Submitted in fulfilment of Doctorate in Health Science.

Online social networks and the pre-registration student nurse: a focus on professional accountability

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November 2017

CONTENTS

Acknowledgements ... vii

Abstract ... viii

Glossary of terms ... x

List of figures & tables (chapter number-item number) ... xi

Chapter 1 Background & Rationale ... 1

1.1 Personal Reflection ... 2

1.1.2 The '5 rules' ... 2

1.1.3 The positives: socialisation of Facebook ... 6

1.1.4 How I came to the research topic ... 8

1.2 Credibility as a researcher ... 10

1.2.1 Intellectual rigour: my assumptions about Facebook and accountability ... 10

1.2.2 Professional integrity: why accountability is important to me? ... 12

1.3 Research question, aims and objectives ... 16

1.3.1 Research Question ... 16

1.3.2 Aims ... 16

1.3.3 Objectives ... 16

1.4 Theoretical principles of professional accountability, socialisation & OSNs ... 17

1.4.1 Professional accountability in nursing ... 17

1.4.2 Social capital & professional socialisation in the context of OSNs ... 20

1.4.3 Socialisation ... 21

1.4.4 Professional socialisation ... 22

1.4.5 Online Social Networks ... 23

1.4.6 Facebook ... 23

1.5 Significance of the research question for pre-registration nursing ... 25

1.5.1 Professional accountability and Facebook ... 25

1.5.2 Significance to pre-registration nursing ... 28

1.6 The scope of this research ... 29

1.7 Outline of this thesis ... 30

1.8 Chapter summary ... 31

Chapter 2 Literature Review ... 32

2.1 Introduction ... 32

2.2 A summary of Facebook ... 34

2.2.1 Use of Facebook ... 34

2.2.2 The 'visible-invisible' complexities of Facebook ... 36

2.2.3 Boundary Management on Facebook ... 37
2.3 E-professionalism, e-accountability and Facebook ... 42
2.3.1 e-professionalism & e-accountability ... 42
2.3.2 Who says what's unprofessional? ... 43
2.4 Chapter summary ... 46
Chapter 3 Study design and justification ... 48
3.1 Introduction ... 48
3.2 The nature of research philosophy ... 50
3.3 The four paradigms: a focus on post-positivism ... 52
3.3.1 Post-positivism ... 52
3.3.2 Roy Bhaskar's [post-positivist] critical realism ... 55
3.4 Justification for post-positivism and Bhaskar's Critical Realism ... 61
3.4.1 Rejection of positivism ... 62
3.4.2 Rejection of Interpretivism ... 65
3.4.3 Rejection of Critical Theory (CT) ... 67
3.5 Methodological choices in post-positivism: a focus on ethnography ... 69
3.6 Justification for ethnography ... 71
3.6.1 Rejection of critical realist evaluation ... 72
3.6.2 Rejection of action research ... 73
3.6.3 Rejection of quantitative evaluation ... 75
3.7 Ethnography ... 76
3.7.1 Realist Ethnography ... 76
3.7.2 Justification for Critical Realist Ethnography ... 77
3.7.3 Why CRE and not just 'ethnography'? ... 78
3.8 Whose Critical Realist Ethnography? ... 81
3.8.1 Hammersley & Porter ... 81
3.8.2 Rees & Gatenby ... 83
3.9 Chapter summary ... 85
Chapter 4 Research Methods ... 87
4.1 Introduction ... 87
4.2 Critical Realism applied to methodological choices ... 88
4.2.1 Sampling frame ... 89
4.2.2 Data collection in CRE ... 90
4.3 Approach to Semi-structured interviews ... 93
4.3.1 Semi-structured interview sampling, sample population & sampling frame ... 93
4.3.2 Recruitment to semi-structured interviews ... 95

4.3.3 Semi-structured interviews: instrumentation 95
4.4 Approach to focus groups 98
4.4.1 Sampling, sampling frame and recruitment 98
4.4.2 Focus groups: instrumentation 99
4.5 Approach to unstructured, non-participant observation 100
4.5.1 Observation sample population & sampling frame 102
4.5.1 Data collection 103
4.6 Method of analysis 106
4.7 Ethical considerations 110
4.8 Rigour 111
4.8.1 Rigour in critical realist ethnography 111
4.8.2 Transparency 113
4.8.3 Accuracy 114
4.8.4 Purposivity 114
4.8.5 Utility 115
4.8.6 Propriety 116
4.8.7 Accessibility 116
4.8.8 Specificity 116
4.8.9 Modified Objectivity 117
4.9 Chapter Summary 118
Chapter 5 Findings & discussion 119
5.1 Introduction 119
5.2 Participant characteristics and data components 123
5.2.1 Semi-structured interview participant characteristics 123
5.2.2 Focus group data 123
5.2.3 Observation data 124
5.2.4 Overview of components found in stage 2 of analysis 126
5.3 Development of Framework I, SPO: Socialisation-Professional socialisation-Online socialisation 127
5.3.1 How do pre-registration nurses perceive professional accountability? 129
5.3.2 How do pre-registration nurses develop professional accountability as part of the journey of professional socialisation? 132
5.3.3 Making decisions as part of the process of analysis 145
5.3.4 Theory II: Primary, secondary and online socialisation & social capital 155
5.3.5 An applied example of the SPO framework 165
5.4 Development of Framework II UAPU: Unacceptable-Acceptable-Professional-Unprofessional 167

5.4.1 Pre-registration nursing student's perceptions of Facebook 168
5.4.1.2 Motivations, reasons and patterns of use of Facebook 180
5.4.2 Behaviours on Facebook and influential factors 184
5.4.3 Development of Framework II, UAPU using theory II & III 212
5.5 Development of Framework III A2A: Awareness to Action 224
5.5.1 How Framework III, A2A will work in practice 229
5.5.2 Summary of findings: The application and impact of the three frameworks 238
5.6 Chapter summary 240
Chapter 6 Conclusion 242
6.1 Introduction 242
6.2 Study Limitations 244
6.2.1 Lessons learned 245
6.3 Response to the research question 247
6.4 Personal reflection: where have I been and where I am going? 249
6.4.1 Where have I been? The '5 rules' revisited 249
6.4.2 Where am I going? 251
6.5 Chapter summary 253
6.6 Thesis conclusion 254
Final words 259
References 264
List of appendices 288
Appendix 1 - Theoretical framework for professional socialisation (Weidman *et al*, 2001)2889
Appendix 2 - Literature review search terms and selection criteria (Healthcare Specific) ... 290
Appendix 3 – A summary of included literature 291
Appendix 4 – Boundary management (Ollier-Malaterre *et al*, 2013) 306
Appendix 5 – NMC competency hearings scoping search (2004-2014) 307
Appendix 6 – Summary of philosophical paradigms 309
Appendix 7 – Typology of theory 310
Appendix 8 – Comparison of inductive, deductive and retroductive reasoning 311
Appendix 9 – Defence against the challenges of critical realism 312
Appendix 10 – Facebook demographics 316
Appendix 11 - Intensive versus extensive research design and methods 317
Appendix 12 – Semi-structured interview schedule of prompts 318
Appendix 13 – Focus group inclusion, exclusion criteria 319
Appendix 14 – Focus group schedule of prompts 320
Appendix 15 – Ethical approval 321

Appendix 16 – Dissemination strategy 327
Appendix 17 – Semi-structured interview participant characteristics 328
Appendix 18 – Focus group participant characteristics 330
Appendix 19 – Components found in the data 331
Appendix 20 – Framework III: Awareness to Action assessment process 332
Appendix 21 – Summary of research process 354

ACKNOWLEDGEMENTS

"It's supposed to be hard. If it wasn't hard, everyone would do it. The hard is what makes it great."[1]

An ode of doctoral gratitude.

A journey of four (or more) years to weather a doctoral degree.

For the debate, the words of wisdom when I'm down, and sharing the 'writing' pain,

for compelling me to read (and read and read) … about philosophy (chapter 3)!

Muchas gracias to my supervisors (particularly Jane).

Almost two decades, all in all (we'd get less for a crime)!

For indulging my frustrations and my [serious] procrastination.

For picking me up during (many) a fall, for being my rock during the climb.

Merci beaucoup à mon mari et mon 'petit amour', my Richard; for your dedication.

Thirty-six years (including this four); the journey of a lifetime.

You gave me values, principles and potential; you are my foundation.

For your unquestionable, unconditional love, for being so proud; I'm glad that you're mine...

To my mum (last but not the least) I give my love, my gratitude, my appreciation.

"Life's a journey, not a destination"[2]

To the future…

[1] (A League of Their Own, Tom Hanks)

[2] ('Amazing', Aerosmith)

ABSTRACT

Background & rationale: The rapid diffusion of social network sites such as Facebook have presented a wealth of challenge and opportunity for the nursing profession. A large majority of student nurses have adopted Facebook but [as developing professionals] may not understand the implications and unintended consequences of the information shared in a personal or innocent way.

No research has yet critically analysed or explained [in depth] the underlying factors that influence and determine the relationships between professional accountability and social media or if there is actually a 'problem' with social media, and if there is explain how we can address it.

Aim: Explain the context and relationships between professional accountability and Facebook for the pre-registration student nurse during their journey of professional socialisation.

Methods: Critical realist ethnography employing focus groups (academic and practicing nursing staff n=8), semi-structured interviews with student nurses over two geographical sites (n=16) supported by online observation of three cohort groups, 30 public profiles and professional group discussion topics.

Results: Six overarching models were explored, 1) the concept of professional accountability, 2) patterns of use, 3) behaviours and activities, 4) physical versus online reality, 5) unacceptable, acceptable, professional or unprofessional behaviours and, 6) perceived knowledge and awareness versus actual behaviours.

To explain the relationship between the pre-registration student nurse, Facebook and accountability three frameworks were developed. The first, Socialisation-Professional socialisation-Online socialisation (SPO) explains the journey of socialisation and the relationship between the online and physical world. Unacceptable-Acceptable-Professional-Unprofessional (UAPU) explains the complex nature of Facebook behaviours and how

individuals understand the difference between the concept of unprofessional and simply unacceptable. The final framework 'Awareness to Action' takes the principles from the previous two frameworks and outlines a proactive tool to raise awareness of online profiles and, a reactive tool using 'the 3Cs' (clarity, context & confirmability) to make [professional] decisions about behaviours and incidents in the online environment.

Conclusion: The relationships between the accountability, Facebook and the pre-registration student nurse are *individual, complex and evolving* (ICE). The very nature of socialisation means that this is based on *individual* background, experiences and values. Society and OSNs are *complex* environments which are changeable and, them and our relationship with them is continuously *evolving*.

A2A and its '3Cs' provides an assessment of self-efficacy, risk and decision-making tool to proactively [for nursing students] and reactively [for educators, employers and professional groups] manage self-awareness and behaviours in the online environment.

Glossary of terms

Term	Description
A2A	Awareness into Action assessment and decision tool
CR	Critical Realism
CRE	Critical Realist Ethnography
CT	Critical Theory
DoI	Diffusion of Innovation (Rogers, 2003)
DREI	Description, retroduction, elaboration/elimination, identification
EOI	Expression of interest
FtP	Fitness to practice/practise
HCP	Healthcare professional(s)
ICE	Individual, Complex, Evolving
NMC	Nursing and Midwifery Council
ONS	Office of National Statistics
OSN	Online Social Networks
PIN	Professional Identification Number
PIS	Participant Information Sheet
RCN	Royal College of Nursing
RN	Registered Nurse
RRRE	Resolution, re-description, retroduction, elimination
SCS	Strategic Case Sampling
SPO	Socialisation, Professional Socialisation, Online Socialisation
TAPUPAS(M)	Transparency, Accessibility, Propriety, Utility, Accuracy, Specificity (Modified Objectivity)
UAPU	Unacceptable, Acceptable, Professional, Unprofessional
UK	United Kingdom
USA	United States of America

LIST OF FIGURES & TABLES (CHAPTER NUMBER-ITEM NUMBER)

Chapter 1 – Background and rationale

Figure 1- 1 Professional socialisation (Weidman et al, 2001) 11
Figure 1-2 Professional accountability of student nurses (adapted from Griffith & Tengnah, 2004) 18
Figure 1-3 An OSN: how boundaries can overlap 26

Table 1- 1 Summary of chapter 1.. 1
Table 1- 2 Outline of this thesis 30

Chapter 2 – Literature review

Figure 2- 1 Iceberg Model adapted from Lovejoy et al (2009)... 37

Table 2- 1 Summary of chapter 2 contents 33

Chapter 3 – Study design & justification

Figure 3- 1 The historical context of post postivism and its influencers 53
Figure 3- 2 Differing perspectives (adapted from Dyson & Brown, 2006:38) 54

Table 3- 1 Summary of chapter 3 contents 49
Table 3- 2 Interaction between stratified domains of reality (adapted from Bhaskar, 2008)...... 58

Chapter 4 – Research methods

Figure 4- 1 Data collection & triangulation 91
Figure 4- 2 The flow of data collection and stages of analysis 108
Figure 4- 3 Measures of quality based on philosophical approach 111

Table 4- 1 Summary of chapter 4 contents 87
Table 4- 2 Sampling and data collection compared to the influences on professional socialisation... 89
Table 4- 3 How data collection and analysis will enable conceptualization of each domain of critical realism... 92
Table 4- 4 – Models of observation adapted from Spradley (1980), Rothstein (2001), Sotrin (1999), Kumar & Whitney (2003). 104
Table 4- 5 Detailed breakdown of stages of analysis.. 109
Table 4- 6 How purposivity has been achieved 115

Chapter 5 – Findings & discussion

Figure 5- 1 The analysis process and overview of results at each stage 120
Figure 5- 2 The three frameworks and how they interact 122

Figure 5- 3 Developing the SPO framework 127
Figure 5- 4 An example of how stage 4 analysis was conducted in order to explain the interaction of components found in the data 144
Figure 5- 5 Initial ideas about how accountability is perceived 147
Figure 5- 6 SPO framework: Socialisation-Professional socialisation-Online socialisation, ... 158
Figure 5- 7 Interdependence of values in the physical world during primary socialisation 159
Figure 5- 8 Interdependence of values during primary socialisation in OSNs (online) (digital natives) 162
Figure 5- 9 Interdependence of values for digital immigrants type II (did not have OSNs during primary socialisation) 164
Figure 5- 10 how UAPU relates to the findings of this study 167
Figure 5- 11 Stage 4 analysis: mapping the components of motivations and patterns of use of Facebook 181
Figure 5- 12 Motivation and reasons for use of Facebook across life domains 183
Figure 5- 13 Acceptable and professional values and impact on behaviour 206
Figure 5- 14 Unacceptable, Acceptable, professional, unprofessional: UAPU framework 213
Figure 5- 15 Diffusion curve of Facebook (Johnston, 2011) 215
Figure 5- 16 The Dunning Kruger effect (adapted from Kruger & Dunning, 1999 for illustrative purposes) 216
Figure 5- 17 The four stages to being 'expert' or being unconsciously competent 218
Figure 5- 18 The assimilation of Dunning-Kruger, impact of innovation and the ability to differentiate between unacceptable, acceptable, unprofessional and professional behaviours . 219
Figure 5- 19 The interdependence of values (competitive or co-operative) and how the online environment increases the likelihood of conflict 222
Figure 5- 20 Framework II, UAPU: Unacceptable-acceptable-professional-unprofessional 223
Figure 5- 21 How SPO, UAPU and A2A interact 224
Figure 5- 22 Moving from awareness to action on the confidence-competency-learning curve in UAPU 226
Figure 5- 23 Development of Framework III, A2A explaining the relationship and levels of awareness and action in relation to ‘risk’ 228
Figure 5- 24 (1-3) How A2A can be used to assess and make decisions about behaviours, actions and incidents relating to professional accountability 233
Figure 5- 25 My three frameworks and how they are related 241

Table 5- 1 Summary of chapter 5 contents 122
Table 5- 2 Description of observed behaviours 125
Table 5- 3 The person experiencing the world and its relation to my findings 197
Table 5- 4 How an individual positions themselves in the world 198
Table 5- 5 Summary of findings 239

Chapter 6 - Conclusion

Figure 6- 1 Response to my research question: ICE 248
Figure 6- 2 Five ‘refined’ rules 250
Figure 6- 3 Suggested five year plan 252

Table 6- 1 Summary of chapter 6 contents 243

Table 6- 2 A summary of this thesis and how it meets my study objectives and DHSci programme outcomes 256

CHAPTER 1 BACKGROUND & RATIONALE

This chapter will set the context and scope for this research investigating the nature of online social networks (OSNs), their relationship to professional accountability and as a result, professional socialisation of pre-registration student nurses. A summary of the chapter contents can be seen in table 1-1.

Table 1- 1 Summary of chapter 1

Chapter section	Content
1.1	Personal reflection
1.2	Credibility as a researcher
1.3	Research question, aims and objectives
1.4	The significance of professional accountability, professional socialisation & OSNs
1.5	Significance of the research question for pre-registration nursing
1.6	Focus and scope of the research
1.7	Outline of this thesis
1.8	Chapter summary

1.1 PERSONAL REFLECTION

My critical realist approach (discussed in section 3.3.2 p55) [and its principle of *modified objectivity*] means it is necessary to outline my personal assumptions about the topic of inquiry along with the origins of my research question.

The topic for this study originated as a result of my own personal and professional experiences of Facebook and my '5 rules' policy. These [unspoken] rules were as a result of my experiences but have since been reflected in Social Media guidance issued by Nursing & Midwifery council (NMC) (2016).

1.1.2 The '5 rules'

Facebook was launched in 2004. In its early years, I was relatively ambivalent to Facebook; the concept of sharing daily activities with those I did not engage with on a regular basis in my personal life, telling a range of 'friends' that "I've just baked a chocolate cake" via the internet just did not seem like an attractive or good idea; who exactly would engage with such information? It took 4 years before I yielded to repeated requests, "are you on Facebook?", "add me on Facebook?" and created an account, added some old photos and posted 'comments' once a month or so. In these early years the available privacy and security settings were 'questionable' in that the majority of information shared could be widely accessed by a whole range of people [not just friends] and, an update of settings by Facebook would 'reset' or 'default' to settings that favoured sharing. By this time, I had moved away from nursing and was a teacher in post-16/adult education, and when I first became aware of the potential issues with Facebook and professional-personal boundaries.

In the first months of an academic year I would receive friend requests from students and started to ask myself how 'appropriate' this was; students being able to view my photos, details about my personal life and activities outside of my professional role? Conversely, the risk of

'ignoring' the friend request could create offence [particularly with the adult students]. It was at this point I began to examine and redefine the privacy and security settings on my profile; this led to the start of my Facebook rules.

> Rule 1: personal-professional boundaries
> *Do not agree to have students as friends at least until they are no longer students in the organisation.*

This, for the most part was effective; boundaries were made explicit and my personal life remained [to a certain extent] 'personal'. Many of these students [having left the college] have since added me and we continue a 'relationship', particularly those who went on to complete their nursing or midwifery programme. Comes with this is the opportunity to continue being part of the person's journey; a journey I had contributed to. I would never previously have the opportunity or reward of knowing how successful some of these students could be and that I was a valued part of their journey.

My next dilemma was staff/colleagues. To what extent were the people I worked with 'friends' and did I want these people to view my personal information? Conversely, as Facebook became more popular I received 'friend' requests from school and university acquaintances, people who I had not spoken to for several years, people who were friends with or who worked with my husband, but also requests from complete strangers! This prompted me to consider the 'social' domain of life; how much did I want these people to know about me, and what would be the purpose? Yes, my colleagues are acquaintances; I did spend time with some of them but were they friends? The concept of 'friend' through Facebook is very different to the traditional concept. Facebook does not differentiate 'friend' 'acquaintance' or 'colleague'.

> Rule 2: personal-professional-social boundaries:
> *Assess each request on an individual basis; do not add anyone as a friend if you would not speak to them if you saw them in the street.*

As mobile technology improved and smartphones became accessible to the masses, I experienced increasing issues with social networks. Individuals were ‘always on’ the internet. Students were using smartphones during class. As staff, we were dealing with increasing numbers of cyber bullying and harassment incidents; where some students [notably, of all age groups] were posting offensive messages to fellow students or contacting them via private messages. The advantage here was that there was hard copy evidence of incidents that occurred! Many of the students just did not understand privacy settings, or that their actions could be deemed as ‘bullying’. It was so easy to interpret the written word in a way in which it was not intended. Alternatively, one group of students set up a ‘fake’ Facebook profile on my behalf as a ‘joke’ with photo-shopped pictures taken whilst I was teaching in class. This was done perfectly innocently, but these incidents raised my concerns about the accuracy or genuineness of Facebook, but also that my students clearly were not aware of the public nature of Facebook, the wider implications of their actions on my personal and professional life, or the security settings available; despite how aware and competent they said they were.

> Rule 3: personal-professional-social boundaries:
> *Assume that the information you choose to share on Facebook is public. Check privacy settings following a Facebook policy update and do not be afraid to use the ‘block’ function – be pro rather than reactive.*

Reflection on these incidents also forced me to consider how responsible I was as a teacher to educate students about Facebook and was the real starting point for this research project. At this point, they probably knew more about how to use it than me! There were certainly colleagues I worked with who completely rejected Facebook [and I still work with colleagues who feel the

same way]. However, it was widely used by students and I felt compelled to understand it, analyse its risks and potential benefits, rather than ignore it; it was not going away.

Given my experiences, I began restricting my privacy and security settings on a person-by-person basis[3] and also adding in my middle name on my profile to make it difficult to search for me if you did not know me that well, or if you were not 'friends' with my 'friends'.

> Rule 4: social boundaries:
> *Use the privacy functions available and spend time getting these 'right for the right people'.*

In 2009, my experience with Facebook became personal. Through no fault of my own, a family member's actions and use of Facebook had a catastrophic impact on my own life. Facebook had apparently facilitated two people to act in such a way that they never would have without social media. My response to this was to react using Facebook; sharing personal feelings and thoughts via my profile. Did this make me feel better? Yes, I felt alone and this led to a wealth of supportive, private messages from friends, and I would never have expressed these feelings on a face-to-face basis. However, everyone else who was a 'friend' also had access to my feelings and thoughts during a vulnerable time; the very reason why I would never say these things on a face-to-face basis with most of these people. But now, everyone now knows what happened at this time in my life and I'm not convinced that's what I really wanted. Conversely, each year at the same time a new 'time hop' function likes to send me a reminder of 'what happened that day'. While this is not something I enjoy reviewing it does reinforce the 'stasis' and timeless nature of information on Facebook!

[3] This was extremely time consuming at this point in time due to Facebook functionality. Nowadays, this process is much easier to manage.

Similarly, I have a close family member who has posted personal thoughts on Facebook after arguments in 'real life' and has wholly regretted it. Status updates are open to comments, comments which may not agree with your point of view, or may not understand the complexity of a situation. Status updates are not 'facts', nor are they reality. 'For example, the concept of 'fraping' where a person accesses a friend's profile and posts 'random' profile updates does [on first glance] have comedy value for some [particularly after intake of alcohol], however there are potentially devastating consequences; leading to long term relationship breakdown or at worst, legal action. Yes, there is the option to 'delete' a status update. However, smartphones and Wi-Fi internet access means that people can see an update as soon as it's posted and deleting a status does not guarantee it won't still be seen!

Rule 5: personal boundaries: be proactive NOT reactive:
Do not update your status or respond to others posts when upset, angry or intoxicated

1.1.3 The positives: socialisation of Facebook

Since I moved into a role in Higher Education on a full-time basis and as Facebook is becoming less 'novelty' and more habit and daily routine for the people who use it, I receive far less 'friend' requests that I have to ignore [given the 5 rules]. The aforementioned family member who posted personal comments and emotions has been observed following my '5 rules' [perhaps their own rules]. While they do often share political or religious views to prompt debate this frequently prompts 'healthy' rather than 'unhealthy' discussion between 'friends'.

Furthermore, I have since lead a research project that specifically seeks to engage patients and the public in disseminating research findings. Disseminating Research Information through Facebook & Twitter (DRIFT) is a Facebook group that aims to make scientific research findings understandable to patients and the public with a focus on paediatric Attention Deficit

Hyperactivity Disorder (ADHD) (Ryan & Sfar-Gandoura, *in press 2017*). Not only does this demonstrate the positive use of Facebook outside of a personal domain, it has followers from over 20 countries and has received a regional innovation award[4].

Another interesting observation is that individuals seem to be learning or 'socialising' into the acceptable and common practices of Facebook, I experience far less negative feelings and conflict. By 'socialisation' I mean,

> *"the process by which the objective world of reality is internalised and becomes subjectively meaningful"* (Jarvis, 1983: 88).

This is the process by which individuals learn, interact, develop and adapt to accepted 'social norms and values' as they grow into and throughout adulthood. Facebook has is a social interactive environment, and I believe, as it enters its second decade of existence, individuals and communities on Facebook are unconsciously developing 'rules' and OSN 'norms' in order to manage its use. Socialisation is a fluid, unique and individual process depending on the environment and social context someone is exposed to and how they respond to these. By the very nature of socialisation, I believe the risks and negative experiences I had on Facebook will become few and far between as these 'unseen' social norms develop. What intrigues me are the underlying reasons [mechanisms] creating these 'online social norms'. There is no Facebook 'law' or rulebook per se; Facebook transverses many cultures and communities where social norms in the physical world can be very different, so what is actually happening in the virtual world? What influences this, what is causing this progression?

[4] East Midlands Academic Science Network Innovation in Healthcare Award Winner (Mental Health) 2014

1.1.4 How I came to the research topic

Since returning to nursing, research and as a Senior Lecturer for pre-and post-registration nurses, these reflections led me to consider my 5 'rules'. My rules were developed based on my role as an educator, not a nurse. Ollier-Malaterre *et al* (2013) discuss similar online behaviours and 'rules' from OSN users not specifically to those from professions. Furthermore, these rules were developed as a result of an analytic and cynical mind; not everyone is like me or aware of their online behaviour to such an extent (Ollier-Malaterre *et al*, 2013). When individuals post status updates, they perceive they are doing so to 'friends', when in reality these may be people from their personal, social or professional life along with their 'friends' [and so on]. What seems to be an obvious risk to me may not to others; particularly the younger generation of pre-registration nursing students who may never have known a life without Facebook, social networks and the internet [known as digital natives (Prensky, 1999)].

Byrnes vs Johnson County Community College (2011), Grant (2013), Nursing Times (2013), Nyangeni *et al* (2015), CBC News (2016) & Kerr (2017) outlined incidents where nurses or student nurses have posted patient information, professionally inappropriate pictures, status updates or videos on Facebook which have been viewed by others and reported [the latter of which was implied to be positive, 'inspirational' and went 'viral'.] These reports continue globally despite professional guidance being issued (Ryan, 2016). It seems that professionals have embraced social media on a personal level, holding what are perceived to be 'personal' profiles they do not seem to approach it with the same caution as they would on a face-to-face basis and, as with Kerr (2017), emotions can clearly cloud our judgement about what we [individually and as a profession] deem to be 'unprofessional' behaviour[5]. As a nurse educator,

[5] I would challenge why a 'stranger' could see what they were saying in this conversation and also that this person may have been deliberately instigating a response (trolling) from them to which they were successful. Conversely, 'rants' and 'selfies' in uniform online (as in this report) are simply unprofessional but seem to be justified because it was in 'defence' of healthcare workers. To use Facebook in a professional, innovative and positive manner was criticised (see section 5.5.1)

responsible for facilitating the journey towards professional registration, and along with it, professional accountability (NMC, 2010; 2015) I began to ask how responsible I am in promoting appropriate use of social media by pre-registration student nurses. Currently, there are generic University based guidelines, the NMC (2016) and RCN (Cox, 2009) provides guidance on social media use but:

- To what extent they are aware of these guidelines?
- Does their perceived awareness reflect their privacy settings and online behaviours?
- Do online behaviours really impact on the professional and conversely, does Facebook impact on the person as a professional?
- What 'is' seen as acceptable online behaviour to and by the profession?
- Can the terms acceptable or appropriate be used synonymously with professional [and unacceptable as unprofessional]?

1.2 CREDIBILITY AS A RESEARCHER[6]

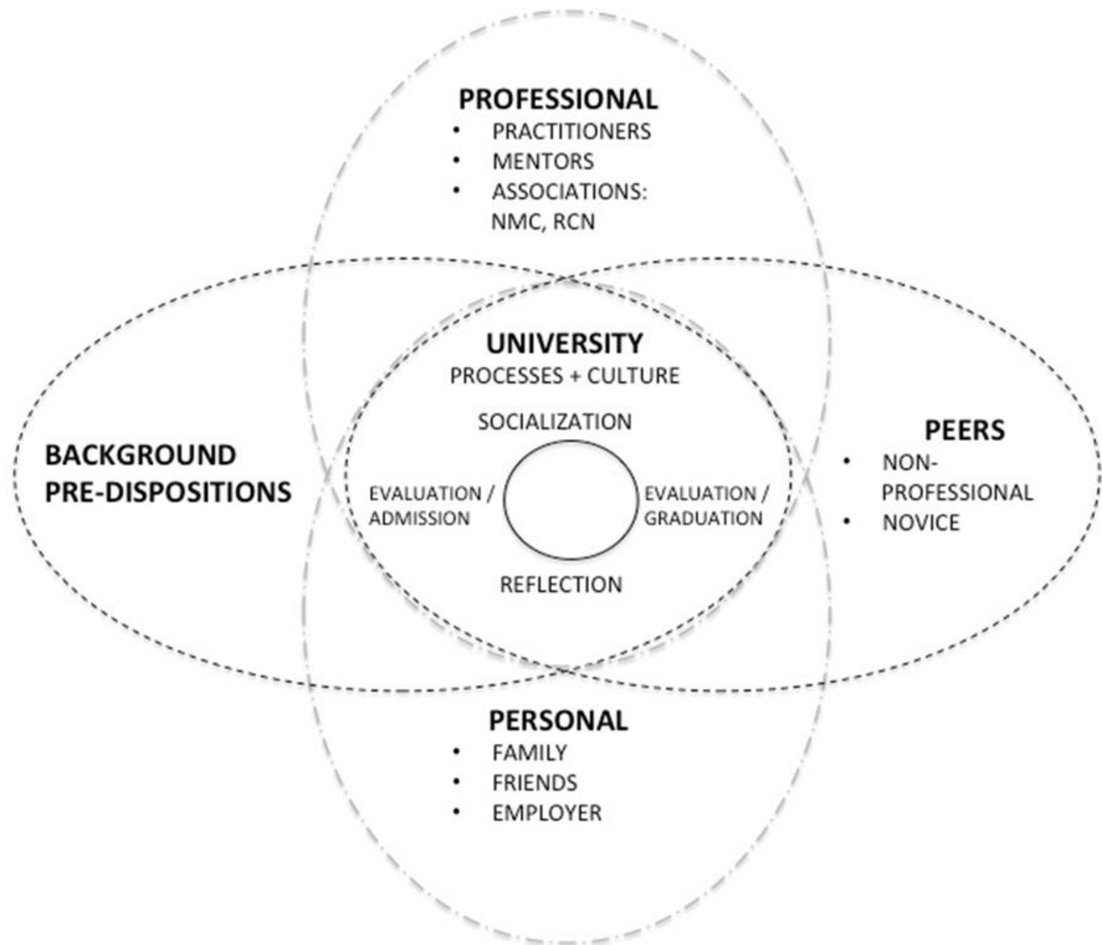
1.2.1 Intellectual rigour: my assumptions about Facebook and accountability

I believe that professional accountability is an inherent and core part of nursing and nursing practice. Without knowledge and understanding of professional accountability, the values of the profession cannot be upheld. Accountability is not only about actions and omissions but also about the consequences of our decisions as a professional and a person. I assert that our personal values and morals are that which lead us into the nursing profession and do influence the way in which we view our professional identity, develop professional values and therefore become socialised into the profession. Conversely, our personal-professional values become intrinsically interdependent as we develop our professional identity. Yes, we are nurses but we are also people, a person with their own identity. This is why the chosen model of professional socialisation from Weidman *et al* (2001) (Figure 1-1 and Appendix 1 p289 for reference) forms the underpinning theory for this study.

Despite my early negative experiences and conflicts relating to Facebook I have since been able to understand the developing nature of OSNs. I approach this study with the assumption that Facebook is still in its infancy; this means that it is continuously changing and its users are developing an unseen, undocumented framework or 'law' associated with defining what the online community views as appropriate or acceptable practices. Hence, those using Facebook are intrinsically involved in developing those 'social norms', but this is likely to be an unintended consequence of their participation; a notable principle of critical realist philosophy.

[6] My professional and academic profile along with research publications, projects and research management experience can be viewed at the Open University or LinkedIn

Figure 1- 1 Professional socialisation (Weidman et al, 2001)



As I embarked on this journey I made a deliberate effort to avoid any pre-conceived ideas on the implications of Facebook use, nor do I have expectations about pre-registration student nurse behaviours. From a scoping study (Ryan, *unpublished*) I can assume that over 95% of student nurses do use Facebook, but I do not assume that they are behaving unprofessionally. Conversely, I make no assumptions that their behaviours will change as they progress through their programme; their journey of professional socialisation. I genuinely sought to explore and explain that which we do not know about these behaviours, and influencing factors that lead to them.

Therefore, the influencing factors or mechanisms that cause[7] or inform Facebook behaviours are not presupposed. I believe that the true nature of reality in the Facebook environment has not yet been identified and, due to the complex nature of OSNs, the reality and knowledge obtained by this study may evolve and change with time. This does not mean that the knowledge and theoretical framework developed cannot be transferred and adapted to the wider nursing profession, but that it acknowledges the dynamic and changing nature of that which is ‘real’.

I argue that we can never know the full ‘reality’ of such a complex social world and therefore, I aim to explain the likely reality as a result of systematic data collection, critical analysis and linkage with theory that may *best explain* the *possible reality* of the current situation. This reflects the chosen critical realist perspective and asserts that ‘truth’ can never be fully ‘known’ and is open to challenge (discussed in section 3.3.1, p52).

By acknowledging this fallibility and changing nature of ‘reality’ I wish to create a transferable and adaptable framework for educators, nursing students and the nursing profession. Something that may be interpreted adapted and implemented as situations and time change.

1.2.2 Professional integrity: why accountability is important to me?

I can honestly admit that nursing was not my first choice as a profession. When visiting my grandmother in hospital as a child of age 6 I was first exposed the nursing profession and my mother proudly announced to the nursing staff that I wanted to be a nurse; I don’t ever remember saying this but it did emphasise that nursing was seen as a credible career in my

[7] As I will discuss in chapter 3 post-positivists perception of ‘causality’ is not used synonymously with that of positivists.

family's values. In all honesty, my primary choice of career was teaching science or working in astrophysics.

Nursing became a chosen profession for me after a difficult time in my late teens. I felt the need to engage with what I believed to be the 'real world', the practical side of life in order to develop 'life' skills and I had deliberately self-sabotaged my A' Levels so that I did not achieve the grades required to pursue astrophysics. This meant my original career pathway of astrophysics through a traditional university programme became unrealistic for me, despite my desire to become a teacher still existed.

Interestingly, one of my first questions in my first nursing placement in a nursing home was asking for a definition and meaning of professional accountability. Conversely, throughout my training some of the most influential experiences related to observing the consequences of our actions as nurses; the disappointment for me were nurses who lacked compassion for 'difficult' patients, one particular alcoholic patient experiencing withdrawal. I empathised with the patient in this situation as a result of personal experience and felt angry that the very people who were meant to hold values of equality, dignity and respect did not understand the patient's behaviour. As a result, this person's care was inadequate.

My nurse training was not enjoyable for me, I felt powerless and inadequate, being referred to as 'immature' and 'naïve' when I challenged such approaches. I genuinely planned to leave nursing after 6 months' post registration experience, particularly when in my first nursing post expressed similar views. However, what I realised when working in my first post as a community nurse was that I had a genuine enjoyment for the autonomy of nursing practice and, I first realised that as a registered professional I was free to challenge and make my own

decisions based on what I knew what right. It was the first time I believed I could ‘make a difference’ despite others opinions.

As a progressed through my career and through recent experiences as a patient’s carer [the ‘other side’] I have become disillusioned with the way in which professional accountability is viewed [or not]. Despite the learning from Francis report (2013) and the role of NMC (2015) code of conduct poor quality care still exists at all levels of nursing. In my most recent experience, basic nursing care such as pain relief was poorly managed and a patient with a pain score of 8 or 9 out of 10 were ignored by a senior unit sister. As a result, a patient suffered for several hours and their perception of the nursing profession is severely damaged. Upon challenging this we were treated with disdain[8] and on further complaint the NHS trust refused to hold the individuals responsible for this poor care to account; blame was laid on a non-registered member of staff. It saddens me to think that some have lost the professional pride that once enabled nurses to challenge poor care and deliver high quality care, regardless of the challenges faced in the NHS. What also concerns me is that these individuals exist in the nursing profession, in supervisory and management roles and they are possibly socialising student nurses into this culture. The challenges faced by nurses should not be used as excuses but we should have sufficient pride and accountability for our profession that we deliver care *despite*, rather than *in spite* of these.

It has led me to ask the question as to whether we struggle to allow ourselves the professional pride that is intrinsically important for us to be accountable, for us to challenge and be challenged. And, if this is the case are we failing our student nurses and the future of the nursing profession. *If we can’t be accountable in practice how can we be accountable on*

[8] We were the ‘difficult’ patient and family from my nurse training experiences

Facebook? I passionately believe in being accountable and not just practically competent. It is this that has led me to focus on accountability and the student nurse with the possibility that there is a link between online behaviours and values and those of the profession [and vice versa].

Having left nursing for a short period I pursued my teaching career and am also a qualified post-16 teacher. It became apparent that I was able to be both a nurse and a teacher. As a result, much of my teaching career is also linked with my early Facebook experiences as outlined previously in this chapter. When reflecting on the experiences that have developed my professional integrity I believe that my family values, experiences as I became socialised into adulthood, those as a teacher and those as I became socialised into nursing are all inextricably linked. It is with the commitment, passion and pride as a nurse, teacher and individual that I embark on this study.

1.3 RESEARCH QUESTION, AIMS AND OBJECTIVES

1.3.1 Research Question

How can we explain the relationship(s) between accountability, Facebook and the pre-registration student nurse during their journey of professional socialisation?

1.3.2 Aims

This critical realist ethnography seeks to:

- Explain how online social networks (OSNs) such as Facebook, influence pre-registration student nurse perspectives, behaviours and professional practice.
- Inform academics, registered nurses, organisations and pre-registration student nurses how OSNs may be used professionally.
- Set a standard framework for [pre-registration nurses] e-professionalism in OSNs.

1.3.3 Objectives

I. Employ a model of professional socialisation to critically analyse the perceptions, behaviours and actions of those who influence the pre-registration student nurse as a developing professional [in the context of Facebook]

II. Critically explore pre-registration student nurse understanding of the concept of professional accountability in the context of Facebook

III. Critically analyse the pre-registration nursing student's behaviours and publicly accessible information on Facebook in the context of professional accountability

IV. Critically analyse and explain underlying causal mechanisms which impact the relationship(s) between Facebook, professional socialisation and the behaviours and actions of the pre-registration student nurse on Facebook

V. Present a practical framework for use in nurse education and make recommendations for future practice.

1.4 THEORETICAL PRINCIPLES OF PROFESSIONAL ACCOUNTABILITY, SOCIALISATION & OSNS

1.4.1 Professional accountability in nursing

All professionally registered nurses are required to operate within the scope of Nursing and Midwifery Council [NMC] Code of Conduct (2015). They outline the conduct that patients, the public and the professional regulator expects from the nursing profession and therefore, underpins the core values in the nursing profession. This should be used by educators to facilitate the training process for pre-registration nurses alongside the NMC guidance for nursing and midwifery students and the standards of proficiency for the education of pre-registration nursing students (NMC, 2010).[9]

Operating within the scope of the NMC (2015) requires awareness and understanding of how both the professional and personal context may impact on the individual's ability to uphold the values of the profession.

The four principles of the code include:

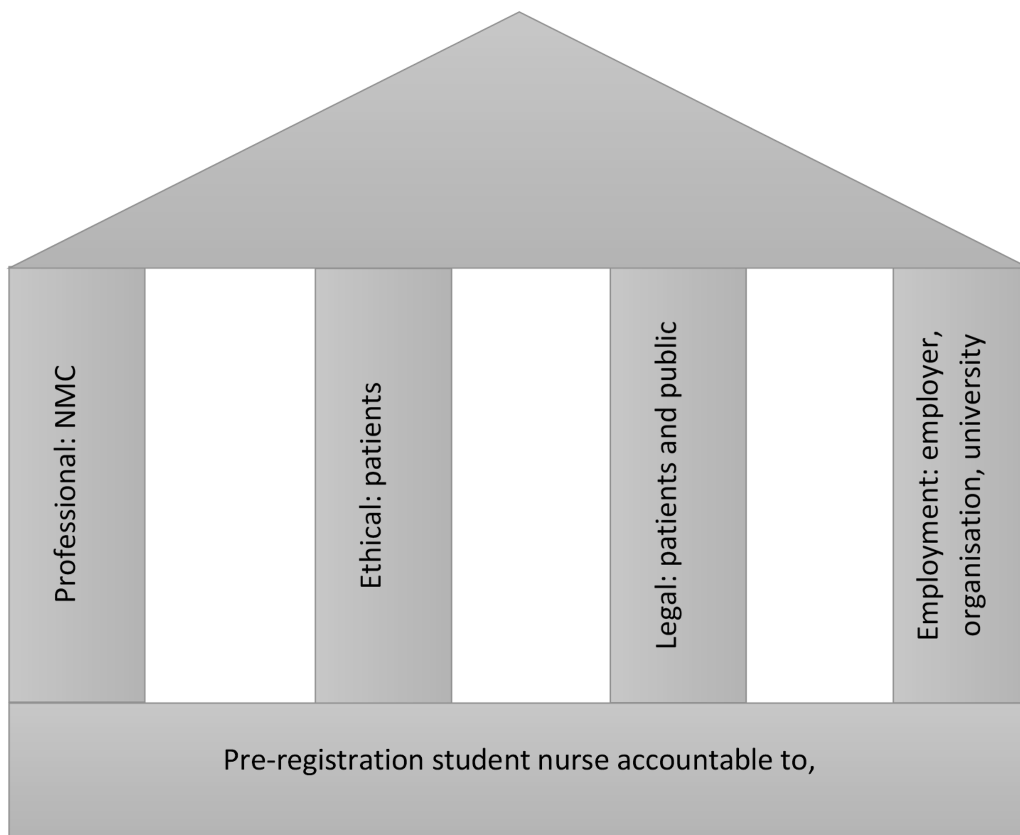
- Promoting professionalism and trust
- Preserve safety
- Practise effectively
- Prioritise people

The principle of promoting professionalism and trust places focus on inspiring confidence in the nursing profession. This involves upholding the reputation of the profession by demonstrating the core values set out in the code of conduct whether in or out of the workplace. Having self-

[9] Incidentally, this is soon to be revised and I would argue that digital competencies need to be acknowledged along with how we facilitate 'professional socialisation' in the context of accountability and the online environment (NMC, 2016a).

awareness of how the behaviours of a professional may influence and impact on the behaviours and perceptions of others. This also includes using OSNs responsibly and not expressing personal political, religious or moral beliefs inappropriately. Both registered and pre-registration nurses are held professionally accountable to the NMC, employer, UK law and the public (figure 1-2). This means that they will be required to justify any actions or omissions which may damage the reputation of the profession, breach privacy or confidentiality, break the law or bring harm to patients, public or other healthcare professionals.

Figure 1-2 Professional accountability of student nurses (adapted from Griffith & Tengnah, 2004)



Professional accountability refers to the NMC (2015) and its code of conduct. Here both pre-registration and registered nurses are required to uphold the reputation of the profession and

abide by the four principles. While many focus this on the clinical environment it also applies outside of the workplace [and therefore in the online environment]. *Ethical accountability* refers to the values and morals by which nurses operate when delivering care. Beauchamp & Childress (2004) name four principles for ethical accountability: respect for autonomy, non-maleficence, beneficence and justice. While there is emphasis on patient care and delivery of care, the values and morals by which a nurse and the nursing profession operates should be reflected in all aspects of life (including their online profile). For example, doing no harm (non-maleficence) in the Facebook environment could mean avoidance of 'fraping' or trolling activity, where an individual deliberately posts information or statements to cause conflict or offence and could be considered as bullying or harassment.

Legal accountability refers to the laws, legislation, rules or penalties agreed by society. Law generally reflects the overarching values of a society at a particular time (Caulfield, 2005). A nurse may be accountable under civil (law with a personal component) or criminal law. This for example, could include a breach of the Data Protection Act (Great Britain, 1998) and can clearly be linked with possible risks associated with Facebook posts about patients or practice area.

Nurses are also accountable to their *employer*; pre-registration nurses are further accountable to their University and placement area. This involves abiding by employer policies, procedures, corporate mission and values. Conversely, pre-registration nurses are also required to adhere to University policy and practice that may be academic or professional training specific regulations relating to placement conduct for example. Most organisations have a policy outlining expected, use of the Internet and social media; therefore, they can be held to account if these policies are not followed. This could also include making negative comments about peers, a University, placement or employer on Facebook. These four pillars are interdependent, breaching legal accountability can also mean a breach of professional accountability (e.g. together they underpin the values of the nursing profession).

As part of their educational journey pre-registration student nurses should be learning or 'socialising' themselves into these professional values. Without the concept of accountability, care quality and care delivery will inevitably be affected. Conversely, a lack of understanding could lead to behaviours that have legal implications, bringing the nurse and the profession into disrepute; this is often seen in the media (Wells, 2016; Houston, 2015). Here, it is contested that professional accountability encompasses all of the pillars; a criminal offense or negative comment about an employer can easily be viewed as unprofessional and damage the reputation of the profession. Therefore, [professional] accountability and a clear understanding of it is one of the core and most important underpinning values in the nursing profession.

1.4.2 Social capital & professional socialisation in the context of OSNs

Unsurprisingly, from the name 'Online **Social** Networks', there is an explicit social motivation for their use; such as communication with friends and family. The more interaction and 'connectedness' on a social level and a feeling of belonging [measures of social capital] are arguably of benefit to society. OSNs have been linked with the enhancement of social capital,

"[Social Capital] describes the pattern and intensity of networks among people and the shared values which arise from those networks. Greater interaction between people generates a greater sense of community. Research has shown that higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes and lower crime rates" ONS (2001:1)

Social capital has a range of dimensions which reflect themes identified in reasons for use of OSNs. Firstly, **bonding social capital** is found in individuals who have strong links with family and friends are more supported in daily life. This is reflected in the primary reasons for use of OSNs within the literature and links with the 'family/friends' life mode, or where the

'family/friends' and 'professional/work' life modes cross. Secondly, **bridging social capital** is found in those networks with acquaintances, wider groups, and friends of friends. In the OSN these activities refer to 'liking' a page, group membership [such as your employer Facebook new feed] or adding individuals as 'friends' who you do not see or meet with socially and are linked closely with the overlap between friends and public life modes or where professional/work and public life modes cross. Thirdly, **linking social capital** [weak ties] enables individuals to connect with organisations or individuals in positions of power, for example the local authority, minister of parliament or the government. This may be illustrated in following the Prime Minister or your local National Health Service (NHS) trusts twitter feed and represented by the public domain of life. Arguably, OSNs such as Facebook have the ability to strengthen all levels of social capital by enabling ease of communication, increasing the level of interaction and therefore, the subsequent social trust or socialisation across networks (Sherchan *et al*, 2013).

1.4.3 Socialisation

Socialisation is *"the process by which the objective world of reality is internalised and becomes subjectively meaningful"* (Jarvis, 1983:88); individuals learn, interact, develop and adapt to accepted 'social norms and values' as they grow into and throughout adulthood. Socialisation is a fluid, unique and individual process depending on the environment and people someone is exposed to and how they respond to these. Social trust is enhanced by operating within accepted social norms, acceptable behaviours and values. In the virtual network, these may be more complex but widely different from those typically found in the physical environments. Firstly, due to the enhancement across the three levels of social capital and secondly, because boundaries between personal, public and professional are less defined in OSNs than they would be in the physical world.

1.4.4 Professional socialisation

Professional socialisation is the process by which individuals acquire knowledge, skills and values relating to their profession (Mackintosh, 2006); for nursing students, this includes understanding the concept and demonstration of professional accountability (NMC, 2010) and whereby they develop a personal and professional identity in which their behaviours and values reflect those of the profession. The outcome of professional socialisation is that,

"newcomers…make sense of their surroundings and…acquire the kinds of knowledge which would enable them to produce conduct which allowed…that group [professional body, qualified practitioners] to recognise them as competent" (Howkins & Ewens, 1999: 1).

Professional socialisation begins upon entry to pre-registration nurse education and the journey is influenced by prior life experiences, individual motivations, external factors and continues throughout the professional career (Lai & Lim, 2012; Wolf, 2007 Ajjawi & Higgs, 2008; Shinyashiki *et al*, 2006; Weis, 2002; Weidman *et al,* 2001; Howkins & Ewens, 1999).

Educational establishments are therefore required to facilitate the development of knowledge and skills for reflection, on-going professional development and accountability (NMC, 2010) to enable the desired outcomes of professional socialisation: development of professional identity, ability to practice within a professional role, demonstration of professional and organisational commitment (Dinmohammadi *et al*, 2013). Nurse educators are responsible for providing learning activities which improve the knowledge, skills and attitudes explicitly related to professional accountability and the core values of the nursing profession; providing an understanding that actions and professional standards are inextricably linked (Krautschied, 2014; Fahrenwald *et al*, 2005).

More recently Rejon & Watts (2014), Rejon (2014) and Hart (2011) have argued that online social networks may have a role to play in professional socialisation. This suggest a need for further exploration into the impact that OSNs have had on the professionally accepted values, behaviours and skills particularly for pre-registration nursing students on their journey of professional socialisation.

1.4.5 Online Social Networks

An OSN is *"an online location where a user can create a profile and build a personal network that connects him or her to other users"* (Lenhart & Madden, 2007: 2). Users are able to upload photos, videos and share information about themselves with friends, followers or networks. There is often also the facility for creating and being members of 'groups' where people who share a common goal and/or interest can network. Each user controls privacy settings and the group creator can be changed at any time, this may be set to public, closed or privately restricted to friends or specific groups. The most commonly used OSNs are social networks where users can generate and manage their own outwardly facing 'profile'.

