care was mentioned but was peripheral to the main study aim.

Data extraction and synthesis

Data were extracted and tabulated by the first author under the headings: author, date, sample studied, country, setting for data collection, design, sub-themes. Since all but two of the papers included used a qualitative design it was not appropriate to conduct a meta-analysis of findings. Instead a meta-synthesis was conducted with the aim of identifying key themes across the data. Synthesis of findings was achieved through a procedure informed by the approach described by Thomas and Harden (2008), which was developed to inform thematic synthesis of qualitative research in systematic reviews. Papers were read and re-read by each author. This was followed by group discussion of sub-themes identified during data extraction and tabulation by the first author. Group discussion resulted in combination of sub-themes to create overarching themes.

Study quality

The quality of the qualitative studies was assessed using a 14-item checklist adapted from two sources (Critical Appraisal Skills Programme, 2013 and Tong et al., 2007). The quality of the quantitative studies was assessed using a 12 item checklist adapted from two sources (Greenhalgh, 2006 and University of York Centre for Reviews and Dissemination, 2008). Quality of the mixed method studies was assessed using a 16-item checklist (O'Cathain et al., 2008 and Pluye et al., 2011).

RESULTS

Study characteristics

The search strategy identified fourteen empirical papers (See table 2) published between 2008 and 2016. Seven drew on samples from the UK, two from Israel (Mansbach et al.2013, Mansbach et al.2014) and the remainder from South Africa, Taiwan, Canada ,Australia, and Turkey (all n=1; N.B., N=15 due to one study conducted in the UK and Australia). The number of participants ranged from 5 to 294 students (median n = 24); in total N=823 nursing and midwifery students were studied. Thirteen studies focused on the experience of nursing

students, and one (Chockwe & Wright 2011) on midwifery students. The clinical environment about which respondents appeared to be reporting their experiences of poor care was mostly a range of general medical settings for adults while *n*=3 studies made explicit reference to experiences in mental health settings (Ion et al 2015; Ion et al 2016; Wojtowicz et al., 2014) and one (Bellefontaine 2009) reported on the experiences of, among others, student pediatric nurses.

Table 2 Study characteristics goes here

Study methodology

Nine studies used a qualitative methodology, all employing thematic analysis to make sense of data with the exception of Ion et al. (2016) who employed discourse analysis. Erdil and Korkmaz (2009), Mansbach et al. (2013) and Mansbach et al. (2014) all used quantitative methods, while Rees et al. (2014) and Green and Garland (2015) used mixed methods approaches. All studies drew on convenience samples, with all but three (Monrouxe et al 2014., Rees et al. 2015 and Levett-Jones and Lathlean 2008) recruiting participants from a single University or School of Nursing.

Study aims

Levett - Jones and Lathlean (2009), Bellefontaine (2009), Ion et al.(2015), Garland and Green (2015) and Bickhoff et al. (2016) aimed to describe factors which students identified as influencing their decisions to report or not report poor care. Ion et al. (2016) further examined the function of arguments provided by students for and against reporting. Chockwe and Wright (2011), Erdil and Korkmaz (2009), Yeh et al (2010), Monrouxe et al (2014), Rees et al (2015), and Wojtowicz et al.(2014) all described students' encounters with professional dilemmas or practices which caused moral distress many of which constituted poor clinical

practice. In contrast, papers by Mansbach et al. (2013, 2014) used hypothetical scenarios to examine how students said they would respond to unprofessional behaviour which would impact on patient care. In the first, the authors considered students' willingness to report wrongdoing by a colleague, and in the second compared student and registrant willingness to report unethical behaviour.

Study quality

With the exception of Green and Garland (2015) all other qualitative (n=8) studies were judged to meet at least 50% of the quality indicators. Five met at least ten of the fourteen indicators, and one (Rees et al, 2015) met all 14. More limited studies provided less information about study design, data analysis and informed consent. Of the three quantitative studies, two (Mansbach et al. 2014, Mansbach et al. 2013) met 50% of the quality indicators, with the remaining work (Erdil & Korkmaz, 2009) meeting fewer. Failure to justify sample size, lack of independence from routine practice, and failure to discuss generalizability were limitations. The mixed methods study by Monrouxe et al. (2015) addressed thirteen of the sixteen identified indicators. Tables 3, 4 and 5 below provide more detail of the critical appraisal of each paper.

Table 3 goes here

Table 4 goes here

Table 5 goes here

Thematic analysis

Four themes were identified in the process of meta-synthesis: witnessing poor practice, reporting poor practice, factors influencing reporting, and impact on the student. Each theme is discussed in the following paragraphs.

Reports of observed poor practice were made by participants in Australia (Levett-Jones & Lathlean 2008, Bickhoff et al. 2016), Canada (Wojtowicz, et al. 2014), Turkey (Erdil & Korkmaz 2009), Taiwan (Yeh et al 2011) South Africa (Chockwe & Wright 2011), and the UK (Bellefontaine 2009, Monrouxe et al 2014, Rees et al 2014, Ion et al 2015, Ion et al 2016 and Green & Garland 2015). Some of the poor practice reported does, taken at face value, warrant the label of abuse, and, if reported to the relevant professional body and subsequently proven, would likely lead to significant sanctions for the perpetrator. For example, Chockwe and Wright's [2011) participants reported witnessing registered midwives in South Africa disregarding the cultural practices and wishes of pregnant women, neglecting a recently bereaved and traumatized mother, verbally abusing patients, and forcing of a pregnant women to clean up her own vomit. Other observed practices included patients being left lying in wet sheets, and a nurse admonishing a patient who had been faecally incontinent (Erdil and Korkmaz, 2009); failure to follow basic infection control protocol when removing sutures (Monrouxe et al.,2015); a registered nurse kicking a dying woman's bed (Rees et al, (2015); and a therapeutically sterile atmosphere dominated by the use of medication and intimidation to ensure compliance with treatment (Wojtowicz,et al., 2014).

Where students were asked to indicate how they would respond to poor practice described in case vignettes (Mansbach et al., 2013, 2014) they reported high levels of intent to report their concerns, and were significantly more likely to say they would whistle blow externally than their registrant colleagues. In contrast, in studies where students were asked about how they had responded in real life encounters with care failure, there was clear evidence that they sometimes chose not to report it. With the exception of studies where participants were sampled purposively because they had reported, only Rees et al. (2014) noted that the majority of their participants took action in the face of concerns. However, the lack of detail

supplied limits conclusions about the extent and nature of this inaction. In Green and Garland's (2015) study, in which all (*n*=5) participants had witnessed and reported issues of concern, students also said they were aware of peers who had witnessed, but not reported, poor practice. Participants in Ion et al. (2015, 2016) included those who did and did not report poor care and it was apparent from a number of other studies that reporting of concerns did not always occur (Bellefontaine, 2009; Levett-Jones & Lathlean, 2009; Rees et al., 2014; Monroe et al., 2014; and Wojtowicz, 2014). Neither Erdil and Korkmaz (2009) nor Yeh et al. (2011) directly focused on whether students reported poor care, however, their accounts of very hierarchical practice environments suggests that non-reporting is probably common. In contrast, at least one participant in Chockwe and Wright's (2011) study reported unethical practice to a manager only to note that this action proved futile. Green and Garland (2015) and Ion et al. (2015, 2016) were the only researchers to consider whether or not there might be differences between reporters and non–reporters. The former, using the Leadership Effectiveness Analysis Questionnaire (Management Research Group 2007) and drawing on a very small sample of four students who had reported poor care and eight who had not, found that those who raised concerns saw themselves as more likely to question the status quo, as being comfortable with making decisions, and also as more able to form relationships at work than their non-reporting counterparts. Studies by Ion et al. (2015, 2016) noted that those who raised concerns explained their actions by their adherence to a personal moral position and/ or a commitment to a professional code of practice.