There is evidence to show that the most popular OSNs such as Facebook can enhance peer relationships through informal cohort groups and departmental pages that share practical information on a programme and study (Ryan & Davies, 2016; Ryan, 2015). Conversely, Facebook allows individuals to share personal beliefs and values that may not reflect nor uphold those of the nursing profession and are accessible to a range of individuals as friends, friends of friends and potentially be publicly accessible.

1.4.6 Facebook

Facebook has been the leading OSN for some time, and enables the user to generate a personal online profile, allowing links to networks of 'friends', 'groups' or 'pages' (Statista, 2017;

eBizMBA, 2014; Top 10 Reviews, 2013). Gross & Acquisti (2005) suggest that there are four types of sub-networks within an OSN such as Facebook: friends [who are listed on your Facebook account], friends of your friends, non-friends who are in the same networks (e.g. same page likes, follow the same groups) and non-friends who are not in the same networks [everyone else]. The level and sharing of information across these groups is controlled by privacy and security settings that can be tailored by the individual owning the profile.

1.5 SIGNIFICANCE OF THE RESEARCH QUESTION FOR PRE-REGISTRATION NURSING

Pre-registration student nurses are in the early stages of their professional career; still developing their own understanding and practice around professional accountability; on their own journey of professional socialisation. Understanding the values and accepted norms of the nursing profession is not always easy and yet is 'required' for an individual to be accountable. Conversely, being accountable is inherently part of the values required. The NMC (2015: 1) specifically states,

"While you can interpret the values and principles set out in the Code…they are not negotiable or discretionary"

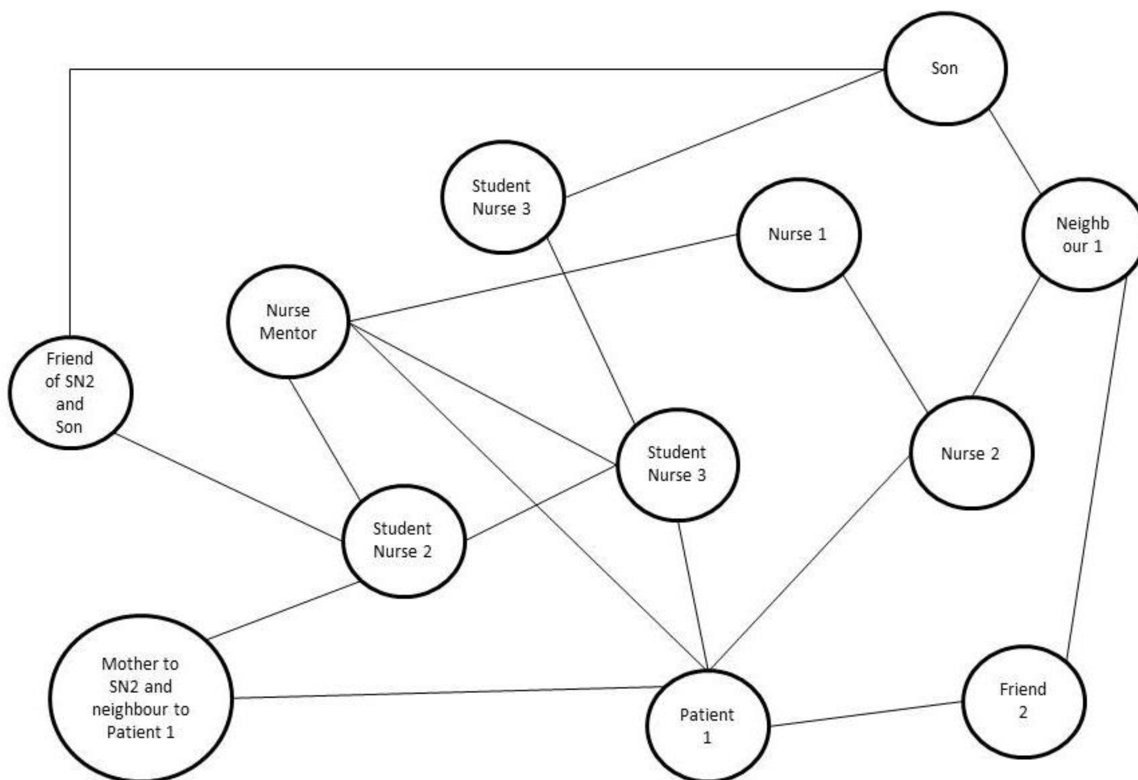
As individuals registered on a professionally recognised programme of education they are held accountable as student nurse (NMC, 2010), required to uphold the values of the profession outlined by NMC (2015) and within the four pillars (Caulfield, 2005). NMC (2016; 2015; 2012; 2010) provide examples of professional and unprofessional behaviours and attributes for professional accountability, but also the values of the profession through academic conduct and personal behaviour. It specifically emphasises the importance of personal behaviour and conduct outside of the workplace (including OSNs) and in maintaining a positive reputation of the nursing profession. This confirms that registered professionals can be held accountable for opinions, behaviours and actions in the Facebook environment.

1.5.1 Professional accountability and Facebook

NMC (2012: 1) states that *"misuse of the internet and social networking sites"* is deemed as unprofessional behaviour, and behaviour in one's personal life may impact on Fitness to Practice (FtP) and therefore, their professional registration.

While individuals may believe that their privacy settings limit what is shared widely, in reality it is difficult to know neither how far a post will reach, nor who it may be visible to. Furthermore, the complex nature of networks on Facebook does not guarantee information will not be shared with patients or the public (figure 1-3). This means that personal opinions and data shared to Facebook timelines may be shared much more widely than if discussed verbally in the 'family/personal' domain.

Figure 1-3 An OSN: how boundaries can overlap



If nurses can be held accountable for their actions on Facebook (NMC, 2012; 2015) then, in theory, their behaviours should reflect those values of the profession. Conversely, these values may conflict with their personal values, personal values which, prior to Facebook would only have been shared within the family/personal domain. This poses a dilemma; the right to a personal 'life' versus the requirements of the profession. It also raises further questions: 'what is acceptable?' and 'what is unprofessional?', 'when?' and in 'what circumstances?' And, what are the online social norms accepted by the nursing profession?

NMC (2016) and RCN (Cox, 2009) have released guidance on the use of Social Media for registered professionals within the UK providing examples of inappropriate professional behaviours on OSNs. From this, there are some clear boundaries about what is professional and unprofessional, such as breaches in confidentiality. NMC (2015) makes further reference to political, religious and moral opinions not being shared inappropriately. However, such a stipulation is subjective, what one person (based on their own experiences, thoughts and values) believes to be acceptable may not be seen as acceptable to another. Conversely, Facebook could be seen as a personal domain where individuals feel they should be able to have their own opinions and beliefs; they are more than a nurse. Arguably this means that the boundary between unprofessional and unacceptable is opaque, leading to confusion and inconsistency when making decisions about what, how, when and in what context an individual can be held to account.

As previously discussed, the use of Facebook has been associated with published professional accountability concerns as a result of registered and student nurses sharing inappropriate information through their OSN profile and the individuals who have been able to view this information. In the United States of America (USA) four student nurses were withdrawn and then reinstated for posting pictures of a placenta on Facebook (Byrnes versus Johnson County Community College, 2011). In the UK, a scoping search of NMC competency hearings found 38 that made specific reference to Facebook or actions on Facebook. Hence, despite the availability of professional guidance since the year 2012 (Ryan, 2016), education relating to professional values and being held to account to a professional body both registered and pre-registration nurses display behaviours on Facebook that are deemed to be unprofessional.

1.5.2 Significance to pre-registration nursing

Pre-registration student nurses are undertaking an educational programme aimed at facilitating their professional socialisation into nursing. As part of this, they are required to operate within NMC (2010), develop their professional accountability within the NMC (2015) in order to demonstrate and uphold the values of the profession. However, the values of the professional are [in part] subjectively applied and may conflict with the values of the person. It is argued that prior to Facebook these were more easily managed as there were clear 'physical presence' boundaries and changes in behaviours to comply with the 'norms' or 'values' of life modes. It is also known that despite the existence of professional codes of conduct, nurses and pre-registration nurses are being held to account for unprofessional behaviours in the Facebook environment. Correspondingly, they are also held to account for actions and omissions in the physical environment. Is this due to the subjective nature of acceptability, 'accountability' or 'professional values'? Or is there more clarity needed based on the 'values' of the profession? Is it Facebook that is the 'problem' or are there deeper mechanisms influencing professional behaviours?

In educating nursing students, it is not only of interest to the professional body and higher education institutions but also to those in the profession, to be able to understand and explain the impact and nature of the relationship that Facebook has had. It is only when this can be identified that methods and approaches to address any underlying issues and opportunities can be developed.

1.6 THE SCOPE OF THIS RESEARCH

This study takes place in a Higher Education Institution in the East Midlands of the United Kingdom, delivering pre-and post-registration nursing programmes. Its focus is on pre-registration student nurses undertaking either the adult or mental health BSc (Hons) Nursing Studies programme. It will also include academic staff members responsible for design and delivery of these programmes, and practice staff responsible for pre-registration students in the clinical environment. These groups represent the core influencing factors on professional socialisation (appendix 1 p289).

It will use qualitative research methods to focus on three processes that reflect the domains of Bhaskarian critical realism (empirical, actual, real) in order to explore and explain the underlying mechanisms (causal factors) that influence the perceptions, behaviours and attitudes of pre-registration nursing students on Facebook. As part of this it will consider the concept of professional accountability and how students understand its relevance in the Facebook and clinical environment. It does not seek solely to understand the perceptions of participants but does aim to explain the underlying reasons and mechanisms that influence Facebook use throughout the pre-registration nursing programme.

1.7 OUTLINE OF THIS THESIS

An overview of the chapters in this thesis can be seen in table 1-2.

Table 1- 2 Outline of this thesis

Chapter	Content
1	Background & rationale
2	Literature review
3	Study design & justification
4	Research methods
5	Findings and discussion
6	Conclusion

1.8 CHAPTER SUMMARY

This chapter has provided an outline of the reasons for, context and scope of this project with an introduction to some key theoretical concepts. Professional accountability is a core component of the nursing profession. Without accountability, approach to care, care quality and care delivery will inevitably be affected. Although Caulfield (2005) outlines four pillars of accountability, it is argued that all four have a component in professional accountability.

Pre-registration nursing students undertake a programme of study that intends to produce competent practitioners. Along with this they are socialised into the nursing profession, developing understanding of the core values and social ‘norms’ of nursing. Professional socialisation is inherently linked to professional accountability. Accountability, whether ethical, professional, legal or employer represents the core values of the nursing profession as outlined in NMC (2015).

The use of OSNs such as Facebook have been identified as both positive and linked with the concept of social capital: linking, bonding and bridging. However, Facebook poses a new dilemma for nurses and the nursing profession. It is known that nurses can be held to account for unprofessional behaviours in the online environment and that these can reflect poorly on the nursing profession, particularly if presented in the media. Conversely, there is a range of behaviours that may not be unprofessional but may still reflect poorly on the individual. What is unclear is the influencing factors and mechanisms that lead pre-registration nurses to use Facebook, how they use it and how they make decisions about what to share and with whom? Without this information, it is difficult for educators and professionals to ‘socialise’ student nurses into the accepted professional values in the online environment.

Chapter 2 will present a literature review which discusses the current research evidence and gaps in knowledge on the topic of OSNs, Facebook and professional accountability.

CHAPTER 2 LITERATURE REVIEW

2.1 INTRODUCTION

This chapter seeks to explore the research literature underpinning my research question,

How can we explain the relationship(s) between accountability, Facebook and the pre-registration student nurse during the journey of professional socialisation?

The initial literature search is a core component of critical realist study. The knowledge and data that already exists contributes to the progression of knowledge[10]. A search for research literature was conducted to identify the 'issues' and 'benefits of Facebook to under-graduate students with a focus on healthcare professionals in May 2013, October 2014 (n=32) and then once again in May 2017 (n=18); (*total n=50*).

The academic databases PsychINFO, CINAHL, EBSCO, ERIC and MEDLINE were used to identify relevant literature and research. Google scholar was also used to enable grey literature to be identified for example, unpublished PhD theses. The search terms used, selection criteria and quality appriasal criteria are shown in appendix 2 p290. Initial results using a keyword search reported 90,495 published articles. This was further reduced by limiting the search terms to healthcare professional students and using 'online' rather than simply 'social networks' which then produced less than 1000 articles. Once limited by the year 2006; based on the inception of Facebook in 2004 and the time required to study and publish research and after review of title and abstract, 80 were selected for full text review with 30 of these rejected based on selection criteria. A summary of included literature can be found in appendix 3 p291.

[10] This will be discussed in more detail in chapter 3

This chapter will discuss the current research evidence and a summary of the chapter can be found in table 2-1.

Table 2- 1 Summary of chapter 2 contents

Chapter section	Content
2.1	Introduction to chapter 2
2.2	A summary of Facebook
2.3	E-professionalism, e-accountability and Facebook
2.4	Chapter summary

2.2 A SUMMARY OF FACEBOOK

2.2.1 Use of Facebook

Survey and observational studies have identified that Facebook is mostly used for keeping in touch with 'friends' and maintaining relationships that have been established in the 'offline' or 'physical' environment (Yang & Brown, 2013; Aydin, 2012; Hew & Cheung, 2012; Wilson *et al*, 2012; Bicen & Cavus, 2011; Hart, 2011; Hew, 2011; Lampe *et al*, 2011; Saleh *et al*, 2011; Roblyer *et al*, 2010; Madge *et al*, 2009; Joinson, 2008; Sheldon, 2008; Dwyer *et al*, 2007; Ellison *et al*, 2007). Other common reasons for using Facebook include: expressing identity (Hew & Cheung, 2012; Manago *et al*, 2012; Pempek *et al*, 2009), seeking social or peer support (Madge *et al*, 2009), passing the time (Hew, 2011) and venting emotions such as frustration or sadness (Hew & Cheung, 2012; Manago *et al*, 2012; Hew, 2011). However, more recent research outlines the benefits of peer support and information sharing in relation to academic study. Ferguson *et al* (2016) presented a small qualitative study with little philosophical steer and Tower *et al* (2015) a qualitative observational study. Both of low quality, they do demonstrate that pre-registration student nurses are effectively using Facebook groups to promote belonging, support and stress reduction.

More generic activities include status updates (what you are doing, how you are feeling), sharing videos, pictures, commenting on and reading others wall posts[11]. The majority of research literature found identifies the basic uses of OSNs through self-reported surveys or observation of Facebook profile activity. This limits the ability to seek to understand or explain the underlying reasons for behaviours and does not prompt participants to do so.

[11] Reading and viewing others profiles without engaging is known as 'lurking' (Pempek *et al*, 2009)

While some of the available research that utilise survey and observational design, may have high response rates and hence, may be seen as representative and generalisable (Call *et al,* 2017 n=1001; O'Sullivan *et al*, 2017 n=1640; Alber *et al,* 2016 n=35; Alsuraihi *et al*, 2016 n=657; Fuoco & Leveridge, 2014 n=299 45.4% response rate; Levati, 2014 n=124; Farooqi *et al*, 2013 n=1000; Cain *et al*, 2009 n=299) they simply describe what is happening on social media rather than propose methods by which we can improve what we do or do not do, or even to use OSNs effectively.

Jain *et al* (2014) & Dwyer *et al* (2007) observed students in a simulated Facebook environment. While the evidence presented does agree with other literature, a simulated environment limits the transferability or utility of the findings to the rapidly changing real world. Conversely, the dependability of the results is questionable, given that participants knew they were in a simulated environment and may have changed their opinions or behaviours as a result.

Findings suggest that individuals view OSNs as 'personal' despite identifying that there are professional/work, university friends and groups along with publicly accessible information included in OSN profiles (Alber *et al*, 2016). Lovejoy *et al* (2009) conducted a mixed method (survey and narrative) study and findings were complementary to the descriptive studies found in my search. However, through narrative interview Lovejoy *et al* (2009) was also able to introduce the concept of routine and ritualized use of OSNs. This illustrated some daily, habitual use of Facebook in order to view others people profiles or the 'news feed' (despite the fact participants felt this fuelled rumours and gossip to negative effect). It also highlighted the uncontrolled nature of Facebook use; participant's ideas about how and why they use Facebook was contradictory to their actual behaviours and thus, awareness of impact on their daily life. This could possibly indicate wider 'unseen' influences and a more complex 'reality' of OSNs.

Research argues that nursing and healthcare students and registered staff use Facebook on a daily basis (Lahti *et al*, 2017; Ryan, *unpublished*) and that this may be for academic purposes such as cohort group pages (O'Sullivan *et al*, 2017; Alsuraihi *et al*, 2016; Asiri *et al*, 2016; Ferguson *et al*, 2016; Guraya, 2016; Kakushi & Evora, 2016; Lagenfeld *et al*, 2016). However, with the exception of Asiri *et al* (2016), Guraya (2016) and Kakushi & Evora (2016) which are systematic reviews[12], the above are survey and observational studies and do little to advance our knowledge in this field. And, while the systematic reviews are of moderate quality, they do simply consolidate the data from the available descriptive and observational studies, identifying the need for further research. Since 2009 research evidence still does not seem to fill these 'gaps' in our knowledge, explaining 'why' and 'how' we should use OSNs; it continues to simply describe the nature of behaviours and context, presenting the same outcomes repeatedly.

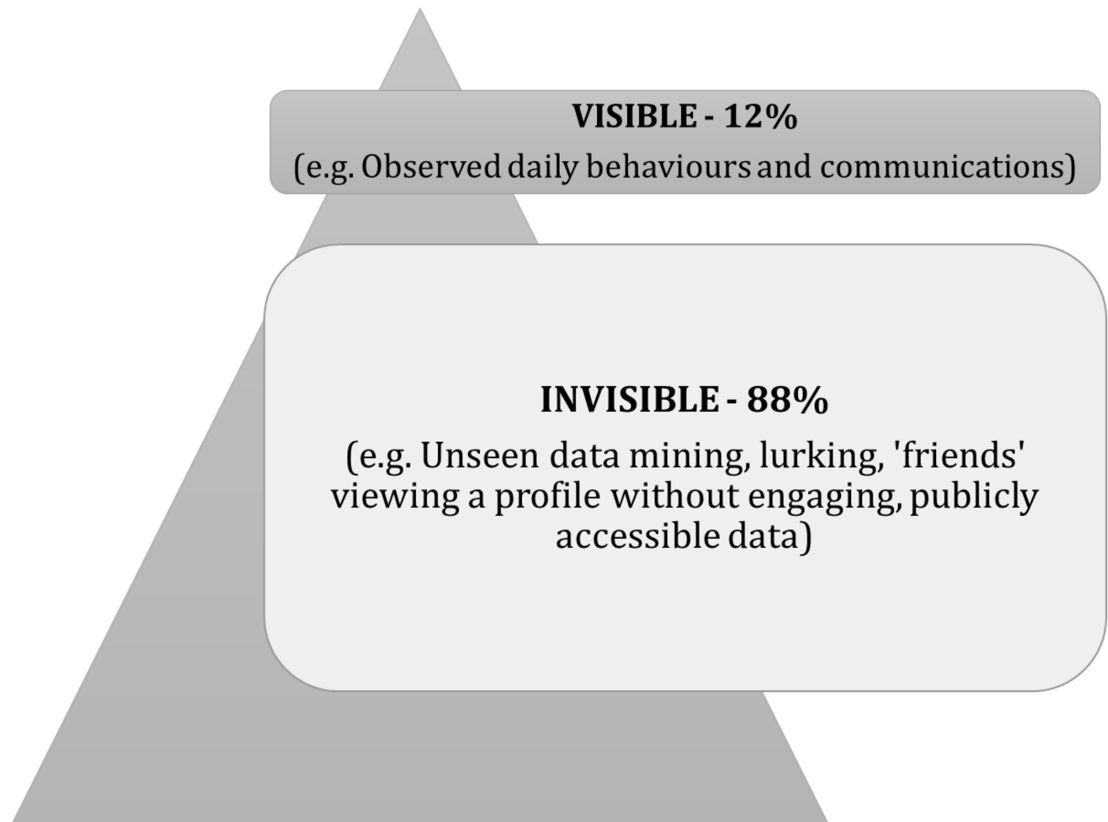
2.2.2 The 'visible-invisible' complexities of Facebook

Lovejoy *et al* (2009) refers to a visible and invisible iceberg model of communication in OSNs which suggests one-eighth of activity is seen and accepted by the user e.g. the fun, social aspect, reading status post and engaging with OSN functions, and the remaining 7/8[ths] accounts for other activity and factors which the user does not consider fully in day to day use (figure 2-1 p37). Although this model is focused on data mining and marketing information, its application for illustrating the complex reality of OSNs is useful; for the majority of users they only see the 'visible' communications and not that of the wider context and implications of these. For example, 'friends' may still read posts and view photos but not engage by commenting or 'liking' giving the user the impression that only those engaging with a post are reading it. Alternatively, individuals may post status updates with a particular set of 'friends' in mind when in fact, all Facebook friends can see it and may not understand the context in which it was

[12] Guraya (2016) was the only one of high quality but added little knowledge due to its limited scope.

intended. This proposed visible-invisible model is also reflected in survey based, descriptive studies of usage patterns.

Figure 2- 1 Iceberg Model adapted from Lovejoy et al (2009)



Although the reasons for using OSNs are confirmed within the literature, there is perhaps more to understand about the underlying mechanisms which impact on use and behaviour.

2.2.3 Boundary Management on Facebook

Boyd (2012: 2) argues:

"privacy is not about restricting information; it is about revealing appropriate information in a given context"

In more recent years, privacy and security mechanisms on OSNs have become increasingly robust however it still remains unclear how much of them are [effectively] used by those owning an OSN account (Skeels & Grundin, 2009; Dwyer *et al*, 2007; Gross & Acquisti, 2005).

Ofcom (2012) found that over 66% of internet users skim read or do not read privacy and security settings for OSNs and webpages. This suggests that individuals can view themselves to be 'aware' of such settings when they are not, there is also the perception that other people are more at risk; an 'it won't happen to me' approach. Lovejoy *et al* (2009) conducted a mixed methods study examining the reasons for use and levels of awareness of privacy in OSNs. This study is of particular use as it does not seek to just describe behaviours but enabled a small sample of participants to share their experience of privacy in OSNs. In addition, it raises questions and concerns about how much information and the types of information individuals are willing to share 'within' their perceived 'safe' parameters/settings.

It is known that Facebook users in particular are more open to sharing personal information and view Facebook as 'safer' than other OSNs such as Myspace (Dwyer *et al*, 2007; Acquisti & Gross, 2006) suggesting that some of the major risks with OSNs can be illustrated using Facebook behaviours.

Ollier-Malaterre (2013), Fogel & Nehmad (2009), Lovejoy *et al* (2009) and Steinfield & Lampe (2007) highlighted the differing meaning of 'friend' in the virtual domain compared to what is accepted in the physical domain. The term 'friend' in OSNs could mean a friend, family member, work colleague or even stranger; meaning that Facebook users tend to have a mix of professional, family and friends who have access to their profile but that they are not typically 'separated' into these groups as they would be in the physical world. It is suggested here that

the nature of boundaries in the physical and online environment can vary dramatically depending on the approach and behaviour an individual takes with them.

Ollier-Malaterre (2013) proposes a model that is directly linked with individual motivations for using social media and behaviours regarding boundary management (appendix 4 p306). While Ollier-Malaterre (2013) agrees that there is blurring of personal-professional boundaries, there is also consideration of how emotions, personality and environment also influence online behaviour. Adding to this complexity and variation, it is possible that individuals move between 'type' depending on life events or mood for example, moving from *content management* to *open boundary management* when a significant life event affects their emotions, resulting in open disclosure of these on Facebook [emotions typically reserved for family and close friends are shared with 'everyone']. Conversely, some individuals [particularly those new to a work area or profession] may take on a progressively more *hybrid* route as they become more experienced as part of their developing 'professional' or 'adult' identity (Alber *et al,* 2016; Usher *et al*, 2014; Deen *et al*, 2013; Ness, 2013; Osman *et al*, 2012; DiMico & Millen, 2007).

There are also concerns relating to reactive approaches to information management on OSNs. Many individuals may mistakenly share information with a wider audience or reflect on what has been shared and deem it inappropriate to share. This may result in removing a friend who was added, blocking their access to the account or removing a post, picture or comment. Many users are not aware that deleting a comment or post does not mean that others do not or will never be able to read this again (Farelly, 2014; Londridge *et al*, 2013). This raises concerns with management approaches, which rely on reactive rather than proactive consideration of information, shared. Therefore, individuals should think about what is being shared before it is posted and not afterwards; this is of particular importance for comments made which may influence the professional reputation or work profile of an individual [or organisation].

Ollier-Malaterre *et al* (2013), Ozenc & Farnham (2011) and Macdonald *et al* (2010) further highlight a need for developing awareness and ability for sharing acceptable content with only appropriate audiences, and in the context of the relevant 'life mode' and that this is true for both pre-registration and registered [nursing] professionals. Despite the limited quality of available research there does seem to be consensus that more 'practical' professional development is needed to facilitate the management of online boundaries (Lahti *et al,* 2017; Alber *et al*, 2016; Asiri *et al*, 2016; Alsuraihi *et al,* 2016; Guraya, 2016; Kakushi & Evora, 2016; Lagenfeld, 2016; Cain *et al*, 2009). Others argue that this is a neomillenial problem (i.e. digital natives who have grown up with the internet) are the individuals who do not understand the risks or are simply not mindful enough of being professional (Alber *et al*, 2016; Smith & Knudson, 2016; Osman *et al*, 2012). While Alber *et al* (2016) is of moderate quality, there is little other high-quality evidence that supports this and I would argue that age is an obvious and superficial measure of something else that is happening under the 'surface' of reality. Conversely, it is in itself a non-modifiable characteristic that we are unable to change or control.

Ollier-Malaterre *et al* (2013) discuss how challenging and time consuming it to only share specific content with specific people, particularly during times of stress or via highly emotive subjects. Consistent consideration and application of privacy settings to specific people and groups is extremely time consuming and complex to manage. Conversely, content and themes posted by others can cause emotive responses, resulting in comments being made without full thought (e.g. religious or political views, extremist ideas). Further complexity arises from individuals who deliberately post sensitive or extreme content with the specific intent to incite/provoke an emotional response in the reader[13]. This can be positive [humorous] or have

[13] Commonly known as trolling. Those seeking positive responses are known as Kudos trollers and those seeking negative responses are known as flame trollers (Bishop, 2012).

serious negative effects, but is also linked with cyber-bullying which can have significant and devastating impact.

Individuals believe that they manage boundaries via privacy settings and information sharing, but there are factors which impact on their ability to do this including: time required to manage profiles, personal motivations, self-concept, emotional state and levels of self-awareness. Therefore, the nature of OSNs pose a range of challenges associated with the management of these complex and dynamic boundaries. The requirements of professional accountability lead to added complexity for those in the healthcare professions.

2.3 E-PROFESSIONALISM, E-ACCOUNTABILITY AND FACEBOOK

2.3.1 e-professionalism & e-accountability

The concept of e-professionalism or digital professional accountability is suggested in Cain (2008), Cain *et al* (2010) and Thompson *et al* (2008) and poses emerging issues for the healthcare professions. It can be defined as '*the attitudes and behaviours reflecting traditional professionalism paradigms that are manifested through digital media'* (Cain & Romanelli, 2009:1). Garner & O'Sullivan (2010) also highlight conflicting perceptions and varying degrees of awareness of OSNs in the professional context with specific focus on medical students; although they are aware of guidance there are still reported concerns with in appropriate use and/or behaviours when using OSNs.

It is suggested that professional accountability and public facing professional behaviour should now be considered in both the traditional clinical practice and digital domain. Several studies since 2009 have emphasised the issue of unprofessional behaviours in the Facebook environment, with many students expressing confusion about what is expected of them (Henry & Molnar, 2013; Ginory *et al,* 2012; Ford, 2011; Finn *et al,* 2010; Garner & O'Sullivan, 2010; Cain *et al,* 2009). Most recently, a low-quality study by O'Sullivan *et al* (2017) suggested that 21% of students shared clinical images without obtaining permission, this was also reflected in Nason *et al* (2016) where 25% of profiles presented 'unprofessional' content. Although a very low quality qualitative study, Nyangeni *et al* (2015) was explicit in saying that nursing students use social media irresponsibly and that they lack accountability.

A scoping study (Ryan, 2015) and content analysis (2004-2014) of the NMC website found 38 NMC competency hearings directly linked to unprofessional behaviours on Facebook as a result of: boundary violation (communication with or 'friending' patients), information sharing

(details about the workplace), breach of confidentiality and failure to uphold the reputation of the profession (see appendix 5 p307).

There are numerous groups on Facebook linked with student nurses both nationally and globally (e.g. the RCN and American Nurses Association do have Facebook pages). The NMC frequently warns registered nurses of the professional implications of a Facebook presence, the wide range of individuals who may be able to view profiles and posts [without the user initially being aware], and provides some guidance on what is deemed to be 'good practice' along with linkage to the Code of Professional Conduct (NMC, 2015; 2016). However, the levels of awareness of healthcare professionals regarding content and resulting behaviour are not yet apparent, and many international nursing guidance documents take a wide range of different approaches to the use of Facebook (Ryan, 2016). In Ryan (2016), I conducted a content analysis of professional guidance documents [social media] and found that most are not evidence based (due to a lack of available evidence as to how best to manage the online environment); often reactively produced in response to incidents and media coverage.

2.3.2 Who says what's unprofessional?

It is argued that nurses may not be fully aware of the links across family, work and social digital profiles; viewing OSN profiles and activity personally and socially. Conversely, there is argument that OSNs, particularly those such as Facebook are leading to confusion of the personal-professional boundaries which exist in the physical domain of accountability; this then leads to published concerns about professional accountability, reputation and the publicly accessible digital footprint of healthcare professionals (Scott, 2013; Jones & Hayter, 2013).

Cain *et al* (2009), Finn *et al* (2010), Garner & O'Sullivan (2010), Ginory *et al* (2010), Hall et al (2013), Maloney et al (2014), Ness (2013), Osman *et al* (2012), Ross *et al* (2013), Thompson *et*

al (2008), Usher *et al* (2014) and White *et al* (2013) explored healthcare student awareness and understanding of online professionalism through questionnaires or survey design. Most students expressed that they are aware of professionalism, stating that life modes should be completely separate, but found difficulty negotiating the values between their personal-professional identity. Many reported that their self-efficacy improved as they approached the end of their training but there was no evidence that their actions reflected this (Alber *et al,* 2016; Ness, 2013). This indicates a possible lack of awareness relating to complex boundaries in OSNs; their confidence and competence to manage these. It also suggests uncertainty about how to manage their different identities when there is no physical boundary to make this explicit (e.g. leaving the workplace).

Students felt that they should be held accountable for illegal or unprofessional behaviour/information shared online (Lagenfeld *et al,* 2016; Hall *et al,* 2013; Finn *et al*, 2010; Cain *et al,* 2009;) and what would constitute this (Kumar, 2014). However, large numbers of students and organisations reported seeing these types of behaviours, some even reported doing this themselves (Lagenfeld *et al*, 2014; Ponce *et al*, 2013; Ross *et al*, 2013; White *et al*, 2013; Henry & Molnar, 2013; Osman *et al*, 2012; Ginory *et al*, 2012; Chretien *et al*, 2009; Ford, 2011; Finn *et al*, 2010; Garner & O'Sullivan, 2010; Thompson *et al*, 2008). Ford (2011) found that nurses felt that their peers 'shared too much about work' on OSNs. Not only does this indicate that unprofessional behaviour is apparent in OSNs, it also suggests that students do not respond professionally in reporting such behaviours, or that perceived behaviours reflect actual online behaviours.

This conflict between [perceived] self-awareness and behaviour were reflected in Alber *et al* (2016), Ross *et al* (2013), Finn *et al* (2010), Osman *et al* (2012) and Garner & O'Sullivan (2010) where a disconnect was found between perceived awareness of professionalism, self-

awareness and behaviour. Students believed that life domains should be separate but then went on to discuss how ‘unrealistic’ this was to manage, and that there should be more leniency given because of their student status. This disconnect is likely to impact on the way in which boundaries and information is shared in OSNs (Ollier-Malaterre *et al*, 2013). I would also argue that a lack of knowledge, confidence and competency of registered staff (clinical or academic) combined with opaqueness about what is unprofessional [and requiring action], compounds this problem (Lahti *et al,* 2017; Ryan, 2016; Jain *et al,* 2014; Kumar, 2014; Muhlen & Mochado, 2012; Landman *et al*, 2010). Unacceptable behaviour will vary from one person to the next (e.g. drinking alcohol is not illegal but often phrased as unprofessional substance abuse in observational studies), unprofessional behaviour should be explicit but may also be context dependent, based on our professional code of practice.

2.4 Chapter summary

The fluid nature of life domain boundaries in OSNs compared to those found in the physical world has implications for information sharing and management of relationships. Being professionally accountable is to understand and demonstrate acceptable behaviours in the online environment. That is, with friends, family and acquaintances, as well as in the clinical and physical contexts and it is no longer possible to completely segregate these. E-professionalism and being e-accountable for online behaviours is therefore becoming an integral part of healthcare professions values, skills and knowledge; the very things individuals develop as part of professional socialisation.

There is some evidence to suggest that health professional students need further guidance and input from educators, but also that the profession in itself has not reached a true consensus about what ‘unprofessional’ behaviour is. Furthermore, while there is some research evidence suggesting discrepancy between perceived behaviours versus actual behaviours (e.g. privacy settings, information sharing, boundary management) utilised by university/healthcare students, much of this is quantitative or based on survey design, is of low quality and there is little evidence of application to practice.

There is limited, high quality research that demonstrates real utility in practice, and no available research has been found which explores the extent to which nursing students are aware of their online behaviours, information sharing, methods of managing their ‘life modes’ and therefore, the impact of OSNs on professional socialisation. Nor is there any evidence that provides an approach by which to 1) address the concerns about online behaviours, 2) proactively educate students, **academics and nurses** or 3) effectively and professionally use online social networks such as Facebook; this study seeks to address these.

Chapter 3 will now outline my philosophical assumptions and present a justification for these choices.

CHAPTER 3 STUDY DESIGN AND JUSTIFICATION

3.1 INTRODUCTION

In chapter 1, I discussed the context, theoretical approach and background to this research and chapter 2 went on to review the current research evidence[14]. Importantly, I conclude that there is a lack of high quality research studies with a transparent philosophical and methodological framework. For me, this is of significance. Firstly, a guiding philosophical framework is necessary to demonstrate transparency of method, to enhance rigour[15]. Secondly, it provides direction as to the research methods and data collection processes to be employed. Thirdly [perhaps most importantly], it is crucial for making decisions about what I believe to be real (ontology) and what constitutes knowledge of this 'reality' (epistemology). Without this, how do we know that we have knowledge and what the nature of this knowledge is? Howell (2013) and Phillips & Burbules (2000) would argue that every inquirer must adopt a framework, perspective or standpoint to be transparent to others in their field; *the way they see things* and *values* with which the research has been approached. This enhances the rigour of the research from the perspective of those with similar values, but also makes clear how the researcher may have viewed the investigation from a different perspective to others. Conversely, transparency about values and assumptions enable the scientific community to be clear that the research has been conducted robustly and without [minimized] bias[16].

[14] The review of research evidence was of great importance to the underpinning philosophy informing this study. The findings from this literature will go on to be used [in combination with the results of this piece of work] to explain the underlying mechanisms that inform behaviours and actions in the online environment.

[15] Regardless of philosophical perspective the scientific community generally agrees that good research and knowledge should be generated through rigourous inquiry and the need to seek and progress knowledge (Phillips & Burbules, 2000). As I will discuss later, the way in which this is assessed is different based on the inquirers perspective.

[16] I do not believe values to be evidence of bias. Bias and 'modified objectivity' is discussed later in this chapter.

This chapter presents four core research paradigms: positivism, post-positivism, critical theory and interpretivism [also referred to as constructivism] (Lincoln et al, 2011; Heron & Reason, 1997). An overview of these, their epistemology, ontology, commonly used methodology and methods are illustrated in appendix 6 p309.

A summary of chapter 3 contents is found in table 3-1.

Table 3- 1 Summary of chapter 3 contents

Chapter section	**Content**
3.1	Introduction to chapter 3
3.2	The nature of research philosophy
3.3	The four paradigms: a focus on post-positivism
3.4	Justification for post-positivism and Bhaskar's Critical Realism
3.5	Methodological choices in post-positivism: a focus on ethnography
3.6	Justification for ethnography
3.7	Ethnography
3.8	Whose Critical Realist Ethnography?
3.9	Chapter summary

3.2 THE NATURE OF RESEARCH PHILOSOPHY

*"Why philosophy? The alternative to philosophy is **not no** philosophy it is **bad** philosophy"*

Collier (1994: 16)

In section 3.1 p48 I assert that a researcher needs an underpinning framework and philosophy by which to guide their process. As Collier (1994) would agree, the reasons I believe a researcher requires a philosophical perspective are threefold:

1. To guide the inquirers beliefs about what is truth, reality and knowledge
2. To conduct rigorous research in the eyes of their scientific community; transparency, credibility, trustworthiness, reflexivity
3. To direct the selection of appropriate research methods for data collection, analysis and use of theory in order to explore the phenomena

Conversely, the approach to inquiry selected here requires me to be transparent about my own epistemology, my own place in the world and my assumptions about knowledge (Ryan, 2006)[17].

Research philosophy is concerned with reality, truth, knowledge and theory (an overview of typology of theory is shown in appendix 7 p310)[18]. Each of the four paradigms take different perspectives, and it follows that the chosen methods of inquiry, data collection and analysis should complement these. *Ontology* (reality) is the values an inquirer holds about what can be known as real or reality; *epistemology* (truth) is the perspective we place on how we may come to know this reality, and *methodology* is the practice by which we can attain this knowledge. *Theory* is the way of explaining how we give meaning, explain or understand the results of inquiry; a means of reflecting reality, truth or knowledge (Howell, 2013). Ontological

[17] Some of my assumptions have been discussed in chapter 1

[18] This thesis presents 'meso theory' through a combination of models and frameworks. Framework III simplifies this into a 'framework' that can be applied to the practice environment

perspectives include empiricism, naïve and logical realism, relativism, historical realism and critical realism. Epistemological perspectives centre on objectivity or subjectivity. Theory may be ontologically or epistemologically informed, and this is reflected in the subsequent methods of analysis used by the inquirer: inductive, deductive and retroductive (appendix 8 p311).

3.3 THE FOUR PARADIGMS: A FOCUS ON POST-POSITIVISM

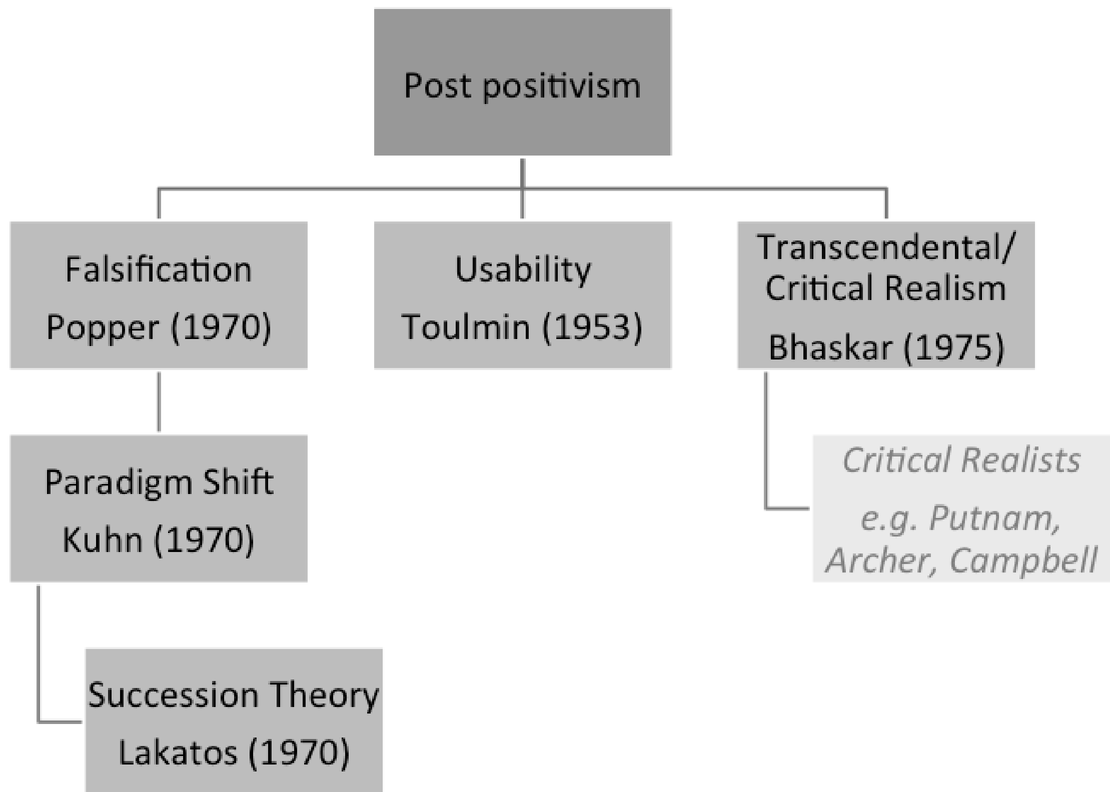
Appendix 6 p309 summarises the four available paradigms. In Ryan (2018) I explain each of these paradigms, the historic context and guiding principles. In this study, I focused on post-positivism.

3.3.1 Post-positivism

Post-positivism should not be considered a progression of positivism, neither is it anti-positivism. Conversely, some of its followers share principles with that of CT. Post-positivism proposes an alternative approach, seeking to resolve the conflicting perspectives of interpretivism and positivism. Post-positivists place emphasis on the meaning and creation of *new* knowledge, acknowledge the notion of progression with time [change], and value the concept of *fallibilism*: that is, 'facts' may be disproven with further inquiry; the evolution of knowledge (Alvesson, 2009; Ryan, 2006; Phillips & Burbules, 2000).

Figure 3-1 p53 illustrates the historical context of post-positivism and the main philosophical influencers. I chose Roy Bhaskar's critical realism (considered the 'founder' of critical realism).

Figure 3- 1 The historical context of post postivism and its influencers

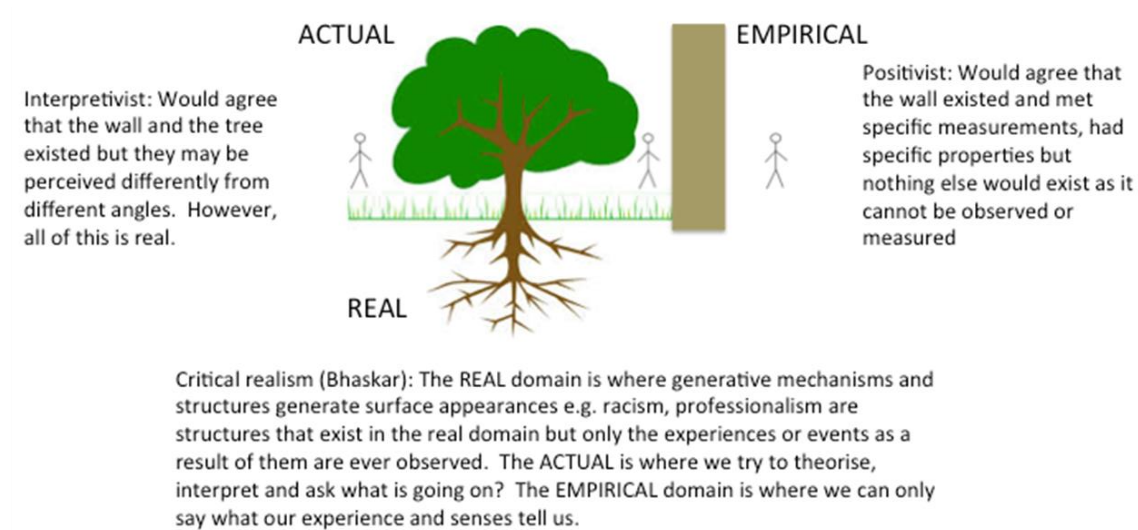


Epistemologically, post-positivists value *modified objectivity*. This is different to the *objectivity* valued in positivism; it recognises that even the most rigorous empirical methods may occasionally fail to produce conclusions and in some cases, may produce undetected errors (e.g. type I and II errors) (Elgin, 1996). Furthermore, post-positivists take the approach that knowledge [while fallible] should be obtained with the best evidence available at the time of inquiry, and that this may evolve as new evidence becomes available and knowledge progresses.[19]

[19] N.B. this is also a professional requirement for nurses and is in the education standards for pre-registration nurses *"always practise in line with the best available evidence" (NMC, 2015: 7) and (NMC, 2010).*

For example, there was once a time that the field of science believed the Earth to be flat, that the human gene contained 48 chromosomes and that tobacco had health benefits. These conclusions were considered to be scientific and 'factual' but were later shown to be incorrect.

Figure 3- 2 Differing perspectives (adapted from Dyson & Brown, 2006:38)



What is believed to be knowledge is not necessarily, what is real. Believing that we know the facts and that these will not change, actually limits the progression of knowledge,

> *"I am wiser than this man, for neither of us appears to know anything great and good; but he fancies he knows something, although he knows nothing; whereas I, as I do not know anything, so I do not fancy I do. In this trifling particular, then, I appear to be wiser than he, because I do not fancy I know what I do not know."* (Socrates, n.d.)

Therefore, while post-positivist approaches may differ, they agree that reality can never be fully known, and by acknowledging this, it makes us more able and open to accept new knowledge[20].

[20] Dunning-Kruger effect argues that those who learn more admit that they don't know what they don't know

3.3.2 Roy Bhaskar's [post-positivist] critical realism

Roy Bhaskar's transcendental realism [later termed critical realism] originated from Kant's philosophical question *what must be true in order for X to be possible?* Bhaskar proposed that the usefulness of knowledge could vary in different contexts.

Bhaskar's critical realism has several core characteristics:

a) Transitive and intransitive dimensions of science
b) Reality is stratified: empirical, actual and 'real'
c) Objects, structures, mechanisms, powers and tendencies reflect the domain of reality
d) An epistemological position of modified objectivity
e) Open and closed systems

a) The transitive and intransitive objects of science

In order to negotiate the conflicting views of positivism and interpretivism, Bhaskar proposed two dimensions of science. He argued that the production of knowledge in the human world always has a human element; science cannot exist without some form of human activity or inquiry (Danermark *et al*, 1997). These were identified as *intransitive* and *transitive* knowledge.

Intransitive knowledge refers to the objects that we study. These objects would exist whether humans existed or not and regardless of human experimentation or observation (e.g. gravity, light). This type of knowledge is most frequently generated and examined at the *positivist* end of the post-positivist spectrum (objectivity is important to make generalisations). *Transitive* knowledge is the knowledge that we create as a result of human intervention or, that which has a human factor (research that involves people, communities, groups). Rival or differing theories

may be presented about the same object of study (e.g. different philosophical approaches, qualitative versus quantitative research methods) (Collier, 1994; Howell, 2013). In essence, these need to be relevant and usable in the environment for which they are intended. It is also important that this type of research is 'accepted' as valid in the field, and the methods and outcomes fit for purpose, rather than what the scientific community want.

b) Objects, events, structures, mechanisms, causal powers and tendencies

In order to discuss these, it is necessary to define what is meant by *causality* from the critical realist perspective. Danermark *et al* (1997: 52) suggest that causality traditionally refers to:

"an explanation of why what happens actually does happen"

The traditional concept of 'causality' focuses on establishment of associations and cause-effect; valued in positivism. In the natural sciences, where the objects of investigation would exist regardless of human intervention (e.g. gravity) there is a valid place for these. These types of investigations are based on measures of directly observable events, theoretical algorithms or experimental conditions. For example, we have determined that gravity exists because we can drop an object and observe the same result repeatedly, until this does not occur [which is not impossible but improbable] this is the best evidence we have. The problem with this approach in research with human and/or social factors is that 'we are simply not that simple'. It explains what we see but not 'why' it exists like that, 'how' we exist like that and 'when' we exist like that (e.g. gravity exists on the moon but we would observe a completely different result if dropping an object from a height; thus, critical realism requires us to examine what happens, why, when and **in what circumstance?**)

As will be discussed in section c) p58, CR does not believe reality to be completely observable (e.g. with the concept of gravity, there is activity at the sub-atomic and astronomic levels that

we simply cannot observe, we can only observe the **effects** of these). Hence, *objects* of inquiry may be observed through *events* or *outcomes* and we can generate a 'most likely' explanation of reality based on these (and this is true in much of theoretical physics; e.g. we have never physically been into space and inside a black hole to observe it, how they behave is just a 'best guess' on the basis of observing their effect).

This concept is even more pertinent in research with a diverse range of human factors [such as nursing research]. Think about the concept of queueing in a shop; we can observe the *behaviours* of people [*entities*], we can observe the *events* that take place that may cause someone to decide to jump the queue. We know that by getting into the queue the people have a *tendency* [moral, value or principle] to behave in this way. What these observations do not tell us is *why* this occurs and the underlying *structures* (e.g. socialisation and social norms) that exist, nor does it tell us the *causal mechanisms* by which these social norms came to exist, and in what circumstances they may not exist; we can only observe the effects of these.

c) Reality is stratified

Bhaskar (2008) proposes three domains of reality; empirical, actual and real. What we observe in the empirical domain and what we critically examine, explain and theorise in the actual domain is what reflects the [unobservable] real domain. We can never know exactly what causal mechanisms exist in the real domain (we cannot possibly see 'everything'). The *empirical* domain is where the objects under inquiry may be observed; this is as far as pure positivist research in healthcare will go. If conducting interpretivist research, this is where we would measure or record *experiences* through the process of inquiry.

The *actual* domain consists of *events* and *experiences*. Collier (1994) & Bhaskar (2008) state that this is the area where we begin to apply *causal laws* or *assumptions* that *might explain* the situation. What are the social norms? Why do they exist? Why might one patient behave in this manner but not in another? Why does this work for patient 'X' but not patient 'Y'? The important factor here is that we consider these factors in relation to 'the best available evidence and theory' along with what has been observed.

The relationship between *mechanisms, experience, events* and *real, actual and empirical* domains is shown in table 3-2.

Table 3- 2 Interaction between stratified domains of reality (adapted from Bhaskar, 2008)

	Empirical	Actual	Real
Mechanisms			X
Events		X	X
Experiences	X	X	X

d) Modified Objectivity[21]

Firstly, CR is similar to interpretivism when it proposes that human factors and values do impact on research decisions (e.g. areas of interest, developing a research question and how society behaves (it is subjective)). A positivist would argue that this approach creates bias and therefore, findings would not be credible or reliable. Conversely, positivism argues that we can

[21] From this point forward when objectivity is referred to it reflects Bhaskar's view of [modified] objectivity

only report on what is observed and measured and we must minimise all human factors (it seeks complete objectivity).