Six papers directly addressed the question of whether decisions to report poor care were influenced by factors other than the incident itself. Students' reluctance to place themselves in conflict with permanent staff, which, some felt, might potentially affect placement assessments and future career prospects, and their desire to belong by complying with local

norms, made them less likely to challenge or report poor clinical care (Levett-Jones & Lathlean 2008; Bellefontaine, 2009; Ion et al., 2015). Students were sometimes skeptical about the likelihood of change occurring as a result of whistle blowing, or had self-doubt about whether the index incident constituted poor practice; conversely, those who reported poor practice attributed their actions to a personal commitment to professional guidance or a strongly held moral position about what constituted acceptable. These findings are very similar to those described by Bickhoff et al (2016) who saw individual moral courage and an acceptance of the responsibility of the nurse to the patient as the driving force. The individual's personal moral positon was also discussed by Ion et al.(2016) who argued that the actual function of the stated reasons, namely attribution to internal characteristics such as moral beliefs about the right course of action for reporting concerns, for those who had done so actually served to show themselves in a positive light. In contrast those who did not report their concerns accounted for their decisions with reference to external factors over which they had little or no control. They presented a case in which they portrayed themselves as blameless insofar as they had acted as any other reasonable person would when confronted by a situation in which they were effectively powerless. Interestingly, and in contrast to the findings of Green and Garland (2015), the argument that the reporting process was unclear was never deployed. However, in studies by Ion et al(2015) and Green and Garland (2015) participants made it clear that the quality of their relationship with academic staff was an influencing factor with the suggestion that poor relationships reduced the chance that a student would report

Students encountering poor practice reported negative consequences, both when they subsequently reported or did not report it. In Levett-Jones and Lathlean's (2009) study this was exemplified by students' adoption of negative behaviours and poor practice as a

consequence of their desire comply with group norms. Wojtowicz, et al (2014) reported poor practice was a source of moral distress for students and also noted that, for some participants, it resulted in their unwillingness to pursue a career in the specialty where they witnessed poor care. To illustrate the emotional implications of encountering poor practice, Monrouxe et al. (2014) focused on a single case example of a student nurse who reported the observed poor practice and continued to experience guilt and distress as a result more than a year later. Rees et al.(2015) reported a range of negative emotional responses to the witnessing of poor care, including, anxiety, stress, and disgust. Participants in Ion et al. (2015, 2016) also described difficulties including sleep loss, demoralisation, guilt, and self-doubt. Those in Green and Garland's (2015) study indicated a degree of personal discomfort and dissonance on encountering and responding to poor practice although, interestingly, some students who reported noted that the commonly perceived negative consequences of reporting did not always materialise. Like participants in the Ion et al. (2015) and Bickhoff et al. (2016) studies, some also felt well supported by academic staff.

DISCUSSION

While we should be cognizant of the small number of studies in this area area and the very different cultural terrains in which data were collected, this should not lead us to believe that poor care is not problem – our findings are consistent with the wider literature that confirms that it is. The review indicates that students do encounter poor care on practice placement, that it occurs across national boundaries, and in a diverse range of settings. As potential patients and relatives of patients, this should cause us concern - these are the services which we are all likely to use in due course. As professionals and educationalists we should also be troubled. Regulatory bodies across the world assert that practice placement is a key component of the learning experience, and that it is the place where students are socialised into the profession. In cases where students encounter poor care we should therefore

legitimately ask what are they learning, and in what ways does this prepare them for the demands of the current and future workplace? It may be that students learn from all experience — both good and bad - but it would be misleading and cynical to believe that anything other than very occasional exposure to poor practice, which is then subsequently well-managed, is likely to result in better quality nurses and midwives of the future. Given that exposure to poor placement experience is associated with burnout and attrition (Eick et al 2012) it may be that some neophyte practitioners are not only being deprived of a quality learning experience, but may also be inadvertently encouraged to leave the profession as a result of their experiences.