Subjectivity arises when describing feelings or thoughts based on personal values of the individual. Objectivity arises when these are removed, or at least minimised as far as possible. Consider the image from the previous figure 3-2 p54 (adapted from Dyson & Brown, 2006).

In order to be objective, we would probably take measurement from the tree, note physical observations, measure and observe growth, ecological and biological factors and [try not to] view it with our assumptions, we would not speculate about what has happened but simply present what is evident to us. Subjectively, we would consider how we experience the image, how it makes us feel, what we believe might be happening. Whichever way these findings are presented, they are simply different ways of presenting a world that exists whether we are observing it or not! The conflict arises between who feels their explanation is more 'real' than the others. In critical realism, we take all of these views on board, we also consider previous evidence, previous theory and the possibility that structures may exist that cannot be seen (regardless of your perspective); hence, a critical realist is objective about all evidence available in a manner that acknowledges the fact that humans and society [by nature] are likely to be subjective. Thus, CR takes on what is known as 'modified objectivity'.

e) Open and closed systems

Bhaskar (2008) proposes the concept of open and closed systems in which inquiry takes place. The difference between the natural and social sciences is noted here; closed systems are those which exist regardless of human interaction, those which can be completely controlled (e.g. a laboratory; measuring gravity in a vacuum), open systems are those in which there is a human factor and contexts where there are uncontrollable factors (e.g. society, organisations, teams,

people, places). Consequently, CR asserts that neither quantitative or qualitative data is right or wrong, approaches to inquiry should complement the object under study and the nature of the research question, aims and objectives.

3.4 JUSTIFICATION FOR POST-POSITIVISM AND BHASKAR'S CRITICAL REALISM

There are some common criticisms of CR and I have addressed these in appendix 9 p312. Here I will discuss why I rejected positivism, interpretivism and critical theory in favour of post-positivism, in particular Bhaskar's critical realism.

The primary reasons for this decision are:

- *stratified reality*
- *truth is fallible*
- social situations can change over time
- the concept of *causality* (discussed above)[22].

Online Social Networks (OSNs) such as Facebook are massively complex social environments. Different individuals view what can be seen and observed differently. What one person feels is acceptable may not be acceptable to others, conversely those in the online environment may express political, cultural, economic or religious values that would not normally be shared in the offline environment. Furthermore, these underlying social structures may also influence actions and behaviours. Based on the influence of media and professional publications there is often the assumption that Facebook is a 'risk' for professionals, with repeated examples of how they may have been disciplined or suspended for what is unprofessional behaviour. Due to the rapidly changing factors in OSNs I do not believe there is a way to ever truly know the reality, why or how individuals behave the way they do. However, the proposition that there is a *stratified reality* would enable the exploration of this and development of a theoretical

[22] N.B. to aide my justification, *italic* text will be used to highlight relevant principles & components of CR

framework that may explain not only what happens, but 'why' this might happen. Acknowledging the complexity and 'openness' of Facebook and the student nurse community means that I am able to 1) explain what happens between the different 'components' of a system, 2) explain why it might happen the way it does (*causal mechanisms and theory)* but 3) how we might approach and manage this *(applied knowledge/frameworks)*.

3.4.1 Rejection of positivism

Positivism claims that there is only one absolute truth, that a researcher's conceptualization taken from observable and measurable facts is actually a reflection of reality; that there is the existence of a universal generalisation that may be applied across contexts (Wahyuni, 2012). This concurs with the concept of deductivism in that science should seek to prove or disprove universal laws that can be observed and/or measured. For example, information shared through Online Social Networks (OSNs) can be recorded and used to prove that individuals share personal information publicly or personally. However, with empiricism, naïve realism or logical realism assuming that [observable] laws are not subject to change or influence is arguably incongruent with the study of society. In OSNs, observable behaviours cannot be attributed to one single cause, nor can they be controlled in the context of an experiment. Even if it were possible to attempt to remove influential factors in order to observe the influence of one, there is no guarantee that the participants involved would not then be affected or changed by the experiment itself.

In chapter 2, I referred to a model of behaviours and information sharing in OSNs (appendix 4 p306), which argues that individuals may respond, that behaviours may change, based on external and more complex influencing factors (e.g. emotions). Hence, there is no single *cause and effect).*

Therefore, when seeking to achieve study objective IV (p16) deductivism was rejected on the basis that there are no consistent laws within OSNs. Inductivism was rejected on the basis that knowledge of OSN behaviours cannot be concluded through observation, quantification of posts and actions on Facebook. Popper (1970) and Howell (2013) would agree that this assumes the social world operates by some clockwork regularity. OSNs simply do not operate in this way. Conversely, such an approach would simply outline the type of information shared, by whom and when; it is descriptive and not explanatory. It tells us what is happening but not why and by what (evidence based) methods we can manage and create change. This was a limitation of the study published by Levati (2014), for example. The majority of research evidence in this field does not acknowledge the complex structures that influence attitudes, norms and behaviours in OSNs and during professional socialisation. Without this it is not possible to 1) change any of these behaviours, 2) inform organisations and professionals how they might be professionally accountable in this environment, 3) explain what the professional 'norms' are within the online environment and, 4) explain why people behave in certain ways in what circumstances.

Bhaskar (2008) presents positivism as 'closed systems' ontology. A closed system aims to remove external influences in order to generate facts and laws that describe what we can see and measure [not explain]. Research on disclosure of information, privacy and professionalism from Guan & Tate (2013) and Clyde *et al* (2014) illustrate the limitations associated with this approach to studying OSNs. Creating simulated profiles and OSN environments that were controlled by the researcher meant that underlying behaviours and therefore, study results were arguably not representative of the 'reality' of behaviours within them. It also implies a fixed environment, which OSNs are not; they can change from minute to minute/day to day. Nor is it possible to attribute one post, behaviour or action to a single observable cause within the vast and ever-changing network.

Observation of the range of influences suggested in the professional socialisation model (appendix 1 p289) identifies clearly that there are many potential underlying structures that may influence the pre-registration student nurses' position, attitude and behaviours relating to OSNs and accountability. Not only because there are both online and physical influences, but also influences from an individual's current emotional state or previous experience in the OSN. Conversely, the number and type of 'friends', levels of privacy and approaches to information sharing (Ollier-Malaterre *et al*, 2013) is dynamic. Hence, it is contested that the [OSN] world is an 'open system', and those in it [including the researcher] are susceptible to a range of influences (Bhaskar, 2008). This further rejects the concept of inductivism; there is not one single causal law that can be applied across any OSN for any individual. This study intended to identify, explain and seek to understand underlying structures or '*tendencies*'.

In positivism, objectivity arises from the assumption that human beings/participants are 'objects' whose actions can be measured as a result of external factors (May, 2002). Conversely, it also assumes that the products of scientific research are representative of what is real in the external world and that the processes and methods in research are devoid of social values, norms or those of the researcher. I would disagree and believe that my assumptions are also relevant in the research process; I too, experience *reality*.

Bisman (2002) would argue that there are frequent differences in an individual's perceptions and their observed behaviours. Literature (some of which takes an objective view) has already identified disconnect between perceptions of acceptable behaviours, attitudes to OSNs and professionalism along with differing views about what is deemed to be appropriate or not (Finn *et al*, 2010). There is also evidence to suggest that individual perceptions of their behaviours [use of privacy settings or information sharing for example] and their actual behaviours differ.

To achieve this is challenging and necessitates constant reflection and management of activities (Ollier-Malaterre *et al*, 2013), compounded by other underlying structures and influences on perceptions and behaviours. While they are different, they are inexplicably linked and thus, an objective measure of accountability and social behaviours is simply, not that simple.

3.4.2 Rejection of Interpretivism

As Benton & Craib (2001: 177) state,

Critical Realism "what we see is less than what there is"

Interpretivism "what we see is what we get"

Interpretivism focuses on the 'insider view' with a focus on *interpretation* of a situation from the participants experience and perspective of it. While CR may share some similarities with interpretivism, such as the value-laden nature of observation, opposition occurs with the interpretivist assumption that the study of natural sciences is different to that of social sciences (as discussed in section 3.3.2) (Dobson, 2003). Under Bhaskarian (2008) assumptions there are a range of biological and scientific forces at work which are not always known or seen by an individual or social group, nor are they dependent on them existing. I argue that there are parts of reality that exist outside the need for humans to exist or to be observing it (e.g. gravity; evolution). For example, we know there is likely to be disconnect between what people *say* they do and what they actually *do* (Ford, 2011 and Cain *et al*, 2013). Conversely, this does not account for unintended or unseen consequences of actions in the Facebook environment.

Interpretivists imply conscious knowledge and conscious action, I would argue that this is not always the case. For example, when creating a post about having been out with friends it is not necessarily posted with the intention to cause emotional distress. However, there may be individuals who see the post and feel upset because they were not invited or because they are feeling lonely.

Furthermore, I challenge the subjectivity of interpretivism. *Is it true to say that what I believe is, in fact truth or a reflection on reality? What would happen if someone else said something different? How can both of our realities be 'true' and 'false' at the same time* (Phillips & Burbules, 2000)*?* Let's take the tree and wall example presented previously (figure 3-2 p54). Each stick figure has a perspective or belief of the world, they can describe the tree, the wall and its qualities from what they *believe* to be *true*. CR would not argue their beliefs, and would certainly promote understanding of perspectives from those within a social situation in order to explain it further (Phillips & Burbules, 2000; Danermark *et al*, 1997). However, these perspectives or 'beliefs' are not taken as *reality*, this knowledge merely informs the inquiry based on how individuals interpret the world they experience. The *reality* that is the world, the *real domain* in itself does not change just because someone different is looking at it.

For example, *if a tree falls in the woods does it make a sound or does it only make a sound because someone was there to hear it?* Sound is the vibration of particles and does not rely upon someone to hear it in order for it to have happened (*intransitive knowledge*). Hence, it is incorrect to say that personally and socially constructed perceptions and attitudes are *truth,* they are *beliefs*. Consequently, I should not *believe* something to be *true* because others *believe* it to be *true.* If so, the figures in the diagram would be viewing different worlds, multiple realities and they are not (there is just one picture and therefore, one reality). Hence, interpretivism **misinterprets** the difference between *belief* and *truth* and therefore, *reality*.

Furthermore, the interpretivist would emphasise that the human experience and their construction of this is of primary importance in generating knowledge of a social system or

culture. However, it is contested that cultures and social systems are 1) not always shared by everyone in them, and 2) are not solely influenced and constructed by those within them. I would agree that understanding perceptions and experiences of Facebook are useful. However, there are underlying *structures* and *mechanisms* that lead to these perspectives, social interactions and behaviours in the Facebook environment. When using and responding to Facebook, it is unlikely that individuals are considering the *real* reasons [and underlying *mechanisms*] as to why they are doing so. For example, some of the common reasons for using Facebook were presented in chapter 2 and included 'keeping in touch with family and friends'. The interpretivist would be interested in the experiences and reasons for this; however, they would not consider the social structures that might influence these reasons, nor the possible reasons for appropriate or inappropriate behaviour. This leaves us with a deep description of how people experience Facebook but little explanation about *why* and *what* and [more importantly] *how* this may be managed. Without knowing this it is not then possible to influence professional behaviours going forward[23].

3.4.3 Rejection of Critical Theory (CT)

There are some shared principles in CT with that of post-positivist CR. Firstly, CT and CR both agree that there are underlying social structures and mechanisms that influence social behaviours and events. However, CT considers these to be oppressive and that investigating them and their influence can raise awareness and bring about social change (Bronner, 2011). CT also places particular emphasis on politics, culture, religious and economic structures.

In section 3.3.2 p55 I discussed the concept of Bhaskar's (2008) transitive and intransitive knowledge, which is relevant when critiquing CT. By valuing modified subjectivity, CT places

[23] I would have been unable to achieve study objectives IV & V the 'application' of knowledge

focus on that which is historically and socially constructed and defined; how people experience things, how power structures affect them, and this behaviour is the object of inquiry. Conversely, CT wishes to create social change through emancipation[24]. In this way, CT displays no real interest in intransitive knowledge [even though a CT might not deny the concept of such science e.g. gravity, light]. Furthermore, CT already assumes that power structures are oppressive, and I argue that this limits the *structures* that can be examined and *the way* in which they are examined. CR does not assume oppression, but I would consider oppression to be something that **could** be experienced. I argue that underlying mechanisms may either be enabling or oppressive [or even both] depending on the context and object of study. If a CR were to study racism, the objective would be to understand the mechanisms by which this presents itself (e.g. Porter, 1993) and not only to focus on the consequence that is 'oppression' or freeing people from 'racism'; it tells us little about how to 'address it' and we cannot make the assumption that it exists, nor that it exists in the way we assume.

As discussed in chapter 1, I did not make the assumption that professional standards, accountability and Facebook to be oppressive. I can see how mass media and even politics might have a role to play in OSNs, however that was not the sole objective of this study. Secondly, my aim was not to change behaviours nor create social change [although change might be a bi-product of participation and of the conclusions I have drawn]. We do not yet know if or what change is needed in the context of my study. Conversely, [as I conclude in chapters 5 and 6] there are many structures involved in the relationship between the pre-registration student nurse, accountability and Facebook.

[24] *"The fact or process of being set free from legal, social, or political restrictions; liberation" (Oxford Dictionaries, accessed 21 July 2017).* CR **may** be emancipatory but by this definition, emancipation is not the primary focus of CR. Also, the generation of new knowledge may be 'emancipatory' but we cannot assume such enlightenment will occur (Hammersley, 2002)

3.5 Methodological choices in post-positivism: a focus on ethnography

Through reviewing the available literature, I found four common methods used in post-positivism. Critical realist evaluation, action research, quantitative evaluation and ethnography. I will begin with an overview of ethnography and follow with a justification of my choice to employ critical realist ethnography (CRE).

Ethnography has many proposed definitions a result of its history and evolution. However, Atkinson (2001: 4) suggests that ethnographers are,

"grounded in a commitment to the first-hand experience and exploration of a particular social or cultural setting on the basis of (though not exclusively by) participant observation."

Ethnography has often been the preferred method of inquiry for post-positivist realists such as Barron (2013), Porter (1993) and Hammersley (1992). The statement provided by Atkinson (2001) above emphasizes the commitment of ethnographic study to the exploration of cultures or social settings, and complements the knowledge sought by critical realists such as Bhaskar.

As critical realists, we have a particular interest in what is happening but also *why* something is happening in a particular situation. Although traditional forms of ethnography aim to describe and understand cultures and social groups, the *critical realist* component is that it enables the researcher to examine what is happening, but also apply theory to explain why and what this reveals about the underlying mechanisms *causing* these behaviours and the context in which they occur (Ackroyd, 2009).

Danermark *et al* (1997) assert that the realist ethnographer may begin with the 'traditional' approach to ethnography, which provides understanding of how social actors behave and perceive a situation. However, adding the term *critical* has clear purpose. The term *critical* can be defined as,

> *"expressing or involving an analysis of the merits and faults of a work…"*
>
> (Oxford Dictionaries, n.d.)

Thus, the *critical* in CRE is focused on,

1. Challenging the *behaviours*, perceptions and beliefs [*tendencies*] of social actors [*entities*], about a phenomenon in a given context [for beliefs are not necessarily the *truth* of *reality*]
2. Consideration of the possible *causal mechanisms* and *structures* that explain why the phenomenon occurs as it does in a given context [possible *theories*]
3. Explaining the phenomenon (not simply description of what was seen) through retroductive analysis (appendix 8 p311), which evaluates the benefits and limitations of each *theory* considered in point 2 above
4. Recognises that the conclusions are *fallible*

3.6 JUSTIFICATION FOR ETHNOGRAPHY

Here, I will provide a brief justification for the use of ethnography and justify my rationale for rejecting critical realist evaluation, action research and quantitative evaluation.

Online social networks (OSNs) such as Facebook are complex networks of individuals and communities. As a result, there are a diverse range of social norms and practices that are accepted or not accepted. Conversely, professional accountability and therefore, professional socialisation in nursing has a wide range of influential social structures (Weidman *et al,* 2001). The approach for this study needed to acknowledge these complexities, but also enable some objective observation of what goes on within Facebook. Furthermore, we know that what people *say they do* does not always reflect what *they actually do* in the online environment. Layder (1993) argues that ethnography, through extended observation of behaviours, can be used to present a structured scientific process to the analysis of social structures, while at the same time recognising the importance of meaning within that structure.

I assert that ethnography was an appropriate method for the following reasons:

1. The research question is looking for meaning and explanation to understand the nature of complex social situations and their relationships
2. I do not have preconceived assumptions about what behaviours are or are not present and why this is so
3. In order to explain the behaviours in Facebook it requires a method that enables observation of these over an extended period of time
4. Ethnography advocates the triangulation of several different sources of knowledge
5. Theory developed from the triangulation of sources can be ‘tested’ using the raw data

As discussed in chapter 2, this study will add much needed knowledge and explanation about *why* behaviours occur as they do and *what* the influence is on professional accountability; something that the current evidence base fails to do.

3.6.1 Rejection of critical realist evaluation

Critical realist evaluation as proposed by Pawson & Tilley (1997) originated from Bhaskar's critical realism and therefore seems like an obvious and logical method to adopt, particularly as one of my objectives seeks to inform development of educational intervention, guidance and policy on the use of OSNs; *what might work for whom and in what circumstance*. And, I have attested to how I see the relevance of such an approach in healthcare. However, I feel that Pawson & Tilley's (1997) model for evaluation is [for this study]:

- Too simplified
- Too focused on outcomes and key performance indicators (KPIs) as empirical measures
- Does not genuinely seek to explain the underlying social structures

It is too simplified in the way that it lends itself to more rapid evidence assessment and implementation through a structured cycle. It was designed to be this way, to make it accessible to a range of stakeholders who may use it in the healthcare or social intervention/programme context. However, in order to explore, understand and explain the vastness and complexity of Facebook and professional socialisation I felt that this was inadequate.

I also believe that critical realist evaluation is too focused on outcomes and KPIs that typically lend themselves to empirical measures rather than genuinely seeking to explain why things occur as they do. Even the example given by Pawson & Tilley (1997: 134) illustrates the outcomes as items that would be measured by percentages or statistically. This means that there is relatively little scope for qualitative outcomes to be explored, which I believe, are also of

value. Conversely, I was not focused on one particular outcome or intervention, but those social structures and mechanisms that might lead to specific outcomes (i.e. mechanisms and context are of primary interest, but I must start with that which is observable to work backwards) (Danermark *et al*, 1997). Porter (2015) would agree and further argue that, while informed by Bhaskar, critical realist evaluation often deviates from Bhaskar's critical realism by seeking to 'falsify' or 'verify' interventions that do or do not work (and may [unknowingly] take influence from a wider range of post-positivists such as Popper, 1970).

Furthermore, critical realist evaluation requires a 'hypothesis' and 'series of theories' to be established for testing in stage 1 of the process (e.g. for public health interventions) (Pawson & Tilley, 1997). This means that the researcher enters with a particular set of assumptions about what does [not] work and this influences the process of inquiry. It also means that there is little scope for generating 'new' theory. It is in this way that I do not feel this model genuinely seeks to explain why things occur as they do but is committed to explaining why an intervention will or not work. Hence, this would not allow me to achieve my study objectives (chapter 1 p16).

3.6.2 Rejection of action research

There are authors who advocate the use of realist action research (Houston, 2010; Winter & Munn-Giddings, 2001; O'Hanlon, 1996). These authors argue that action research enables collaborative action, learning and change by understanding what is going on in a situation. However, I challenged action research for the following reasons:

- It is highly value-laden
- It is relevant locally
- It fails to understand social structures and explanation of *why* something works

- Complete immersion as a facilitator-researcher means that situations may be more likely to be misrepresented or misinterpreted

While critical realists acknowledge the unavoidable role that values play in guiding some parts of the research process, we also assert that a clear, structured research philosophy is required to limit the impact of these values on inquiry. This was of particular importance for this study given that I have been a pre-registration nurse, am in the nursing profession and a Facebook user. Hence, as discussed in chapter 1 my background, experience and values did inform my direction with this study; they were the 'spark' to investigate this topic in the first place! In light of this, I have been clear about my assumptions relating to accountability and Facebook as I entered the process of inquiry. However, I did not hold strong assumptions about what I might find in the process of the study. I did believe there will be a process of personal learning throughout the inquiry[25] but this was not the primary objective of this process.

Conversely, I believed that an understanding of perceptions and attitudes of student nurses is an essential part of explaining how they view the social situation, but that they were not the only source of data that could explain this. Action research relies solely on the experience of the researcher and its participants, making it highly subjective. Stringer (2014) highlights this as a limitation to action research; when only looking at perceptions it is easy to lose sight of the relevance of these in the 'bigger picture'. Action research generally produces simple solutions to everyday, practical problems and not 'wider' issues such as 'professionalism' and 'socialisation'.

[25] Chapter 6 includes a reflection of my learning

Indeed, Ackroyd (2009) argues that action research often focuses too much on the researcher and the 'local' area of inquiry (in which the researcher is usually integrated). Hence, this can lead to misrepresentation and/or misinterpretation of a situation. Conducting a local action research project would not have acknowledged the vast nature of Facebook as a global social network and would have merely explained how we *might* change something rather than explain what is going on.

3.6.3 Rejection of quantitative evaluation

From my literature search I concluded that quantitative research dominated the evidence base on this topic. Examining or describing the patterns of use and behaviours of healthcare professionals using Facebook (Campbell & Craig, 2014; Farooqi *et al*, 2013; Ford, 2011; Gray *et al*, 2010; Cain *et al*, 2009). Hence, even before any limitations to this approach are considered, choosing to conduct quantitative research would have limited the progression of current knowledge in this field.

Although post-positivist realists do not particularly rule out the use of quantitative methods, they are sceptical about their affiliation with positivist and empirical research principles. Ackroyd (2009) argues that depth of inquiry into open and complex social systems requires more conceptualization than is provided by quantitative evaluation. I would agree, because of the complex nature of Facebook and its relationship with professionalism, quantitative evaluation was unlikely to produce explanations that would meet the objectives of this study. That is not to say that these pieces of evidence were not used to inform the theory developed from this inquiry; the critical realist approach advocates the use of current literature and multiple methods of data collection.

3.7 ETHNOGRAPHY

Having justified my reasoning for an ethnographic approach to this study, this section goes on to provide an overview of the different ethnographic approaches available to me. In Ryan (2017a) I discuss the historical context and principles of ethnographic study and this also informed my choices.

3.7.1 Realist Ethnography

Ethnography is traditionally the observation and description of cultures within groups. Hence, the term culture is important but arguably often misunderstood across other disciplines. Maxwell (2012) argues that the concept of culture [despite being of primary focus in ethnography] is difficult to define, however most disciplines acknowledge that culture is shared belief or values held by members of a community or social group. Maxwell (2012: 26 emboldened text not in original quotation) defines culture as,

"a domain of phenomena that are ***real****, rather than abstractions; both symbolic-meaningful (i.e. part of the mental rather than physical perspective) and collective (that is, a property of groups rather than of single individuals); that* ***cannot be reduced to individual behavior or thought*** *or subsumed in* ***social structure****; and that is* ***causally interrelated*** *with both behavior and social structure."*

It is in this way that culture can be seen as an interaction between the mind and social experiences. It is not always consciously produced but the influence of such a *structure* might be observed in the common behaviours within and across groups; it is not just about what is happening but *why* it is happening. The term *causally interrelated* complements the concept of

causal mechanisms and *structures* in CRE. The reference to *real, rather than abstraction* also concurs with Bhaskar's (1998) domains of reality.

Hence, traditional ethnographic methods from a constructivist or positivist standpoint can never really go into sufficient depth to explain the *causal relationships* in a culture and why its associated behaviours exist as they do. We need to go beyond telling stories, beyond acceptance of behavioural observations and not take the perceptions of participants at face value. We should also acknowledge that there is a *reality* [and associated social *structures*] that may exist outside of human understanding and/or awareness (Davies, 2008; Porter, 2002, 1993).

Consequently, CRE starts in the same place to that of more traditional methods, with the perceptions and experiences of individuals, but goes further, using retroductive analysis and theory testing (appendix 8 p311) to *explain* the conditions that exist in order for the behaviour and attitudes to occur; drawing on a range of evidence sources.

Hence, CRE acknowledges the perceptions and experiences of social actors but uses this as a starting point for further inquiry through observation, use of previous theory and evidence; to evolve knowledge, to evolve theory. This means it can negotiate the conflict between positivist and interpretivist/constructivist ethnographic approaches by using the interpretivist emphasis on the role of subjective meaning, the structure and rigour of positivists methods.

3.7.2 Justification for Critical Realist Ethnography

I assert that social processes and social activity are interdependent; social processes are the product of our activity, but our activity is what causes such processes to exist and evolve; they

are *open systems*. Such social *structures* are similar to the common 'chicken and egg' scenario; it is not easy to determine which came first. In this way, they are complex and dynamic and as such, studying them is also complex and dynamic.

Reality is stratified across three domains: empirical, actual and real. Social structures and social processes (mechanisms) exist in *reality* but this does not mean we can physically observe them; we can merely observe the *events* and *outcomes* that they create. Having discussed Maxwell's (2012) definition of *culture* I put forward the proposition that *culture* is the name given to a group of behaviours, attitudes and values apparent in a group or community; *culture is an outcome of a social structure and social mechanisms*. Moreover, I would argue that in order to explain professional behaviours and attitudes in Facebook, then I needed to go further than the understanding of pre-registration student nurses and those who influence professional socialisation to really begin to examine the combination of *mechanisms* that exist in these *social structures* that *cause the effects they do* (Reed, 2009; Porter, 2002).

3.7.3 Why CRE and not just 'ethnography'?

In order to examine the *culture* of Facebook and its relationship with professional socialisation I would argue that I needed to go further than just observing and then describing what was going on. Levati (2014), White *et al* (2013), George (2011) and Finn *et al* (2010) all studied Facebook use in healthcare professionals and all employed a qualitative approach to inquiry. Finn *et al* (2010) was the only source that highlighted its approach to epistemology through social constructionism (interpretivism/constructivism), outlining perceptions and beliefs about identity and professionalism in medical students. Al-Saggaf (2011), Tow *et al* (2010) and Heiman (2008) all conducted ethnographic study of behaviours and uses of Facebook. They are unclear about their philosophical approaches but state that they used ethnographic methods such

as semi-structured interviews. I would argue that this lack of transparency results in a loss of structure and rigour, that this approach to 'post-modern' ethnography is being used as a loose term for what is simply qualitative inquiry (Davies, 2008; Porter, 1993, 2002). Furthermore, these ethnographies only describe the use, perceptions and behaviours of their participants and make no attempt to explain what *mechanisms* and *structures* might exist to cause these *outcomes*.

Wagner & Stempfhuber (2013) employed Habermas's critical theory to analyse unruly behaviours on public communication in Facebook. This critical ethnography entered with assumptions from outset; Facebook communications are a 'problem', Facebook is oppressive. This was reflected in the outcomes and structures identified in their conclusions and proposed 'solution'; solutions to a 'problem' that has not yet been confirmed.

To be successful in achieving my study objectives (chapter 1 p16), it meant moving away from the subjectivity of interpretivist ethnography, the authoritative nature of positivist ethnography and the [in my opinion] assumed negativity (oppressive stance) of critical theory.

There are many authors of realist ethnography in the social sciences: [most famously] Rees & Gatenby (2014), Barron (2013), Porter (2002, 1993), Reed (2001), Hammersley (1990). My main criticisms of Porter (2002, 1993), Reed (2001) and Hammersley (1990) is the limited detail provided about the research process and the use of 'traditional ethnographic methods' [rather than those which reflect post-positivist CR]; these only provided a limited steer for my study.

For the purpose of this discussion, I chose to critique Porter & Ryan (1996) and Porter (1993), as the most commonly cited CRE in nursing, Hammersley (1990) as a well-referenced sociology ethnographer valuing *subtle realism*[26] and Rees & Gatenby (2014), from an organisational perspective who provide a more detailed description of research processes and principles.

[26] We know *reality* from our own perspectives and beliefs

3.8 WHOSE CRITICAL REALIST ETHNOGRAPHY?

3.8.1 Hammersley & Porter

Hammersley (1992; 1990) proposes a *subtle realist* approach to ethnography. Hammersley, like post-positivists offered an approach to ethnography that negotiated the conflict between naïve realism and relativism. Subtle realism seeks to 'combine' the benefits of positivist and interpretivist approaches, accepting *fallibilism* and the notion that perceptions and observations may not be the only source of knowledge.

On the surface, these share some of the common principles of Bhaskar's critical realism. And, Hammersley, like Porter (2002) propose that post-modernist ethnography has removed all structure from the approach to inquiry and the positivist places too much emphasis on fixed generalised sociological laws. However, I argue that *subtle realism* is less about *realism* and more about a *modified relativism,* Hammersley's efforts to negotiate criticisms from the tenets of naïve realists and relativists. Unfortunately, it is not possible to please all of the people all of the time. Subtle realism still prioritises beliefs and perceptions of social actors and prior to this, Hammersley's work did align more closely with relativism. Conversely, it makes no effort explicitly align itself with the principles post-positivism. Instead, it uses the term *subtle* to account for deviation from the principles of purer relativists and consequently, away from their criticisms about the credibility of *subtle realist* principles as an ontology. It then follows that this shift leaves *subtle realism* at the critique of post-positivist critical realists.

Porter (1993) conducted ethnographic study informed by Bhaskar's critical realism, proposing that, in order to ensure that knowledge generated from inquiry has purpose and application in practice then we need to go further than description and understanding of social situations. He

asserts that we should also consider the possibility that social actors can misinterpret and misunderstand what is *really* going on. Porter (1993) argues that the purpose of ethnographic investigation should be to examine relationships between social actors and social structures, in order to move from illuminating small scale social events to explanations of the wider context of these *mechanisms, structures* and the *outcomes* they create. Porter's work has similarities with Hammersley's (1990) theory on ethnographic practices. However, Porter (1993) criticises Hammersley's subtle realism for its ignorance of transitive knowledge [and I would agree]. Furthermore, Hammersley's aim in ethnography places focus on human perceptions of their social situation and disagrees that social structure and social actions are interdependent, simply that they both play a role as sources of knowledge. Not only does this dismiss two core concepts of critical realism but also is a contradiction of Hammersley's (1992, 1990) own tenets on subtle realism. For example, how can we place focus on investigating people's perceptions while acknowledging that *reality* exists outside of our knowledge of them?

In my opinion, the problem with Hammersley's subtle realist ethnography is twofold. Firstly, it is opaque in its philosophical approach. I have previously discussed my rationale for the need to be transparent in these assumptions. Secondly, because Hammersley does not make clear the philosophical assumptions informing his ethnographic approach, the approach in itself lacks rigour. By offering a mid-ground between positivist and post-modern ethnography without solid philosophical grounding it creates confusion and contradiction. For example, Hammersley (1992; 55) states,

> *"I do not believe that reality is structure less. In* ***constructing*** *our relevance's, we must take account of what we know and can discover about that structure" (bold format not in original quote)*

Hammersley instead, proposes an approach that focuses on people's constructions of the world while at the same time arguing that objects exist outside of human knowledge of them. Banfield (2004) would agree and suggests that Hammersley's subtle realism promises ethnographers the choice of selecting the best principles from the approaches available, no longer having to choose between positivist or constructivist methodology. This vagueness and 'anything goes' approach is therefore unhelpful to the ethnographer making methodological decisions about the direction of inquiry.

Porter's (1993) critical realist ethnography examined the interaction and relationship between professionalism and racism in doctors and nursing staff through participant observation. Porter & Ryan (1996) subsequently used critical realist ethnography using semi-structured interview and overt observation to explain the much-debated theory-practice gap in nursing. Critical realist ethnography enabled theoretical explanations about the phenomena under inquiry rather than descriptions of racist behaviours or what the theory-practice gap is. Porter & Ryan (1996) were not only able to present evidence that a theory-practice gap exists but were also able to explain potential root cause hypotheses of why, then present the evidence to support that a theory-gap exists in the wider context of nursing as a profession. Hence, critical realist ethnography enables the researcher to consider current evidence, theory and practice in combination with in depth explanation of why things occur as they do, underpinned with theoretical & research evidence which in turn progresses knowledge but identifies the likely root cause[s] of social problems and social phenomena.

3.8.2 Rees & Gatenby

I acknowledge the contribution to critical realist ethnography provided by Porter & Ryan (1996), Porter (1993) and Hammersley (1990). They present an evolving justification of the

relevance of realism to ethnographic study in the social sciences. However, their approaches are evidently flawed. Hammersley has little underlying philosophy and lacks detail in description of the principles of how to go about realist ethnographic study. Conversely Porter provides a well-argued philosophical rationale, but his methods of inquiry and analysis lack detail and justification. I suggest that this is because critical realist ethnography is generally rare in healthcare and health education by comparison to other approaches (e.g. post-modernist, interpretivist ethnography). Hence, I looked to other fields of social science to find an ethnographic approach that mediated these shortfalls.

Rees & Gatenby (2014) are explicit in their philosophical approach. Like Porter, they are informed by Bhaskarian critical realism and its principles. As do Porter & Hammersley, they provide a well-justified reasoning for the links between ethnography and critical realism [although Hammersley fails to justify his philosophical position]. The main advantage of Rees & Gatenby (2014) is their detailed account of methodological implications and approaches to analysis. For example, retroduction is a core element of the analytical logic of critical realism yet neither Porter nor Hammersley make reference to this, nor do they fully describe the stages by which they conducted analysis. Although there are still areas of vagueness in Rees & Gatenby (2014) they at least acknowledge these limitations based on the limited detail available elsewhere in published CRE research. Hence, I took the detail provided by Rees & Gatenby (2014) and aimed to be explicit and sufficiently detailed about my methodological framework where others had failed. In order to achieve this level of detail I draw on ‘good practice’ from a range of authors including: Rees & Gatenby (2014), Elder-Vass (2010), Reed (2009) and Danermark *et al* (1997).

3.9 CHAPTER SUMMARY

This chapter has discussed the rationale for employing an underlying research philosophy:

- To guide the inquirers beliefs about what is truth, reality and knowledge
- To conduct rigorous research in the eyes of their scientific community; transparency, credibility, trustworthiness, reflexivity
- To direct the selection of appropriate research methods for data collection, analysis and use of theory in order to explore the phenomena

I have presented the argument for employing Bhaskar's 'Critical Realism under the post-positivist paradigm. The primary reasons for this are threefold:

1. It acknowledges the complexity of OSN social structures through the principle of *stratified reality*
2. It acknowledges that due to the nature of social structures and the changeable nature of OSNs there can never be one confirmed *truth* of what is *real*
3. It enables me to theories and explain what might happen, the way it does and in what circumstances [*causal powers*] by using appropriate evidence & sources available at this time

Methodological considerations for post-positivism were considered. These were action research, critical realist evaluation, ethnography and quantitative evaluation. Subsequently, I provided a justification for my choice of ethnography. My justification for selecting critical realist ethnography is presented along with a discussion of relevant leaders in this field have influenced the design and methods of this study. Primarily, critical realist ethnography shares commonalities with more traditional ethnography however, taking a critical realist approach to data collection and analysis, allowing for more depth of explanation about the social structures that impact on behaviours and actions. I have also proposed that critical realist ethnography serves to negotiate the conflict between positivist-post-modern perspectives about ethnographic

inquiry while maintaining a detached approach to observation that is not typically afforded in critical ethnography.

Chapter 4 will take the concept of critical realist ethnography and apply this to the methods of inquiry in this study. It will describe and justify the methodological decisions made and describe the processes employed in order to achieve my study objectives (chapter 1, page 16).

CHAPTER 4 RESEARCH METHODS

4.1 INTRODUCTION

Chapter 1 provided an outline of my background, assumptions and rationale for conducting this research. Chapter 2 discussed the available research evidence on the topic of Facebook use among students and healthcare professionals. Chapter 3 has provided a discussion and justification of my guiding post-positivist philosophical assumptions and choice of critical realist ethnography as my approach to study.

This chapter will first provide an overview of how critical realism influenced my methodological choices, how these were then used in observation and semi-structured interview and how these achieved study objectives II-V. A summary of this chapter can be seen in table 4-1.

Table 4- 1 Summary of chapter 4 contents

Chapter section	**Content**
4.1	Introduction to chapter 4
4.2	Critical Realism applied to methodological choices
4.3	Approach to semi-structured interviews
4.4	Approach to focus groups
4.5	Approach to unstructured, non-participant observation
4.6	Method of analysis
4.7	Ethical considerations
4.8	Rigour
4.9	Chapter summary

4.2 CRITICAL REALISM APPLIED TO METHODOLOGICAL CHOICES

Some of the core characteristics of ethnography have been discussed in chapter 3. Ethnographic study generally requires intensive field-research observation and triangulation of a range of data sources. As described in Reed (2009) and Rees & Gatenby (2014) there are several core characteristics specific to critical realist ethnography as discussed in chapter 3.

With further detail Rees & Gatenby (2014) and Elder-Vass (2010) present the 'holy grail' of critical realist research with a focus on ethnography. The inquiry must identify:

1. the *events* and *outcomes* that constitute the phenomena under inquiry
2. parts of each of these and the *relationships* between them
3. *emergent properties, tendencies/causal powers*
4. the *mechanisms* by which these present themselves
5. *morphogenetic* causes that bring about the *events* and *outcomes*
6. *morphostatic* factors that sustain the *events* and *outcomes*
7. the ways in which all of these interact to cause the *events* we seek to explain

Of particular importance is the 'working backwards' from phenomena to theoretically identified *causal powers, mechanisms and structures* (Reed, 2009) [retroduction]. As with many ethnographic and non-ethnographic methods, CRE can employ data collection methods such as interview and observation commonly used in ethnographic study. But analysis methods need to be more than traditional descriptive, 'story telling' and interpretive approaches employed in other fields of ethnography (Rees & Gatenby, 2014). The aim of CRE is to *explain* what is creating the *events* we observe; hence I contend that sampling and methods of analysis need to complement critical realist philosophy; something that Porter (1993) and Porter & Ryan (1996) failed to do when they employed 'conventional' ethnographic sampling and analysis methods without more specific detail about what they were and how they were employed.

4.2.1 Sampling frame

The model of professional socialisation presented in chapter 1 (Weidman *et al*, 2001) illustrates a range of influencers on the journey for the pre-registration student nurse (appendix 1 p289). As a result, the sampling frame for this study came from several sources to reflect this wide range of factors but also enable triangulation of data from a range of sources; as advocated for CRE in Rees & Gatenby (2014), Reed (2009) and Danermark (1997) (table 4-2).

Table 4- 2 Sampling and data collection compared to the influences on professional socialisation

	Profession	**Peers**	**University**	**Background**	**Personal**
Observation of student nurse public profiles		X		X	X
Observation of academically orientated public Facebook pages		X	X		
Observation of professionally linked public Facebook groups	X				
Focus group with professionally registered, practicing staff and mentors	X				X
Focus group with academic staff	X		X		X
Semi-structured interviews with pre-registration student nurses	X	X	X	X	X

4.2.2 Data collection in CRE

As illustrated in table 4-2 I employed several sources of data collection: semi-structured interviews, focus groups and observation. My literature review also played an important role in the analysis of data[27]. An overview of the different types of data collection methods used and how they were triangulated is summarised in figure 4-1 p91.

Collier (1994) and Bhaskar (1989) describe the critical realist stratification of reality. In light of this, data collection and the research process should enable me to conceptualise and theorise the most likely representation of 'reality'. As the real domain 'creates' the events in the actual and empirical domains, it is necessary that data collection should enable the researcher to consider what is happening in each of these. Hence, the data collection methods used directly informed or enabled me to theorise what mechanisms **might** be *real* (table 4-3 p92).

[27] Discussed in section 4.6. This reflects the principles of '[re]description' in critical realist analysis

Figure 4- 1 Data collection & triangulation

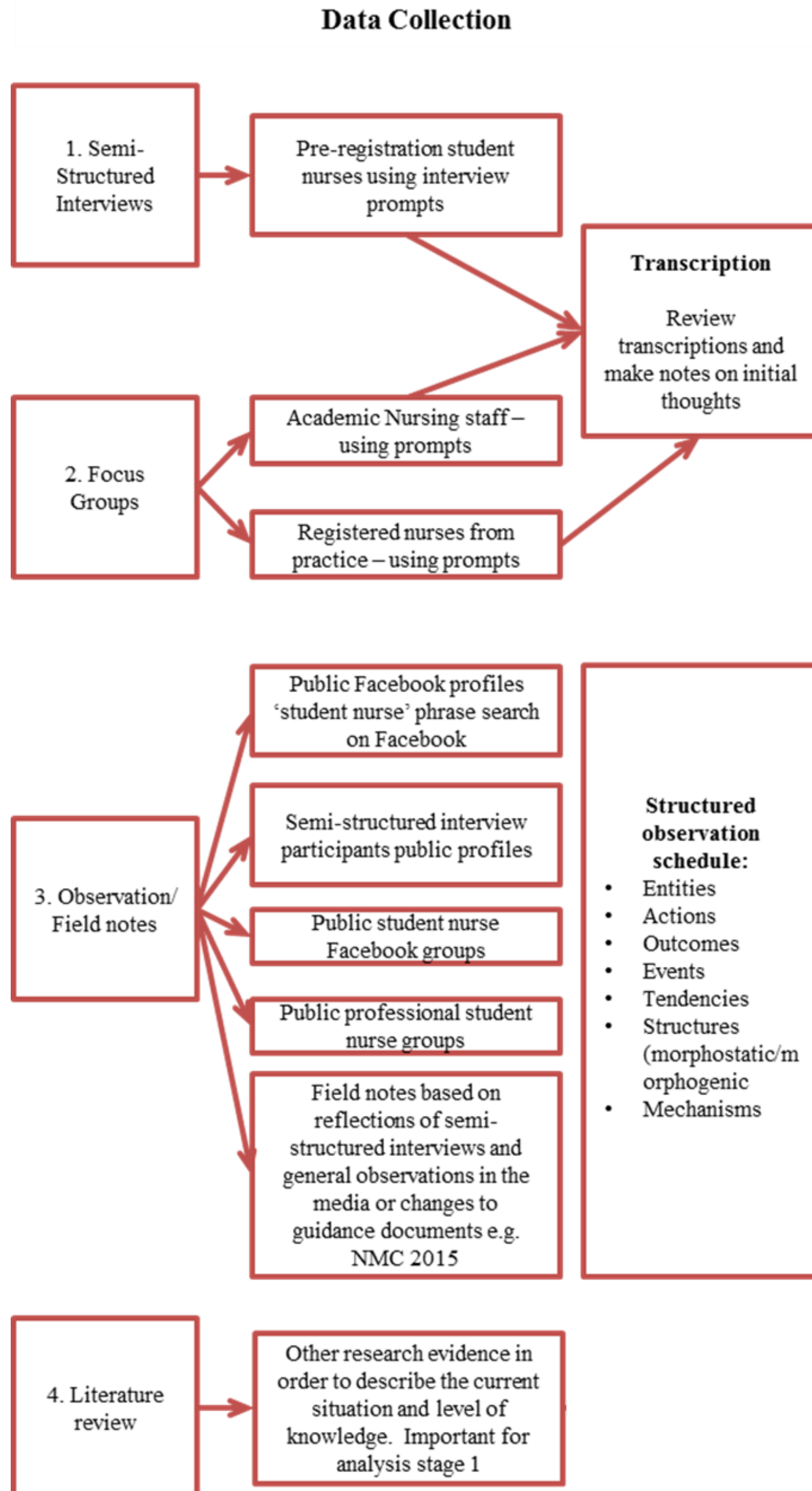


Table 4- 3 How data collection and analysis will enable conceptualization of each domain of critical realism

Data collection method / **Domain**	**Empirical**	**Actual**	**Real**
Observation of student nurse public profiles	X	X	
Observation of academically orientated public Facebook pages	X	X	
Observation of professionally linked public Facebook groups	X	X	
Focus group with professionally registered, practicing staff and mentors	X		
Focus group with academic staff	X		
Semi-structured interviews with pre-registration student nurses	X		
Retroductive analysis, relationships, hypothesis testing (models and theories) and framework generation			X

4.3 Approach to Semi-structured interviews

Semi-structured interviews are commonly used in traditional methods of ethnography with several critical realist studies that have combined semi-structured interview alongside other data collection methods (Barron, 2013; Oladele *et al*, 2013; Porter & Ryan, 1996).

Participant interview is of value to *explain* how meanings might be made, they enabled me to gain insight into the pre-registration student nurse perceptions and experiences of professional accountability, socialisation and Facebook. Combined with observation, they also allowed me to identify any disconnect that exists between the *empirical* and *actual* domains. Hence, participant observation and focus groups played a vital role in achieving my study objectives (chapter 1 p16) (Sharpe, 2005). The contextualisation of these semi-structured interviews alongside the other data sources was essential to go beyond the surface of a phenomena and explore plausible causal mechanisms (Rees & Gatenby, 2014; Smith & Elger, 2012)

4.3.1 Semi-structured interview sampling, sample population & sampling frame

Often, [due to the nature of ethnography] convenience or purposive sampling is applied (Bryman, 2008; Atkinson *et al*, 2001). Ethnographic sampling is typically self-selective which can lead to challenges about credibility and transferability. Random or probability sampling methods are not typically employed in ethnography, commonly the favoured approach in positivist inquiry. Having reviewed the range of ethnographic sampling methods in published research literature, I employed convenience sampling (Rees & Gatenby, 2014; Barron, 2013; Boellstroff *et al*, 2012; Bryman, 2008; Banfield, 2004; Atkinson *et al*, 2001; Danermark, 1997; Porter & Ryan, 1996; Porter, 1993). I acknowledged the criticisms associated with credibility and transferability regarding convenience sampling, however, as I discuss in section 4.8 my

approach to rigour is a model known as TAPUPAS. Conversely, as a critical realist and in complement to intensive research design, I am not necessarily focused on representation or generalisability. Furthermore, I have also employed unstructured observation (section 4.5 p100) looking at a variety of different events and individuals to complement my semi-structured interviews and focus groups; this additional approach to data collection assisted in mediating the potential limitations of convenience sampling.

Sampling was guided by evidence presented in the most recent statistical literature on the demographics of Facebook users (appendix 10 p316). Gender, ethnicity and age were the demographics considered. Ethnicity was particularly difficult to assess given that Facebook does not routinely record ethnic group in the UK. Hence, the most recent data from Duggan *et als* (2015) 'Facebook use by ethnic group' was used as a guide for this characteristic.

Typical users of Facebook were White Females aged 16-24 years. SCS assisted to recruit males and females from all ethnic backgrounds, aged 25-34 and 35-44 years. This reflected a range of *normal, critical* and *extreme/varied* participants (reported in appendix 17 p328). Students from the University of Derby were recruited through my [previous] role as Deputy Director, College of Health & Social Care Research Centre. The target sample size was 15-20 which was considered to be sufficient to explore the topics required, in the time frame and within the resource parameters available for this project (Silverman, 2011; Ritchie & Lewis, 2005; Danermark *et al,* 1997). This was deemed to be an appropriate number of participants to complement the intensive research strategy (appendix 11 p317) required for CRE.

4.3.2 Recruitment to semi-structured interviews

Stage leaders, programme leaders and module leaders were approached to gain access to students and explain the project across all cohorts; 1st, 2nd and 3rd years starting programmes from September 2012. There were between 500-550 nursing students within the University, across two campuses[28]. Students completed an expression of interest (EOI) form and returned it to the member of staff or myself via email or in hard copy format. A deadline for the EOI was given, following which they were reviewed against inclusion criteria and the sampling method described.

Potential participants were contacted via email or telephone and a mutually acceptable date and time was agreed to take informed consent and conduct the interview process.

4.3.3 Semi-structured interviews: instrumentation

Smith & Elger (2012) emphasise the importance of a theoretically informed interview process. As previously discussed, this study was 1) Guided by the principles of critical realist philosophy, 2) Informed by Weidman *et als'* (2001) model of professional socialisation and 3) Caulfield's (2001) perspective of professional accountability. Furthermore, in chapter 2 I conducted an extensive review of current research evidence in this field. Complementary to CRE, I [as the researcher] steered interviews in order to clarify, explore and understand the perspectives of my participants. My role was to draw on the insights of my participants and go beyond their explanations, challenging and confirming my understanding of their responses throughout the interview process (Smith & Elger, 2012). Within CRE the researcher does retain the *power* within the interview and, while this may be construed as a potential limitation or

[28] One in the centre of Derbyshire and one in the North of Derbyshire. Both attract slightly different demographics and have different sized cohorts; 120 and 40 per intake respectively. In the North of Derbyshire these students are predominantly 'local' to the area, first of their family into HE (49%) and mature students (mean age 28 years).

negative aspect in post-modern, interpretivist approaches to interview, here it complemented the modified objectivity valued in CR. And recognised the role and importance of my own background and knowledge of theoretical frameworks and research evidence surrounding the topic (Buchanan & Bryman, 2009).

As a result of these considerations I developed an interview schedule (appendix 12 p318) with the purpose of:

I. Understanding the concept of professional accountability from the student nurse perspective. This is based on the critical realist concept that I cannot seek to explain accountability without understanding the perspectives of those who are expected to practice it.
II. Explore behaviours, actions, motivations and patterns of use of Facebook with the use of prompts and ‘challenges’ e.g. ‘why is that?’ ‘why do you think that is?’ to aim to get to the ‘root’ of the response and enable me to *explain* further why and how events and actions occur as they do
III. Seeking clarification and enabling reflection on any dissonance between perceived and actual behaviours e.g. public privacy settings. This is important to enable me to explore any unconscious or unintended consequences of actions and events

The interview schedule was not ‘fixed’ and, as a result of ongoing observation, events in the media or on Facebook I made slight amendments or additions to my prompts or included probing questions in the interviews. My interview notes and reflections recorded at the end of each interview guided the amendments to prompts but also assisted in my reflections about my thoughts, learning and assumptions throughout the process[29].

[29] Reflections on the learning process are in chapter 6

During and after the interview process I (Whitehead & Hyg, 2005):

- Made notes on the interview schedule of concepts I wish to revisit with the current and/or future participants
- Carried out a reflection following the interview where I noted any questions I still had, anything I might need to clarify through other methods of data collection or any 'hypotheses' I had that might explain the relationships between the pre-registration nurse, Facebook and/or professional socialisation and accountability. These reflections were noted immediately after the interview but I also made notes in my journal intermittently throughout the data collection and analysis process

4.4 APPROACH TO FOCUS GROUPS

While the use of semi-structured interviews and observations explored the personal and peer influence on professional socialisation, Weidman *et al* (2001) (appendix 1 p289) identified university academics and nurses based in practice as part of the journey. Hence, the purpose of focus groups in this study aimed to explore perceptions of other entities who influence the journey of professional socialisation.

4.4.1 Sampling, sampling frame and recruitment

Practice based staff were post-graduate students on continuing professional development modules with the university (but were not taught or known by the researcher). Academic staff were from both the main and hub university campus. The researcher had previously worked as an academic in the main campus team but was no longer in this position.

The university email system was used to send out an invitation, participant information sheet and expression of interest was by return email: two invites were sent over a 4-week period. In addition, there was face to face recruitment of practice based staff through post-graduate module leaders, at the end of lectures. In this case, expression of interest was by completing a form and returning it to the researcher. Once expressions of interest were received (by a set deadline), an online doodle poll was used to choose a preferred date and time for the focus groups.

Before participation, both academic and practice staff were made fully aware of the standard operating procedure for reporting of unprofessional behaviours that may present themselves by participating in the research process (as approved as part of the research ethics application) and there was also explicit reference to the NMC (2015; 2016). This was also recognised as part of the process for obtaining informed consent and on the consent form itself. It was acknowledged that discussion about professional accountability with peers as part of research could raise certain ethical issues. However, nurses frequently undertake this type of discussion as part of

the process of clinical or professional supervision with the purpose of reflecting upon and improving practice and care (RCN, 2003). Thus, a similar ‘ethos’ and associated good practice principles were taken in the focus groups (and included as part of the ethical approval process).

4.4.2 Focus groups: instrumentation

For consistency and to facilitate the process of triangulation of data the focus group schedule of prompts was adapted from the schedule of prompts used in my semi-structured interviews (appendix 14 p320). This was based on theoretical assumption; if academics and practice staff influence the development of professionalism, learning about accountability and thus, professional socialisation, I was eager to explore the same topics and themes within the focus groups as I did with my student participants. I hoped to identify any similar or dissonant themes between the perspectives, and the level of influence these groups may have on each other.

4.5 Approach to unstructured, non-participant observation

Field observation is commonly used in ethnographic study and this is a characteristic that has been adopted by CRE (Rees & Gatenby, 2014; Denzin & Lincoln, 2011; Reed, 2009). Barron (2013), Porter & Ryan (1996) and Porter (1993) employed observation as part of CRE research and this had the added benefit of exposing what might 'actually' be going on, taking the study from *description* of experiences into *explanation* of the phenomena. Unfortunately, the 'approach' or 'strategy' of the process of CRE observation is not well documented and therefore, I explored some of the most common approaches to field observation.

Unlike traditional ethnographic approaches where observation may be the primary route of data collection, here it was to enhance the data collection, analysis process and rigour. I included observation to:

I. Go beyond participant perceptions and experiences (empirical domain) and enable insight into the 'actual' actions and behaviours of pre-registration student nurses in the Facebook environment.
II. Observe of publicly accessible data to enable me to revisit and 'test' my hypotheses about the most plausible *theory* and *frameworks* that explained the relationships between the pre-registration student nurse and online social networks (OSNs). This was an essential part of the retroductive analysis process (discussed later in this chapter).
III. Observe generic behaviours and themes within different realms of the Facebook environment.

Although observation was used alongside semi-structured interview and focus groups, the intention was that it would be complementary; assisting me to consider the 'actual' domain and test hypotheses when conducting the analysis process.

Bryman (2008) discusses several types of observational research:

- Structured
- Unstructured
- Participant
- Non-participant

Structured or systematic observation involves using closed questions or rules to systematically record behaviours. Each participant is observed according to the 'rules' presented in an observation schedule. This would have been inappropriate for my study as it dictates specific types of behaviours I should have been searching for. In doing this, I would have been entering with assumptions about the types of behaviour I wanted to find and, as discussed in chapter 3 (p48) my philosophical approach aims to be open.

As a result, I chose to employ unstructured observation. Bryman (2008) suggests that unstructured observation enables the researcher to observe participants and create a narrative account of the behaviours in a situation or environment. This does not necessarily mean that there was not an observation schedule[30]. However, it meant that there was flexibility to observe a range of behaviours and events that emerged from events in the 'world' (e.g. politics, mass media).

Non-participant observation was chosen over participant observation. Non-participant observation allows the researcher to observe the environment and its participants covertly and without interaction with the participants. In the physical domain, this can be difficult to achieve. Porter (1993) conducted unstructured, convert observation but being a researcher

[30] Discussed in section 4.3.2 p99

working within the team being observed impacted on the timeliness and accuracy of observation field notes. Observing online behaviours in publicly available environments (such as those in Facebook), is done 'behind a computer' and therefore, the challenges faced by Porter in the physical world do not exist. Furthermore, non-participant observation was chosen in order to observe the actual behaviours of pre-registration student nurses (as a community rather than individuals) in the online environment and reduced the risk of researcher influence.

4.5.1 Observation sample population & sampling frame

The principles of Strategic Case Sampling (SCS) were used to identify the four different types of 'events' in the online environment (Danermark *et al*, 1997). *Extreme cases* were those participant profiles, community comments or posts which provide more extensive detail than which is considered to be 'normal' or 'typical'. This might be a very long comment or it might be a profile that displays no security and privacy settings, hence it is completely public. This does not necessarily mean they have to be 'uncommon' but that they deviate from that which is typically observed (Danermark *et al*, 1997). *Extremely varied cases* were those profile pages or post comments that are vastly different from each other in some way. For example, it might be extremely differing views on a particular post or comment. *Critical cases* were selected on the basis that they are very different from what is expected. This might be expression of particularly strong political or religious views or a comment deemed to be inappropriate. Any cases that present with unprofessional behaviour under the NMC (2015) would have been examples of this. *Normal cases* were those who do not fit into any category but those individuals and posts, post comments that are deemed to be 'expected' or 'typical'. These individuals had some level security and privacy applied to their profile or those who posted simple questions on group pages or relatively inoffensive pictures (e.g. cancer awareness campaigns).

In order to obtain a range of examples of behaviours this sampling technique was applied to the following types of Facebook environments over a period of 3 months:

A. Unstructured responsive and ongoing reflections of responses to comments and Facebook activity (e.g. posts as a result of media coverage of political debate)
B. Strategic observations over a 3-month time frame to observe themes and content
C. Observation of semi-structured interview participant public profiles
D. A Facebook search of ‘student nurse’ and the types of information that was shared publicly

I knew that it was likely this type of observation would produce an immense amount data, the combination of SCS and a relatively short 3-month observation period enabled sufficient depth of data. Individual participant’s personal and identifiable details were not of interest to this study but events, types and themes of comments along with context of the responses were (e.g. were comments positive or negative, was there evidence suggesting ‘trolling’ behaviour?)

4.5.1 Data collection

The purpose of observation in this study was:

I. To go beyond participant perceptions and experiences (empirical) and enable some insight to be gleaned from the ‘actual’ actions and behaviours.
II. To revisit and ‘test’ my hypotheses about the most plausible theory that explains (not describes) relationships
III. To obtain an overarching observation of more generic behaviours and themes within different realms of the Facebook environment.

There were a range of research strategies and frameworks available for observation. For example, Spradley (1980) outlines nine dimensions of descriptive observation which is

commonly used in ethnographic study. Table 4-4 outlines these nine dimensions compared to a selection of other models of observation.

Table 4- 4 – Models of observation adapted from Spradley (1980), Rothstein (2001), Sotrin (1999), Kumar & Whitney (2003).

Spradley (1980) 9-dimensions	**Sotrin (1999)**	**Rothstein (2001) A(X4)**	**Kumar & Whitney (2003) POEMS**
Space	Territory	Atmosphere	Environments
Actors	People	Actors	People
Activities		Activities	
Objects	Stuff	Artefacts	Objects
Acts	Talk		Services
Events			Messages
Time			
Goals			
Feelings		Atmospheres	Messages

The first problem encountered with these models was that they take a descriptive rather than explanatory position and, they focus on social actors and not the wider context of what is happening[31]. Hence, this would have simply described what was happening and what was being spoken about in the Facebook environment, but would not facilitate deeper thought about ‘why’. Secondly, they consider ‘things’ or ‘artefacts’ which could not be observed in the Facebook environment. They were not designed to observe *online* behaviours and activity, focused on describing an environment rather than ‘explaining’ what is going on.

[31] These are more applicable to *subtle realism*

I decided to focus on the 'components' of CR (figure 4-1) 'structured observation schedule'). The decision to deviate away from 'traditional' ethnographic models of observation and take this approach was to:

I. Streamline the process of data triangulation and thus, visual 'mapping'[32] that enabled the emerging context and component interaction across all sources of data
II. Ensure that the observation method was fit for the online environment
III. Ensure that the observation method reflected the philosophical principles and aims of CR

[32] See section 4.6 for methods of analysis

4.6 METHOD OF ANALYSIS

Collier (1994) and Bhaskar (1989) described methodological frameworks that can inform critical realist analysis. The first is known as RRRE: resolution, re-description, retroduction and elimination; the second is known as DREI: description, retroduction, elaboration/elimination and identification. Both frameworks inform the logic of inquiry but are less specific about *how* to conduct inquiry and *what* inquiry should look like. As a result, I sought wider evidence from critical realist ethnographic research literature to obtain detail about the practicalities associated with CRE analysis. Although, Rees & Gatenby (2014) and Danermark *et al* (1997) outline similar stages of analysis there is still limited detail about methods of coding, theme building and theoretical mapping of mechanisms, outcomes and structures along with [applied] framework generation.

It is known that the critical realist should seek to find the most likely and appropriate, theoretically informed and practically applicable findings (Collier, 1994). However, current literature on the processes of analysis in CRE omits any level of detail about *how* to go about generating these findings in a practical way. Porter (1993) simply uses the phrase 'conventional' analysis with no further detail and, Danermark *et al* (1997) lists a five-phase approach which has clearly been informed by the RRRE described in Collier (1994) and Bhaskar (1998), but it still does little to provide a detailed account of its practical application. Rees & Gatenby (2014) go further to describe a process of analysis but again, there is insufficient detail about the processes of coding, theming and testing of theory; it simply says 'to do it' as a stage. Therefore, I developed a six-stage analysis process that has been informed by these authors but goes further into detail about the practical steps required in each phase in order to form conclusions, recommendations for practice and theoretical framework (figure 4-2 illustrates how this builds on the triangulated data sources). (N.B. To avoid the stated

limitations of other CRE researchers I provide examples of how each stage of this approach are applied in chapter 5, results).

A more detailed breakdown of each stage of my approach to analysis can be seen in table 4-5 p108.

Figure 4- 2 The flow of data collection and stages of analysis

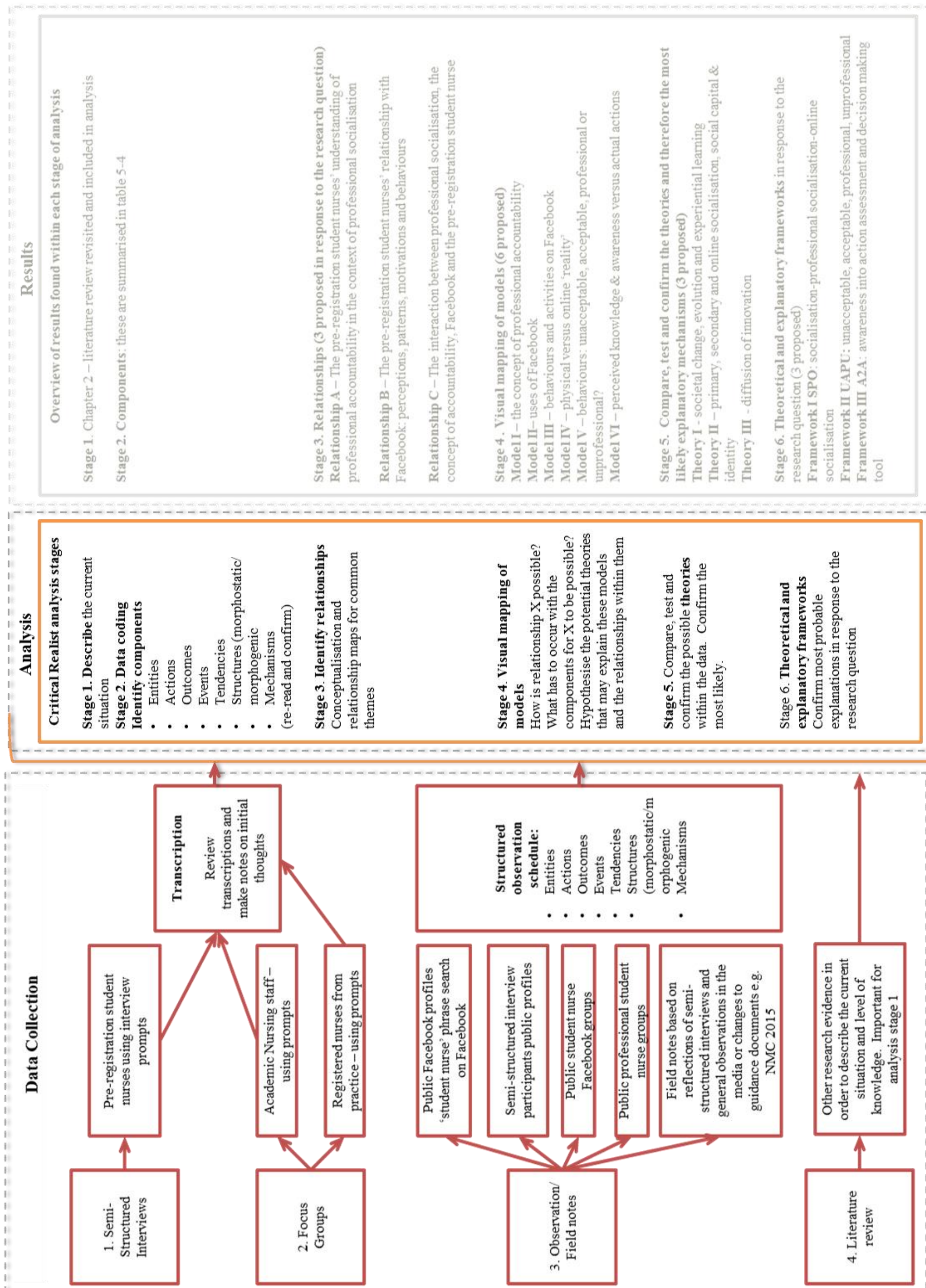


Table 4- 5 Detailed breakdown of stages of analysis

Stage of analysis	Description
Stage 1: [Re]description Review literature and describe the current situation along with assumptions (Chapter 1 and 2 achieves this)	Description is the process of reviewing the current evidence surrounding a phenomenon and understanding any analytical or theoretical frameworks associated with it. In this case, it entailed several scoping activities. Re-description involves revisiting this evidence after data collection to enable the confirmation of the phenomena in the context of the current study. Description and re-description in this study involves: A review of my own assumptions, the current context of Facebook, how and why individuals and healthcare students use it and how it is linked with professional socialisation (with a focus on accountability) (Chapter 1 & 2). Propose a guiding theoretical framework for data collection. In this case I have proposed the model of professional socialisation (Weidman *et al*, 2001) and considered my own personal reflections (Chapter 1). Re-description of the context of Facebook once data has been collected e.g. reasons for use, motivations for use (Chapter 5). This process is useful in the progression of knowledge and planning for future research to build on my study.
Stage 2: Data coding – Identify *components* - *Entities* - *Actions* - *Outcomes* - *Events* - *Tendencies* - *Structures (morphogenic/morphostatic)* - *Mechanisms (potential)*	The coding framework of critical realist 'components' of reality will be applied to the data sources. For example, within the transcribed interviews an individual may state that: *"I think age impacts on the way someone will approach what they share…the young ones don't always see that they are doing anything wrong…I suppose it's based on your own values…"* This may indicate that age could be a morphogenetic structure that changes actions or outcomes i.e. what is 'wrong'. The concept of what is wrong would be cause for further prompting from myself (as the researcher/interviewer). Conversely, personal values may be a theme that informs the tendencies of individual's behaviour/actions. At this point it may be appropriate to note down ideas about the underlying causal mechanisms that may be related to these, asking questions such as: *'why does age have an impact?'* *'Does age always impact?'* *'What conditions need to be in place for age to have/not have an impact?'* *'What theory might explain this?'*
Stage 3: Identify *relationships*	This stage of analysis examines case examples and scenarios in the data and how these relate to the research question. In my case I will be examining the relationship(s) that may be evident between the pre-registration student nurse, accountability and Facebook. At this point I note down case examples (using the described in my strategic case sampling approach) that explain and/or evidence the possible relationship(s) and examine the components that interact within these case examples. These form the basis of stage 4.
Stage 4: Visual mapping of *models*	Retroduction requires me to confirm the tendencies, morphostatic and morphogenic properties of events and outcomes. During the process of analysis stages 1-3 I will have already noted any of these that I feel might be plausible in the data. Thinking about *'what has to happen for X to occur?' 'What conditions need to exist in order for X event to happen?'* The previous stages inform the decisions made during this stage of analysis. In my findings and discussion I will provide examples of how this stage was completed.
Stage 5: Hypothesise, compare, test and confirm the *theories* that explain the *models.*	This stage will consist of proposals for suggested theories and possible frameworks that respond to the research question. This will be guided by the mechanisms and theories that emerged during stage 4. The visual 'concept' maps will be used to 'test' some of my proposed theories and causal mechanisms to establish which are most likely to explain the relationships between the pre-registration student nurse, Facebook and accountability during their journey of professional socialisation. These theories will then form the basis of my own explanatory *frameworks* which may be applied to practice. An example of how this stage was completed will be demonstrated in chapter 5.
Stage 6: Theoretical and explanatory *frameworks.*	Take the underpinning theory and use it to develop practically applicable *frameworks* by way of explain the response to the research question. This stage consolidates stages 1-5 and finally presents the explanatory frameworks in response to the research question. These may be applied to case scenarios in order to evidence their relevance to the likely 'real' world.

4.7 ETHICAL CONSIDERATIONS

Ethical approval was awarded through De Montfort University Health & Life Sciences Ethics committee and the University of Derby School of Health research ethics committee. Appendix 15 p321 contains:

- A discussion of some of the main ethical considerations
- The ethical approval letter from De Montfort University

4.8 RIGOUR

4.8.1 Rigour in critical realist ethnography

Validity, trustworthiness and rigour can be appraised in a variety of ways. Many of the approaches to appraisal of validity or 'rigour' were typically developed as part of either the positivistic or constructivist/interpretivist paradigms, thus meaning that they place value on the principles of these paradigms. Bryman (2008) and Lincoln & Guba (1985) suggest two approaches to the measure of 'quality' typically employed (columns 1 & 2 of figure 4-3). This indicates that such measures are linked to research strategy.

Figure 4- 3 Measures of quality based on philosophical approach

	Positivist (adapted from Bryman, 2008)	**Post-modern (constructivist/ interpretivist)** (adapted from Lincoln & Guba, 1985)	**CR** (adapted from Pawson *et al*, 2003)
Quality criteria	**Reliability** Are the result of the study repeatable and replicable?	**Dependability** Can the results be replicated and be relevant in other contexts?	**Transparency** Is the process of generating knowledge made explicit? **Accessibility** Does it meet the needs of those seeking the knowledge?
	Internal validity Construct validity. Can the conclusions and relationships be trusted? Do measures do what they say they will do?	**Credibility** How believable are the findings?	**Accuracy** Are the claims made based on relevant information? **Propriety** Is the research legal and ethical? **Purposivity** Do the methods achieve what they claim to?
	External Validity Ecological validity. Can the findings be generalised more widely, to a community or population? Can the findings be applied to natural, social settings?	**Transferability** Can these findings be applied in other contexts?	**Specificity** Does the research generated consider and apply to source specific standards? **Utility** Is the research appropriate to the decision-making setting? Does it provide practical answers to the practical questions?
	Objectivity Consider areas of bias	**Confirmability** To what level has the research allowed their own values to influence the process? (Subjectivity)	**Modified Objectivity** Does the research review a range of evidence and draw the most likely conclusions based on this?

Ethnography traditionally presents researchers with limitations such as control, researcher bias (which I have addressed in chapter 3) and generalisability. Some authors have criticised ethnographic study due to the power and control that the researcher retains as a passive or covert observer (Bryman, 2008). It relies upon the interpretation and 'objectivity' of the researcher and may not necessarily represent the views of the participants. However, I would argue that the use of passive or 'disguised' observation in the online environment ensures that what I observed is reflective of what is 'actual' and 'real' – thus complementing CRE (Fine *et al*, 2009).

The concept of generalisability is indicative of positivistic inquiry and therefore, I contest that this is an inappropriate term to use when considering the rigour of post-positivist, CRE study. Hence, as supported by Fine *et al* (2009) and in complement to the TAPUPAS model (third column of table 4-3) I have considered *accessibility* and *utility* as alternative measures of transferability and generalisability (figure 4-3 p111).

It is known that CRE favours an intensive rather than extensive approach to research design and method (see appendix 11 p317). Combined with the discussion of the criticisms of ethnographic rigour I consequently considered an alternative method of critical appraisal in order to complement the intensive research design favoured by CRE.

Other than TAPUPAS I could not locate a model that reflected the principles of CR. Those which complemented ethnography predominantly applied the 'constructivist' or post-modern quality criteria. Although Pawson & Tilley (2003; 2008) do not completely concur with Bhaskar (2008), the basic principles of CR are similar and based on Bhaskar's initial

proposition. Hence, I explored the use of a framework proposed by Pawson *et al* (2003; 2006) that has also been 'endorsed' by Porter (2007).

The proposed system is TAPUPAS (figure 4-3 column 3): Transparency, Accuracy/authenticity, Purposivity, Utility, Propriety, Accessibility and Specificity. Given the principles of CR outlined in chapter 3 and given that the model was developed through a more 'practical' rather than a philosophical or academic research perspective, I would also argue for an additional 'modified objectivity' criterion. Conversely, one of the objectives of CR and therefore, my study sought to apply my findings and frameworks (i.e. applied research)[33]. Hence, the role of 'utility' is essential and is not necessarily appraised in comparative models (Porter, 2007).

4.8.2 Transparency

Transparency considers how the researcher came to the research question aims, objectives and methods. In considering my own background, reflections on my views of accountability and providing a justification and context for the topic of OSNs and Facebook I have provided a clear account of how I came to the research question, aims and objectives. Furthermore, the purpose of conducting a literature review was twofold: it was included in the process of analysis but also serves as part of the justification for taking the approach of CRE.

Consideration of my philosophical approach was important for transparency. As discussed in chapter 3, I strongly believe that a researcher should consider their own values and situate

[33] This is also reflective of the requirements of a professional doctorate and the associated learning outcomes of this programme

themselves within a philosophical paradigm so that they can justify methodological decisions. This is evidenced in both chapter 3 and this current chapter.

4.8.3 Accuracy

Porter (2007: 85) asks,

> "*are the claims made based on relevant and appropriate information?*"

Pawson *et al* (2003) provide further detail for considering accuracy. Claims to knowledge should be representative of the participant's perceptions and experiences, and the process of inquiry should use sources appropriate and relevant to the context. In light of this I have addressed the concept of accuracy in four ways:

I. The use of multiple data collection methods with processes informed by theoretical models/frameworks (Fine *et al*, 2009)

II. Employing a retroductive approach to analysis with consideration of plausible explanations, mechanisms and testing of subsequent hypotheses in order to develop a CR framework/theory

III. Direct quotations and sections of transcripts from semi-structured interviews and focus groups will be used to demonstrate accurate interpretation of participant views

IV. Member checks of my proposed findings, framework and conclusions with academic staff and pre-registration student nurses (Fine *et al*, 2009)

4.8.4 Purposivity

Purposivity refers to the approaches to inquiry and whether they achieve what my aims and objectives stated. This requires me to consider whether this research and its methods are 'fit for purpose'. Table 4-6 outlines the measures I have taken to ensure purposivity.

Table 4- 6 How purposivity has been achieved

Study objective	Purposivity met by
Employ a model of professional socialization to critically analyse the perceptions, behaviours and actions of those who influence the pre-registration student nurse as a developing professional [in the context of Facebook]	By employing observation, semi-structured interview and focus groups (RNs & Academics) this considers the perceptions, observed behaviours and actions of the influencers outlined in the model of professional socialisation.
Critically explore pre-registration student nurse understanding of the concept of professional accountability in the context of Facebook	Semi-structured interviews aim to enable participants to consider their knowledge of professional accountability and the concept of this in the online environment. I will note critical reflections and possible emerging themes in field notes as these are conducted. Although many of these may not subsequently and explicitly be reported in my final results (Barron, 2013) they will guide subsequent interviews to enable an ongoing 'critique' of perceptions and experiences. In addition, I will employ 'critical questioning' and clarification questions as part of the semi-structured interviews and focus groups in order to challenge participants to think deeply about their thoughts.
Critically analyse the pre-registration nursing students behaviours and publicly accessible information on Facebook in the context of professional accountability	
Critically analyse and explain underlying causal mechanisms which impact the relationship(s) between Facebook, professional socialization and the behaviours and actions of the pre-registration student nurse on Facebook	The process of analysis I have designed is complementary to Bhaskar (1998) and Danermark et al (1997) and therefore reflects the principles of CR but with sufficient detail to indicate that it is fit for purpose. Chapter 5 will specifically discuss the results obtained through this process of analysis with specific reference to the proposed theory of causal mechanisms and testing of hypotheses relating to this theory.

4.8.5 Utility

Porter (2007) states that utility refers to whether knowledge generated is of use to the 'practitioner' or '*fit for use'* and that the results respond explicitly to the research question. In order for my research to be 'fit for use' this emphasises the need for my findings to be applicable to 'practice'. Hence, in chapter 5 I provide an example of how my explanatory framework(s) can be applied to a practical situation. In chapter 6 I also discuss the next steps for application of my findings to practice.

4.8.6 Propriety

Propriety refers to legal and ethical considerations along with the presentation of adequate evidence that I considered these issues (section 4.7 p110 and appendix 15 p321).

4.8.7 Accessibility

Accessibility involves dissemination and implementation of findings and that these findings should be presented in a way that is accessible and usable for a range of target audiences (Porter, 2007; Pawson *et al*, 2003). As a result, a dissemination strategy can be found in appendix 16 p327.

4.8.8 Specificity

This refers to whether the knowledge generated as a result of this study meets source specific standards (Porter, 2007). In this case *sources* have been identified as those involved in the professional socialisation process (Weidman *et al*, 2001) such as the university, academic staff, peers and placement based staff. This was met in the following ways:

a) Clarification of concepts and themes with participant groups:
    I. Pre-registration student nurses
    II. Academic staff
    III. Registered nurses
b) I have considered the current research evidence and guidance documents presented by the UK and international governing bodies for nursing
c) Following the processes outlined in *4.8.7 accessibility* and *4.8.5 utility*

Other source specific standards might include: professional codes of conduct (NMC, 2015; 2016) and university policies and procedures.

4.8.9 Modified Objectivity

My philosophical perspective and the notion of modified objectivity have been outlined in chapter 3 (p48). This discussed my perspectives on the concept of bias, objectivity and subjectivity. Furthermore, I believe that by collecting data through several sources, observation, semi-structured interview and focus groups, and from a range of entities identified in the model or professional socialisation (Weidman *et al*, 2001) I gave sufficient scope and quantity of data to achieve modified objectivity (as defined in chapter 3). In addition, my model of analysis (section 4.6 p106) complements the concept of modified objectivity.

4.9 Chapter Summary

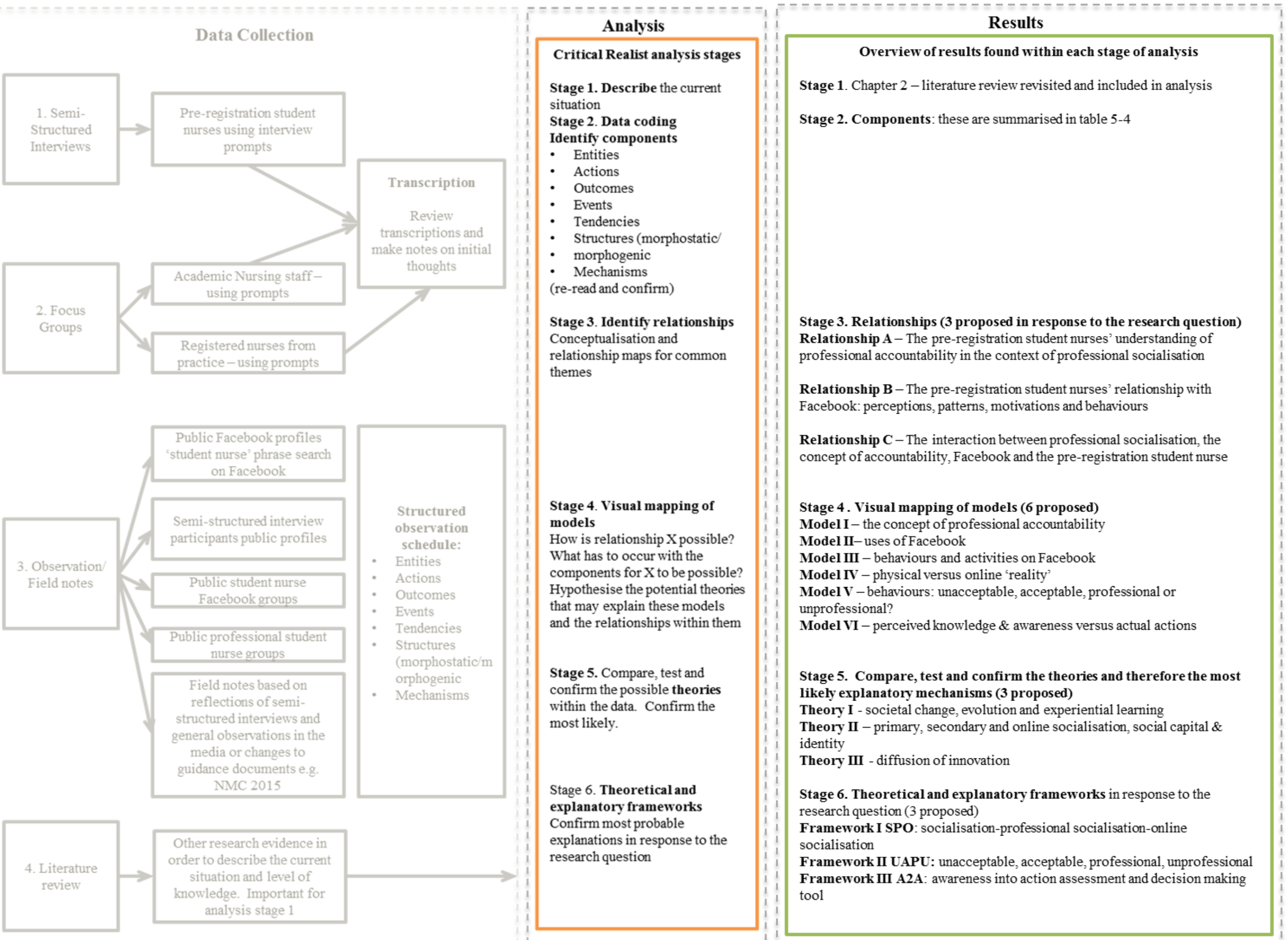
Chapter 4 has taken philosophic and ethnographic principles from Chapter 3 and applied them to research methods. I justified the use of semi-structured interview, focus groups and observation in the Facebook environment in order to achieve study aims and objectives. These data collection methods and the strategic sampling method complemented intensive research design that is typical of critical realist research. Conversely, I highlighted the importance and relevance of retroductive analysis (as opposed to traditional ethnographic approaches to analysis). In the absence of detailed analysis methods available in CRE I presented a six-stage process. In section 4.8 p111 I outlined TAPUPAS(M) to highlight how I considered rigour. Chapter 5 will go on to present my analysis, findings and discussion.

CHAPTER 5 FINDINGS & DISCUSSION

5.1 INTRODUCTION

This chapter will report on my analysis, findings and discuss these in the context of the research question (analysis stages 2-6 in figure 5-1); study objectives II-IV (chapter 1 page 16). The approach to critical realist ethnographic (CRE) analysis I developed during chapter 4 will be implemented in this chapter. As this was a novel approach to CRE analysis, I will provide some examples of how each stage was applied to the data [analysis] and thus, how I developed three explanatory frameworks [findings and discussion] and practically apply the final framework to a case example [discussion and practical application].

Figure 5- 1 The analysis process and overview of results at each stage



This chapter will present these findings and discuss the development of three theoretical and three explanatory frameworks in response to my research question, *how can we explain the relationship(s) between accountability, Facebook and the pre-registration student nurse during their journey of professional socialisation?*

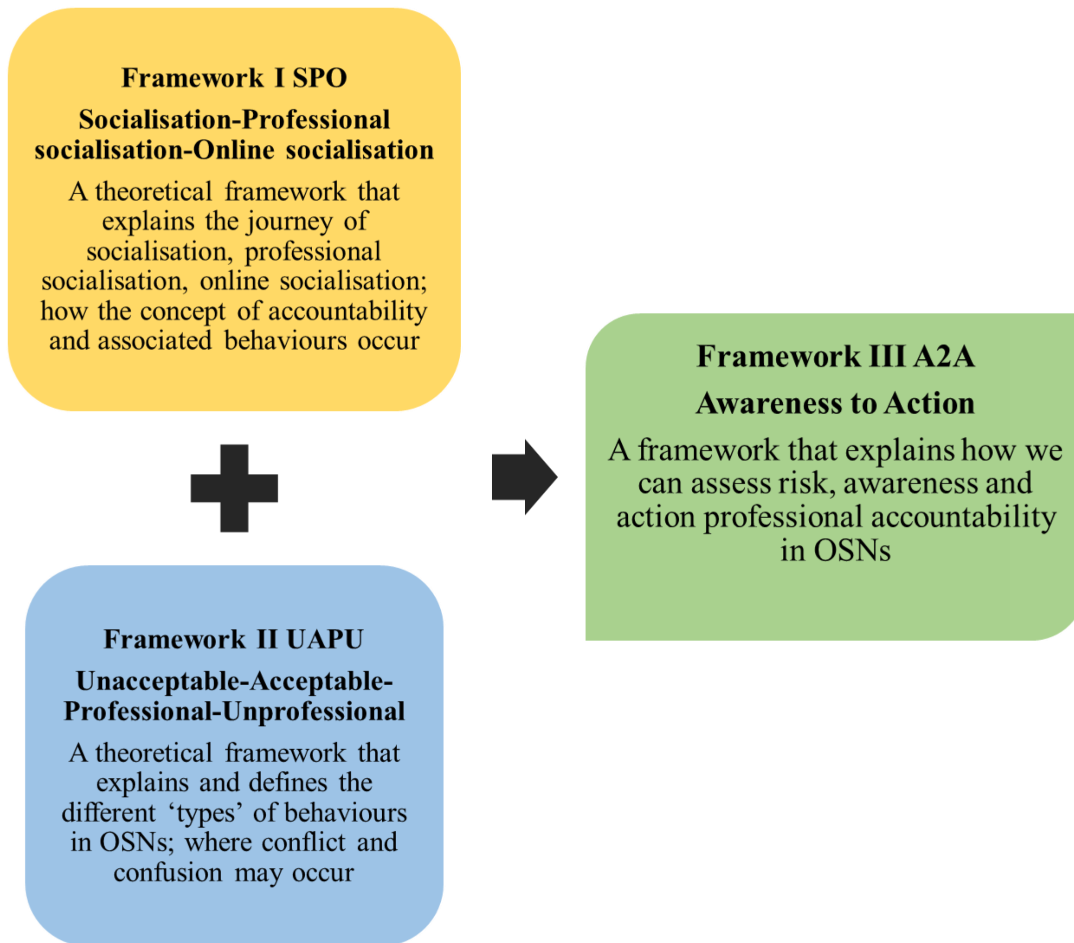
Section 5.2 Framework I: Socialisation-Professional socialisation-Online socialisation (SPO)

Section 5.3 Framework II: Unacceptable, Acceptable, Professional, Unprofessional (UAPU)

Section 5.4 Framework III: Awareness to Action (A2A assessment and decision-making framework)

The relationship between three frameworks is summarised in figure 5-2. In essence, Framework I is used to firstly explain the relationships between professional socialisation, accountability and the pre-registration student nurse. Framework II explains the relationship with and behaviours of the pre-registration student nurse in Facebook [OSN]. Finally, Framework III considers the interaction and complexities of frameworks I and II. Framework III is an explanatory framework that seeks to negotiate the complex relationship between having 'awareness' of professional accountability and 'acting' professionally.

Figure 5- 2 The three frameworks and how they interact



A summary of this chapter's contents can be seen in table 5-1.

Table 5- 1 Summary of chapter 5 contents

Chapter section	Content
5.1	Introduction to chapter 5
5.2	Participant characteristics and data components
5.3	Development of framework I, SPO: socialisation-professional socialisation-online socialisation
5.4	Development of framework II, UAPU: unacceptable, acceptable, professional, unprofessional
5.5	Development of framework III, A2A: awareness into action [assessment & decision tool]
5.6	Chapter summary

5.2 PARTICIPANT CHARACTERISTICS AND DATA COMPONENTS

Due to the very diverse nature of each method of data collection I will address the description of each method of data analysis in sub-sections:

- Semi-structured interviews
- Focus groups
- Unstructured observations

5.2.1 Semi-structured interview participant characteristics

Sixteen (n=16) participants consented and participated in interview out of 21 students that expressed an interest in participating. The remaining five did not participate as we could not agree a mutual time for interview (n=3) or they had changed their mind (n=2).

Appendix 17 p328 provides an overview of the participant characteristics. Of the participants recruited, n=11 were female and n=5 were male. In this study, n=5 participants were aged 18-25 years of age; n=5 participants were aged 25-34 years of age; n=5 were 35-44 years of age and n=1 was 45-54 years of age. The average age of a student nurse in the UK is 29 (RCN, 2012, 2008). With a mean age of 31 years the participants in this study were therefore, close to the mean age of pre-registration nurses across the UK. This also sits in the most common age demographic for Facebook users in the UK (25-34 years of age; 22%) followed by 18-24 years (15%) and 35-44 years (13%) (Statista, 2016).

5.2.2 Focus group data

Two focus groups were conducted in order to represent the practice mentors/peers and academic staff that influence professional socialisation (Weidman *et al*, 2001). One consisted of registered nursing staff (n=4) working with pre-registration nursing students in the practice environment. Appendix 18 p330 provides an overview of the group characteristics in relation to

nursing experience and length of time they have been registered with the NMC. The length of time registered ranged from 3-26 years with a median of 13 years. The second consisted of academic staff registered with the Nursing and Midwifery Council (NMC) who are involved with the pre-registration nursing programme (n=4) (appendix 18 p330). Length of time qualified ranged from 15-32 years with a median of 23 years. From all of the registered nursing staff included as participants in the focus groups, one was male.

5.2.3 Observation data

This section describes the main findings from my observation strategy. Observations were conducted through the following processes:

E. Unstructured responsive and ongoing reflections of responses to comments and Facebook activity (e.g. posts as a result of media coverage of political debate)
F. Strategic observations over a 3-month time frame to observe themes and content as per the observation schedule outlined in chapter 4
G. Observation of interview participant public profiles during the interview process
H. A Facebook search of 'student nurse' and the types of information that was shared publicly

A summary of what was observed can be seen in table 5-2.

Table 5- 2 Description of observed behaviours

Approach to observation	Description
A) Unstructured observation of critical or extreme cases in the media B) B) Unstructured observations of professionally or educationally linked Facebook groups	Over the period of data collection two core events in the media prompted increased and a shift in the types of activity in the Facebook environment that I considered to be 'critical' cases for discussion. I spent time reflecting on the content, context and perspective of posts shared by my own professionally linked Facebook friends but also those within the professional groups/pages already chosen for observation as part of this study. Reflection included scrolling through recent posts and considering the topics, context and possible motivations/agenda/intended outcome of the content along with possible unintended consequences. My reflective notes were included in the data analysis to identify the core *components* (themes). The events were focused on: 1) The UK government spending review announced on 25 November 2015 that indicated student nurse bursaries to fund their training would stop from September 2017 and they would be subject to university fees 2) The UK governments health minister announcement during a King's Fund speech on 16th July 2015 that 'suggested' NHS services were primarily Monday – Friday 7am-7pm and that the NHS needed to function 24 hours a day, 7 days a week Both events produced increased discussion and activity on Facebook with the majority of professionals using the social media site to protest against the actions of the government. This was of particular interest to me because it evidenced Facebook activities and behaviours from professionals that could be perceived as unprofessional and/or unacceptable in other circumstances (e.g. sharing pictures of themselves at work, in uniform or sharing extreme political views in a relatively public environment). Conversely, these events sparked my interest in collective activism and the role of social media in creating unity of purpose across professional groups and initiating action on a national level.
C) Observation of the public profiles of semi-structured interview participants	Of the 16 interview participants, 12 (001-012) gave permission for their public profile to be copied and saved for the purpose of analysis. These were included in the final analysis.
D) Observation of 'student nurse' publicly accessible data on Facebook	When the words 'student nurse' were entered into a Facebook search the first 30 profiles that appeared on the search results were viewed. Profile details were not recorded but the type, content and extent of information shared publicly was observed.

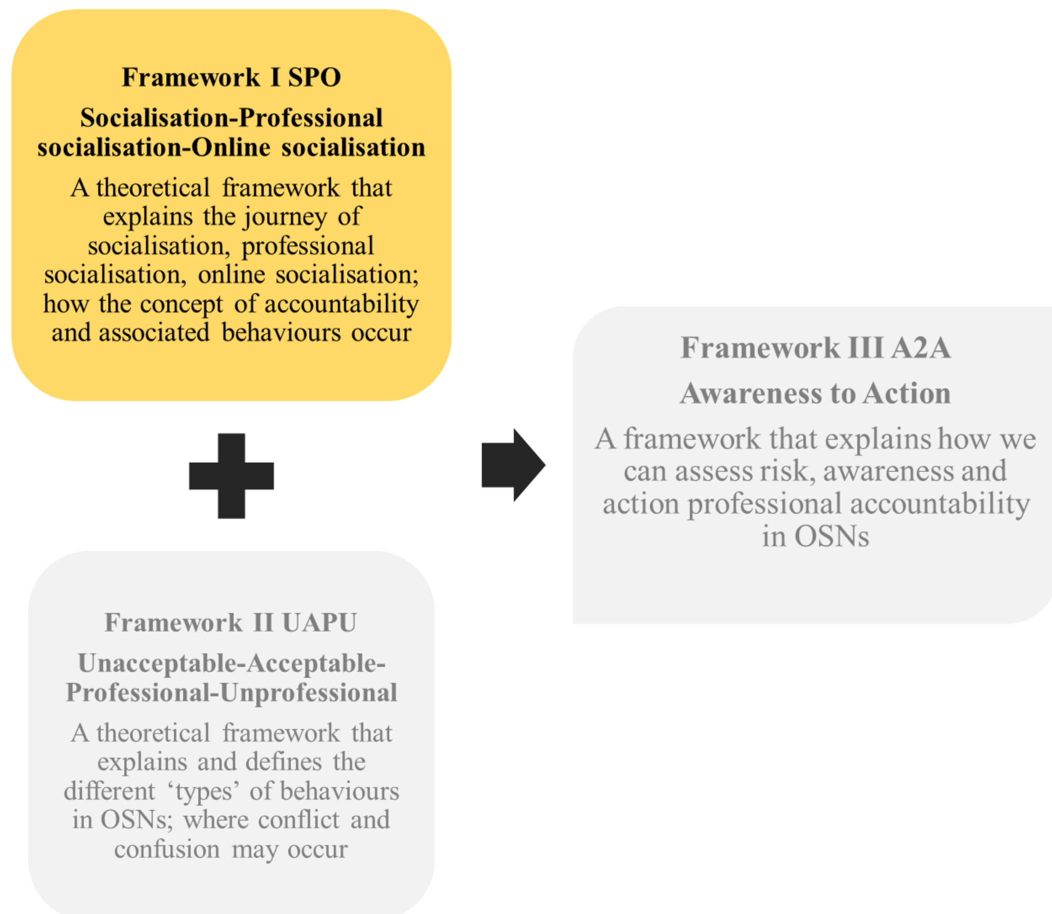
5.2.4 Overview of components found in stage 2 of analysis

The coding process detailed in chapter 4 p106 was applied to all data sources. Appendix 19 p331 provides a summary of the *components* found within the data sources. By way of reminder, an explanation of each *component* is provided, this information may also be useful when reading the rest of this chapter.

5.3 Development of Framework I, SPO: Socialisation-Professional socialisation-Online socialisation

In this section, I will discuss the development and reasoning of the SPO (Socialisation-Professional socialisation-Online socialisation) framework (figure 5-3 illustrates how SPO contributes to the results of this study).

Figure 5- 3 Developing the SPO framework



Firstly, I will highlight some important discussions from my data. These explain how the concept of professional accountability is developed and understood by the pre-registration student nurse. For the purpose of rigour, I will provide some examples of how each stage of analysis was conducted and present the rationale and justification of explanatory framework I, SPO. Explanatory framework I serves to explain the relationship between the various

components (appendix 19 p331) in the context of socialisation, professional socialisation and how these influence behaviours and outcomes related to professional accountability.

In chapter 1 and 4 I argued that it is not possible to expect someone to behave professionally [in practice or online] and to be held to account for their actions or omissions if their perception and understanding of professional accountability is inaccurate or misunderstood. It is important to highlight some of my observations and discussions about the concept of 'professional accountability'. For reference, direct quotations from semi-structured interview participants use *participant XX*, those from the academic focus groups use *Academic Focus Group* and those from the registered practicing staff focus group are referred to by *RN focus group*.

5.3.1 How do pre-registration nurses perceive professional accountability?

5.3.1.1 Defining professional accountability

While there was some reference to relevant terminology (e.g. rationale, justification, actions, omissions and the concept of *being* current), when asked to explain the concept of professional accountability, the pre-registration student nurse participants demonstrated difficulty and occasional confusion in articulating their definition; frequently confusing it with the concept of responsibility,

"just being responsible for your actions; in and out of work I suppose. Making sure you're up to date with your training…. that you are doing everything you should accordingly to standards and regulations and laws, I suppose" (Participant 01 line7-10)

"being responsible for your own sort of actions. Anything you do then you're held accountable for it" (Participant 02 line6-7)

"I suppose that it's almost a responsibility. I don't know…I'm not very good with words…so…I don't know how to explain it…" (Participant 04 line10-11)

"Responsible. It's sort of you are in control so you are sort of; you have to answer to them." (Participant 03 line8-13)

Only one semi-structured interview participant was close to correctly defining and explaining the concept of professional accountability in relation to responsibility (*participant 14)* who, demographically was an *extremely varied* case sample with a private Facebook profile and therefore, not typical of the student nurse majority. This participant was also very conscious of pausing to think before proceeding with their definition,

"Professional accountability (PAUSE) Being able to understand that you are answerable for your own actions as a professional whereby if you do something then you should be able to give answers if asked as to why you did it. And you should expect like . . . when you are questioned about your actions or what you did you should expect that whoever is asking you whatever or whoever is giving the expectations should expect you to answer to what you have done." (Participant 14 line7-11)

While there is some interdependence between accountability and responsibility, there is clearly lack of clarity in how pre-registration nurses in this study viewed the concepts; using the terms interchangeably. One participant made a statement that clearly confused the two concepts,

> *"I suppose that it's almost a responsibility. I don't know, I'm not very good with words. So . . . I don't know how to explain it..." (Participant 04 line10-11)*

It could be argued, if a student nurse is not able to articulate the meaning of accountability then to what extent should we expect them to be able to display the behaviours that are commensurate with professional accountability (online or offline)? This concept is also reflected in literature, for example Cornock (2011) identifies the incorrect and frequent assumption that responsibility and accountability are synonymous; too often used interchangeably in the nursing profession. In fact, accountability relates to the ability to justify, explain or give an *account* for taking [or not] action whether this be based on evidence, policy, and clinical guidance or otherwise. Responsibility relates to a lower level activity of task or role completion. Taking responsibility or being responsible does not mean being held to account. Responsibility can be delegated and accepted by a non-registered member of staff [for example], however the *accountability* is retained by the nurse who delegated the task. Most people take or are responsible for tasks, roles, behaviours or actions, however accountability is akin to *being professional,* and *is* therefore a professional value and [arguably] required for socialisation into the nursing profession (NMC, 2015). The inability to differentiate between the concept of *accountability* and *responsibility* is therefore of significance for student nurse ability to act within the parameters of the nursing profession and associated professional guidelines.

5.3.1.2 What does it mean to 'be' accountable?

When asked to give examples of *being accountable* several of the participants were more able to articulate the concept of *accountability* and differentiate this from responsibility. All of the semi-structured interview participants primarily associated being *accountable* with *blame or fault*, more easily providing examples of negative consequences of actions or simply doing something that is incorrect. Medication errors and breaches in confidentiality were common themes,

> *"if you are at work and you are picking obviously, a patient and behind the bed it says they are transferring with two people and you do it yourself with one and without their stand aid or whatever it may be and the person falls. Obviously, you are accountable yourself" (Participant 15 line14-16)*

> *"If there is something that you have been held accountable for it's something that you have actually done or something that you could be accused of doing you would be held accountable… Being accountable you can be held responsible for; so again, you have got like drugs that you would give out. You could be held responsible or accountable for giving a wrong drug and not checking dates, not checking the patient's name…" (Participant 12 line16-18)*

> *"I can only think of bad ones but I know that there are good ones. But you know, for example, if I was to make a medication error, as a registered nurse, I would be held accountable; it's my responsibility." (Participant 10 line14-15)*

> *"It's all going to come down on you if it was inappropriate and something did come of it then you are the one that is going to be disciplined or something along those lines for it." (Participant 02 line16-17)*

One participant went as far as to explicitly associate accountability with being guilty:

> *"If you are held accountable then you have actually done it; you are guilty." (Participant 12 line16-17)*

Scrivener *et al* (2011) and Savage & Moore (2004) assert that such a perception leads to a negative interpretation of accountability that is damaging rather than constructive in protecting and supporting staff, patients and the public. Caulfield (2005) takes a more positive view, contextualising professional accountability as the confidence that allows a nurse to take pride in

their practice. However, this was not evident in the definitions provided by the participants in this study, which may be associated with those influential on the journey of professional socialisation, and also the processes by which the concept of professional accountability is learned and experienced.