Like many of their registrant colleagues (Jackson et al.2014), not all students who encountered poor care reported it. This is at odds with the findings of Mansbach et al. (2013, 2014) whose participants indicated a clear ability to identify poor practice in clinical vignettes and a very strong willingness to bring it to the attention of others. This does call into question the ecological validity of studying this complex phenomenon through hypothetical scenarios. In light of the frequency with which studies reported that students opted to ignore poor care, it is difficult to conclude anything other than that the perceived need for self-preservation is sometimes privileged over the professional expectation to always act in the best interests of the patient. The tendency toward self-interest is understandable and although it explains why people may behave in a way which promotes, or at least maintains their own position, it does not excuse the failure to protect the vulnerable other, which is the consequence of not reporting poor care. In this context, findings by Green and Garland (2015) that negative consequences did not always materialise for those who reported concerns are important and suggest that an open reporting culture could be sustained. Findings from a number of studies that students' supportive relationships with university

tutors were instrumental in reporting suggest that further development of links between practice settings and the higher education institutions could prove fruitful. The findings of Ion et al. (2015) and Ion et al. (2016a) suggest that it may be fruitful to consider whether reporting might be promoted by providing evidence to students that positive action makes a difference, and also by taking steps to help them better understand the issue of professional accountability.

The factors that reportedly influence decisions about whistle blowing were in line with findings from studies which explore the issue among registrants (Jackson et al. 2014) Students can, in the main, correctly recognise poor care, and they know how to report it. However, they also understand the potentially damaging consequences of whistleblowing and fear that these may impact future career prospects, current grades, and relationships with mentors and significant others. Some are also cognisant of the possible futility of reporting. Despite this, there is evidence that some students choose to take the risk associated with speaking out. Adherence to codes of practice and /or a commitment to doing the right thing appear to drive these decisions. According to Ion et al. (2016), both those who did and did not report concerns were careful to present themselves in the best possible light. The former indicating that their decisions were driven by internal characteristics and a developing professionalism, while the latter accounted for their omissions by constructing an argument which portrayed their decision as possibly regrettable but also highly understandable under the circumstances. This finding is consistent with social psychological theory around the concept of self-serving bias (Allison et al 1989, White & Plods 1995) and suggests that these theoretical elements should form a key part of educational interventions around whistle blowing. In addition, a degree of consequential psychological discomfort was not uncommon even for those who did not report their concerns. It seems that, regardless of what they do,

once they encounter poor care some students will experience a level of distress. Again this is consistent with the whistleblowing literature in general (Wilkes et al.2012) and suggests that students need to be prepared specifically for this and to explore ways of responding to it.

Limitations

This review has a number of limitations. First, we only included English language studies which may limit the number of relevant papers. Second, our review revealed that there have been relatively few studies on this topic; the majority drew on small samples and, overall, quality was varied. As such, readers should be cautious about the generalisability of our findings. In addition while there is evidence that students encounter poor care, in the absence of any survey data in a range of settings, we can make no claims about how widespread or otherwise this might be.

Conclusions

In bringing together research evidence from a range of different settings in eight countries, this paper indicates that students are aware of the issue of poor practice and that some have personally witnessed very poor care . The relative recency of the work suggests that this may be an emerging problem. Further, the UK focus of six of the thirteen identified papers may reflect some of the problems which have been highlighted in that country's health services in recent years (e.g., Francis, 2013). It could equally, of course, be argued that this level of inward scrutiny is evidence of a robust culture of reflection which makes future care failure less likely.

The fact that students can recognise poor care when they see it, and that some at least are prepared to speak out against it, should provide some comfort to current and future service users and a degree of support for the argument put forward by Francis (2015) that students bring an untainted perspective to the clinical environment which in turn may militate against

the prolongation of negative cultures of care (Paley 2013, 2014; Timmins & De Vries 2014). When they do this, they should be listened too. Some students expressed reluctance to report as they felt that there would be no point as nothing would change. Faugier and Woolnough, (2002) in their description of care failures reported by UK nursing students confirm these fears noting that although the concerns raised by students were investigated, it was over two years and following additional reports by temporary staff before effective action was taken to address the abusive culture that existed in one of the Trusts' mental health wards.

The perceived potential costs of reporting concerns are all too clear to students. To paraphrase Duffy et al. (2012), perhaps we are asking too much to expect that students will call out poor practice when they come across it. The potential physical and psychological negative consequences of speaking out have been noted earlier (Jackson et al 2014). It is important, therefore to consider Glasper's (2015) point that, if we expect students to raise concerns, we need to take steps to support and protect those who do so. This should involve the provision of clear guidance which students, educators and practitioners can follow when they encounter problems of this nature. These should be underpinned by a commitment to support and protect those who report and to take seriously their concerns by both investigating them and providing information on the outcome of such investigations. Without this and in the absence of evidence that reporting results in positive change, it seems likely that for some, the view will persist that reporting is not only a high risk activity, but also futile.

In view of the very clear professional expectation that those in training will report poor practice, it is worth considering why, despite the many reasons given for not doing so, some choose to take this difficult course. What little evidence we have appears to suggest that it may be driven by a commitment to a moral and /or professional code. However, it is unclear if students enter training with this commitment, or whether it is developed over their time in

education. This is an important matter which cuts to the heart of the question of the extent to which education programme providers should rely on values-based recruitment, or whether students can be educated to become positive moral agents. Finally, despite the importance of the topic this is an area which remains under explored. Future research might focus on determining the extent to which students encounter poor care, where they encounter it and how best they can be supported to report it .In considering this it would be useful to develop a better understanding of those who speak up, and the outcome of these actions for those individual, and for patients. It would also be helpful to know more about what students perceive to be poor care and whether this changes over time as they progress toward registration.

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Encounters with poor care: systematic review

Table 1 search example (CINAHL)

Domain	Search term	No of hits
Population	student* AB	38868
	nurs*	68433
	midwi* AB	4215
	trainee AB	641
	novi* AB	1093
	cadet AB	31
	Intern* AB	366
	(S2) OR (S3) OR (S4) OR (S5) OR (S6) or (S7)	72596
Focus	(S1) AND (S8)	9637
	whistle blowing AB	32
	"blow the whistle" AB	26
	rais* AB	22811
	concern AB	72609
	moral* AB	7025
	distress* AB	20975
	unprof* AB	167
	report* AB	88344
	"poor care" AB	160
	"ethical dilemma*"	1265
Population and Focus	(S12) AND (S13)	4889
	(S14) AND (S15)	422
	(S13) AND (S17)	5068
	(S10) OR (S11) O (S16) Or (S18) OR (S19) OR (S20) OR (21) OR (S22)	11597
	(S9) AND (S23)	146

Table 2 Characteristics of included papers

Author	**Country**	**Aim**	**Sample**	**Method**	**Sub-themes**
Bellefontaine 2009	UK	Explore influences on student decision to report / not report poor care	N = 6 Nursing students	Semi-structured interview	Encounter with poor practice Influences on reporting / not reporting: relationships with mento likelihood of support from clinical and / or academic staff, confi and knowledge, fear of being failed.
Bickhoff, Levett-Jones &Sinclair	Australia	Explore how students demonstrate moral courage when they encounter poor care	N=8 Nursing students +1 recently qualified nurse	Semi- structured interviews	Influences on decision to report include; commitment to professionalism and role as patient advocate, desire to prevent n consequences to patients, accepting potential negative consequer choosing when to raise concerns. Accountability accepted. Impact of not reporting might include, psychological distress, sleeplessness, negative consequences for patients. Reporting is an act of moral courage.
Chockwe & Wright 2011	South Africa	Explore learner midwives encounters with caring and uncaring practice	N=76 Midwifery students	Diaries and focus group x 2	Examples of encounters with poor care included abuse and negle pregnant woman and new mothers Impact on student of witnessing poor care Potential for poor role models to influence future student practic
Erdil & Korkmaz 2009	Turkey	Explore student encounters with ethical dilemmas in practice	N=143 Nursing students	Survey with open questions	Encounters with abuse, neglect and privacy breaches Impact on student of encountering poor care