5.3.2 How do pre-registration nurses develop professional accountability as part of the journey of professional socialisation?

The routes by which pre-registration student nurses learn about professional accountability and 'being' accountable could be explained to the Weidman *et al* (2001) model of professional socialisation, and indeed this is how this research study began. However, while I can see clear agreement about the influencing factors (e.g. academics, peers, background), through the process of data collection and review of literature, I found evidence that pre-registration student nurses still find it challenging to define and know how to be accountable (Cusack *et* al, 2013; Iacobucci *et al*, 2013). Conversely, it has been claimed that personal values and experiences are far more important than codes of practice when it comes to knowledge about accountability (Numminen *et al*, 2009) and that the concept of professional values are predominantly focused on clinical care and patients, and not necessarily the behaviours outside of the workplace (or online, in this case) (Rassin, 2008).

5.3.2.1 The role of academic and registered nurses concept of professional accountability

It is known that academic and registered nurses supervising students in practice environments have an instrumental role to play in the professional socialisation of pre-registration student nurses (Parandeh *et al*, 2015; Duquette, 2004; Weidman *et al*, 2001). The values and attitudes developed as a result of exposure to academic and practice based staff are pivotal in the facilitation of professional identity and therefore, the process of professional socialisation.

When asked about their definition and understanding of professional accountability there was perhaps less confusion between the principles of responsibility and accountability, but still evidence of a struggle to, and diversity of opinion in articulating what accountability actually means, even between registered staff,

"professional accountability comes from the day you start your nurse training because you are training to become a nurse and when I registered you were actually given a pin number from the very day that you entered your training so you have been accountable and held that same pin number since day one so it was instilled in me from then 24 hours a day, even as a student nurse, I was accountable for my actions. And then obviously when you register with NMC you are accountable for all of your acts, omissions and all of that sort of thing to do with care as stated within the NMC code and your standards of proficiency" (Academic Focus Group I, lines11-17)

"being able to justify your actions really and whether that's in a professional capacity or any sort of capacity really I think that, probably pre-empting your conversation, I think that there are different scenarios where you may have to justify your behaviour and being accountable for me is being able to do that easily without sort of fear of doing something wrong or embarrassment..." (Academic Focus Group IV, lines45-49)

I also had concerns that [although implied] the registered staff could not confidently distinguish between responsibility and accountability, nor define the concept of duty of care, which is directly related to professional accountability (NMC, 2015),

"that it guides you in your professional life but also there is that overlap with personal because if we are walking down the street and we see a situation we have a responsibility whether we are in a uniform or not." (RN focus group II, lines16-18)

Conversely, it seemed to be challenging for the RNs to distinguish between unprofessional behaviours and acceptable behaviours,

"Well whatever we do whether it is within work or outside of work has got to be professional. We don't go around pole dancing or something on your night, off, would you?" (RN Focus group I, lines8-9)

"And like sort of . . . Not breaking the law." (RN focus group III, lines11-12)

When challenged about whether pole dancing was unprofessional, this created confusion. Hence, this raised questions about whether registered staff were clear about the difference between unprofessional and unacceptable. Would a registered nurse be suspended from the NMC register for pole dancing? Would this depend on whether it was a hobby or for earning an additional salary? And, does this matter if they are not identifiable as a registered nurse while doing it?

The act of being given a professional identification number (PIN) seemed to be favoured as a physical action that impacted positively on student nurses and nurse's behaviours. However, the practice of being given a PIN upon entry to training is no longer commonplace, but could indicate the differences between the concept of professional accountability across the nursing profession based on when, where and under which educational regime they were trained or 'socialised' into the profession.

Such a disconnect across registered nursing professionals and particularly those educating pre-registration nurses, could suggest a possible reason for such confusion in the student nurse participant interviews and will inherently impact on the process of professional socialisation. I began to ask questions about the interdependence (competing and co-operative) between personal and professional values; which values are they being socialised into? Which are the values of the profession or the person? Which are current values and which are dated?

This was reinforced during the academic focus group when the participants (*I and IV)* raised some discussion and subsequent confusion between personal and professional values *(Academic focus group lines 14-29)*. I found it of particular interest that this discussion was raised between

the participants who had been qualified for the longest *(academic focus group I)* and least time *(academic focus group IV)* out of the group,

> *"I think some of your own personality, your own characteristics, your own traits if you like, become part of that as well, or is it the other way around? I don't know? So, some of my moral values are my [moral] values because of who I am or am I who I am because of being a nurse?" (Academic focus group I, lines19-22)*

> *"I think that there is an important distinction between moral values and your professional values…is it that you are who you are because of your profession? Professionally I have been in nursing in some respect since I was 16 and a half…so they are sort of formative years of your life" (Academic focus group IV, lines24-28)*

Interestingly, there seemed to be some indication that starting the journey of professional socialisation earlier in life may lead to more interdependence of personal and professional values. Both of these participants began their nurse training in their teenage years and this led me to question the significance of primary and secondary socialisation; with professional socialisation occurring at the same time secondary socialisation into society occurs, such as the comment about *'formative years'*.

5.3.2.2 The role of employers and organisations

Several participants recognised that their perception and concept of professional accountability was influenced by current employers or from their previous employment. It was recognised that employers, university and the NMC can hold them to account:

> *"employers, university, NMC…" (Participant 02, line20)*

> *"yourself and your employers I guess" (Participant 13, line24)*

> *"the NMC…" (Participant 03, line28)*

> *"Like the Nursing Midwifery Council…do you mean like on placement?" (Participant 06, line27)*

While there was some acknowledgement that as a nurse [student] you can be held to account by an employer, the university, professional bodies and brief reference to personal accountability these responses were limited to a small proportion of participants. Furthermore, the students paused and struggled to respond to the question. No participant was able to articulate or make reference to the four pillars of accountability that form the basis of nursing practice (Caulfield, 2005). This suggests that there may be genuine confusion between the context of professional accountability in creating a framework of practice and conduct versus more general concepts of accountability based on legal, social or personal values. It is believed that the journey of professional socialisation is influenced by the interaction of many factors but what this may illustrate is that those factors may also cause conflict and confusion where there are inconsistent messages or values associated with them (e.g. considering how being accountable to the NMC interacts with legal accountability and the values of the profession).

5.3.2.3 The role of the public

Interestingly, in both the focus groups and interviews patients and the public were typically the last 'entity' discussed as having an impact on professional accountability. Essentially, participants recognised the need to protect patients from harm and linked accountability with negative consequences, but this was overall an egocentric perspective of professional accountability (i.e. the consequences to 'themselves' were noted first).

Several participants recognised the importance of patients and the public in being accountable. Some highlighted the conflicting values about 'being in the public eye' as a professional while at the same time asserting that they are entitled to a personal life too. This suggested the existence of conflict of 'identity'; being professional in the public domain but also being a person with their own culture, background and characteristics,

"I mean I do accept that people have got their personal lives and they can't be a nurse 24/7 in such a way if that makes sense… I mean people do all sorts in their personal life and you know that's your private life and that should be kept private as well. You don't want to see .

. . I certainly wouldn't want to see the nurse that's looking after me, if I've typed her in Facebook and seen her ... does that make sense?" (Participant 02, lines158-168)

"I think that there's a fine line between it because you have . . . actually no, now I'm thinking about it no. Responsibility it's personal; you have your own personal responsibilities but you also have your professional responsibilities as well. But with nursing it's hard; I think that there is a very fine line because you are always in the eye of the public so to speak." (Participant 05, lines56-59)

"I think that most people understand that their personal lives and their professional lives mingle but I think that some people and I do think that it's an age thing that maybe let things slip when they shouldn't do and it's not clear for them. (Participant 07, lines236-238)

"I think when you have gone into this career if your page can be looked at, which they are saying that it can freely be looked at; more fool them. That would be my slant on it. I think when you know that you are coming into being a nurse you are a nurse out of nursing hours as well as being in a uniform as well as being out of uniform…you don't just walk down the street 'I'm a nurse'. Nobody knows that you are a nurse but I think it's probably the same as the police, the ambulance; you are a professional person serving the community aren't you as such? If you want to be a pillock and go off doing drugs and drinking and fighting I think you know what's coming." (Participant 12, lines 606-614)

"I think that it is your dedication, your commitment, who you are maybe as a person, your actual personal values that are inside of you that you can't change, how you have probably been brought up, are you a caring person. Even down to silly things like on the news where you have got carers and they are dragging people round and beating and punching them; obviously quite clearly should never, ever have got into the nursing profession. Whether they mask it well I don't know but you have got to have something inside you that you want to do. You've got to be of a caring nature and I think that you need a fairly honest outlook on life don't you of what you want and where you want to go with it. I think that there are people that have got in it and even now, like that male, I don't know how they have got in it. Anyone can come here and tick boxes and that's all you need to do, isn't it? You keep doing your assignments and you keep doing your tests, you keep passing and the next thing is that you are a nurse but are you ever going to be any good? But I think that you can see. I mean I'm not a nurse yet but I can go on that ward and tell you who is any good or not and I'm not a nurse." (Participant 12, lines1045-1057)

This led me to explore the impact of personal identity (and the values that developed during primary and secondary socialisation) on the journey of professional socialisation. At what point does the personal identity integrate with the professional? How does the public see this? Clyde *et al* (2014) explored the public perceptions of professional's Facebook profiles and found that the public would judge the individual's professionalism [compared to their positive perceptions

of the profession as a whole] based on the behaviours and activity on a personal Facebook profile. Conversely, there is also evidence of more traditional and social norms about the image and characteristics of nurses. However, it is not entirely clear what is socially acceptable or appropriate in the online environment. This could indicate that the identity conflict expressed by some of my participants is compounded by the profession and the public's lack of clarity of what is or is not appropriate. Do the public really believe a nurse should be a nurse all of time? Are they entitled to behave how they wish in their personal life as long as this is not criminal or explicitly unprofessional (e.g. breaches of confidentiality)? While the NMC (2015) does explicitly set boundaries for professional conduct (e.g. duty of care) these do not expand to what happens outside of the professional identity,

"years ago, part of your training would be how you dressed, the colour of your hair – I wasn't allowed to dye my hair and things like that. Whereas nowadays there are people with tattoos and all sorts of things but because you were this outward facing role model it was deemed inappropriate to have tattoos or bright red hair…but that wasn't something imposed by the regulatory body, that was the school of nursing" (Academic Focus group I, lines76-82)

On participant discussed photographs of a very large tattoo and there was some evidence that she was negotiating the acceptability of this in relation to her personal and professional identity,

"it's a lovely tattoo…I looked at that and thought that is lovely…I think a bit of both because like I said, I keep my personal life and my professional life, even though it's not ***who*** *I am it's* ***how*** *I am" (Participant 005, lines477-480)*

This comment was interesting because she seemed to be claiming that her 'personal' identity is **who** she is and that her professional identity is **how** she should behave. From a critical realist perspective, the notion of **who, what, why and where** was of particular interest to me; the essence of critical realism seeks to explore these interactions and complexities in the hope of explaining the **reality** of a situation rather than solely the observable, measurable (**empirical strata**) and participant perspectives of it. In this case, the relationship between the pre-registration student nurse and public perception of nurses [the profession and being accountable].

I also observed and [re-]interpreted this concept from previous research literature. For example, Finn *et al* (2010) discuss 'identity negotiation'; students do acknowledge that they need to behave professionally and that they will be under external scrutiny [**public perception**], but during the journey of professional socialisation they need to also negotiate where their own personal identity [**who I am**] will 'fit' within this practice [**how I am**]. Hence, this process requires the pre-registration student nurse to negotiate their own values in relation to both the professional and public/social domain but also has the added complexity of the parallel existence of offline and online environments, the physical and virtual world[34].

In relation to the public perception of professionalism Finn *et al* (2010) suggested that students tended to negotiate this complexity with the concept of 'being a role model' and being 'exposed to good role models' during the educational process (i.e. students develop professional behaviours by imitating others who are presented as role models). There were no specific role models identified as 'leaders' for whom they wished to 'imitate' in order to become professional, be accountable and to be a 'good nurse'. Placement mentors and lecturers were mentioned by my interview participants, but more so as those who 'instruct' 'warn' and 'tell' and not those who 'inspire' and 'model' the essence of how, when and why to be [a nurse] professional; the philosophy, art and science of nursing as I perceive it. The apparent absence of these types of role model did not negate the existence of the role model concept. My interview participants acknowledged that **they** should **be** role models for public perception and confidence in the profession; this was also explicitly linked to the negotiation **who I am**, **how I**

[34] As a critical realist, I would also argue that this is not necessarily and observable, measurable or even conscious process but triangulation of my data sources has enabled me to begin to explain what may **actually** be happening.

am, when and **why**? Nurses who smoke tobacco and those who are obese were used as frequent examples of this dilemma,

> *"I mean I'm a bit against smoking and things like that so you know, I don't like it when I see nurses smoking because I just think that it's not really giving a good example…but then you get obese nurses don't you?" (Participant 01, lines411-416)*

> *"Yes, I think it's subject to morals. There might be someone out there that is a nurse that believes that you shouldn't smoke, you shouldn't drink, you ought to be tee total and stern faced and that's it, and that's their morals and that's fine for them." (Participant 05, lines797-799)*

> *"I wouldn't say that it's not acceptable or professional to be causing trouble but who isn't going to drink and I think unfortunately you live in a world, as you know, through stresses of nursing that a lot of people drink or smoke. Fine but there is a line again where you start causing trouble to the public" (Participant 12, lines529-532)*

Public perception is increasingly anti-smoking due to legislative changes (for example) this is currently legal and a person's 'right' as an individual **[who I am]** but is it a right as a professional **[how I am]**? What is the difference between being seen smoking outside of the hospital or in a bar and being seen smoking on Facebook **[where I am]**? It was evident from these conflicting ideas that the journey of professional socialisation is one of negotiating boundaries and values **[who I am versus how I am or how I should be]**. Participation in my interviews facilitated reflection and triggered a thought process about the concept of professional accountability and being a professional **[how I am]**. So, should we be doing more [group based] critical analysis and reflection in pre-registration nurse education? I would argue, yes, we should. This would facilitate the journey to professional consensus, pride, promote critical thought and define through consensus the collective values of 'being' a nurse while situating the 'person' within this and vice versa [negotiating **what, who and how I am, what I/we should be** and **in what circumstance**][35]; an experiential learning process.

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[35] *N.B. Critical realist research seeks to explain what happens, with who and in what circumstance so there may possibly be a role for 'critical realist reflection' as a learning process – critical realist pedagogy perhaps?*

5.3.2.4 The role of experience and experiential learning

Participants from the semi-structured interviews and focus groups consistently agreed that professional accountability, and the ability to demonstrate shared values of the nursing profession was inherently linked with personal attributes and previous experiences. Several semi-structured interview participants had been in the military prior to their nurse training and this seemed to produce a more confident understanding of professional accountability,

"So, do you think that [military] affects the way you see accountability?" (Researcher, line36)
"massively yes…" (Participant 013)
"More so that perhaps what you have done here [in nurse training]?" (Researcher)
"95%..." (Participant 13, line39)

Furthermore, this raised discussions about a *spectrum of accountability*, with some professions and areas of work as less accountable than others. This was based on the potential scale and magnitude of the consequences of any unprofessional behaviour. This was not isolated to the participants who were from the military but those with a range of backgrounds,

"I think I've never had a job where I've been as accountable before, you know, directly for people's health and well-being and things like that" (Participant 01, lines31-32)

For one participant, this was explicitly linked with the potential impact, severity and magnitude of behaving unprofessionally,

"people set up a Facebook page saying I hate a certain person and the girl tried killing herself" (Participant 02, lines42)

For the participants from the military it also meant that they recognised the importance of challenging and reporting unprofessional behaviours; these were seen as a threat to their profession. Other participants, even those from the focus groups did not explicitly discuss this as component of professional accountability. Having said this, these participants also noted that the profession of nursing did not have the shared *'pride'* that the military had[36]. Coupled with

[36] The concept that nurses believe they do a good job in spite of adversity rather than despite adversity of a situation

the potential scale and magnitude of consequences this made nursing *'less accountable'* than the military but *'more accountable'* than other employment,

"Because being in the military was all about being disciplined and having self-respect and self-pride and trying to promote yourself to be the best that you can be and promote your squadron and your regiment to be the best that they can be and maintaining a level of professionalism. It is such a massive thing in the army and that's . . . Because it maintains a standard. It maintains discipline and it is something that everyone can be proud of." (Participant 13)

"Do you think nursing is the same as that [military] or do you think that nursing is different?" (Researcher)

"I think it's the same principles that are there; I think the same principles should be there but at the same time there are differences. Well there should be differences. The army is a bit stricter."

"I have witnessed sometimes where professionalism and accountability is a bit…more so professionalism but accountability as well is a bit lacking…it's very important; being proud of yourself and what you're are doing… you are a soldier, you need to be, you should be so proud of yourself and you should have a lot of self-respect and discipline and portray that because what you are doing is amazing. And everyone who was above me in like the promotional ladder portrayed that onto everyone that was below them" (Participant 13, lines41-80)

This was an interesting finding for two reasons. Firstly, the academic focus group noted that NMC guidelines were not *black and white*, were open to interpretation and application based on the individual and the context. Secondly, it suggests that there may be a perceived *spectrum of accountability,* which I believed would add further complexity for pre-registration student nurses to determine what is or is not professional. It reconfirmed my interest in personal and professional values and the influencing factors on primary, secondary and professional socialisation.

I would argue that the model of professional socialisation from Weidman *et al* (2001) and the identified entities that influence professional socialisation also confirm this to be the case. I was also interested in the interaction between primary and secondary socialisation based on semi-structured interview participant comments about how their culture, religion and family influence their perception of accountability and *professional pride or identity*; something that was seen

viewed as both a group and individual component of accountability (i.e. 'I' am a nurse; 'we' are nurses and 'they' are not),

"It's part of my identity because it's just something that I've found that is like, I don't know if many people know the term, but it's my bailiwick" (Participant 05, lines42-43)

"So, is it important to you that you are identified as a nurse?" (Researcher)

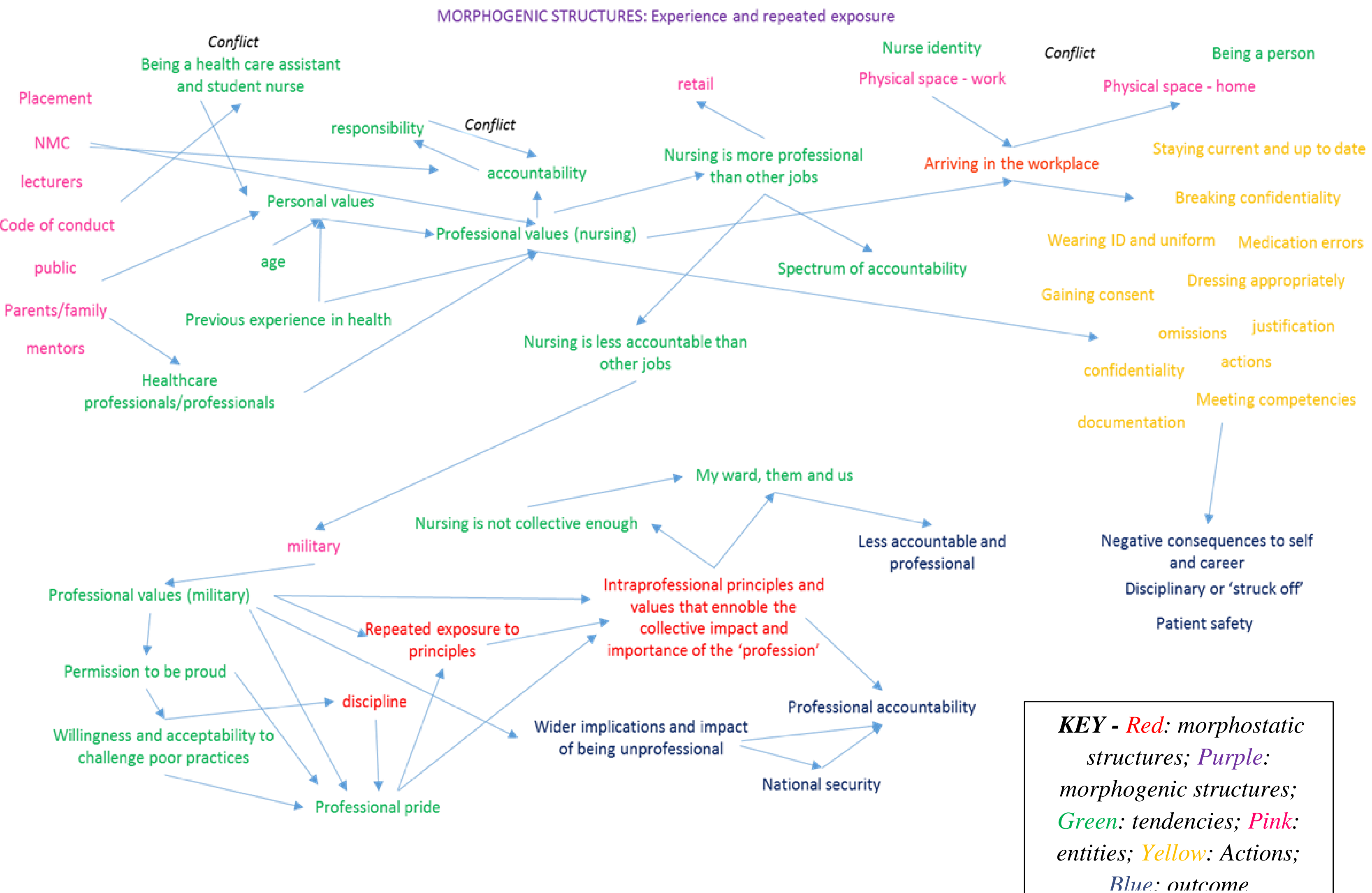
"I wouldn't say that it's important. I am proud that I'm a nurse; I like the fact that I can say that I'm a mental health nurse or just a nurse in general." (Participant 09, lines598-600)

"So, there is kind of a pride – you are proud to be doing this course, you are proud to be nursing and you are seen in high regard. It is not just your personal pride but it is like a family and community pride that this person from this community is a nurse. So, is nursing seen as in the same regard in Kenya as it is here?" (Researcher)

"You get a lot of respect being a nurse. Being a nurse or being a teacher, you know you get a lot of regard. Even the way that they talk to you as a nurse. Probably the way, outside of society; probably when you go in there in the hospital environment you will be treated different because you are professionals. Because my wife was a nurse in Kenya before she came here" (Participant 14, lines598-605)

Figure 5-4 provides an example of how analysis stage 4 enabled mapping of the different components found within the data in order to explain how perceptions of accountability are developed.

Figure 5- 4 An example of how stage 4 analysis was conducted in order to explain the interaction of components found in the data



The concepts of lifelong learning and exposure to primary experiences was also related to participant's concept of having common sense (i.e. lifelong learning and experience means that you have more common sense),

"I think common sense would be the first thing I'd say and being on this course and learning about the code of practice would be the second thing. But common sense would be the first thing."

"…my mum is a service user…I think it is personally and then coming here and learning about it professionally" (Participant 07, lines33-38)

"…I think you learn it with age as well as anything else but I think you learn it in…when you get into jobs that require you to perform professionally" (Participant 01, lines19-20)

"You learn about it throughout your life because obviously, I've done health and social care at college so you learn about it at college" (Participant 15, lines24-25)

"…but I think a lot of it is just the way I've been brought up as well. I think that you know what's wrong and right sometimes. I don't know but it's just something ongoing forever" (Participant 04, lines23-25)

To a certain extent this was also reflected in the focus group discussions with academics and practicing nursing staff. This further confirmed the importance of these factors in the process of professional socialisation (Weidman *et al*, 2001). The perceptions of what accountability is and what influences these are multiple and complex, based on the individual's background, experiences and family. These factors then influence the way in which professional training and education is received and comprehended. I believed this could therefore impact on decision making and reasoning both in the online and offline environment.

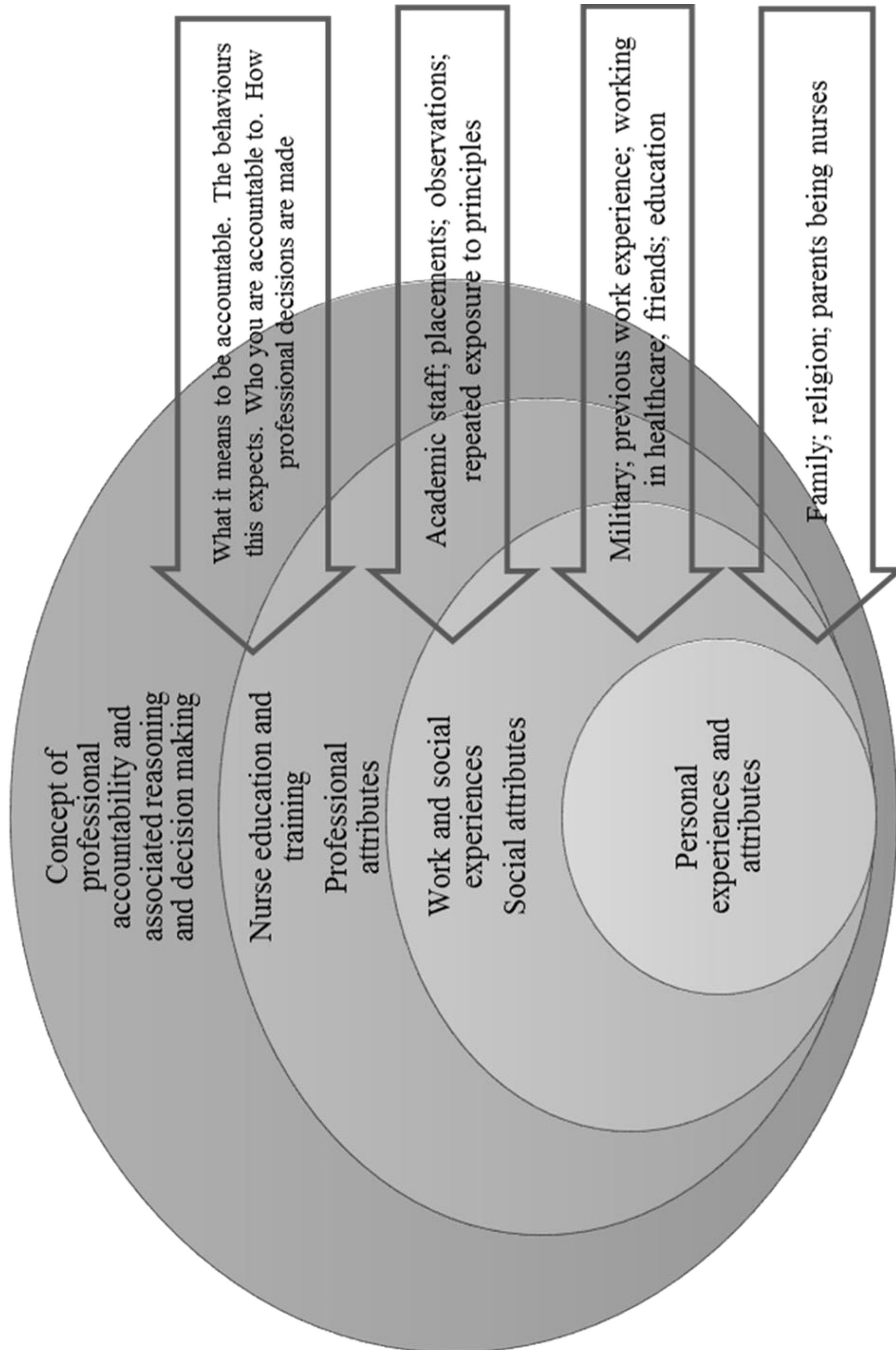
5.3.3 Making decisions as part of the process of analysis

Firstly, for the purpose of TAPUPAS(M) (rigour, as discussed in chapter 4) I briefly provide an example of how stage 5 of data analysis was conducted within this study: testing the models and

confirming theory (i.e. how I made decisions about accepting or rejecting a theory and/or framework).

Figure 5-5 provides an outline of my initial thoughts about the context of how professional accountability and decisions associated with *being accountable* are made. It illustrates a 'layered' approach with initial experiences and values (primary socialisation) embedded within professional socialisation. It takes into account the principles of experiential and human learning (Jarvis, 2006) and that of primary, secondary and professional socialisation theories (Weidman *et al*, 2001; Berger & Luckmann, 1966).

Figure 5- 5 Initial ideas about how accountability is perceived



Initially an individual is socialised into their family and personal life, upon going into education and the workplace they are then exposed to a wider social culture that further contributes to their

own identity and values. Once they enter nurse education and training they are exposed to professional values through a variety of routes, some of which have more impact than others.

For example, some participants felt that the academic staff along with repeated exposure to NMC principles, policy and guidance were of most impact,

“How did you learn about accountability?” (Researcher)
“There are obviously guidelines with the NMC and professional conduct and bodies” (Participant 04, line23)

“Your lead lecturers; they do tell you when you in that from this minute you are accountable for things that you do.” (Participant 12, lines43-44)

“it is in the NMC code of conduct but obviously at University they tell you as well about it and you kind of get it made very, very clear to as at the start that you are becoming a professional so you need to present yourself in a professional manner.” (Participant 09, lines28-30)

“I think that it is just a bit drilled into you when you are doing the course” (Participant 06, lines64-65)

“You follow codes and things like that. And I suppose that is drummed into you from the beginning. And you’ve got to meet standards throughout the training as well and I suppose that is drummed into you.” (Participant 01, lines24-26)

Others felt that observation of mentors and learning in practice did this to better effect,

“Well probably from what I have read because we have to read the policies and procedures and when I’ve been at work I ask questions; is it meant to be done this way? And other professionals will tell you which way it is meant to be done and why…I never knew about the NICE guidelines before, and obviously the NMC, even though I worked at the hospital I didn’t really know what it was. And then doing this course I look a lot more into it…” (Participant 11, lines31-42)

Some participants felt that experience and observation of negative consequences had most impact on this,

"Just knowing; it's mainly that if I mess up and it's my fault not only is that my job on the line but it's everything that I've worked so hard for but not just for me. That mess up could affect the person that I'm looking afters life. It could really be very detrimental; it could kill them really." (Participant 05, lines72-74)

Furthermore, these examples were open to understanding and interpretation based on individuals, their previous and lifelong experience. Hence, the combination and interaction of all of these contribute to the perceptions and decisions about *being professionally accountable*. This seeks to explain why there may be the concept of a *spectrum of accountability* but also why there is such disparity in certain aspects of participant responses [through the interviews and focus groups].

As part of the retroductive analysis valued by CR, I tested the concept of 5-4 within the mapped research data it appeared to be too linear and 'simple' to explain a more complex interaction between the different types of socialisation (i.e. I should not assume that one succeeds another or that one only influences that which happens later in time; this is based on the individual journey). It implies that primary socialisation forms the basis of subsequent types of socialisation but does not well demonstrate how professional socialisation may change and challenge those values that derive from primary socialisation (i.e. changing or influencing the values from previous points in time).

A further reason that the model in figure 5-4 was rejected as a final 'theory' was on the basis that it did not acknowledge the noted difference between offline and online values and 'social norms'. While professional socialisation is the focus of this study, it would be inaccurate to view it as a stand-alone concept (i.e. that professional values are built upon personal and social values and hence, decisions relating to accountability are as well). When in fact there is more evidence to suggest that they are interdependent. Primary socialisation does inevitably happen

first, followed by secondary socialisation and thus, professional socialisation. However, with experience and the passage of time these may impact on preconceived values and social norms. It may challenge some of those that were established as a child. Conversely, if an individual has grown up with professional parents/family then these values may be similar,

> *"But my mum was a nurse and I've got family that is in the nursing trade/career" (Participant 12, lines1076)*

> *"Oh yes, because as a nurse there are certain…let's say they see something wrong, my family and friends are nurses anyway and they would tell me, oh boy, this is so wrong." (Participant 16, lines244-245)*

> *"I think because obviously in my family there are nurses anyway so I've already had a personal experience to what it is like to be a nurse so you've got to portray yourself in a certain manner but obviously at University" (Participant 09, lines26-28)*

> *"Because my sister, the eldest one, she works for the Royal Family and so she is very, very . . . she has to be and I have kind of learnt from that as well" (Participant 03, lines501-502)*

or it may be that digital immigrants[37] have transitioned into the online environment where social norms are not consistent and extremely varied.

This raises some confusion as to where values and therefore, the concept of 'being accountable' comes from. As highlighted previously,

> *"…it goes further than that…I think some of your own personality, your own characteristics, your own traits if you like, become part of that as well, or is it the other way around? I don't know? So, some of my moral values are my [moral] values because of who I am or am I who I am because of being a nurse?" (Academic focus group I, lines19-22)*

[37] Defined as *"those not born into the digital world but have, at some later point in our lives, become fascinated by and adopted many or most aspects of the new technology"* (Prensky, 2001:1)

5.3.3.1 The relevance of digital immigrants and digital natives on professional socialisation and the relationship with OSNs

What has been shown in my data, is that there are a range of **components** [values, experiences] that influence how an individual is socialised and that accountability, behaving professionally are influenced by these. For each individual, they experience this differently. For someone born in the 1990's (digital natives)[38] they may have been exposed to online socialisation much earlier in life than someone born in the 1970s or 1980s (digital immigrants). Hence, their journey of professional socialisation and their relationships between 'being a professional', 'being online' and 'being professional online' are likely to be different to one another. This is also true of academics and practice based staff who educate and mentor pre-registration student nurses; a large proportion of this group of staff are accepted by their profession but cannot always agree on acceptable and professional behaviours in Facebook; predominantly because they are digital immigrants and the online world has been introduced after their professional world was established. This means that there can often be confusion, conflict and disagreement on the personal and professional level about online values. Some digital immigrants learn quickly and become socialised to the online environment more easily than others[39] (e.g. those who may still print out a document for editing rather than doing it on the computer). As Prensky (2001:6) states,

> *"Our Digital Immigrant instructors, who speak an outdated language (that of the pre-digital age), are struggling to teach a population that speaks an entirely new language."*

Hence, if the profession cannot always agree on what is or is not acceptable (i.e. professional values related to OSNs) then how is it possible to impart these values with pre-registration student nurses?

[38] Defined as *"native speakers of the digital language of computers, video games and the internet"* (Prensky, 2001:1)
[39] That is not to say that they professionally socialise any more quickly. This is determined by individual circumstance, background, experience and not solely about being a digital native.

This concept of digital immigrants and digital natives led me to propose that:

a) Online socialisation refers to the process by which an individual learns the norms and values of a particular OSN environment in their given context

b) In the current situation, where OSNs are still a relatively new technology there are three types of pre-registration nurses [N.B. and registered nurses] and therefore three types of socialisation journeys within the SPO framework:

1. **Digital immigrants I:** primary socialisation without OSNs, secondary and professional socialisation without OSNs, online socialisation in later life
2. **Digital immigrants II:** primary socialisation without OSNs, online, secondary and professional socialisation with OSNs
3. **Digital natives:** primary socialisation, secondary and professional socialisation and online socialisation occur concurrently

c) Each of these types of pre-registration nursing student have their own individual set of values based on their individual journey.

d) Each of these individuals have varying potential for change of values based on a range of other components (e.g. morphogenic and morphostatic structures such as experiential learning or the passage of time (table 5-4), or events and outcomes such as seeing someone else being disciplined for a particular action).

5.3.3.2 Theory I: the role of experiential and human learning

Theory I informs the development of the SPO framework and refers to the role of societal change, evolution and experiential learning. In explaining the relationship between the pre-registration student nurse and their perceptions of professional accountability, it has been established that experience across a wide range of time points, domains and the [lifelong] learning from these, influences the process of professional socialisation.

After reviewing a range of literature relating to experiential learning theory, I noted how these might be applied to how we learn about the concept and practices of professional accountability. However, I felt that the philosophical approaches to these did not align with that of the models found in my data (Gould *et al*, 2005; Knowles, 1989; Kolb, 1984; Rogers, 1983 & Dewey, 1938). There was one particular theory that I felt was most appropriate and negotiated the similarities and differences between other theorists. Although there is some focus on social context this does not necessarily align with the social constructivist philosophy and hence, Jarvis' (2006) theory of human and experiential learning has the following strengths:

- He very clearly recognises the importance of a philosophical aspect to human and experiential learning in which he recognises the complexities of the process (Jarvis, 1987: 26 and Jarvis, 2006: 23)
- Aligned with my critical realist approach, he recognises the importance of the genetics, biology and biology of the mind and not just social, cognitive and behaviouristic theories of learning. Humans exist and therefore we will inevitable learn from the world we are in whether we see it or not [as per my Chapter 3, I like to use the example of evolution; whether social or biological]
- Hence, he consolidates and builds on the work of a wide range of experiential learning theory (such as John Dewey, Carl Rogers, David Kolb and Malcolm Knowles) along with wider consideration of some of the components I have identified within my data.

Jarvis (2006) also makes explicit reference to the concept of lifelong learning. The role of life experience, previous education and lifelong learning was also noted as an integral part of *being accountable* as a pre-registration and future nurse. Although, Jarvis (2006) proposes a definition of lifelong learning, he also acknowledges the components of it,

"Lifelong learning is the development of human potential through a continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills

and understanding they will require throughout their lifetimes and apply them with confidence, creativity and enjoyment in all roles, circumstances and environments." (Longworth and Davies, 1996: 22 cited in Jarvis, 2006:140)

One of the most important and relevant constituents of this definition is *'apply them with confidence…in all roles, circumstances and environments'*. This implies that the development of the knowledge and skills to be professionally accountable should prepare pre-registration nurses [and indeed registered nurses] to apply these to any environment or circumstance (i.e. across life domains and in the online and offline environment) which is a concept that pre-registration nurses do often struggle with in practice (Rassin, 2008). They are able to articulate some of the principles (particularly those focused on the patient and/or clinical practice) but their application of these principles is not always evident in other life domains.

5.3.4 Theory II: Primary, secondary and online socialisation & social capital

5.3.4.1 Primary, secondary (professional) and online socialisation

Weidman *et als'* (2001) model of professional socialisation does acknowledge the diverse influence of a range of factors and, I too have found this to be the case. However, the Weidman *et als'* (2001) model of professional socialisation fails to acknowledge three key factors:

I. It illustrates professional socialisation as the central component (i.e. the person, family and background are acknowledged but only as to inform professional socialisation and development of the associated norms and values). It implies a successive relationship of primary socialisation to professional

II. It views professional socialisation as 'successive' to primary socialisation and does not acknowledge that professional values can be embedded during primary socialisation (e.g. parents as nurses). Nor does it acknowledge the journey of professional socialisation on challenging and changing values and social norms previously established during primary socialisation

III. Therefore, as a pre-OSN model, it does not explain the relationship and impact of the digital age on an individual as a person and/or professional; my concept of online socialisation

As a result, I believe that there are three types of socialisation relevant to my research question:

Type I: Primary (usually during childhood)

Type II: a) Secondary (usually during adolescence and early adulthood) and b) professional socialisation (considered a form of secondary socialisation)

Type III: Online (development of shared norms and values in an online environment e.g. OSN)

These three types of socialisation should be acknowledged as interdependent[40] and not necessarily successive. I propose figure 5-6 p158 which illustrates a three 'gears mechanism' and reflects the three types of socialisation[41].

A cog or 'gear' mechanism is one that takes account of input such as direction and size (in this case a change or continuance) of force and motion (in this case, events, tendencies, entities), and will generate different outputs (in this case *actions and behaviours* of the pre-registration student nurse that should reflect *professional accountability*), based on other factors such as the lubrication, material, size and number of teeth on the cogs (in this case morphostatic and morphogenic structures such as time, time spent in each type and the combination of experiences in each type along with when they occurred on the journey). This concept also acknowledges the fact that if one set of values changes, the other may also change and this will be dependent on whether they move in the same (co-operative) or opposite (competitive) direction.

This 'gear mechanism' or 'SPO' represents the interdependence between primary socialisation through social and personal circumstance, moving into secondary socialisation in what was described as 'formative years' by my academic focus group participant I, which is also where professional socialisation occurs [for those embarking on a professional career] and I introduce a new concept of **online socialisation**. The framework also acknowledges the 'entities' of 'life domains' have **most** (but not necessarily all) influence on each type of socialisation; professional, personal, social.

[40] Interdependence as a [mutual] dependence between one or more groups, people or things. Social interdependence states that there are co-operative (agreement of values) and competitive (conflicting values) dependencies (Johnson & Johnson, 2005) which here, are considered to be the tendency component working within the context of the journey of socialisation (appendix 1 p289)
[41] The components of the data have been colour coded in the text in respect of the SPO framework diagram figure 5-6

Critical realist (CR) philosophy emphasises that research should examine that which can be observed (empirical domain), consider the events and factors that create that which can be observed (actual domain) and discuss the 'causal mechanisms' (figure 5-6) or the proposed 'real domain', the context by which the actual and empirical exist; this then explains the reality of the socialisation journey in relation to the pre-registration student nurse.

5.3.4.2 Causal mechanisms: social capital, socialisation and life domains

During primary socialisation, the social and personal life domains dominate. Figure 5-7 illustrates how the interdependence of values is typically developed for those individuals not exposed to OSNs during primary socialisation and before OSNs were available. Firstly, as Ollier-Malaterre *et al* (2013) informs us, the management of boundaries in the physical or 'offline' world is much simpler than the online world [but not necessarily simple]. There are well-established social and professional norms that can be separated by physically being in or out of the workplace; the audience is physically visible, and psychologically this assists in an individual to clearly identify where norms and values in one environment begin and end.

Figure 5- 6 SPO framework: Socialisation-Professional socialisation-Online socialisation,

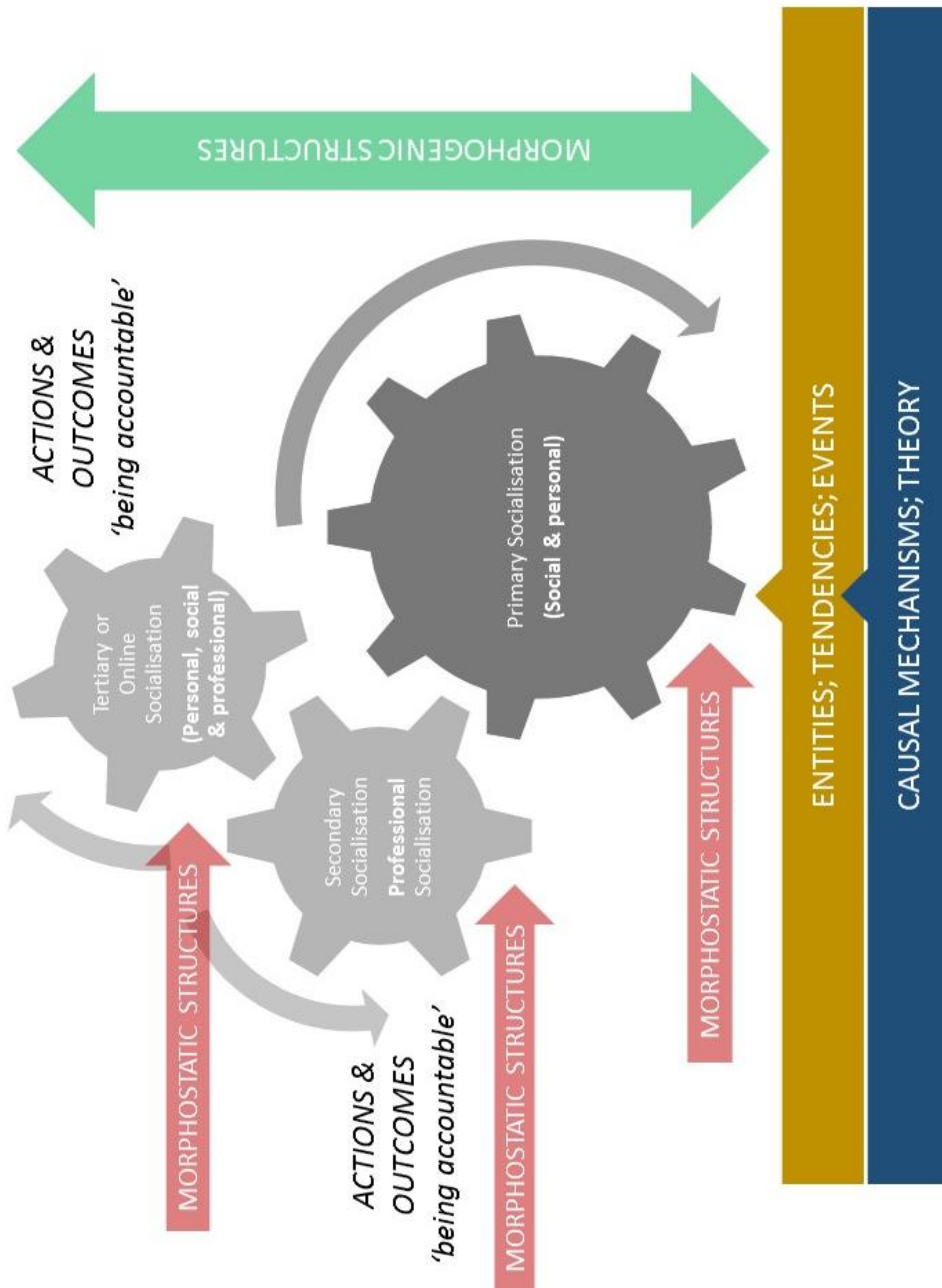
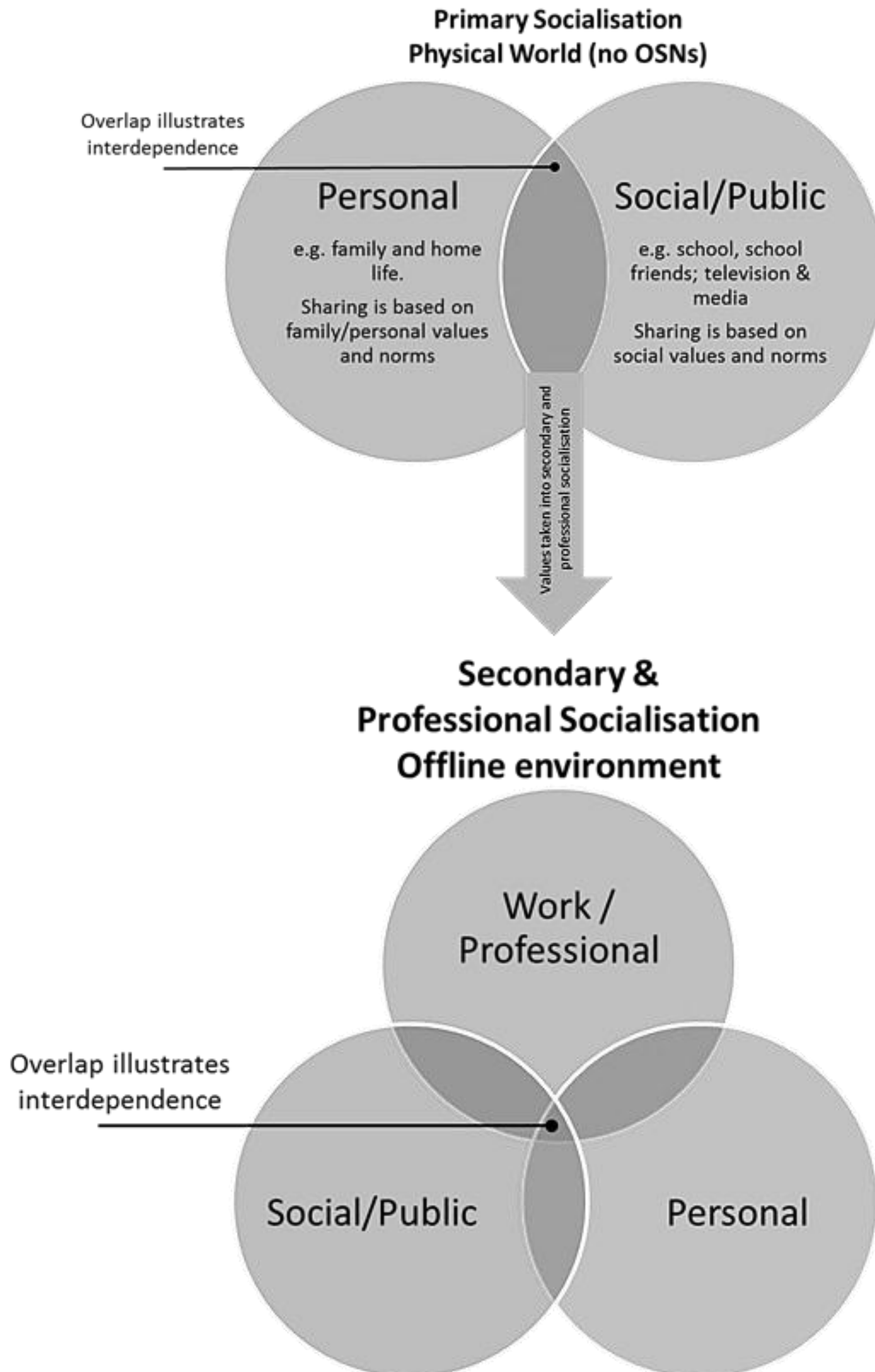


Figure 5- 7 Interdependence of values in the physical world during primary socialisation



In chapter 1 I discussed three types of social capital; bonding, bridging and linking and illustrated how they may interact and be represented across life domains. Social capital plays a vital role in the way in which life domains interact in the offline and online environment. However, in the online environment, due to the overlap of life domains, this provides a broader opportunity for interaction across a range of networks, not just those you would usually come across in the physical [offline] world. For example, I observed several professionally and academically linked Facebook groups as part of my unstructured observations and these clearly identified **linking social capital** between students and professional organisations (linking the person with the profession). **Bridging social capital** was observed through the use of academic and University Facebook pages and groups. While the interview participants themselves did not indicate that this had an impact on their concept of professional accountability and thus, part of their journey of professional socialisation, my observation data indicates that the presence and opportunity of linking and bridging social capital generates dialogue between individuals and organisations and thus, there will be some [albeit unconscious] learning and impact of these interactions. Hence, an individual may take on the values and socially accepted behaviours from within this professional group.

This unconscious learning or the 'unintended consequences' of interacting with a professional Facebook group (bridging or linking social capital depending on the origin and status of the page or group) can directly be likened to Jarvis' (2006) assertion of learning in the social context: culture and,

"in order for humanity to survive, it is necessary that we should learn our culture…the learning occurs, as we have pointed out, through personal interaction (I-Thou) with significant others in the first instance, and then with the wider life world…However, it is clear that globalisation and rapid social change have affected the nature of society and that our life-world is now multi-cultural" (Jarvis, 2006: 55-56)

Jarvis (2006) goes on to suggest that the passage of time and social evolution, such as the diffusion of the internet and OSNs throughout society, means that the concept of social norms, life domains and the opportunity for social capital on all accounts has changed significantly [and is likely to continue as we experience these as a society and changing culture]. I would therefore go further and assert that, as a profession, the **online socialisation** in society and for individuals will impact on our future socialisation as a **profession** and thus, our online behaviours and practices; our professional values and norms.

During traditional primary socialisation where OSNs did not exist (figure 5-7), an individual develops a personal identity and a social or public identity, as they experience life they enter into the workplace, and [for pre-registration student nurses] they have an additional 'professional' domain added. The interdependence of values in each of these domains can be viewed as the overlap between boundaries.

Figure 5-8 illustrates a comparative scenario; online socialisation for the digital native. This diagram provides an example of how the interdependence of values may occur for someone who has access to OSNs during their journey of primary socialisation. It provides an example of how the online world of OSNs impacts on the way in which values are developed but also how far more complex they are to navigate and manage; the more interdependence of values, the more complex they are to understand and manage and therefore the more conflict and confusion may occur.

Figure 5- 8 Interdependence of values during primary socialisation in OSNs (online) (digital natives)

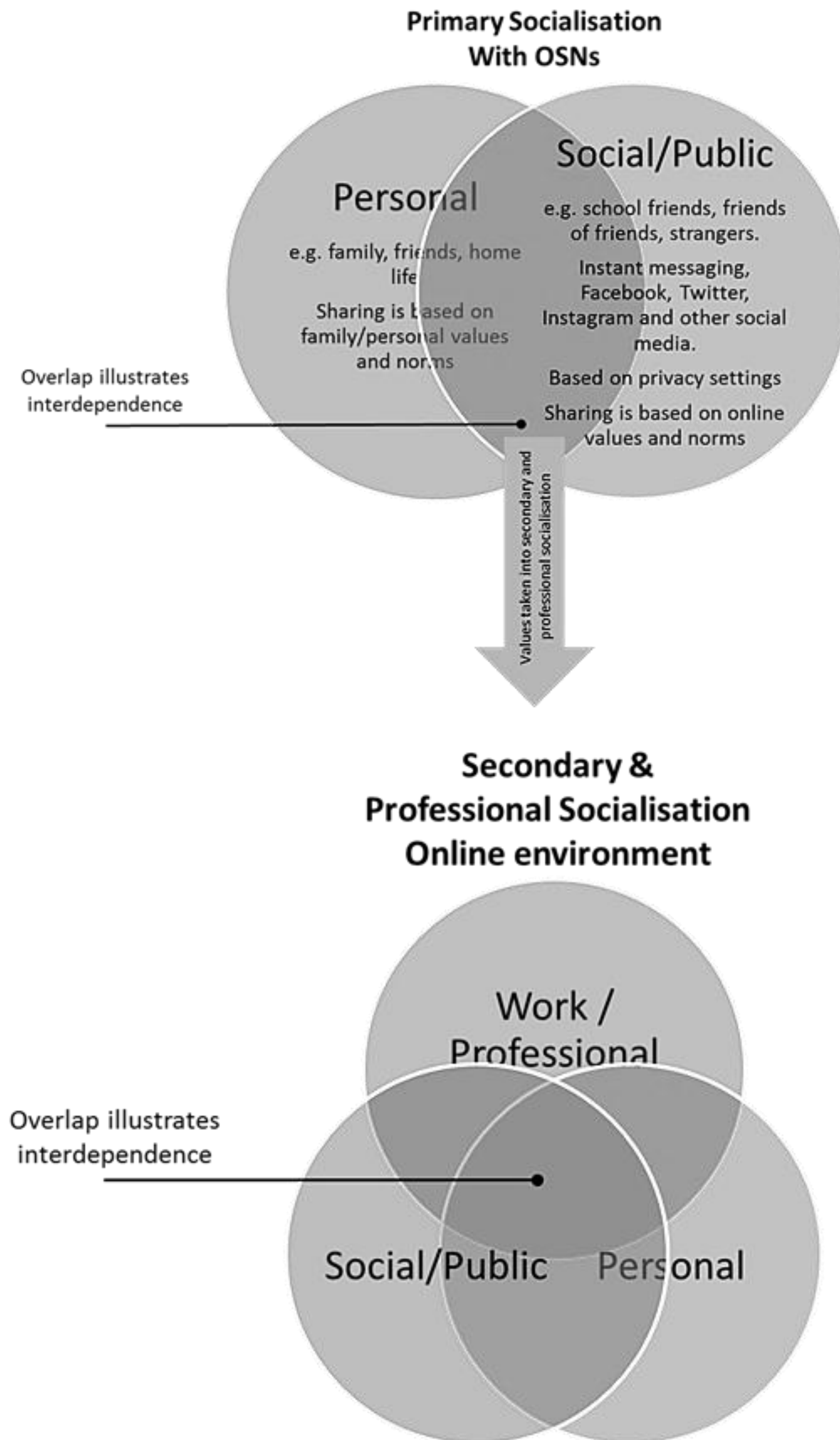
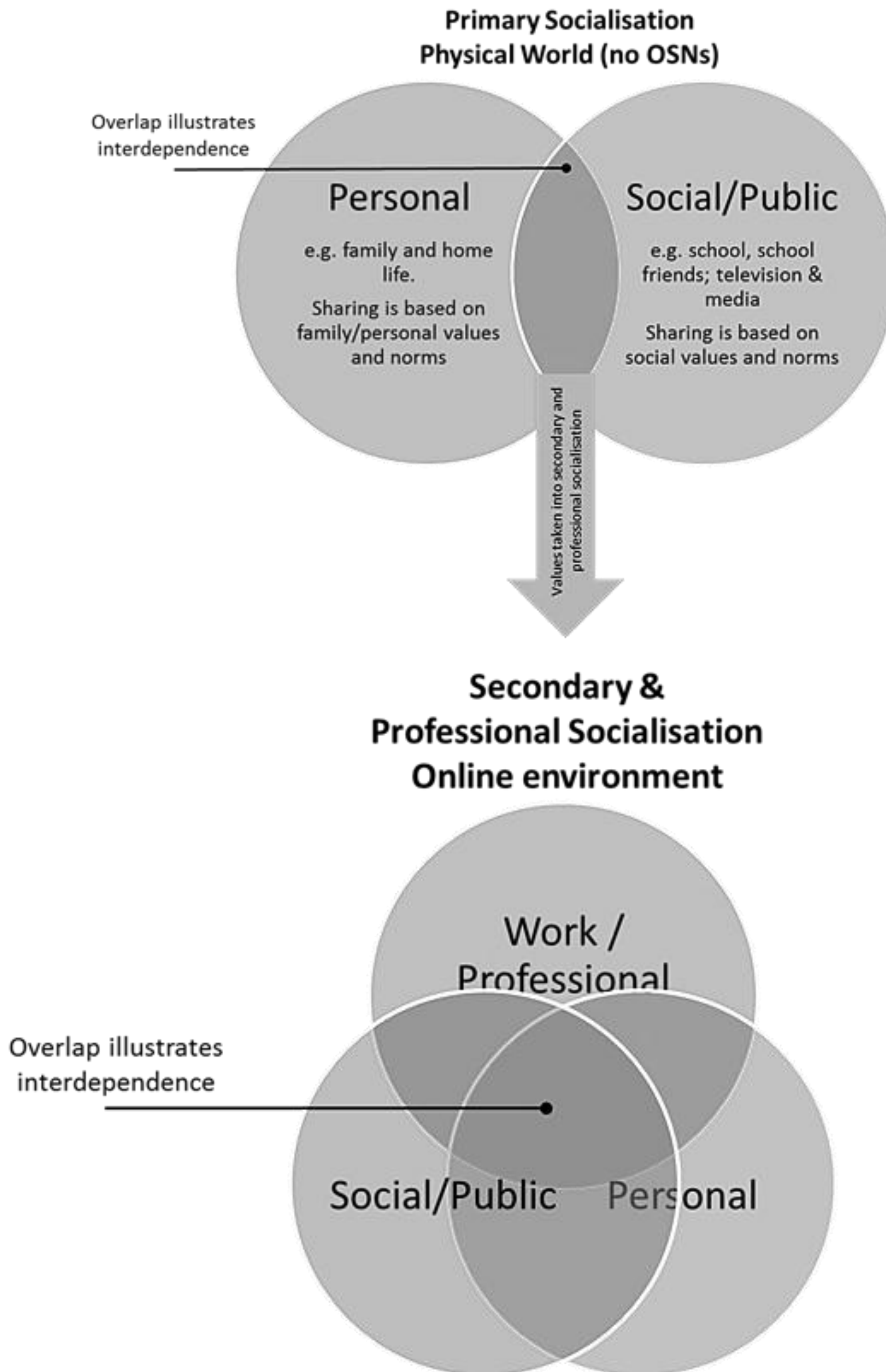


Figure 5-9 provides a final comparative example that reflects many of the academics, nursing workforce and certainly those pre-registration nursing students born pre-1990. It illustrates how complex this scenario may be for a digital immigrant moving into the relatively new online environment of OSNs; online socialisation for the digital immigrant. Not only is there an increase in the interdependence of values, and therefore potential conflict of these values, but this also may require a shift of long standing values developed during primary and professional socialisation.

This concept of co-operative and competitive values across life domains and how these boundaries were managed in the online environment was of particular interest. This could explain the decision-making process when posting in OSNs and why some individuals participate in risky online behaviours that can be considered to be unprofessional.

Figure 5- 9 Interdependence of values for digital immigrant's type II (did not have OSNs during primary socialisation)



5.3.5 An applied example of the SPO framework

Figure 5-6 presents the SPO framework. Morphogenic structures such as experience, repeated exposure to values and learning or negative consequences may enable an individual to change their personal values (known as tendencies) [those from primary socialisation].

This can be seen with participant 02, lines42-46,

> *"I hated Facebook, I hated it. I used to be in the Navy and we had people who set up a Facebook page saying I hate a certain person and the girl tried killing herself…but when I left the Navy I set up my own business and that is the only reason that I've got a Facebook account, because it's been brilliant for business. So, with that, and coming into my nursing course as well because everyone else is on Facebook"*

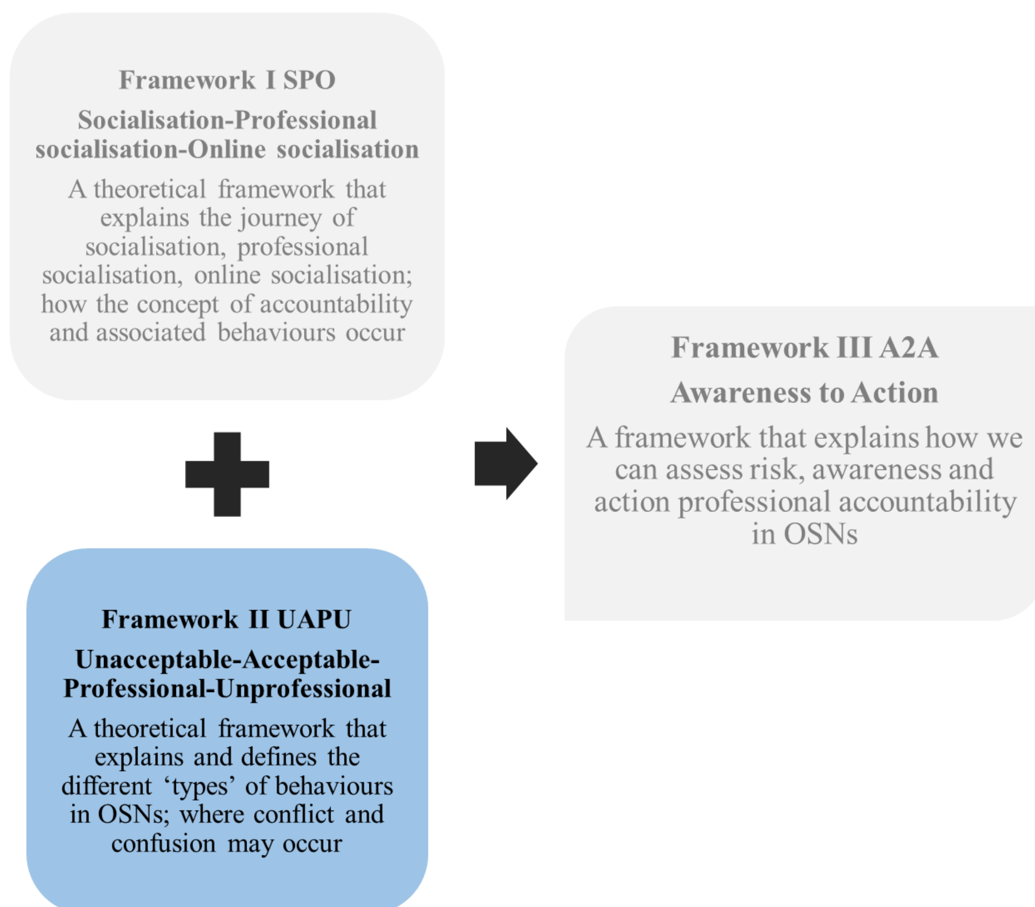
Initially, when in the Navy (professional socialisation) participant 002 was explicit in saying she did not have, nor did she want a Facebook account. Her perception of Facebook was negative and hence, her actions were to refrain from opening a profile. Here, morphostatic structures such as negative experience and fear of the consequences (an event in this case) impacted on her actions. However, owning her own business and changing profession (morphogenic structure) resulted in a change of perspective because of what the social norms were in those contexts. For example, the nursing cohort group (secondary & professional socialisation) and hence, she opened Facebook profile (online socialisation). Consequently, opening a Facebook profile not only impacted on her business values and networks (928 Facebook *friends*, over 300 were business related, some Navy related, some nursing related and others real world friends and family) but also opened up an online world to a 'digital immigrant' who started a new journey of **online socialisation** where her social, personal and professional life domains significantly overlap. The combination of such processes, whether consciously or not influence the individual's values, actions and feeling of identity, perceptions of professional accountability and thus behaving in a professionally accountable way.

After having confirmed the explanatory mechanism for the journey of socialisation I then needed to consider the relationship between the pre-registration student nurse and the Facebook environment; what they do, how they do it and why.

5.4 DEVELOPMENT OF FRAMEWORK II UAPU: UNACCEPTABLE-ACCEPTABLE-PROFESSIONAL-UNPROFESSIONAL

Framework II, UAPU explains the pre-registration student nurse's relationship with Facebook. In order to explain the pre-registration student nurse's relationship with Facebook it is necessary to understand how they perceive, use and behave on it. (Figure 5-10 illustrates how this framework relates to the overarching results of this study along with the SPO framework).

Figure 5- 10 how UAPU relates to the findings of this study



Consequently, it will then be possible to examine how this interacts with being professionally accountable in the OSN environment. This section will discuss my findings and development of the UAPU framework, beginning with the pre-registration nurses' perceptions of Facebook, explaining behaviours on Facebook and where risks may arise. The theories and proposed

causal mechanisms that have informed the developed of this Framework will be discussed. It will conclude with an illustrative example of explanatory Framework II.

5.4.1 Pre-registration nursing student's perceptions of Facebook

Student nurse perceptions of Facebook are important in establishing the relationship between them and Facebook, and consequently, the nursing profession and Facebook. Overall the participant's perceptions of Facebook were both positive and negative; and often both. However, through this aspect of discussion it was evident that there are some conflicting and contradictory opinions about what Facebook is, what its role is and how it has diffused/is diffusing in our society and culture. While I refer to 'diffusion' and 'change' [as this is the terminology used by the authors] such as Rogers (2003), my personal preference in my theory is the term '*evolution*' which encompasses both the notion of diffusion and change but with the added [CR morphogenic/morphostatic] structure of time.

In accordance with, and further to my proposed Theory I, Rogers (2003: 8) suggests that the diffusion of innovations (DoI), research and/or learning is a type of social change,

> *"Diffusion is a kind of social change, defined as the process by which alteration occurs in the structure and function of a social system. When new ideas are invented, diffused, and adopted or rejected, leading to certain consequences, social change occurs."*

While I had already established an evidence base for Theory I, societal change, evolution and experiential learning, the structures and tendencies that form the theory of DoI were essential for explaining the behaviours, decisions to use and perceptions of Facebook for the pre-registration student nurse. For example, for those students who chose not to have a Facebook profile *(non-adopters)*, those who choose to use Facebook after having disliked the concept *(late adopters)*, to those individuals who continue to use Facebook even though they still dislike

it *(continuance)* or [rarely] those who deactivate their Facebook account for the short or long term *(discontinuance)*.

Incidentally, not having a Facebook account or having presence on Facebook was viewed as unusual or weird. While participants acknowledged that this was acceptable and a personal choice, they often stated that this meant that these individuals 'missed out' on information or that they did not 'belong' to the group in the same way as those who were on Facebook. To the extent of making sympathetic comments,

> *"It's a whole new world, Facebook. Because I grew up in a world where you didn't have any of this and yes, it is quite strange and people think it's a bit strange; why aren't you on Facebook? not everybody on the cohort is on Facebook and part of that group so I think I've kind of said that it was important that if people were being invited on a night out socially, for example, that we included those people who weren't on Facebook who might feel a bit 'I didn't get an invite' or . . . (Participant 07;91-106)*

> *"...because you assume that everyone has got it and they haven't. Like there are a couple of girls in the cohort that don't have it and we think they don't have it. So, like when you are all getting invites to all of these things you get missed out because you're not on it. I think it is seen weird" (Participant 15:281-284)*

> *"Yes, you just automatically assume that everybody knows or they are up to date with everything and then there's poor old Tim who hasn't got a clue." (Participant 01)*

Facebook was viewed as a valuable networking tool for communication with those who are geographically dispersed, or who you may not have sustained contact with in the absence of digital communication such as Facebook. Other positive comments referred to the ability to stay in touch with peers in their cohort using the Facebook group's function which further illustrated the importance of **social capital**. This was of particular interest as one aspect of professional socialisation from Weidman *et al* (2001) who suggest that peers and peer support influence this journey. Hence, Facebook groups could be a medium for creating a sense of 'belonging' to a professional group and the associated peer support that it provides. This could

also reinforce the development of professional identity; developing norms and values within a professional cohort. This suggested that the role of Facebook groups may play an important part in the relationship between the pre-registration student nurse and their journey of professional socialisation.

The concept of Facebook *friends* added a further complexity for self-efficacy and a confidence-competence debate for participants. One the one hand, they recognised the risks associated with having distant friends or acquaintances as Facebook friends but conversely, felt that Facebook also offered this as a benefit, for retaining social ties that would otherwise not continue to exist. For the majority, participants recognised the diverse nature of Facebook *friends* and the concept that they may not reflect what they deem to be a *friend in the real world,*

> *"Probably not to be honest. In fact, I don't know who would be my real friend if I'm honest. I've got one best friend at home but again we are happy just to text every other week or maybe every month it can be but I still feel as close to her forever that I have always been. I don't speak to her on Facebook" (Participant 04, lines204-206)*

Participants seemed to recognise that they would not share their personal life with many of the people they have on their Facebook friends list and expressed confidence in the way in which they use Facebook due of this. However, this 'confidence' in their Facebook management did not always reflect their actual behaviours [competence] of Facebook management. And this was also true for registered and academic staff.

5.4.1.1 The relationship between registered nurses and pre-registration nurses perceptions

Facebook was generally seen as a personal space that should remain separate from their role as a professional [nurse] and should not be publicly accessible. However, the academic focus group contained one academic who did not restrict his profile, implying that he used it in an acceptable and professional manner had nothing to hide,

"Probably the cynic in me says that at some stage Facebook profiles are going to be breached and anyone will be able to see anything at some stage and so I think having the philosophy of only putting stuff on that you think is appropriate in the public domain. My privacy settings are open meaning that if you search me you can see." (Academic Focus group IV, lines210-213)

"I know and I don't have any domestic violence issues and I don't have any sort of skeletons and of people trying to find me and all of that but I understand how that can have an impact but equally I think that if you have it completely open it sort of . . . I don't really think about it; it's forcing me to keep things appropriate because I don't feel like I would ever put anything inappropriate on" (Academic Focus group IV, lines215-218)

When challenged about this he then adjusted his statement and realised there were potential unintended consequences to his decisions (i.e. having multiple roles of being a clinical nurse, and academic and having a personal profile) but also contradicted himself,

"I never considered that at all and I'm in a similar scenario to you in as much as I have only had Facebook while I've been in a predominantly an educational post. My clinical role wouldn't have led me to forming those sorts of intricate therapeutic relationships with people . . . but actually that has never crossed my mind and actually when I work as a staff nurse I do (because I do work as a staff nurse from time to time) people can and would be able to find me." (Academic Focus group IV)

"I think the guidelines are quite clear; the NMC guidelines, the social media guidelines are quite clear and that is the conversation we started off with, with the rights and the wrongs. I think that they are quite clear. Where we are talking about moral judgements and subjective decisions I think obviously, everyone has their own idea of what they think is appropriate, inappropriate, safe, unsafe and I think that we can all be prone to be challenged based on sort of our own assumptions of how we think we act in that context." (Academic Focus Group IV, lines713-726)

This was also evident for others in the conversation, particularly when we began to consider the 'patient' and public as a factor along with our duty of care as professionals (NMC, 2015),

"…despite the fact that it is in the public domain, I would feel very uncomfortable about searching for a patient. And is there anything to stop us doing that? If it's in the public domain then it's in the public domain but I am sort of feeling uncomfortable talking about it so . . ." (Academic Focus group IV)

"I wouldn't even have thought to have done it till you mentioned it." (Academic Focus group II)

"But equally if a third party said a patient had discussed me on Facebook I would then go and look to see what they were saying." (Academic Focus group IV)

"Or if a patient was at risk? Suicidal?" (Researcher)

"But then, I don't know, you are using it in a professional capacity, then aren't you? Or are you? I don't know." (Academic Focus group IV)

"I don't know it's quite a difficult one . . . I was just thinking if somebody . . . but then who is going to be telling me that a patient . . . I'm just trying to understand . . ." (Academic Focus group II)

"A patient could message you because you don't have to be friends with someone for someone to message you." (Researcher)

"Don't you?" (Academic Focus group IV)

"Not always." (Researcher)

"Well I'm just thinking what you said about yours [Academic IV] being open. So, you, from a mental health background, probably wouldn't even entertain that idea because you have all sorts of patients looking . . ." (Academic Focus group II)

"I've got mine set as tight as they can be but you know . . . but again it never even crossed my mind." (Academic Focus group III)

"Patients can find you actually." (Researcher)

"Do you know that never, ever occurred to me?" (Academic Focus group III, lines665-689)

Not only did this illustrate an overarching dissonance between values, self-efficacy and actions in the Facebook environment, it also emphasises the complexity and contradictory values and perceptions linked to life modes and identities. Conversely, if this is evident in highly experienced, registered nurses I would argue that negotiating these ideas is even more challenging for pre-registration student nurses. Furthermore, as these individuals educate student nurses, my research participants and Weidman *et al* (2001) assert that they are influential on the journey of professional socialisation. This illustrates the potential for contradictory and confusing values to exist and develop as part of the professional socialisation process and thus, form the basis of these values within the profession. As a result, the defining characteristics of professional and unprofessional behaviours within the Facebook environment and the very nature of 'being' professionally accountable become confused, contradictory and even disputed.

What was also apparent within these focus groups is that perceptions of Facebook, its management and usage in the nursing profession was debated. Both academics and student participants agreed that context was extremely important but online is very difficult to assess.

And, also similar to the student participants while some actions were noted as explicitly unprofessional; the defining characteristics of unacceptable, acceptable, professional and unprofessional were still conflicted,

"But I think the issues about challenging as well isn't as black and white as it might seem because you might see something once and think well shall I let that go and see if it happens again and if it happens next time then I'll challenge it. Obviously if it is something like blatantly like you saw, I don't know, a patient being hit or something that would be a definite I need to challenge this now but there might be something, I don't know; someone hasn't written the records that day so you think perhaps it is just because they've had to go on a transfer with somebody else therefore they have just missed these records. So sometimes you might give someone the benefit of the doubt on that occasion within that context. But if you saw it happen again when actually they had four hours to be completing the set records and they still weren't done then you would have to challenge the contemporaneousness of those records so it is not as clear cut as even challenging people." (Academic Focus group IV)

"And it may also depend on who it is as well because I would have a much higher threshold for challenging one of my colleagues than I would for challenging a first-year student because I think that we all understand what it is that we are . . . we understand our attitudes towards accountability and we understand our responsibilities and where we put something that maybe initially out of context may be inappropriate there may be a background. But certainly, students don't . . . I think that you would be much more inclined to comment a flippant comment that a student makes as a learning point rather than . . . to try and help them see that actually . . . (Academic Focus group IV: lines280-304)

The unintended consequences of such actions were also noted as relevant but created added confusion and debate,

"I think it depends what you do when you're drunk to be fair" (Academic Focus group II)

"And how you portray it then . . . friends that are posting regularly about different types of drinking but then they are not posting videos of themselves out that night having drunk it. They say that they like a drink but they are not filming themselves doing something stupid. Obviously not that my friends would ever do anything stupid but you know . . ." (Academic Focus group III)

"It's about the behaviour and like you say drinking is not illegal, getting drunk isn't illegal. Some of the behaviour that is expressed when people do get drunk does cross that boundary of, not necessarily what is legal but it would undermine your confidence in their ability to make professional decisions sometimes if the public were to see that this is a regular thing that you as a nurse do. And, you know, everyone goes out and gets drunk from time to time or lots of people do and you know you may act in a way that isn't necessarily completely professional but you don't post it on Facebook." (Academic Focus group IV)

"But like you were just about to say I think you might have friends who aren't anything to do with the health service that don't even know about the trouble that it might get you in if you were seen doing something bizarre when you're drunk, I don't know. So, they put it on their Facebook account and by a third party it ends up back with your line manager and it is taken

not even out of context but you never intended that to get out there." (Academic Focus group II, lines311-333)

Additionally, the academics felt that it was not their role to 'check-up' on student's public profiles despite the impression I that student participants had been given in face to face lectures (i.e. that academics would 'know' when they had done something or behaved inappropriately),

"But sometimes you find out by default, don't you? We had a student who was late for her exam so therefore didn't sit her exam. Only the student has told us, because then she put in for an EEC and said that someone was very poorly but the other students felt really . . . oh no she arrived late and had to go at the end of the day but she should have been first because it was like a viva. But the other students, who she thought were her friends, took really umbrage at this because actually she had put on Facebook that she had been out; I don't know someone's hen night or something. She had a hangover, couldn't drive yet and she was still drunk so then came in later. Only we found out about that so again we had to go down the professional suitability route." (Academic Focus group III: lines619-636)

Given that these individuals are claimed to be so influential for the pre-registration student nurses this caused me concern and led me to question whether the debate and dissonance in the profession is an explanatory reason for why students have the perceptions, values and behave the way they do? Conversely, I was also interested in the concept of [unintended] consequences of behaviours; a factor to consider in the diffusion of any innovation (Rogers, 2003).

How perceptions relate to awareness, behaviours & consequences.

While many pre-registration participants expressed confidence in their knowledge and understanding of the diverse and unique nature of Facebook *friends*, all stated that they would not agree to a stranger's friend request, and the risks this may bring. However, many went on to acknowledge that they do little to manage and update these based on their current situation (e.g. removing friends from high school who they added when young to increase their number of friends and social acceptability among them),

"Obviously, I've added them on haven't I so I've got to take responsibility for adding them. I think that I do need to do a bit of a Facebook cull to get rid of people that I've not really spoken to for ages and things like that. For me; they're not close friends. I've probably got about five close friends and then all the rest are like acquaintances. And I think a lot of people could say that." (Participant 01, lines103-109)

"Again, over the years . . . so when I first had Facebook it was just like a popularity thing that everybody was doing it so I had to do it. And at that point it was whoever asked me to be their friend I accepted. So, I was in competition with my friends to try and get more Facebook friends so it was like the one thing. Whereas now when I go through my feed and I think I don't know who you are I'll un-friend them. And now people send me friend requests or try and go on their profile and sometimes they are as private as I am and I can't see anything and I can see their name but if they just don't ring a bell or anything or I don't know who you are then I won't accept them. I do have a lot on there, from the past that I don't even know." (Participant 03, lines110-117)

Conversely, one participant did state that they regularly manage their friends list and knew who their Facebook friends were but then [once we accessed her profile] went on to acknowledge that they had four times as many [Facebook] friends as they thought,

"Yes, I know who my friends are but I don't know how many I've got…Maybe 100 and something." (Participant 11, lines171-175)

"Okay so do you remember who these nearly 400 friends are? Because you thought you had a lot less." (Researcher)

"I know. I know that I've probably got everybody on Facebook from here and work places I used to work before. I do know all those people that you are scrolling down." (Participant 11, lines390-393)

One participant argued that they had never removed people from Facebook as they did not 'care' about it, they simply compared it to a telephone contacts list,

"Before when I was younger, before I joined the army; I was just having I seen them about or have I had a chat with them or do I even know of them slightly? And they will say add me on Facebook or I'll say I'll add you on Facebook and then you get the invite or you send the invite and then that's that and then you probably never speak to them again." (Participant 13)

"And are those people still on there?" (Researcher)

"I've not removed . . . I don't think that I have ever removed anyone." (Participant 13)

"Why would that be? So, you have got people that you know you don't even know." (Researcher)

"There are definitely people that I don't know on there." (Participant 13)

"So why leave them on there?" (Researcher)

"Because I don't care about it. I don't care about Facebook at all." (Participant 13)

"It's not a platform to express myself. It's not a platform to share my life. It's not a storage of anything at all for me. It's literally there like a contacts list in your phone; that's it." (Participant 13, lines301-313)

These discussions indicated that pre-registration student nurses may well be correct in their perceptions of what Facebook friends are (i.e. not necessarily close or real-world friends) but that their actions and management of these does not correspond with their perceptions.

As discussed widely in the literature reviewed in chapter 2, the very nature of Facebook and their *friends* on Facebook, creates a unique and complex online audience that are from a wide range of your social, personal and professional roles and often 'unseen' or 'forgotten'. For example, Facebook generally prioritises comments and new activity on an individual's wall based on those *friends* who you interact with most, and this can limit the conscious consideration of who and what you are sharing on your own profile. Hence, tens or hundreds [in some cases[42]] of your *friends* may still have sight over what you post or share regardless of the relevance or acceptability of this in the context within which you know them in the *physical world* [if at all in some cases]. Participants noted that they would not announce parts of their personal life out loud in a public place but have been shown to do so on Facebook. Conversely, there was also reference to the unintended consequences of posting on Facebook as opposed to real-life,

> *"I don't share my life on Facebook to be fair. I'm not updating it and tell people what I'm eating and what I'm not eating and things like that. Whereas some people are like tell you everything, don't they? And I use it to upload photos and things like that and my little boy and family and things like that. I use it more personally to be honest; in my personal life." (Participant 01, lines92-96)*

[42] Such as participant 02 with 928 friends, some of whom she had never met

Overall, these aspects of the discussion raised confusion, contradictory comments and uncertainty. Does this suggest that students are unaware of the public nature of Facebook even with levels of privacy and security settings in place? And does this then explain why individuals may share aspects of their emotions and personal lives on Facebook that they would not in a physical social or professional situation? I noted this complexity as an important part of the relationship with life roles in the online and offline environment that could potentially be explained with Ollier-Malaterre *et al* (2013) and Rogers (2003) DoI theory, and the three classifications of *consequences,* those changes that happen to a social system or individual as a result of an innovation:

a) Desirable versus undesirable consequences.
   This refers to whether the effect of the innovation is positive or 'functional' (e.g. the perceptions of Facebook are positive because it enforces **social capital**) or negative [dysfunctional] whereby negative experiences such as cyber bullying or possible negative impact on self-esteem.
b) Direct versus indirect consequences.
   This refers to whether the change to an individual or social system is a direct result of the innovation (e.g. peer support and obtaining information by being a member of a Facebook cohort group) or whether this is secondary (e.g. feeling left out within the cohort group offline due to not being part of the Facebook group)
c) Anticipated versus unanticipated consequences.
   This refers to whether the changes that take place are recognised by the social system or individual or whether they are unintended consequences (e.g. the opinions of others developed about an individual if they like a particular Facebook group or share something they perceive to be offensive).

The perceived rationale for different positive and negative impressions of Facebook were varied. Typically, this involved an emphasis on having multiple life roles and an 'entitlement' to a personal identity outside of nursing, but also the wish to have a professional identity in order to belong with the profession. The motivation and willingness to *be professional* was acknowledged but the notion of *being myself* was also important. I felt that this may indicate that conflicts may arise where personal and professional values do not align, consequently leading to unprofessional or unacceptable behaviours in the online environment.

Facebook privacy policy seemed to cause further confusion. While participants were clearly aware that it existed, they were not necessarily confident or able to employ the settings they would like,

> *"like on Facebook they are always updating the privacy settings as well so you'll think that you have had something on private and then they'll update it and then it's shared publicly again and you just think . . . and then you'll just update something and you'll think oh yes that's fine and then they'll like oh by the way we've changed it again. But they don't tell you when they change it so if they update something and change your privacy settings you are not informed." (Participant 09, lines577-582)*

> *"I know that people can view my profile but I know they can't view everything on there. As far as I'm aware I don't think that they can view what I'm posting or anything like that. But I know that the settings consistently keep changing so I don't know if that's like . . . because it's a while since I looked at my privacy settings; maybe years. And I know that they change it constantly." (Participant 05, lines443-446)*

One particular case was of interest. Participant 05 was a critical case for discussion as he expressed high levels of confidence in his ability to use and manage his Facebook profile. However, upon reviewing his public profile we discovered that everything he posts was fully public. This particular scenario led me to question the role of confidence versus competence or the concept of conscious and unconscious competence (Kruger & Dunning, 1999). Students [and indeed the registered staff focus groups] clearly had awareness of privacy policies and that there were settings available but there was clear confusion about 'what' settings were available

and how to use them. Conversely, there were students who claimed they knew about their settings, but their public profile was viewed it transpired that they were sharing photos and information that they were not aware of, or that they believed to be inaccurate.

Some of the most conscientious and 'suspicious' participants who did clearly did restrict their public profile were then unaware that this only applied from the point of amendment and all previous publicly shared information was still available to view. This meant that anyone (including patients or potential employer) searching for this individual would immediately see pictures that were sometimes more than 6 years old and taken prior to entry into nurse training, often when the person was in their teens. Hence, these could be viewed as unacceptable and/or unprofessional (e.g. drinking, smoking, promiscuous images, comments about the workplace). The risk was further compounded if a current workplace or information about being a nurse/healthcare assistant or student nurse was available through the public profile, leading to a possible negative association between that individual and the profession (despite the information being out of date).

The relationship between the student nurse and privacy settings is clearly an influential entity that informs the relationship between the student nurse and their Facebook profile. This also confirmed my interest in the interaction between perceived awareness (self-awareness or self-efficacy), unconscious awareness and competence (actions and behaviours) in the Facebook environment. Rogers (2003) identifies that the adoption and use of an innovation is inherently linked to motivation, need, ease of use and perceived advantage of the innovation (*relative advantage, compatibility* with existing values and experiences, *complexity*). It is in my mind that Facebook and the platforms of use (e.g. mobile devices) displays these qualities. I had also

already identified that the very nature of Facebook creates *observability*[43] and offers *trialability*[44] across a social structure (the profession of nursing, the person, the public). However, in order to explore these concepts further I had particular interest in understanding the motivations and patterns of use in Facebook.

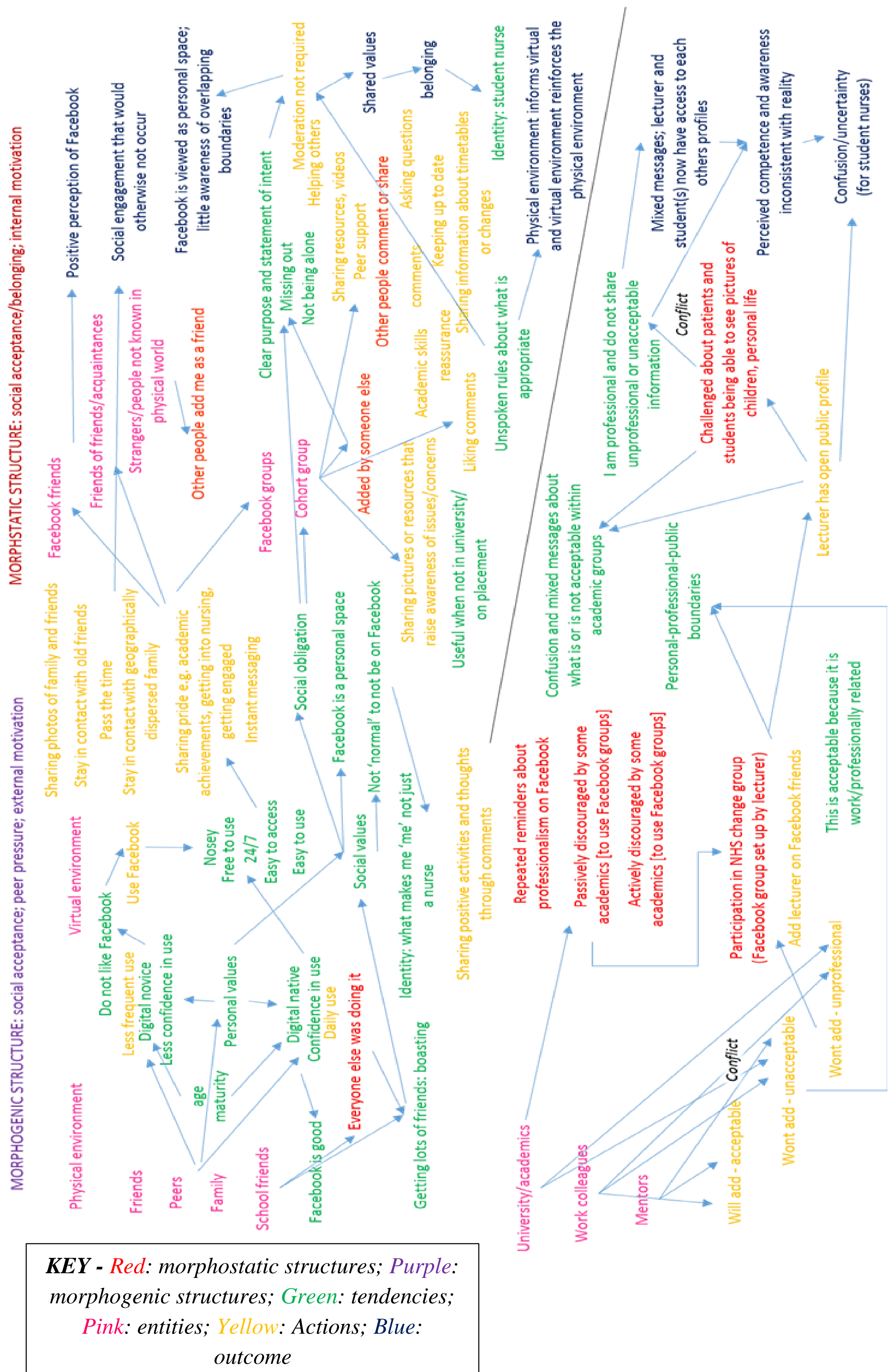
5.4.1.2 Motivations, reasons and patterns of use of Facebook

Figure 5-11 illustrates the stage 4 analysis, mapping of the components that explains pre-registration student nurse relationship with Facebook and their motivations, reasons and patterns of use.

[43] The degree to which an innovation and its results are visible to others in the social network (Rogers, 2003)

[44] The notion that individuals can 'test' the innovation without ongoing commitment to its use

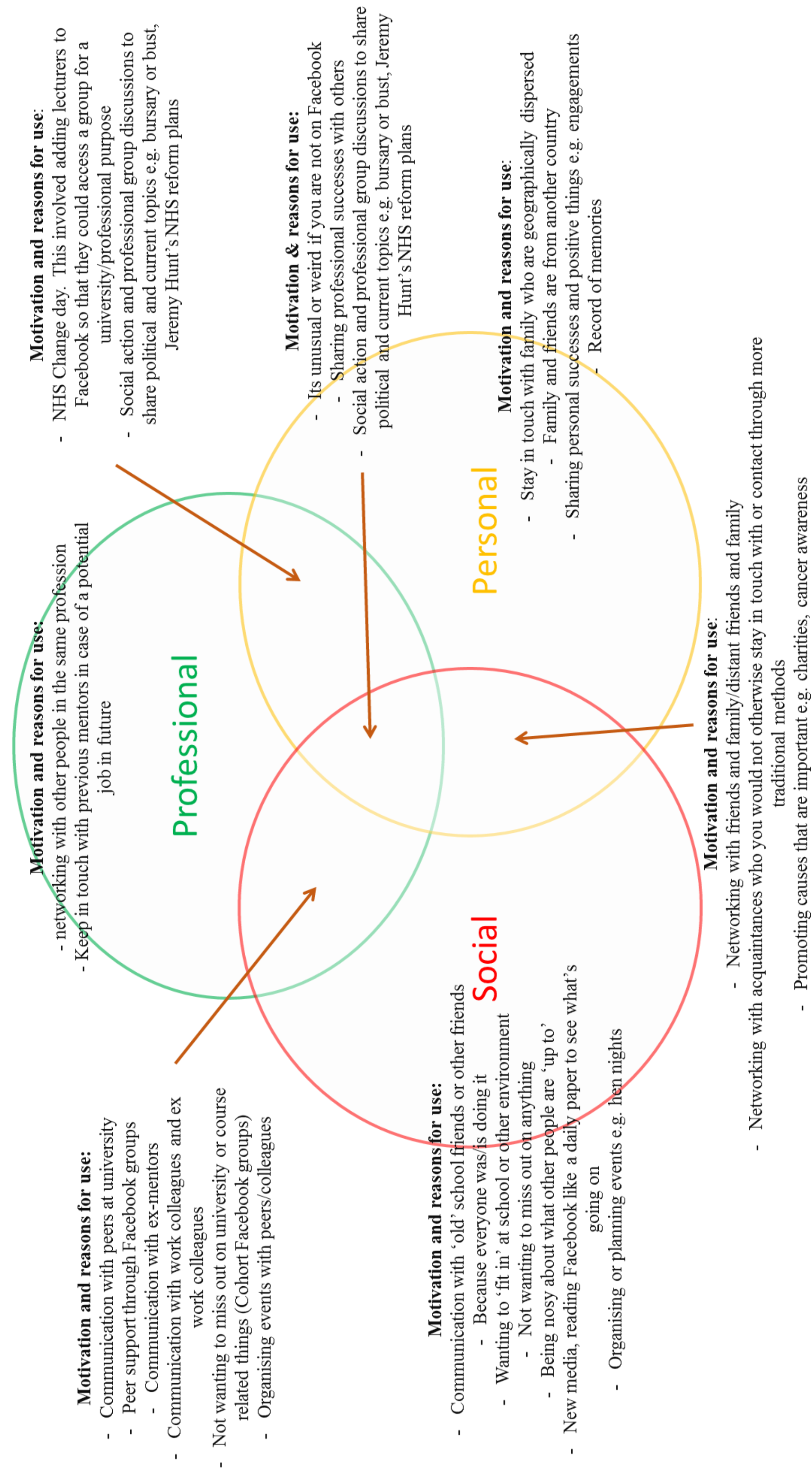
Figure 5- 11 Stage 4 analysis: mapping the components of motivations and patterns of use of Facebook



KEY - *Red: morphostatic structures; Purple: morphogenic structures; Green: tendencies; Pink: entities; Yellow: Actions; Blue: outcome*

When discussing motivations for using Facebook, students, academics and registered staff most commonly suggested that it was a method of communication with friends and family. This was also reflected in current literature evidence, and indicated that they viewed the use of Facebook with a more personal and social purpose rather than one of a professional nature, even if their original motivations for joining Facebook were business networking (such as student participant 02 who started a Facebook profile to network with fellow driving instructors and had 928 'friends'). However, despite the majority of participants claiming Facebook as personal, my observations indicated that there are clearly professional purposes for using Facebook. While these may not be the primary motivations, it is inevitable that there is an overlap of the boundaries between different life modes in the online environment. Considering the different life domains in the physical environment I reflected on how they may overlap. Figure 5-12 illustrates some of the identified motivations and reasons for use and how these link with the personal, professional and social life domains.

Figure 5- 12 Motivation and reasons for use of Facebook across life domains



5.4.2 Behaviours on Facebook and influential factors

5.4.2.1 Facebook groups for academic cohorts

Through discussion during semi-structured interview and online observations in university cohort, professionally linked groups and general scoping search of 'student nurse' on Facebook I was able to reflect on the types of actions and behaviours of student nurses.

The use of Facebook for academic and university related reasons has been noted as a behaviour related to **bridging social capital** (Tower *et al*, 2015; Scherchen *et* al, 2013; ONS, 2001). Both semi-structured interview participants and my observations of Facebook groups suggested that cohort specific Facebook groups where membership was limited to those in their academic cohort were commonplace,

> *"Because you're in the loop and you're up to date with things and it helps with assignments and things like that, you know; like if you've got any questions you automatically think oh I'm the only one going through this but then you put it on there and it's like yes, I've found this and I've found that and you need to do this or you need to do that. . ." (Participant 01, lines600-605)*

> *"It's an easy option, isn't it? Again, it's probably your contact methods of old where you would have to e-mail and you would probably then tag a load of people in. Facebook is a closed group and everyone is on the group and you send the message out and you know everyone sees it. And for me, in this day and age, that is just an easy thing...It just seems to be an easy method. There is nothing wrong on there and there has been no violence from our group or anything silly going on so for us it's just an easy method of contact." (Participant 012, lines391-398)*

All of the students in the semi-structured interviews claimed to be part of a specific cohort related group and this seemed to reflect the need to 'belong', but also so that they did not 'miss out' on anything that was going on. Peer support has been noted as an important part of professional socialisation (Weidman *et al*, 2001) so the use of Facebook groups in development and maintenance of bridging social capital with peers seemed to be significant in the training

experience. Common actions and behaviours within the cohort groups included: questions about assessment submission, difficulties with motivation to write assessments, social events out as a group, supporting others and clarification of day to day practicalities (e.g. attending university in uniform for clinical skills sessions).

I found that students were confident in the behaviours of other students in the cohort group with several implying that there were 'unspoken' rules about the purpose and appropriateness of behaviours within the group,

"Yes; I mean there's nothing inappropriate like you are going to be talking about patients or . . ." (Participant 02)

"Is that because you've agreed that or . . .?" (Researcher)

"No, I think it's because when we started we were informed about Facebook and what could be put on there and what shouldn't and everybody has just sort of stuck to that because they know that they can get into a lot of trouble." (Participant 02, lines288-293)

Aacademic staff felt that the use of cohort groups should be discouraged (despite using Facebook themselves),

"but the other thing is those Facebook groups sit with our establishment but they are nothing to do with us in terms of . . . so the students, we never suggest to students that they set up a Facebook group I don't think? But they do it because that is how they . . ." (Academic FG participant IV, lines525-527)

However, students felt that there was no evidence that anyone behaved or acted unprofessionally within the group page. This was interesting, firstly because I have repeatedly discussed the role of 'physical' boundaries such as leaving the workplace or physically being in the company of others in the context of Ollier-Malaterre *et als*' (2013) model of boundary management. Secondly, it led me to consider the concept of 'virtual boundaries' created by the Facebook group or page context. Does the membership of a Facebook group and physically

'clicking' on the comments and group news feed indicate the concept of a conscious 'virtual boundary'? Within this virtual boundary students consciously adhere to the cohort (professional) values and norms because they are consciously aware of the audience with whom they are engaging? And as such, take on their 'professional identity' and associated unspoken values and social norms developed as part of that social structure (Rogers, 2003). Furthermore, was this a reflection on how students had been socialised into the university cohort? Emphasising the importance of professionalism when on social media. Were students creating a social change that created an unconscious competence (Kruger & Dunning, 1999) regarding what was and was not acceptable and professional within the boundaries of the cohort group? I was particularly interested in how this effect of the Facebook group may facilitate the social change and 'social norms' to reduce the risk of unprofessional and unacceptable behaviours in wider Facebook environments. Tower *et al* (2015) also found that the use of Facebook cohort groups in the transition into nurse education could promote 'sharing' of experiences and could contribute to alleviating stress through peer support. I would also argue that it may facilitate the process by which they come to define professional 'social norms' and 'values', both on and offline and thus, contribute to the development of professional accountability during their professional socialisation process 'online' [see framework I, SPO].

5.4.2.2 Privacy and sharing settings

I also considered this concept in the context of their personal Facebook profiles. Finn *et al* (2010) first suggested this when examining medical student's perceptions of professionalism and peer behaviours in the Facebook environment. This suggested that many of their participants claimed to be confident and competent in managing their behaviours, actions and information sharing in the Facebook environment while they felt 'others' did not. This type of perspective was frequently referenced in my semi-structured interviews. However, this awareness of their own confidence and also competence to manage their personal profile did not

always reflect their actual behaviours and actions available on their public profiles. Once again, this emphasised 1) the need for more clarity on what is and is not acceptable and professional within the Facebook environment and, 2) explaining how co-operative and competing values within Facebook meant that awareness of what actions should be taken, does not necessarily get translated into actual actions.

For example, participant 05 expressed confidence in what they shared and competence in how they managed this but it then transpired that their profile was fully public! Conversely, several participants 03, 07 and 12 all claimed to know what they do and how they manage it but elsewhere in the interview they did express uncertainty about their Facebook settings; what they are, how to manage them and so on.