Green & Garland 2015	UK	Explore reasons students had reported poor care. Examined differences in leadership styles of those who reported and those who had not	N= 5 Nursing students N = 12 Nursing students	Semi- structured interviews Questionnaire	Influences on reporting Reporting is a choice Some students opt not to report Differences in leadership characteristics of reporters and those w never reported. Reporters saw themselves as socially confident, easier to challenge status quo and comfortable with decisions ma Those who had never reported saw themselves as more reserved to minimize risk and the status quo
Ion et al. 2015	UK	Explore factors influencing decisions to report	N=13 Nursing students	Semi- structured interviews.	Moral and professional factors influenced decisions to report. Reporting is a choice with some opting not too Potential consequences of reporting perceived to be negative Absence of personal accountability Impact on student
Ion et al. 2016	UK	Explore discursive strategies used to explain decisions to report / not report	N = 13 Nursing students	Semi- structured interviews.	Students took care to explain their actions and omissions in term reporting in a way that cast them in a favourable light. Absence of personal accountability
Levett-Jones & Lathlean 2008	Australia & UK	Explore extent to which need to belong accounted for reluctance to report poor practice	N = 24 Nursing students	Semi- structured interviews.	Student need to ‘fit in ‘ and ‘belong’ Reporting is a choice

Mansbach et al. 2013	Israel	Compare student and registrant willingness to report wrongdoing by a senior colleague	N = 82 (Nursing students) and N = 83 (Registrants)	Vignette with responses via multiple choice questionnaire.	Like registrants, students able to recognise unacceptable conduct believe they would report this. Accountability accepted
Mansbach et al. 2014	Israel	Assess students willingness to report wrongdoing by a senior colleague	N = 82 Nursing students	Vignette with responses via multiple choice questionnaire.	Students able to recognise unacceptable conduct and believe they report this Accountability accepted
Monrouxe et al. 2014	UK	Explore encounters with professionalism dilemmas	N = 13 Nursing students	Individual and group interviews	Emotional impact on student of witnessing poor practice Dilemma of what to do
Rees et al. 2014	UK	Describe most significant professionalism dilemmas	N= 294 Nursing students	Online survey collecting narrative data	Emotional impact on student of witnessing poor practice Recognising poor care
Wojtowicz et al 2104	Canada	Describe experiences of moral distress encountered on mental health rotation.	N = 7 Nursing students	Semi- structured interviews	Impact on student Negative influence of witnessing poor practice on career choice Powerlessness and futility of reporting – nothing will change Recognising poor care
Yeh et al 2010	Taiwan	Explore ethical issues encountered on practice	N= 44 Nursing students	Focus groups	Student powerlessness and its impact on reporting Recognising poor care

Table 3: Critical appraisal of qualitative studies

	Explicit aims	Qualitative method appropriate	Design appropriate	Recruitment strategy appropriate	Setting of data collection described	Data collection methods clear	Questions/ schedule included	Ethics discussed	Consent discussed	Description of analysis	Relationship considered	Clear statement of findings	Clarity of themes	Research valuable	Total score (max. 14)
Bellafontaine 2009	+	+	-	+	-	+	+	-	-	-	+	+	+	+	8
Chockwe & Wright 2011	+	+	-	+	+	-	-	+	-	-	-	+	+	-	7
Green & Garland 2015	+	+	-	-	+	-	-	+	-	-	+	+	-	-	6
Ion et al 2015	+	+	+	+	-	+	-	+	-	+	-	+	+	+	10
Ion et al 2016	+	+	+	+	-	+	-	+	+	+	-	+	+	+	11
Levett- Jones & Lathlean 2008	+	+	+	+	+	-	-	+	+	-	-	+	+	+	10
Rees et al 2014	+	+	+	-	+	+	+	+	+	+	+	+	+	+	14
Wojtowicz et al 2013	+	+	+	-	+	+	+	+	+	+	+	+	+	+	13
Yeh et al 2010	+	+	+	+	+	+	+	-	+	+	-	+	+	+	12