Contradictory thoughts were evident between the personal nature of Facebook and the behaviours that were actually observed in the Facebook environment. Equally, these contradictions were also apparent in the way in which participants perceived their use of Facebook. For example, student participant 05 adamantly expressed the 'right' to personal life, that Facebook was a personal tool, but then went on to say that they participated in university related cohort groups, shared their workplace, had previous work colleagues as friends, promoted and shared useful information to their peers who were also their friends. A range of healthcare professional research literature also reflected this conflict; Campbell & Craig (2014), Craig *et al* (2013), Ross *et al* (2013), Ginory *et* al (2012) and Garner & O'Sullivan (2011) all noted that healthcare professional students used Facebook for educational or professional purposes despite claiming that personal life should remain 'personal', or that Facebook is a personal space [something that they are entitled to have even if they are a professional],

"I think it matters how you look. I mean I don't think it matters but if you are a little bit drunk you probably can't tell in a photo. If you are very intoxicated you can definitely tell in a photo. And I think that they should be acceptable because that is somebody's person life and they are not hurting anybody and it shouldn't affect their career or their employment. But they are probably not the most professional things to do either." (Participant 13, lines223-227)

Conversely, other research literature such as Hall *et al* (2011) agreed that students do feel conflict between personal and professional values in the online environment, claiming that they should be held accountable while at the same time claiming entitlement to a personal identity.

This was reinforced within my participant interviews and academic focus group when several students claimed to have added a lecturer as a friend on Facebook for the purpose of NHS change day[45],

"[Academic Focus group participant IV] *invited me because I'm part of the NHS change study, helping to do that event so he invited me to that. I asked him when he created the group; is it closed? And that's not because I think I'm going to put anything up offensive but because I'm aware of everybody else… It was the easiest way to communicate because we are all doing different jobs and it was the easiest way to communicate what we were doing." (Participant 03)*

"Okay, so you are kind of working as a professional team within the group and using it for that purpose." (Researcher, lines374-386)

"And at the minute we are also doing; there's kind of another group which is for NHS Change Day and a couple of the lecturers are part of that and that has been really handy in organising what we are doing on that day so that has been quite good." (Participant 07, lines144-146)

The crossing of these professional boundaries was deemed to be acceptable and 'professional' because it was for a 'professional' purpose, despite the fact that this meant the lecturer and students then had access to each other's personal profiles,

[45] Academic Facebook group participant IV was the identified lecturer leading the group which meant that students were added as friends, although there are ways to be part of a group without doing this.

"some people are a bit of a Facebook stalker and they will look through all your photos and whereas I'm not kind of interested in [lecturer's name] personal life and I'm sure that he's not interested but if he was to look at my photos I'm not, I wouldn't be too worried about it." (Participant 07)

"I suppose [lecturer's name] not because he's an adult lecturer . . . he's not necessarily my teacher but I wouldn't add . . . basically I added [him] because of this group and he had to add us to put us in the group but actually I didn't think of it." (Participant 07)

"You were thinking about the end goal rather than the actual process of . . ." (Researcher)

"I was thinking about the group and getting the organisation done but I didn't think any further." (Participant 07, lines357-369)

Not only does this then send mixed messages to pre-registration student nurses from influential entities [academic staff] but it also illustrates that being 'aware' of what is professional conduct does not always lead to the correct decisions and actions in the Facebook environment; the co-operative values of wanting to be part of NHS change day but the competing values of crossing professional boundaries between student and academic. Along with other research evidence currently available on this topic (Lathi *et al,* 2017; O'Sullivan *et al*, 2017; Asiri *et al,* 2016; Kakushi & Evora, 2016). This also illustrates that even those academics with a high level of confidence in using social media [Academic Focus group participant IV] they were still unaware of the functionality that would allow a group to be set up without having to add someone as a friend.

Upon reflection of this phenomena this further enforced several concepts that I had previously considered:

- Facebook and online social networks are part of a social evolutionary process and are still in their infancy as far as their 'integration' or 'socialisation' into the physical world
- Not only student nurses but professionals and [likely] the public are still not conscious of the complexity of OSNs such as Facebook and how this integrates into their 'world' and their 'identity' whether it be personal, professional [work] or social

- The role of primary, secondary (and professional) socialisation was interdependent with the ongoing ‘virtual’ socialisation that exists in the OSN environment

The conflicting values between personal, professional and public (or social) domains creates confusion when making decisions about what is or is not acceptable/appropriate or professional.

5.4.2.3 An example of digital immigrants, digital natives, behaviours and life domains

Interestingly, participant 02 used as a previous example for SPO (framework I Facebook) used Facebook professionally as a driving instructor, adding people onto her friends list because they were in the national network of driving instructors; people she had not necessarily met offline. In order to demonstrate how my flow of ideas moved from Framework I to Framework II, I felt that this was an appropriate and interesting case to examine for illustrative purposes.

Firstly, this participant had previously been in the Royal Navy and expressed very specific and appropriate ideas about professional accountability and the consequences of being unprofessional. Not only this, she seemed able to differentiate across her previous and present ‘identities’ about what was and was not deemed as *acceptable* and/or *professional behaviour*. Hence, her professional values as a driving instructor were clearly defined and could be recognised as unprofessional and/or unacceptable in the nursing profession or the Navy (for example, the NMC, 2016 would not recommend adding strangers to a Facebook account). Conversely, she was also able to justify (through reference to professional values) a picture of her in a Navy uniform while drinking alcohol, outside a bar with friends and then went on to rationalise why this would not be appropriate in nursing. This discussion was part of my thought development and reasoning about the difference between professional, acceptable, unacceptable and unprofessional behaviours, how decisions are made about these and how these are determined in the social, personal and professional sense. Conversely, I questioned whether these are deemed to be different when in the online environment?

This participant was also defined as a digital immigrant. Facebook administrators had subsequently forced her to change her profile name to remove her professional affiliation [letters after her name] as their policy is that profiles are personal and not to be used to promote professional services[46] (i.e. this was not deemed as acceptable behaviour as depicted by Facebook policy). This suggested that while she evidently had a strong awareness of professional values and being 'accountable' in different contexts, her naivety, knowledge and ability to transfer this offline knowledge into the Facebook environment was clearly lacking. The phenomenon associated with high levels of awareness and knowledge of professional accountability and the ability to differentiate the meaning of [professional] accountability across different life modes was therefore of interest. Why was this participant able to clearly define what was acceptable behaviour offline but did not necessarily demonstrate this online? Thus, raising a question about how we differentiate between what is socially acceptable, professionally acceptable or behaviours that are unacceptable or unprofessional.

Conversely, I was also interested in the corresponding awareness [or lack thereof] of using a personal Facebook profile across these life modes (i.e. for professional purposes) and whether this phenomenon was isolated to digital immigrants. And, despite a demonstrable knowledge of professional accountability and associated behaviours it was evidently difficult for this participant to successfully manage her online boundaries (i.e. what she was able to differentiate in the physical world and in her own mind was not as easy to differentiate on Facebook). A concept that is further supported by Ollier-Malaterre *et al* (2013) model of boundary management.

[46] According to Facebook usage policy this should be done via groups or pages

Consequently, this led me to question what dynamic exists between awareness and behaviours (actions) [confidence and competence or 'self-efficacy'] but also how the community (i.e. professional, personal, social) changes or is influenced by the diffusion of such technology. For example, being professional in the clinical environment but not in the online environment, or perceiving certain types of behaviours to be unacceptable offline, yet acceptable online,

"I think almost Facebook, you think it's not going to damage as much whereas if someone said something and you witnessed it being said then you know, you've got the tone of voice, you've got the body language. You can see it with your own eyes whereas if someone just types something on Facebook it is almost as if it's not as harmful although it could be, you know, it could be. I mean, there's a lot of things in the media about trolling and things like that on social media and all that and they are saying that that's, you know… "(Participant 01, lines226-232)

"I would probably say when you are online things do not feel as real, they do not feel like they are real people that you are talking about and like I say I am careful when I write but I can understand that sometimes you might write something and because it's so quick to post you haven't had chance to think about it. But when you are in practice we are thinking things through so much, like too much, a lot of the time; we question everything we do and so I think that you are less likely to make a mistake and more likely, because you are being so observant, to report something that you see as being malpractice because you've seen it with your own eyes." (Participant 10, lines250-257)

Rogers (2003) emphasises the importance of the social system on the development of social norms, but also how individual changes as a result of the diffusion of an innovation such as Facebook [and consequently, the 'social norms' within Facebook and their relationship with those offline]; a concept that Ollier-Malaterre (2013) also attests to.

One further interesting scenario relates boundary management and acceptable behaviours in the Facebook environment is the act of 'fraping'[47]. This act is often deemed to be amusing or

[47] A common term that merges the words Facebook and raping and describes the act of a friend physically using your phone or computer to write on your profile wall without your knowledge. Something I had experienced and explained in chapter 1 personal reflection.

comical but frequently involves offensive or inappropriate comments such as toilet humour or sexual references,

"I was at a driving instructor thing the other night and when I went to the toilet someone had just decided to put it on there for me." (Participant 02)

"Someone put it on there for you?" (Researcher)

"Yes." (Participant 02)

"As in someone got your phone and posted something on there?" (Researcher)

"Yes." (Participant 02)

"Okay. So, what complications could there be?" (Researcher)

"It's not good. Yes. In some ways, there can be complications to that but that's obvious that that is not me that has done that." (Participant 02)

"Is it do you think? I'm not sure." (Researcher)

"That's because you don't know me." (Participant 02)

"That is true. Does everybody on your Facebook profile know you?" (Researcher)

"Well, I'm not doing that. And I mean in the comments straight away it says that wasn't me that has done that." (Participant 02, lines494-508)

This interested me because it is an act that could only really be carried out within the online or digital environment, but also because of the unintended or *unanticipated* consequences this could create (Rogers, 2003). A further concern was that these participants seemed to have the perception that this was humorous and that their *Facebook friends* simply knew it wasn't them who had posted the comment. However, given that participant 02 had 928 friends with at least a third being people from her driving instructor network and who had never met her, I challenged whether this was the reality of such. Consequently, I later wondered why the profile owner would not then remove the 'false' profile update given that they had clearly identified it as unprofessional. And why [or indeed how] was this unprofessional yet acceptable at the same time?

I additionally questioned whether this was isolated to the fact that participant 02 was a digital immigrant, but noted that participant 03 had experienced a similar scenario and had used Facebook since her early teens (and therefore was a digital native) and had quite a restricted public profile. There are several pieces of research indicating that digital natives are more liberal with their online sharing and privacy while digital immigrants are not, conversely there are other pieces of research literature that argue the opposite. However, what I seemed to find here, and what I argue with framework I SPO, is that each individual has a different journey of socialisation, professional socialisation and online socialisation. And, while the passage of time is a noted morphogenic and morphostatic structure that may create or prevent an individual changing their perceptions and/or actions, being a digital native or immigrant alone was not sufficient to determine whether someone was more or less likely to understand what is acceptable or unacceptable or make risky decisions. My findings would assert that, to simplify this to 'age' is naïve and primitive; describing what is on the surface (*empirical domain)* rather that explaining why this appears to be the case.

5.4.2.4 Individual tendencies that influence perspectives, decisions and behaviours about what is acceptable and unacceptable

Firstly, I made two important observations here, the concept of 'them and me' and the concept of 'conscious competence' and self-awareness. While the role of Facebook cohort groups was a positive factor for developing and maintaining peer support, acceptance into the group and the profession of nursing, many of my interview participants seemed to separate themselves from others in the cohort and/or other student nurses/nurses,

> *"some of the younger ones like put selfies on all the time; not on the closed group thing but you know just on Facebook and there are a lot more posts by the younger ones and I just think that I choose more wisely what I put on and what I don't because I just find that like it's appropriate to a situation." (Participant 08, lines272-275)*

> *"I would say that out of our cohort of 46 I would say that there is probably a handful who . . . so you are probably looking at 80 to 90% are all fully aware of the consequences and then you have got the odd handful out of it that I wouldn't say ruin it but they are the ones that are putting things about them being drunk. There is lots of sexual innuendo stuff; just silly stuff.*

And I think well that is fine but you are now . . . I think that they are acting very immaturely myself…" (Participant 12, lines882-887)

Furthermore, some of the digital natives even separated their 'past' self from what they are now which suggests a change or evolution of their behaviour,

"Emotional; and I wish that I hadn't wrote those types of things because it is pointless to have and nobody really cared about it and I don't want to see it again and I don't want people to think a certain way of me because I go really angry and wrote something. At the same time, it was very acceptable at my age." (Participant 10, lines396-399)

"and I kind of . . . because I've obviously got family who are younger than me, like 17/18, and I kind of think was I doing that when I was their age and you do start comparing and contrasting and you think I wouldn't. And just looking back; I go back through my Facebook and I just cringe so hard. I just look at something – what were you thinking?" (Participant 09, lines244-248)

This notion of 'me and them' seemed to be used to differentiate between different types of behaviours based on their perceptions of individual tendencies and/or circumstance.

Jarvis (2006:15) refers to 'the person experiencing the world' as an episode in time, an experience in which we situate ourselves in one of four ways. The self and identity were also identified as a core component of experiential learning. Harre (1998) suggests that 'self' has three aspects, 1) how one identifies them self, 2) the emerging self, self-awareness and changing human behaviour over time and 3) the combination of all previous experiences and how they are represented in the 'self'. Table 5-3 illustrates the ideas of Jarvis (2006) and Harre (1998) compared with my own conclusions.

The identified *tendencies* and [morpho-genic/static] *structures* in my data reflected these different aspects shown in table 5-3. Table 5-4 illustrates how components found in my data may reflect how an individual situates them self in the world and their experiences.

Table 5- 3 The person experiencing the world and its relation to my findings

Jarvis' (2006) four ways to situate ourselves	Jarvis' (2006) four ways we experience the world	Harres' (1998) three aspects of the self and how they may relate to experiential learning	My comparators in relation to being a pre-registration nurse, accountable & on Facebook during professional socialisation
Person to person	I – thou	How one identifies them self	me – them, what and how I am
Person to thing/event	I – it	The emerging self, self-awareness and changing behaviour over time	me – the situation, how I am
Person to future	I – envisaged thou or it	The emerging self, self-awareness and changing behaviour over time	me – the future 'them' or situation, how I or they will be
Person to self	I - me	The combination of all previous experiences and how they are represented	me – what I am

Table 5- 4 How individuals position themselves in the world

Jarvis' (2006) four ways to situate ourselves	Jarvis' (2006) four ways we experience the world	Harres' (1998) three aspects of the self and how they may relate to experiential learning	My comparators in relation to being a pre-registration nurse, accountable & on Facebook during professional socialisation	Examples of related components identified within my data
Person to person	I – thou	How one identifies them self	me – them, what and how I am	I behave professionally and acceptably by not posting XYZ but others may not i.e. it's acceptable for them and how they are but not for me [age.] What is unacceptable to me may not be for others (e.g. others share their personal life on Facebook to get a response and engage others and I do not.) Conflicting behaviours and perspectives: some people are different on Facebook than they are in the physical world but others are not.
Person to thing/event	I – it	The emerging self, self-awareness and changing behaviour over time	me – the situation, how I am	Observing unacceptable behaviour from others and other professionals. Facebook cohort groups self manage and there is not evidence of unprofessional or unacceptable behaviour. Social capital and acceptance into the profession. Being professionally accountable. Experience of the research interview process/reflection creates 'change' to my security and privacy settings, what and how I share information on Facebook. Sharing pictures (e.g. it is not professional to share pictures of nurses at work in uniform, swear or 'bully' others but as a result of political comments and mass media coverage of something 'we' disagree with it becomes 'acceptable and professional' within the professions.)
Person to future	I – envisaged thou or it	The emerging self, self-awareness and changing behaviour over time	me – the future 'them' or situation, how I or they will be	Experiential learning [in different life modes] will change what I do. Experience of the research interview process/reflection creates 'change' to my security and privacy settings. Social action e.g. sharing 'our' thoughts and beliefs to raise awareness of and prevent political initiated changes and reform to the NHS.
Person to self	I - me	The combination of all previous experiences and how they are represented	me – what I am	Primary, secondary, professional and online socialisation [structures/mechanisms.] What I previously used and posted on Facebook and how that has changed due to time and being a student nurse. My beliefs, values and culture. Experiential learning, lifelong learning and the passage of time Adding and removing 'friends' on Facebook; Facebook 'cull'

For example, the role of 'age' and 'maturity' seemed to be given as a primary reason [*tendency*] as to why they behaved in a more professional manner in relation to others in their cohort or other professionals on their Facebook profile and, this is also true of more recent research literature (Alber *et al,* 2016; Smith & Knudson, 2016); however, I disagree. While age and maturity may contribute to how an individual behaves this is likely more to do with experiential learning and, as per framework I SPO, their journey of professional socialisation and online socialisation is unique to them. Hence, the claimed 'causality' of 'being young' or a 'digital native' [as these pieces of research do] is unsubstantiated when *explaining* rather than simply *describing* the current situation. As a critical realist, I would argue that the interaction of the components of the 'real world' needs more than the statistical testing of a hypothesis that 'age' is associated with unprofessional behaviours. Conversely, how are we to judge against what is unprofessional, rather than simply unacceptable, if we have not yet defined this clearly? Furthermore, this type of evidence does little to progress our knowledge and create change; it is not possible to change the fact that someone is a digital native!

I have also noted that the passage of time [*structure*], life experiences and [lived or observed] experience on Facebook also played a major part in what was deemed to be acceptable and unacceptable behaviour. Furthermore, the passage of time and the nature of Facebook comments being in 'stasis' was noted as an important difference between the online and offline world. This was noted as both a positive and negative component of Facebook by way of written 'proof' of an action that is not always possible in the physical world. This was also evident in my scoping search of the NMC competency hearings where Facebook posts and activity had been used as evidence of unprofessional behaviours (appendix 5 p307).

For my research participants, the nature of a 'passing comment' in the physical world being unacceptable but 'lost in the moment' versus making the same comment in the online environment was often used to justify whether an action was deemed to be unprofessional or simply unacceptable. Alternatively, the lack of 'context' and 'tone of voice' in the online environment limited an individual's willingness to 'judge' or 'challenge' behaviours that may actually be unacceptable or unprofessional. As was observed previously, further tension was observed between what was acceptable in the current time (as the person and professional they are now) versus what was acceptable in the past (as the person they were) and [for some] what will be acceptable when they become registered nurses in the future [**who I was versus who and how I am, what and how I will be.]**

The combination of these *tendencies* and the *morphogenic structure* of time seemed to impact on individual perspectives about what is deemed to be acceptable, professional, unacceptable and unprofessional behaviours and how they positioned themselves in 'time' (their life journey) based on the experience of socialisation and professional socialisation. Conversely, many of my younger interview participants maintained the same view as those who were more mature. While their perspective on acceptability of behaviours on Facebook were sometimes different or less well defined, for the most part they were able to agree on what is clearly unprofessional behaviour. Hence, I argue that behaviours are not necessarily just about age or maturity but about the experiential and lifelong learning that happens with the passage of time.

5.4.2.5 The interaction between patients, the public and professionals

In section 5.3.2 p132 I discussed the influence of patients and the public on how pre-registration student nurses develop ideas about 'being professionally accountable'. And, having discussed how pre-registration nurses position their 'self' in the online environment, and how experiential learning may sustain or change their perspectives about what is acceptable, unacceptable, professional and unprofessional in the online environment, I wanted to explain how this is

defined by the different *entities* involved in the journey of professional socialisation; without doing this it is near to impossible to assess and determine if behaviour is simply unacceptable but not a breach of employer, legal and/or NMC practices and therefore, if disciplinary and/or NMC action is required. I argue that unacceptable behaviour (without clear breach of professional guidelines, employer policy and/or legal/ethical protocol) does not require such action; primarily because it is influenced so much by the values of the individuals involved (which ever life domain they exist in). While we are constantly reminded of the 'risks' on Facebook, in essence, unacceptable behaviour on Facebook can be considered just as unacceptable in the physical world, it is still context dependent and subject to individual perspective (e.g. swearing or smoking tobacco at a bus stop). Doing this in uniform will likely breach employer policy, but doing this in civil clothing is an individual's right whether you believe it to be acceptable or not; it cannot firmly be placed in the 'unprofessional' domain.

Hence, I argue that general day to day activities and behaviour on Facebook should be reserved for the 'personal' profile, and shared to a customised friend sharing list using Facebook settings. Not only is this also reflected in Ollier-Malaterre *et al* (2013) *hybrid* approach to boundary management. This as a default setting reduces the risk associated with impulsive sharing; only close friends and family (or those who may share your perspective on acceptability) will be able to see what you share unless you actively change the settings on the post. This means that it is difficult to share information more widely than with those you would usually associate with in the physical world and/or those who share the same values as yourself.

On the other hand, after observing widely available posts in professionally linked pages I do believe that we [as society and as a professional group] need to set explicit boundaries about what is 'unacceptable' to share and do **publicly** on Facebook (e.g. bullying type behaviour).

Furthermore, these boundaries need to be enforced by those in the profession (i.e. people who do this need to be held to 'account' for their actions). Accountability (both personal and professional) is only as effective as the processes by which we operate; challenging and reporting unprofessional practice is equally as important as behaving professionally (NMC, 2015).

Despite anecdotal literature and some limited research evidence outlining what is deemed to be unprofessional on Facebook, my data have demonstrated that pre-registration student (and even registered) nurses find it extremely difficult to define those scenarios that are 'unprofessional' **and** require challenge/action/reporting. While activities such as naming patients, criticising the workplace [with or without names], criminal activities or adding patients [or previous patients] as friends were deemed to be unprofessional, and the general consensus was that individuals should be held to account for these actions, the willingness to challenge or report these occurring in the Facebook environment was extremely limited.

When discussing what actions would be challenged in physical practice and why such actions would not then be challenged in Facebook there were three main reasons identified, a lack of:

I. **Clarity** in what actions are only unacceptable (rather than unprofessional), this created confusion about what action (if any) should be taken.

II. **Context** in the Facebook environment (i.e. physically seeing someone act unprofessionally towards a patient is not the same as someone implying this in a Facebook post).

III. **Confirmability** in the online environment also made individuals reluctant to act on/challenge/report Facebook posts (i.e. photo's may be several years old, posted by someone else or not actually show what is *really* happening or the events that led to it).

A further observation was individual's reluctance to report actions that might get someone into trouble when the existence of the three reasons above could not confirm a breach of professional

guidance. One other concern of mine is that there was a general reluctance to challenge or report unprofessional practice of any kind across both the online and physical domain, despite high profile cases and reports such as Francis (2013) promoting the need for individuals to be 'held' to account and 'whistleblowing'. This suggested to me, that as educators we perhaps need to more explicitly define, explain and critically discuss differing perspectives, context, challenges, the concept of professional accountability and what it *really* means; *how*, *when* and *why* we are accountable (i.e. why is a scenario unprofessional or not, the four pillars of accountability and *when* they apply along with the intended and unintended consequences of actions/omissions). However, in the context of Facebook we first need to define the boundary between acceptable, unacceptable and unprofessional.

I have previously identified through an examination of NMC competency hearings that breaches of confidentiality, crossing professional boundaries, patient harm and damaging the reputation of the profession (e.g. working while on sick leave, being on holiday while claiming to be on sick leave) were referenced in 90% of investigations, and while 38 of these were found over a 10-year period, these are also some of the most common reasons for competency hearings in clinical practice. Hooper (2013) identified four typical groups of misconduct cases; clinical, dishonesty, abuse and boundaries are identified key 'danger areas' for misconduct which included social media and professional boundaries. However, my data suggest that the risks associated with social media can be just as likely in the clinical or public domain; negative comments about the workplace, communicating with patients and making comments about activities that could be linked to being at work (e.g. drinking alcohol and stating that you will be working in a few hours) (Hooper, 2013). I would argue that a professional should not be behaving in these ways whether online or offline, they could equally have the same impact on patients or the profession. The difference is that on Facebook the comments are fixed in time (as evidence) but are also made in view of people who can identify the person who made them.

Surely, this tells us something about the values that this individual has and we should be asking 'how' and 'why' they believed this behaviour was acceptable and/or professional? Hence, I questioned whether Facebook is simply raising the profile of individuals who do not demonstrate the values we would expect in a nurse, something we would not always be able to identify if these were comments made in a public place, such as a bus?

Conversely, while some behaviours are clearly unprofessional, some of these unprofessional behaviours will also be unacceptable to all three 'life domains' (e.g. breaking the law, abuse). Figure 5-13 illustrates how different behaviours may be deemed as acceptable and unacceptable (those in the personal and social life domains), the overlap with the 'profession circle' is where professional and unprofessional behaviours may also exist. For example, drinking alcohol is legal, generally deemed to be socially acceptable in western culture (context) and hence, this is likely to personally acceptable to many. However, this is not typically deemed to be unprofessional unless it is done in the context of being a nurse or alongside breaking the law (i.e. you drink or have been drinking before being on duty). Therefore, it may be frowned upon by the profession but it is not [as a general rule] unprofessional. I found that pre-registration participant's difficulties in deciding whether these activities were or were not unprofessional with a range of examples used in attempt to navigate these competing values. Clyde *et* al (2014) and Jain *et al* (2014) explored the concept of social/public perceptions of professional in the Facebook environment, and importantly found that unprofessional behaviour that was evident on simulated Facebook profiles reflected negatively on the individual rather than the profession as a whole.

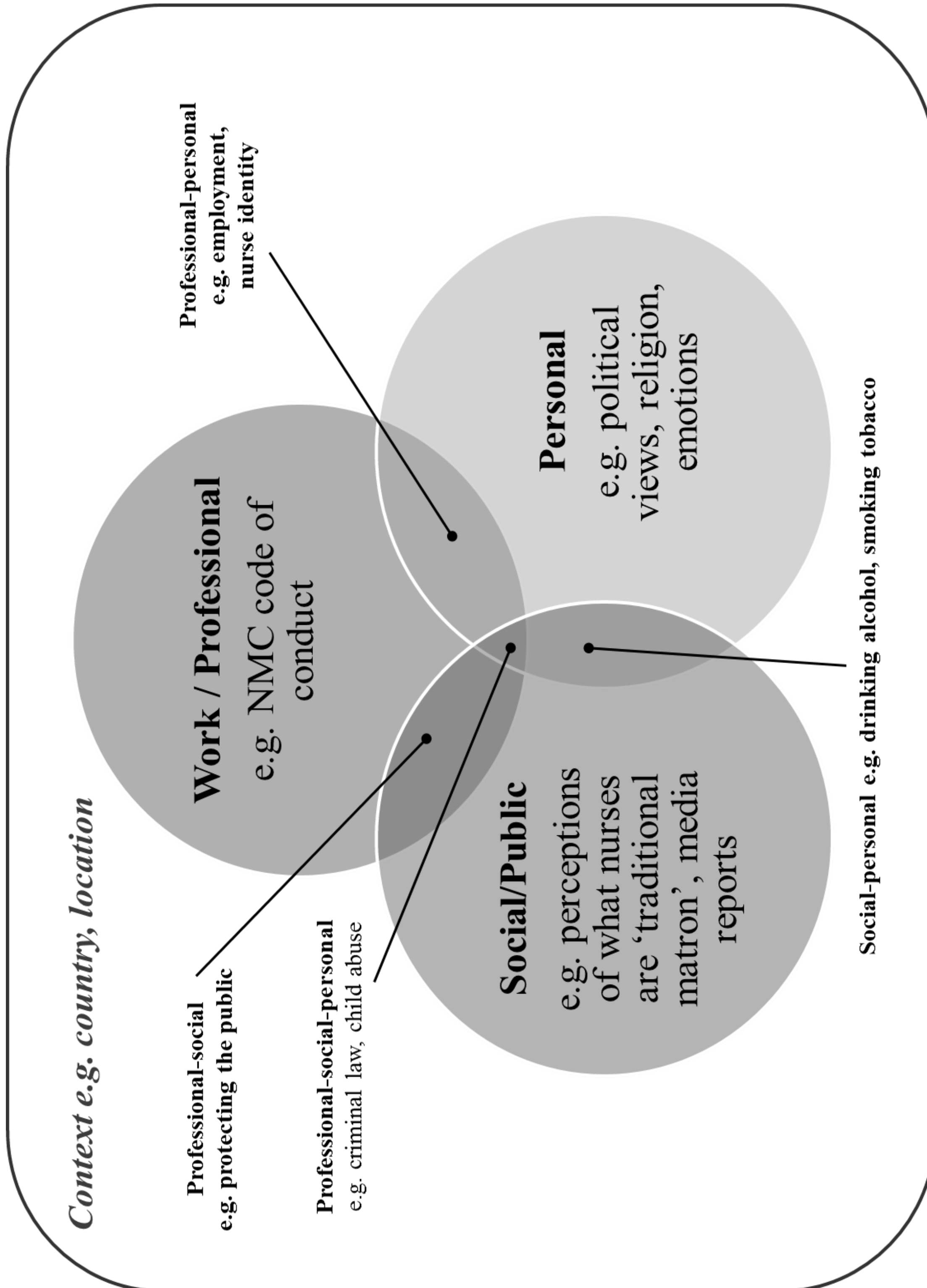
Until now, and as reflected in my discussions with study participants, confusion occurs where such 'norms' are in competition. Consequently, I maintain that we need to understand what the

social values are in relation to the nursing profession in the *professional-social* overlap (figure 5-13) in order to differentiate between what is socially unacceptable **and** unprofessional. This is also true for the other areas of overlap, particularly for pre-registration student nurses where activities should facilitate reflection and exploration in the *professional-personal* and *professional-social-personal* domains. Thus, reducing the risk of explicitly unprofessional behaviours, and raising awareness of potential risk for unacceptable behaviours.

One factor I found to be of particular interest was the influence of Facebook from the patients/relative's perspective and the resulting challenges to personal-professional boundaries and the duty of care (NMC, 2015). This was evident in two case examples,

- **Case 1 (participant 12 lines81-136):** a patient's granddaughter used the Facebook direct private message function to send a student nurse a message of thanks for caring for her grandmother. She had died when the student was not on shift. This student acknowledged the thanks and expressed his condolences but had no further contact with the family.
- **Case 2 (participant 09, lines 83-114):** a student shared an experience where a young person on a mental health ward located a female nurse on Facebook and tried to add her as a friend. The staff member did not accept but then had to have a difficult conversation with the patient about the situation which then impacted on the nurse-patient relationship.

Figure 5- 13 Acceptable and professional values and impact on behaviour



Upon analysis, these examples raised several issues relating to boundaries and social norms:

1. Boundary management (the patient and public values)

Facebook is seen as socially accepted by a large proportion of the public. This creates issues with boundary management. The second case example indicates that [for some] members of the public and patients may find it difficult to negotiate the boundary between 'being a patient' and 'being a friend' particularly in situations [e.g. mental health units] where patients may be of the younger generation and/or the therapeutic relationship is of great importance. This relied upon the nurse 'being' professionally accountable, rejecting the friend request and discussing the event with the patient. However, this also raised concerns about how not accepting such a friend request could impact on trust, redefine what the patient views the relationship to be and thus, potentially damage the therapeutic relationship and impact on patient (or the nurses) well-being.

2. From the physical to the online world (a power shift?)

In the past [before the internet and Facebook] it would be extremely difficult for a patient to locate information about a nurse with just their name to work with. The information they had about the nurse caring for them solely relied upon the nurse sharing such information. Facebook shifts this power. With a google search of a nurse's name it may be possible to locate photos, personal information and indication of someone's values and beliefs. For example, you may be able to see that someone is homosexual and, for the patient, this may not be socially acceptable, it may damage the respect and confidence in that individual to provide care. As previously discussed, my interview participants felt that they were entitled to their own identity but sharing it online and publicly may impact on their professional identity. We [the profession] cannot tell people to disassociate themselves from their personal values and identity in these circumstances, so what **can** we **tell** them? Or what **should** we **show** them? How can we [as a profession, as educators] facilitate an understanding and acceptable conduct in the current online climate?

3. Duty of care

The NMC (2015: 12-13) outlines the duty of care expected of registered nurses. This includes,

"15 Always offer help if an emergency arises in your practice setting or anywhere else"

"16 Act without delay if you believe that there is a risk to patient safety or public protection"

"17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection"

In the physical work environment, it is far easier to manage circumstances like these. In the online environment, context, tone, body language and general non-verbal communication skills are removed. Not only is it difficult to assess if a statement on Facebook actually requires action and/or intervention it also opens a professional up to direct contact from patients and the public via instant messaging.

While the first case example was positive and a complement to the student nurse, it also raises questions about whether we [the profession] have an agreed protocol for dealing with such incidents. Furthermore, it is also evident that such a message could pose serious ethical and professional dilemmas (e.g. what happens if a patient sends a private message that they are feeling suicidal? There are in fact procedures that Facebook, 2017 has in place but I would argue that most are not aware of these).

Further issues with duty of care are also evident in the sharing and posting of videos, resources and information. Through my observations of interview participant profiles and professional group content it is evident that students and nurses share a wide range of information and this sharing of knowledge is [for the most part] a positive thing. It has been shown to have a positive impact on health and well-being through raising awareness (e.g. mental health). However, the NMC (2015: 16) clearly states,

"18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines"

"21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications
21.5 never use your professional status to promote causes that are not related to health…"

Hence, I question to what extent we are aware of the unintended consequences of what we share. For example, during my online observations I found a range of individuals sharing a picture advocating a 'cardiac thump' for a family member of member of the public who might be having a heart attack. This is clearly not evidence based and could result in serious harm (Resuscitation Council UK, 2017) but was being widely shared by students and the public alike with the belief that it was authentic.

5.4.2.6 What factors change behaviours in professional groups?

The impact and interaction of the mass media, politics and emotions became apparent during my unstructured observations of professionally linked groups. While guidance documents and published literature (Ryan, 2016; NMC, 2016; NMC, 2015) state that nurses should not [through social media or otherwise],

"20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way" (NMC, 2015: 15)

And despite media reports, NMC hearings and widely documented disciplinary proceedings for sharing images while at work and in uniform, media coverage of the 24/7 care claims from politician Jeremey Hunt triggered this very behaviour. The announcement of reforms to nurse education, meaning bursary support and university fees would no longer be funded seemed to

create a collective shift about what was perceived to be acceptable and professional to share in the public domain. Arguably, this is freedom of speech and a right of an individual? Furthermore, such events meant that the collective shift was [positively] inter-professional (i.e. junior doctors, allied health professionals and nurses were not only behaving in a similar way but were also supporting each other's cause through the medium of Facebook profiles and professionally linked groups).

Individuals also used social media to share and discuss their beliefs and feelings about the governments planned reforms of nurse education, junior doctor employment contracts and the NHS in general. This [on first glance] appeared to be quite an empowering and positive way to share thoughts, feelings and ideas (albeit that they were mostly against the changes and politically orientated). The notion of collective activism was of particular interest here (Marwell *et al*, 1988; Olson, 1965). Collective activism is simply a group or community taking steps to address what they believe to be unjust or 'wrong'. I am not against such activity, individuals and groups have the right to freedom of speech and the use of social media was successful in petitioning the House of Lords to debate the decision to abolish the bursary. The unity generated by participation in Facebook groups, and the use of Facebook to promote a cause close to the hearts of NHS professions initially led me to conclude that it could be an effective medium to facilitate collective activism and social change. Consequently, it reflected the interdependence between social capital, online actions and some of the concepts of DoI such as 'critical mass' (Ostrom & Ahn, 2007; Rogers, 2003).

However, as my observation of the debate continued I began to notice more negative and unprofessional consequences of the situation. While the majority of the Facebook posts were clearly against the reforms, there were a minority who were brave enough to come forward and

provide an alternative perspective, discussing the reasons why the reforms need to happen and why they believe this to be the case. These individuals were [in all observed accounts] publicly isolated and attacked by other nurses, professionals and indeed, pre-registration student nurses for 'going against' the majority. While this interaction was of interest, it also raised grave concerns about professionalism, accountability and the values of the individuals willing to form [sometimes] personal attacks on fellow nurses/student nurses (something that is explicitly noted as unprofessional, NMC, 2016: 3-4).

Conversely, I also noted that the emotions, political standpoint and perspectives about the NHS reforms seemed to negate the ability of some individuals to behave professionally; a *morphogenic* structure that is 'mass media' had represented Jeremy Hunt's comments in a negative light and was taken on face value. The facts surrounding the *events* were rarely quoted and rarely shared, and when they were shared, they were frequently attacked or ignored completely (e.g. one student nurse was called all manner of terms and her non-EU heritage was targeted because she had experience of healthcare that was not funded like the NHS). The concepts of treating people with kindness, respect and compassion (NMC, 2015) or *"bullying, intimidating" "inciting hatred or discrimination"* (NMC, 2016:3) were explicitly being broken but were deemed to be accepted in the wider community [non-removal of posts by administrators and wider supporting comments from other professionals.]

Furthermore, there seemed to be unwillingness to consider the alternative perspective, the justification for such reforms and changes. For example, as a general consensus I have found that swearing on a public Facebook page is deemed to be unprofessional and often removed by page administrators, however, in some cases swearing and foul [and personal] language targeted at fellow nurses and politicians was deemed to be 'accepted' in the groups where it was posted.

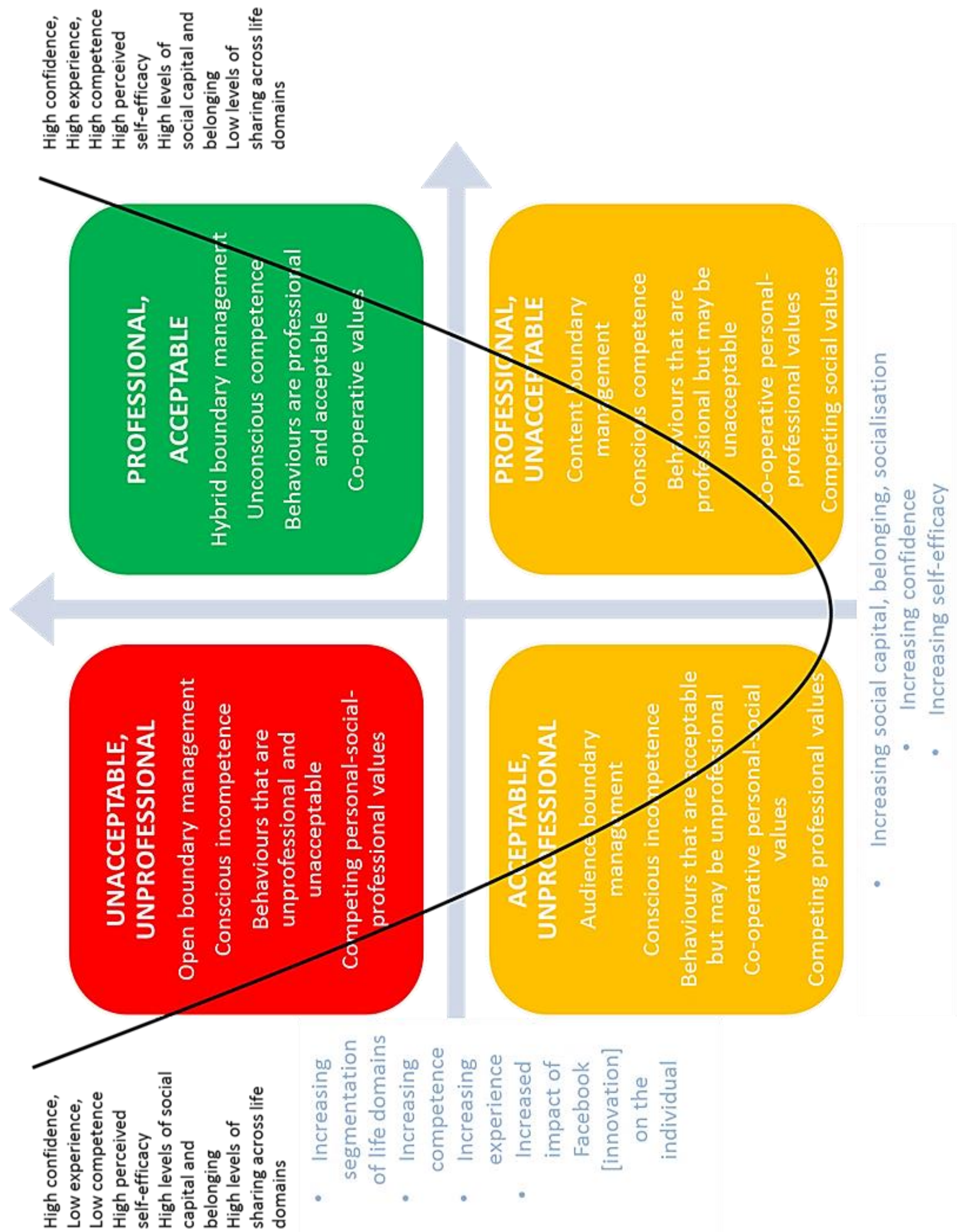
On occasion, a person would state that it was ‘extreme’ or not appropriate, but would then continue to be part of the discussion and the post would not be removed (e.g. calling politicians swear words; one student did this and was told he was ‘braver’ than others for doing so!)

So, what is it about these scenarios that seem to create a change in behaviours and activity, what is deemed to be professional on one day but not on the previous day? Is it because the reforms are a threat to care, safety, quality, and the profession, its values and/or the NHS as an institution? Is it because of individual values, beliefs and emotions (i.e. individual *tendencies*)? Is it a resistance to change or even the unknown? Collective values and beliefs between that of certain parts of the social, professional and personal domain initiated what seemed to be justifiable unprofessional behaviour; people were not being held professionally or personally accountable because [for whatever reasons] the behaviour was deemed to be justifiable in the circumstances.

5.4.3 Development of Framework II, UAPU using theory II & III

Figure 5-14 illustrates the UAPU framework. This section will discuss the proposed theories and therefore, causal mechanisms that informed this framework and thus, explain the relationship between the pre-registration student nurse and Facebook.

Figure 5- 14 Unacceptable, Acceptable, professional, unprofessional: UAPU framework



5.4.3.1 Theory III: diffusion of innovation

Diffusion of innovation is an essential part of explaining the impact and influence of Facebook and the social change it has led to. Not only does this theory explain the motivations and reasons for use of Facebook, its principles may also explain behaviours in Facebook and the difficulties in differentiating between acceptable, unacceptable, professional and unprofessional behaviours or 'personal and professional' values and norms. Rogers (2003) illustrates the diffusion of innovation as a 'curve' whereby the uptake of an innovation such as Facebook is illustrated by the number of users, new users and the passage of time. The diffusion of Facebook in relation to market share is illustrated in figure 5-15.

This illustrates Facebook as a well diffused innovation with approximately 80% market share at the point of publication. As Rogers (2003) also indicates, the diffusion of such an innovation represents a societal change. Conversely, as society evolves and changes as a result of this [Facebook] innovation I would argue that it indicates that society becomes more unconsciously-competent in its use (i.e. society is following its own experiential learning curve). The Dunning-Kruger effect is a theory that refers to the development from novice through to expert and, like the diffusion of innovation is frequently illustrated by a curve (figure 5-16). A comparison of figure 5-15 and figure 5-16 can therefore be made. As Facebook has diffused into society, society has progressively increased in confidence with its use.

Another significant point to note is that Facebook has not yet completed its diffusion journey and therefore, learning cycle; hence, I would argue that society is not yet 'expert' in the use of Facebook [and, given the location on the diffusion cycle, other social networks that are available].

Figure 5- 15 Diffusion curve of Facebook (Johnston, 2011)

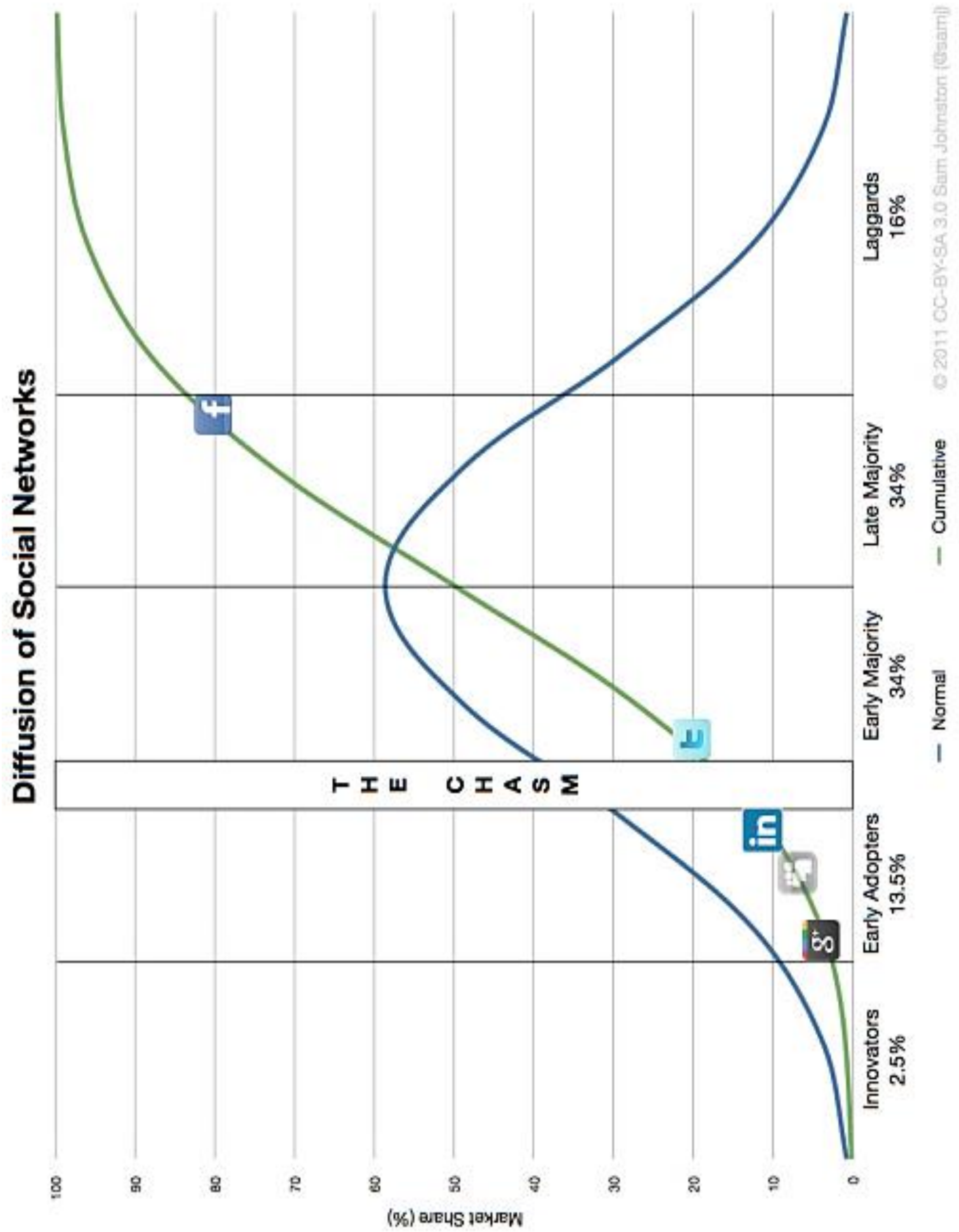
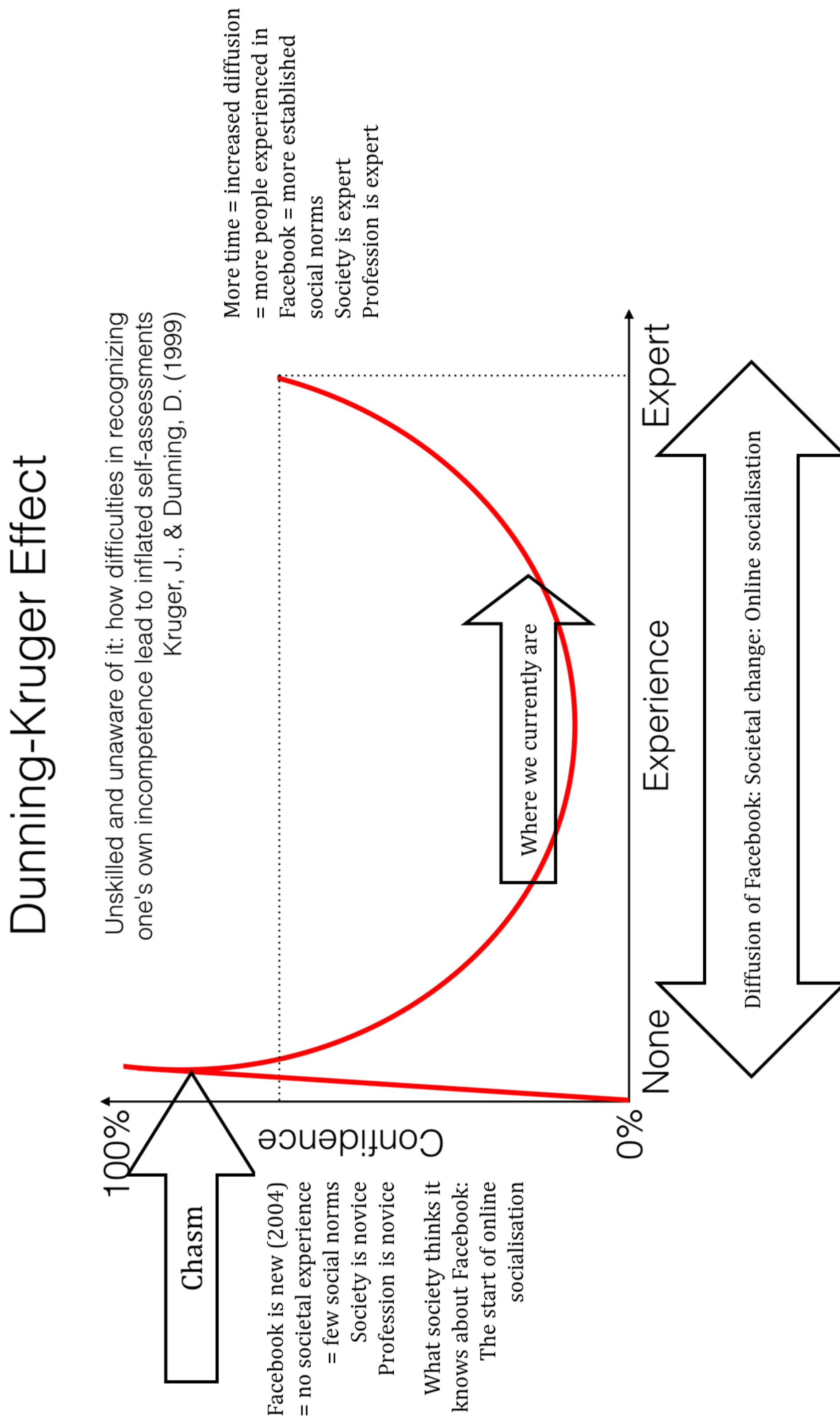


Figure 5- 16 The Dunning Kruger effect (adapted from Kruger & Dunning, 1999 for illustrative purposes)



The significance of this, is its relationship with the development of social norms and ideas about what is acceptable, unacceptable, professional and unprofessional and hence, how both society and the nursing profession differentiates between these in the Facebook environment. As we are not yet 'experts' we are still in the process of learning and developing established social and professional norms for behaviours and actions in the Facebook environment. I would also argue that if we begin to establish these now, we will be more competent in the use of other [still developing] online social networks too.