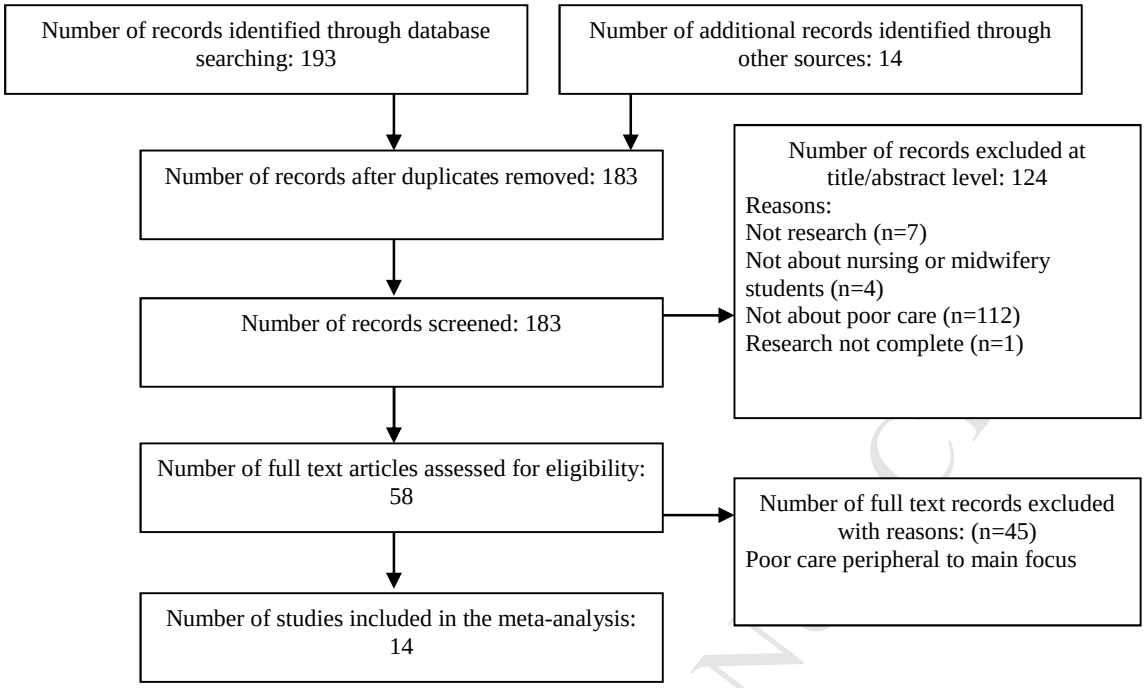
Table 4: Critical appraisal of quantitative studies

	Erdil & Korkmaz 2009	Mansbach et al 2014	Mansbach et al 2013
Explicit aims	+	-	+
Sample size justified	-	-	-
Research independent of routine practice	-	-	-
Well described sample	-	+	+
Representative sample	-	-	-
Explicit inclusion/exclusion criteria	+	+	-
High response rate (50+)	+	+	+
Instrument development described	-	+	+
Validity and reliability justified	-	+	+
Question wording available	+	+	+
Discussion of generalisability	+	-	-
Statement of funding source	-	-	-
Total score Max 12	5	6	6

Table 5: Critical appraisal of mixed methods studies

	Total score Max 16	13	
Integration	Consideration of limitations of integration	-	
	Integration of data relevant	+	-
Qualitative	Relationship with data considered	+	-
	Recruitment strategy appropriate	+	x
	Method appropriate	+	x
	Method described	+	x
	Role clear	+	x
Quantitative	Clear inclusion / exclusion criteria	+	-
	Representative sample	-	-
	Method appropriate	+	-
	Method described	+	X
	Role clear	+	-
Mixed methods	Design for mixing methods described	-	X
	Mixed method justified	+	X
	Mixed method appropriate	+	X
	Explicit aims	+	X
		Monrouxe 2015	Green & Garland

Figure 1 : Flow diagram of literature search: Modified from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement flow diagram (Moher et al., 2009).



Highlights

Student nurses and midwives encounter poor clinical care while on practice placement.

Evidence indicates that this occurs across national boundaries and specialties.

A number of barrier to raising concerns about poor care are described, along with factors which promote reporting.

Action should be taken to increase awareness of the importance of dealing with poor care and the student role in this.

Future research should explore the prevalence of this phenomenon and the steps that might be taken to ensure that students are fully equipped to play their part in tackling patient safety issues.