The concept of unconscious competence and the 'four stages to learning a new skill' has been related to the 'Dunning-Kruger' effect. This suggests that the journey to 'expert' or 'unconscious competence' as it is referred to in figure 5-16.

This model of learning can also be mapped to the boundary management capabilities referred to by Ollier-Malaterre *et al* (2013) (appendix 4 p306 and figure 5-17).

Figure 5- 17 The four stages to being 'expert' or being unconsciously competent

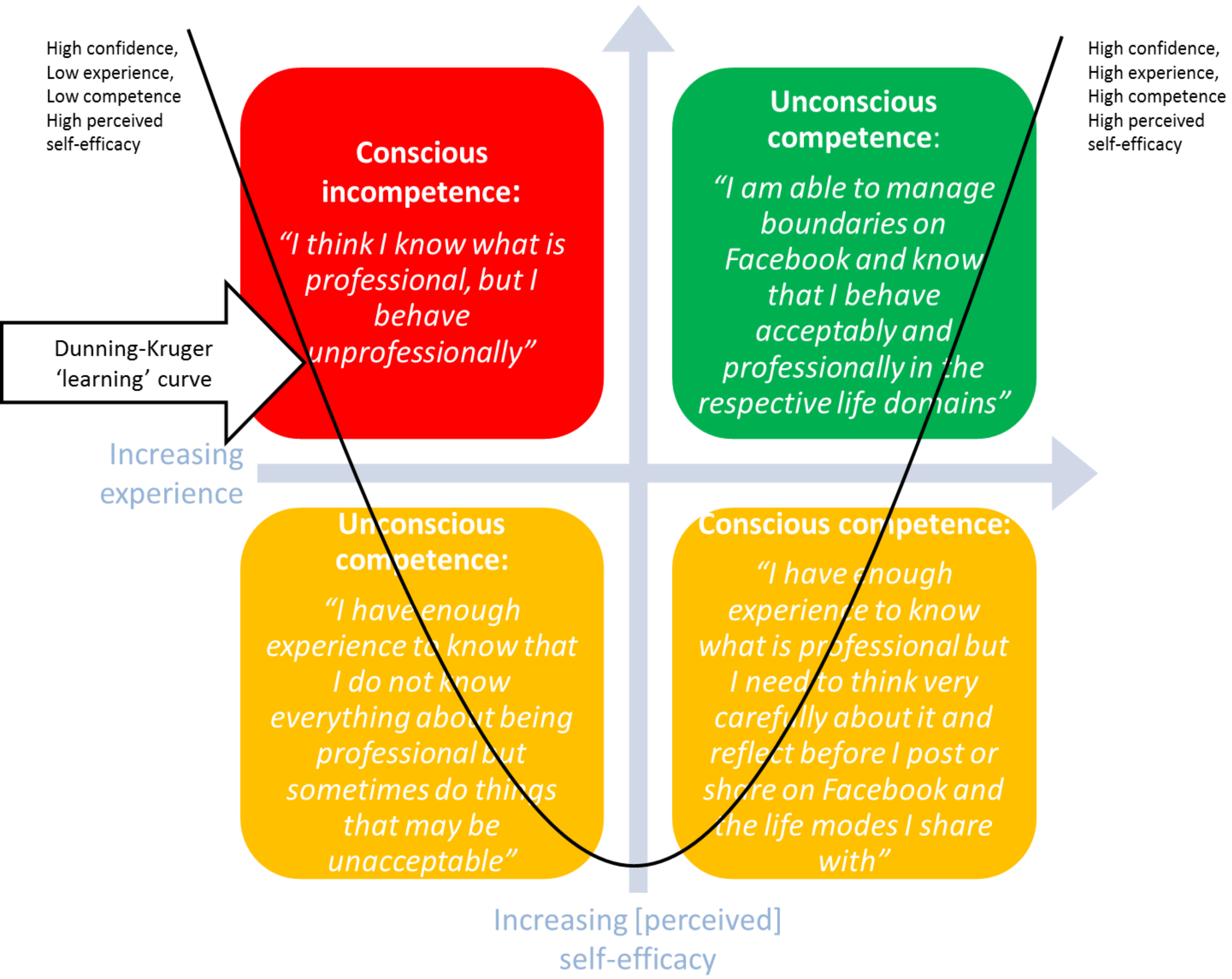
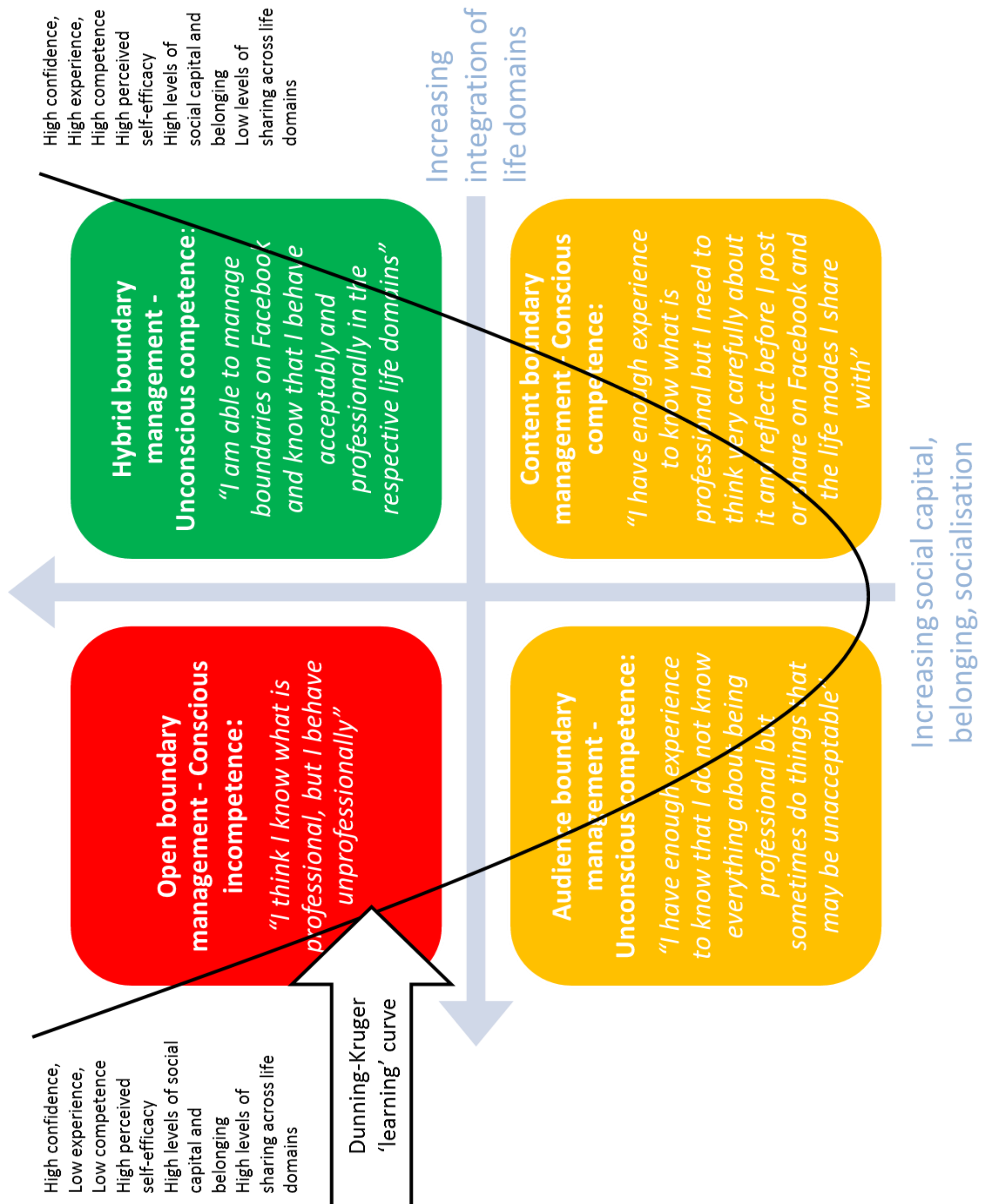


Figure 5- 18 The assimilation of Dunning-Kruger, impact of innovation and the ability to differentiate between unacceptable, acceptable, unprofessional and professional behaviours



Hence, Diffusion of Innovation (Rogers, 2003) can not only help to explain why pre-registration student nurses adopt Facebook, it can also help to explain the impact, influence and change to the individual and social structure (personal-professional-social) that occurs as a result of

Facebook as an innovation. Coupled with the interdependence of [co-operative and competitive] values through Framework I, SPO it helps to explain why it is still difficult for individuals, the public and the profession to differentiate between and consistently manage life domains (Ollier-Malaterre, 2013) and unacceptable, acceptable, unprofessional and professional behaviours (figure 5-18). In order to do this, there must be some framework by which to define these, raise awareness and facilitate the skills to negotiate the interdependence of those values that are in competition and thus, enable both acceptable and professional outcomes; I propose UAPU (figure 5-19).

5.4.3.2 Theory II: Primary and secondary (professional) socialisation and social capital

Socialisation is a process by which an individual or group take on the social norms and values of a society, community or profession. As illustrated in figure 5-18 norms and values are interdependent, some may be co-operative (in agreement) or in competition (in conflict). I have also identified that the online environment, such as Facebook may increase the likelihood of values that are in competition with one another. This, coupled with the ongoing experiential learning curve society [and the nursing profession] is experiencing means that:

1. Primary and secondary socialisation is still yet to establish what is or is not appropriate in the online environment (i.e. what is acceptable and unacceptable?)
2. The nursing profession is also still socialising itself into the online environment (i.e. what is the difference between acceptable, professional, unacceptable and unprofessional and what is or is not a disciplinary offence?)
3. Where personal, social and/or professional values are in competition how do we determine what the 'right' action is or is not? (e.g. photos of drinking alcohol, smoking)
4. We should also be able to establish which personal, social and/or professional values are co-operative and therefore, clearly both unprofessional and unacceptable (e.g. theft, violence)
5. We are still learning to understand the concept and importance of 'context' on how we determine what is acceptable, unacceptable, professional and unprofessional (e.g. photos of being drunk the night before an early shift versus photos of being drunk generally, or being

photographed with a glass of wine versus being photographed unconscious outside a nightclub).

Hence, I propose that Framework II UAPU that explains the relationship between competing and co-operative values and levels of risk related to online behaviours (figure 5-19). This UAPU framework, combined with the SPO framework I forms the basis of the third and final explanatory framework III Awareness to Action; an explanatory framework that informs a practical assessment and decision-making tool.

Figure 5- 19 The interdependence of values (competitive or co-operative) and how the online environment increases the likelihood of conflict

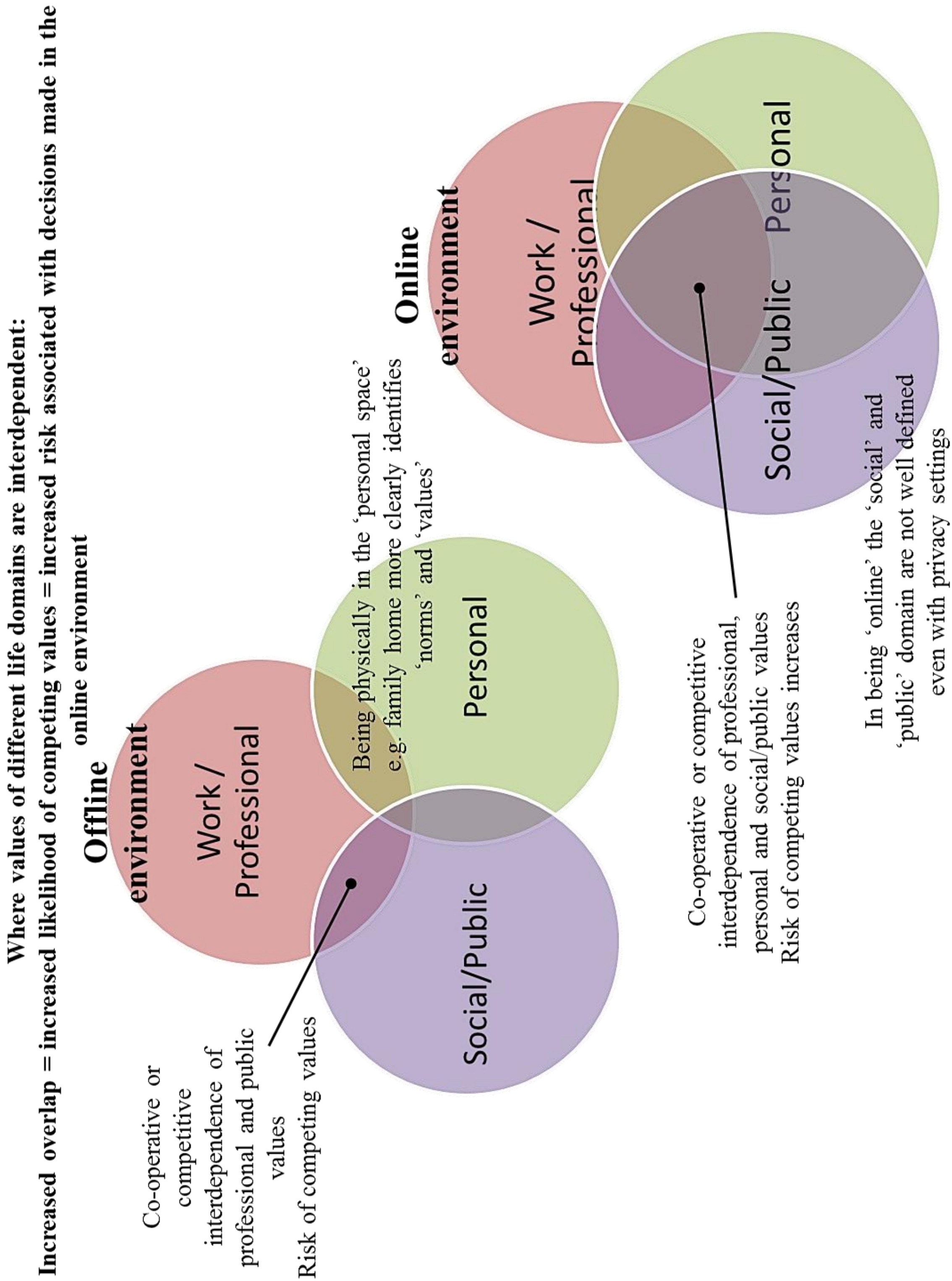
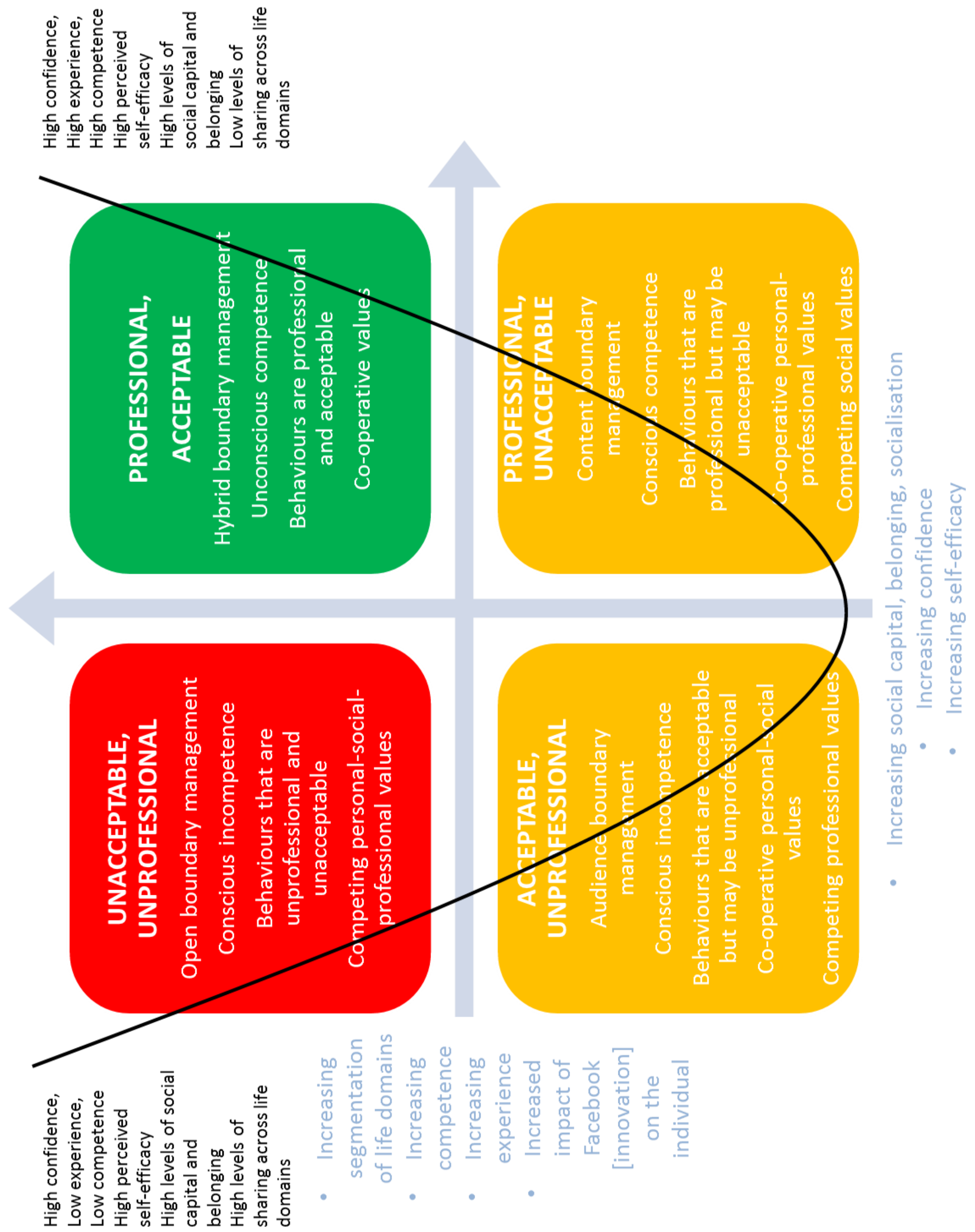
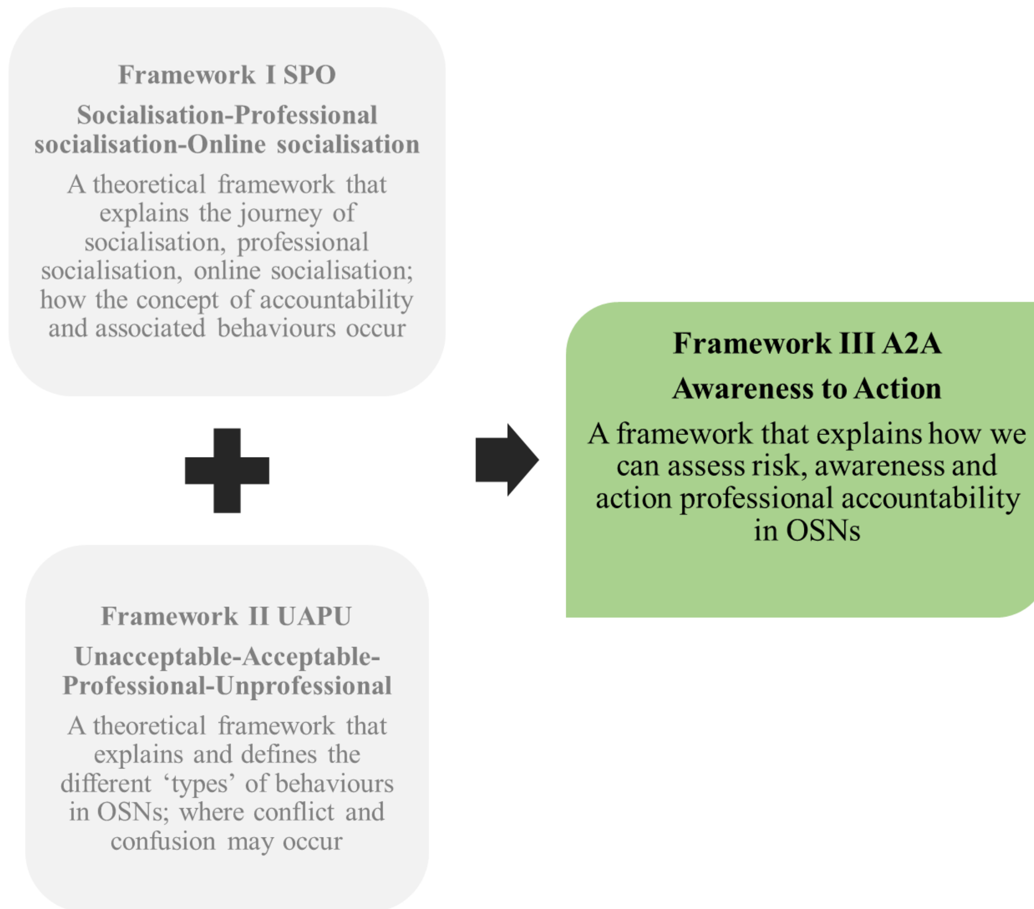


Figure 5- 20 Framework II, UAPU: Unacceptable-acceptable-professional-unprofessional



5.5 Development of Framework III A2A: Awareness to Action

Figure 5- 21 How SPO, UAPU and A2A interact



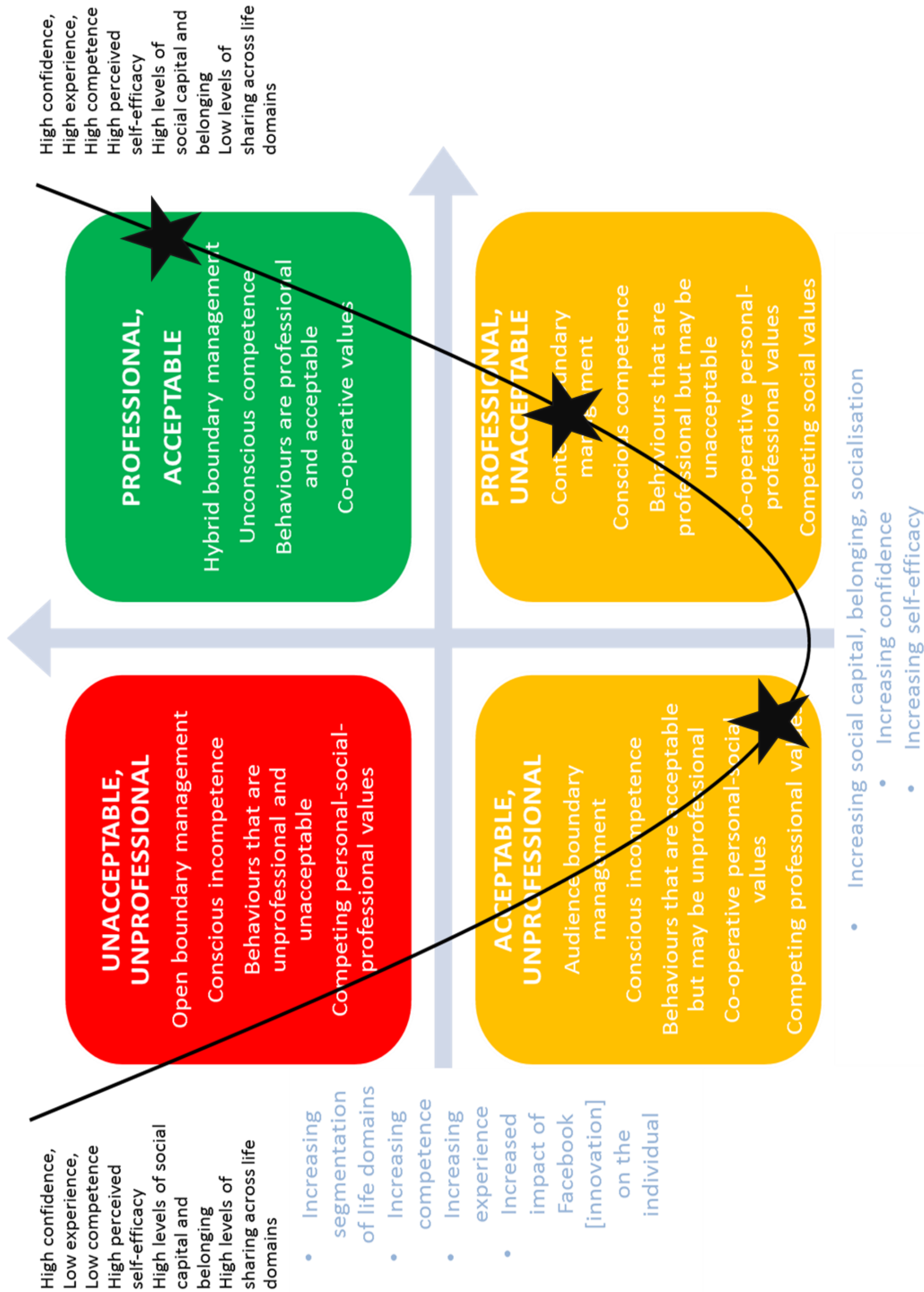
Having identified the relationship between professional socialisation, the pre-registration student nurse and Facebook (Frameworks I, SPO and II, UAPU)[48] (figure 5-20) I now propose a final framework, Framework III A2A (section 5.5.1 p229) that explains a developing relationship between accountability, Facebook and the pre-registration student nurse during their journey of professional socialisation. The A2A framework seeks to identify where on the 'confidence-competency-learning curve' [UAPU] an individual or group of individuals may be, the implications of this and the actions they may take to reduce risky behaviour and promote

[48] SPO: Socialisation-Professional Socialisation-Online Socialisation
UAPU: Unacceptable-Acceptable-Professional-Unprofessional

positive online behaviours (figure 5-22). There is a proactive and reactive component to this framework,

- Proactive: an individual or small group **assessment tool** for those entering, during and after nurse training
- Reactive: a **decision-making tool** that enables academics, employers and professional organisations to determine the action required once an incident has been reported or occurred.

Figure 5- 22 Moving from awareness to action on the confidence-competency-learning curve in UAPU



In developing framework I SPO and II UAPU, I conclude that many individuals express high levels of awareness [self-efficacy] (i.e. they think they know what is unprofessional or that they are not unprofessional) but their actions in the online environment do not reflect this. Hence, I have considered what this means and what we can actually 'do' in order to assess this risk, raise awareness and therefore, improve knowledge and practice [online] in nursing. Figure 5-23 considers the concept of 'awareness' and 'risk'. Risk may be defined as the likelihood of an individual acting unprofessionally or in a way that is likely to require formal action (their level of competency). Awareness is defined as the level of confidence an individual has that they behave professionally in the online environment (their perceived competency). I took these ideas and began to examine the data in order to identify 'what' we have to do in order to explore these factors. This is discussed in the next section.

Figure 5- 23 Development of Framework III, A2A explaining the relationship and levels of awareness and action in relation to 'risk'

5.5.1 How Framework III, A2A will work in practice

This section discusses the proposed awareness to action (A2A) framework III; assessing **awareness**, raising **awareness**, facilitating decisions and recommending **actions**. The awareness assessment has two main features,

1. **Proactive - the A2A as an awareness, personal and professional development tool:**

   Enable reflection and critical discussion (where used in a group approach) about self-**awareness** of online behaviours, **actual** online behaviours and recommended **actions** based on this evaluation process.

2. **Reactive - the A2A as a decision-making tool:**

   Facilitate the decision-making process by way of a three-stage **assessment** when potentially unprofessional behaviours are observed in the online environment and the recommended **actions** as an employer, academic or professional.

5.5.1.1 A2A as an awareness tool

The A2A awareness tool[49] can be used for professional development. As appendix 20 p332 shows this is an ongoing and evolving process that can be repeated upon entry to and throughout nurse training but also the professional career. As Jarvis (2005) and my research here attests, repeated exposure to concepts facilitates reflection and experiential [lifelong] learning; skills that are valued in the nursing profession and that are akin to being professionally accountable (NMC, 2015). Conversely, we also know that sites such as Facebook change their privacy and security settings intermittently and this tool supports an individual to consider how these changes may have affected what they share and who they share it with. Hence, the A2A assessment tool should be used every 6-12 months [depending on the recommendations of 'risk' from the initial assessment].

[49] This tool is presented on paper in this thesis but will be in digital format through a web app.

One of my criticisms of current research is that much of it is superficial (e.g. survey design), observational or simply only describes what nurses do or do not do on Facebook. It provides little knowledge that can be used in a practical way. As a critical realist researcher and as I am undertaking a professional doctorate I am particularly interested in *utility*[50]. Utility requires me to conduct research and generate knowledge that is practically applicable and can be used in the nursing profession. It needs to present solutions to practical problems in the education of pre-registration student nurses. The A2A Framework does exactly this. Having consulted with academic colleagues about my findings and the A2A assessment it is envisaged that this assessment would be delivered as part of the induction period as pre-registration nurses enter the profession. It is best situated after initial introduction of the concept of professional accountability and the NMC code of practice (2015).

While this assessment seeks to facilitate reflection of self-efficacy (awareness) of online behaviours versus 'actual' behaviours, it also serves to prompt discussion about what *being professionally accountable* actually means in reality. Furthermore, group discussion as part of conducting the assessment will serve to negotiate and confirm the values of the profession in relation to online socialisation; what is simply unacceptable or what is clearly unprofessional and requires action. Here, I have previously discussed the lack of clarity and confusion about what is unacceptable or unprofessional. Much of this is likely to be the way in which an individual situates themselves in the 'bigger picture' (section 5.4.3 p184) but also the lack of shared values and social norms within the nursing profession. The nursing profession is not well socialised online. Rogers (2003) illustrated this as a 'critical mass'; innovations are unlikely to be advantageous if there are only a small number of adopters then the presence of

[50] See TAPUPASM as measures of quality and rigour section 4.8

'social norms' is minimal. Hence, the benefit of large cohorts of pre-registration student nurses taking the A2A assessment at regular intervals should create a critical mass of individuals, confirm the values of the profession in the online environment and as they follow their journey of professional socialisation, they will also diffuse more widely.

5.5.1.2 A2A as a decision-making tool

Framework II, UAPU[51] explained where different values and life domains created confusion about what was acceptable, unacceptable, professional and unprofessional in the context of Facebook. The A2A assessment framework is presented in section 5.5.2 p238 illustrates an individual or group approach to evaluating 'own' behaviours (e.g. this can be used upon entry to nurse training or by academics to raise awareness of behaviours and their impact). However, a further component of A2A needs to address the ambiguity and lack of clarity when registered nurses, student nurses, educators, employers and other professionals observe what they may believe to be unprofessional behaviour in the Facebook (or any social media) environment.

Using the three core components identified in the development of UAPU framework; clarity, context and confirmability, I propose the process in figure 5-24 to assess what (if any) action needs to be taken as a result of online behaviour/activity. This component of A2A seeks to enable more objective and evidence based decisions to be made about whether a reported (or indeed, whether to report) incidents in the online environment are unacceptable, acceptable or unprofessional and the recommended route of action. This also incorporates the A2A assessment as a method of self-reflection, management and monitoring by way of a developmental process.

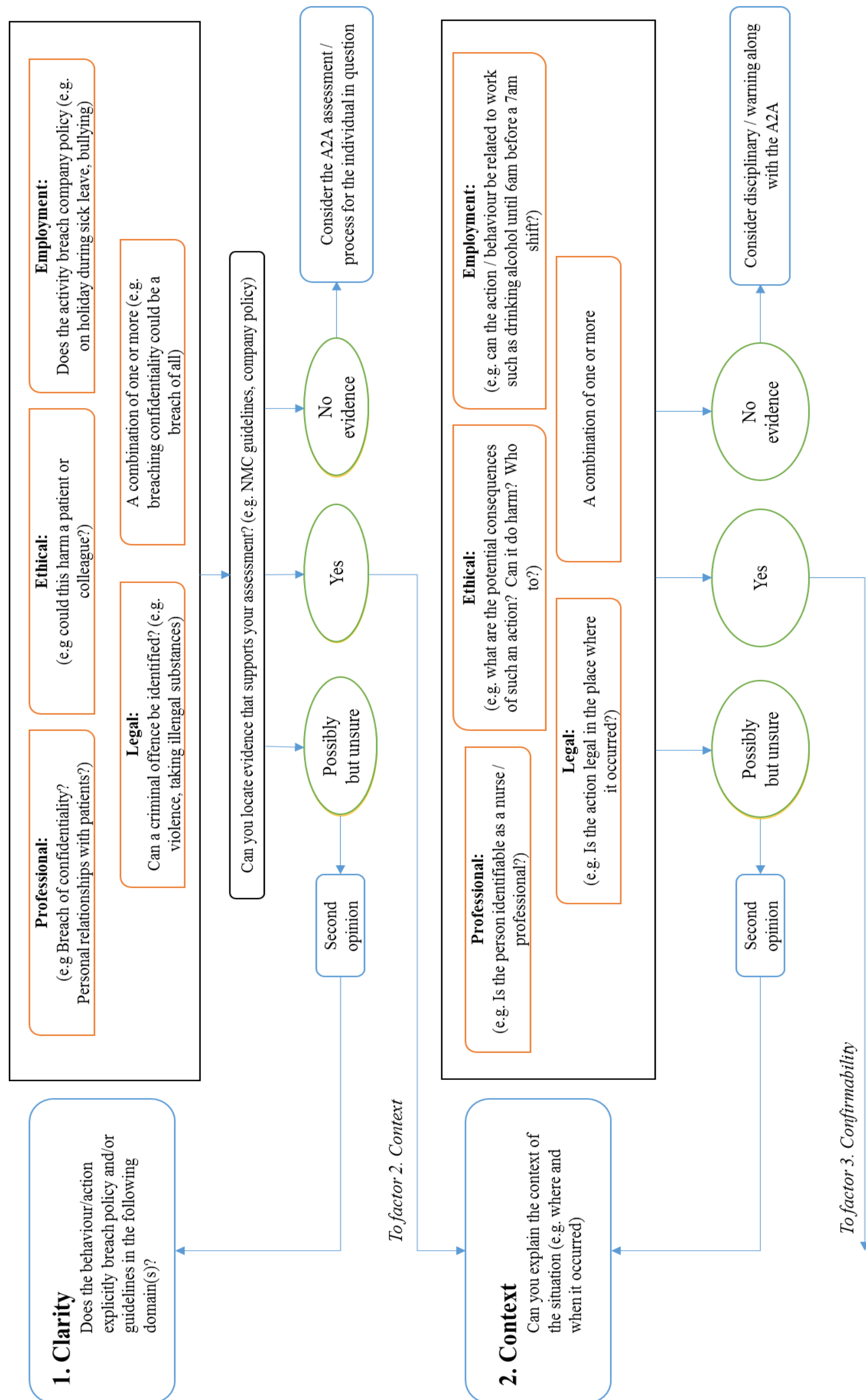
[51] Unacceptable, Acceptable, Professional, Unprofessional

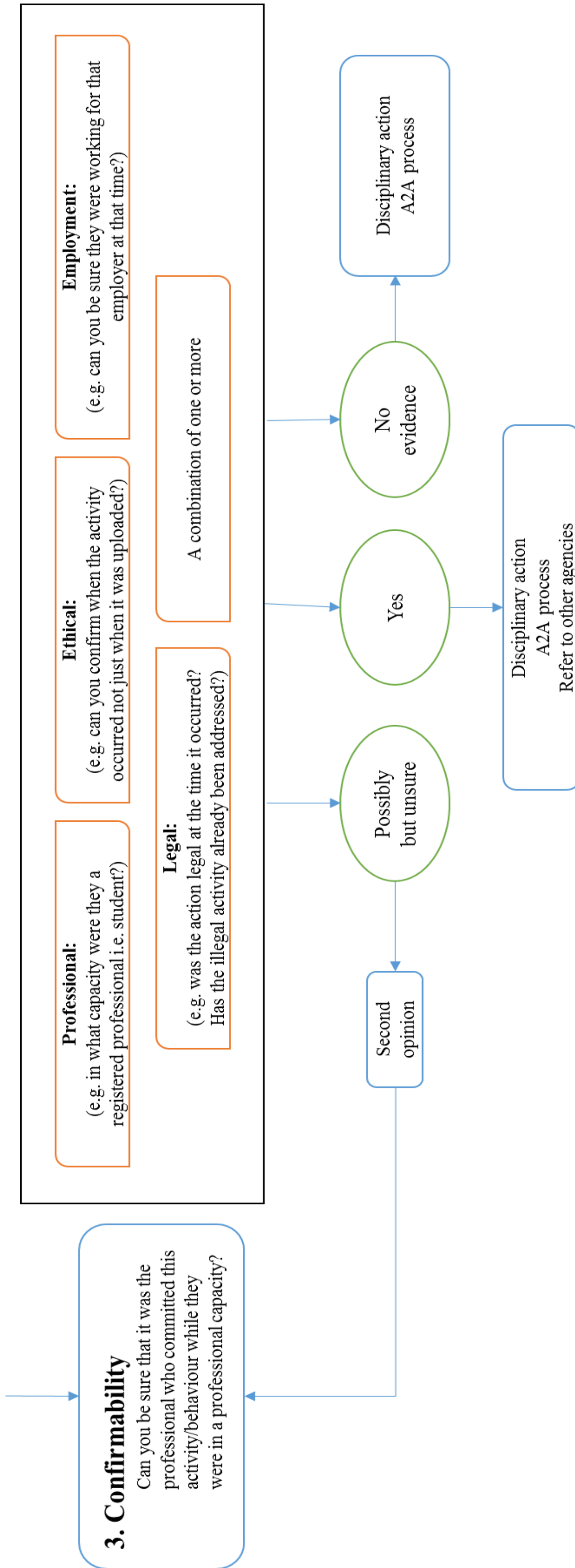
In order to demonstrate the utility of this tool I have applied it to a recent post on Facebook. In example 5-1 the headline of the incident is presented (Nursing Notes, 2017).

The notion that a nurse had shared an actual picture and detail of a challenging patient case on a professional group page created conflict and debate across the pre-registration and registered nursing communities. Some felt that this was innovative and a positive impact to patient care, seeking and sharing knowledge and experiences with the profession in order to improve a patient's outcome. Conversely, I would also argue that it reflects the NMC (2015) in that it clearly demonstrates that the nursing team had acknowledged their limitations, but had also been providing evidence based care. While the patient was not identifiable from the picture, issues surrounding confidentiality were soon addressed when evidence of patient consent was presented. Arguably, it is difficult to really confirm if a patient would really understand the impact of what they were consenting to, their picture may likely be accessed on an international level. However, they were not identifiable from the image, nor the discussion. Moderators of the Facebook page finally deleted the post, however I would argue that this is due to lack of clarity about what it 'meant' rather than an issue of professionalism. Again, this highlights the need for communities and the profession to have guidance about what we can and cannot do; we need some kind of consensus, some kind of evidence.

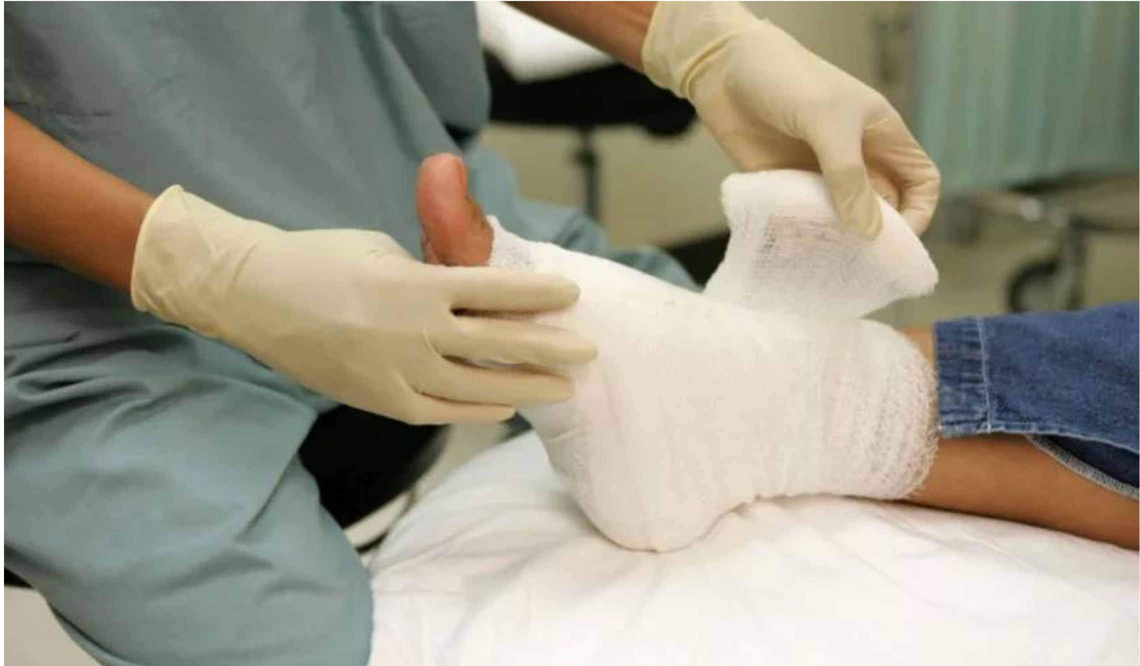
What this very current debate illustrated is that the findings of my study were very real and that the concept of 'professionalism' and 'accountability' in the online environment was subjective and lacked clarity. Conversely, it also served as a real-world example to apply my A2A decision-making tool.

Figure 5- 24 (1-3) How A2A can be used to assess and make decisions about behaviours, actions and incidents relating to professional accountability




3. Confirmability
Can you be sure that it was the professional who committed this activity/behaviour while they were in a professional capacity?
Professional:
(e.g. in what capacity were they a registered professional i.e. student?)
Ethical:
(e.g. can you confirm when the activity occurred not just when it was uploaded?)
Employment:
(e.g. can you be sure they were working for that employer at that time?)
Legal:
(e.g. was the action legal at the time it occurred? Has the illegal activity already been addressed?)
A combination of one or more
Possibly but unsure
Yes
No evidence
Second opinion
Disciplinary action
A2A process
Refer to other agencies
Disciplinary action
A2A process

Example 5- 1 Example post on social media (Nursing Notes, 2017)



A Nurse, in a final act of desperation, reached out to fellow healthcare professionals online in a bid to assist in the healing of a chronic wound.

The Nursing and Midwifery Council (NMC) offer nurses extensive guidance on their conduct online but it seems this case has delivered somewhat of an ethical dilemma for many.

The Nurse involved claimed to have exhausted all other available options including tissue viability and a multitude of second opinions and only turned to a Facebook group for Nurses as a last resort.

The patient, who remains unidentified, was struggling with a leg wound that despite a multitude of treatments had failed to heal. Her Nurse reached out to colleagues online for help but was met with a mixture of comments with some saying she was "thinking outside the box" and others calling it "inappropriate", a "breach of confidentiality" and "unprofessional".

According to the Nurse involved the patient provided full, informed, consent for the discussion and the post contained no identifiable information simply an image of the wound, a short description of the issue and a call for help.

The post was later deleted by the community moderators.

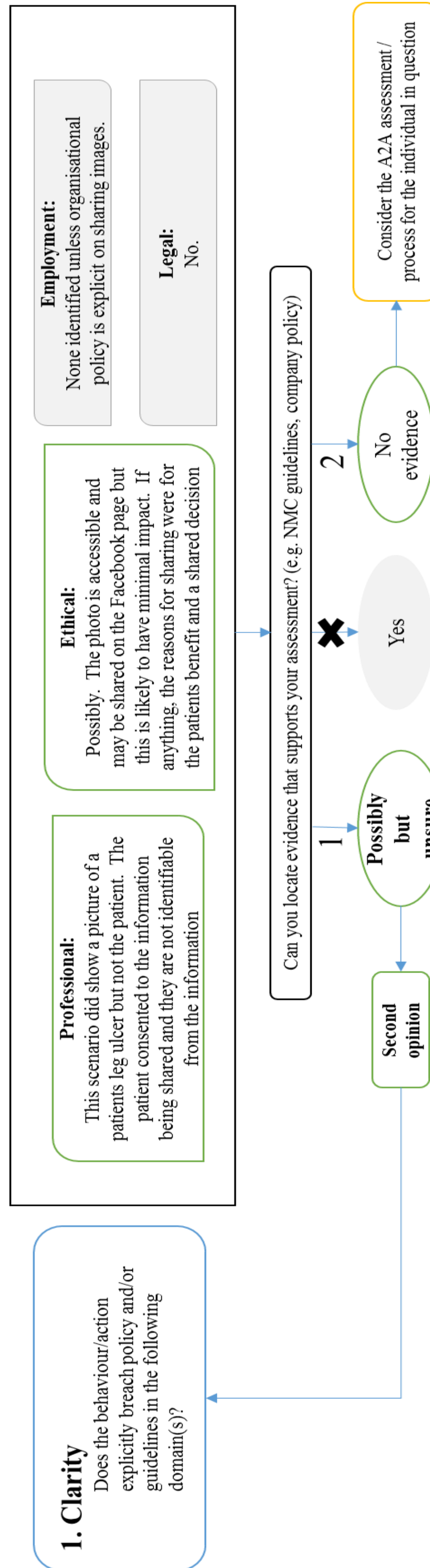
Example 5-2 uses the A2A decision-making tool as applied to the scenario. As can be seen with the '1' under 'second opinion', I chose to obtain a second opinion by discussing the case with

academic nursing colleagues. While I knew that the NMC (2015; 2016) state that we should not show pictures of patients,

"posting pictures of patients and people receiving care ***without their consent****"* (NMC, 2016:3 *emboldened not in original text*)

I felt that there was insufficient evidence to identify the patient and hence, this is why I discussed it with colleagues, I also noted that there was evidence of patient consent. Had the patient's face or name been in the picture I would have immediately moved onto the next stage of the assessment. We discussed the scenario and a summary of the discussion can be seen in the 'professional' and 'ethical' boxes in the example 2. Interestingly, despite this post being removed from the page, we felt that it did not warrant further action under the context and confirmability stages. This may have been a different scenario if the post was public or if the patient had not consented, or if the nurse themselves was visible. However, speculation does not confirm unprofessional behaviour, and as such my A2A decision making tool [if widely employed] could have enabled moderators to allow a professional discussion to potentially improve patient care! I would argue that we need to embrace the benefits of such professional communities (particularly those which are closed groups to the community itself) but this needs a framework [A2A] to empower and enable us to do this effectively. As I have demonstrated here, it can work.

Example 5- 2 Using the A2A decision making tool with a real-life example



5.5.2 Summary of findings: The application and impact of the three frameworks

Having presented three frameworks that explain the relationships between accountability, Facebook and the pre-registration student nurse during their journey of professional socialisation, table 5-5 outlines the routes by which the three frameworks, SPO, UAPU and A2A[52] will likely impact on the education of pre-registration student nurses, nurses and the nursing profession.

[52] Framework I SPO: Socialisation, professional socialisation, online socialisation. Framework II UAPU: unacceptable, acceptable, professional, unprofessional. Framework III A2A: awareness to action.

Table 5- 5 Summary of findings

Framework	Possible method of application and/or relevance in nursing and the nursing profession	Potential impact and wider application
Framework I SPO: Socialisation, Professional Socialisation, Online socialisation	A theoretical framework that explains the complex and individual relationship between primary, secondary, professional and online socialisation.	It represents the evolving and very individual process that is socialisation. By understanding this explanatory mechanism it is possible to consider the broader context of what 'reality' may be and how we situate ourselves within it and/or how and why others have different perspectives and perceptions. Knowledge of this framework forms the underpinning theory for the evolving nature of society, nursing and the nursing profession in relation to the values and beliefs developed during primary socialisation; the constant change and impact of this change.
Framework II UPAU: Unacceptable, Acceptable, Professional, Unprofessional	Developing policy, procedure and professional guidance. What actions fit where?	Being able to identify and form a consensus for defining actions and behaviours in the online environment enables learning to occur. Social change and social evolution along with the experience of this will be how nursing as a profession (and other healthcare professions) respond to the opportunity of online social networks. Acknowledging that we are still 'learning' to be competent in their use for us as professionals.
Framework III A2A: Awareness to Action 1) Personal and professional development tool 2) Decision making tool	Self-assessment, peer assessment of self-efficacy on social media: student nurse and registered professionals Personal and professional development, reflection and critical discussion. An individual, employer, manager, academic or professional(s) assessing the level of professionalism in an online incident, post or similar. Developing policy, procedure and professional guidance. What actions fit where?	This process enables any nurse, educator or group thereof (and potential for wider use by other healthcare professionals) to assess their current knowledge of their online behaviours such as security settings compared to their 'actual' behaviours in the public domain. Individually, this can be a personal and professional reflective experiential learning process that also makes recommendations to improve their behaviours and settings. As such it also raises awareness and 'competence' in the online environment. Bringing together primary, secondary, professional and online socialisation journeys. As a small group process this can enhance critical discussion about the concept of professionalism but also confirm shared values of a professional nature, hence contributing to the journey of professional socialisation while forming consensus about what is or is not acceptable, unacceptable, professional and unprofessional along with critical discussion as to why this is the case. This framework and the process of its implementation also reflects the principles of experiential learning and the evolving nature of nursing as a profession but also the individual and society along with our use of online social networks. Lack of clarity and 'grey areas' combined with anecdotal literature on the use of social networks and guidance documents/policies that inform their use causes confusion about what should be reported and/or disciplined and/or referred onto other agencies. The decision making tool within A2A allows for a structured and objective approach to the assessment of online activity/incidents and employs the awareness, personal and professional development tool to help contribute to the development of unconscious competency in the online environment; recognising that pre-registration student nurses may simply need to experience and learn in certain circumstances.

5.6 CHAPTER SUMMARY

This chapter has presented the characteristics of my semi-structured interview participants and focus group participants. As part of the process of analysis I have three *relationships*:

A – The pre-registration student's nurses' understanding of professional accountability in the context of professional socialisation

B – The pre-registration student nurses' relationship with Facebook

C – The interaction between professional socialisation, the concept of accountability, Facebook and the pre-registration student nurse

I demonstrated how the components of these relationships were visually *modelled* using 5 overarching diagrams and confirmed three *theories* that helped to explain these scenarios:

I – societal change, evolution and experiential learning

II – primary and secondary socialisation, social capital and identity

III – diffusion of innovation

From these *theories,* I developed and tested explanatory *frameworks* in my visual models and research data that could explain the relationships between accountability, Facebook and the pre-registration student nurse during their journey of professional socialisation. These were:

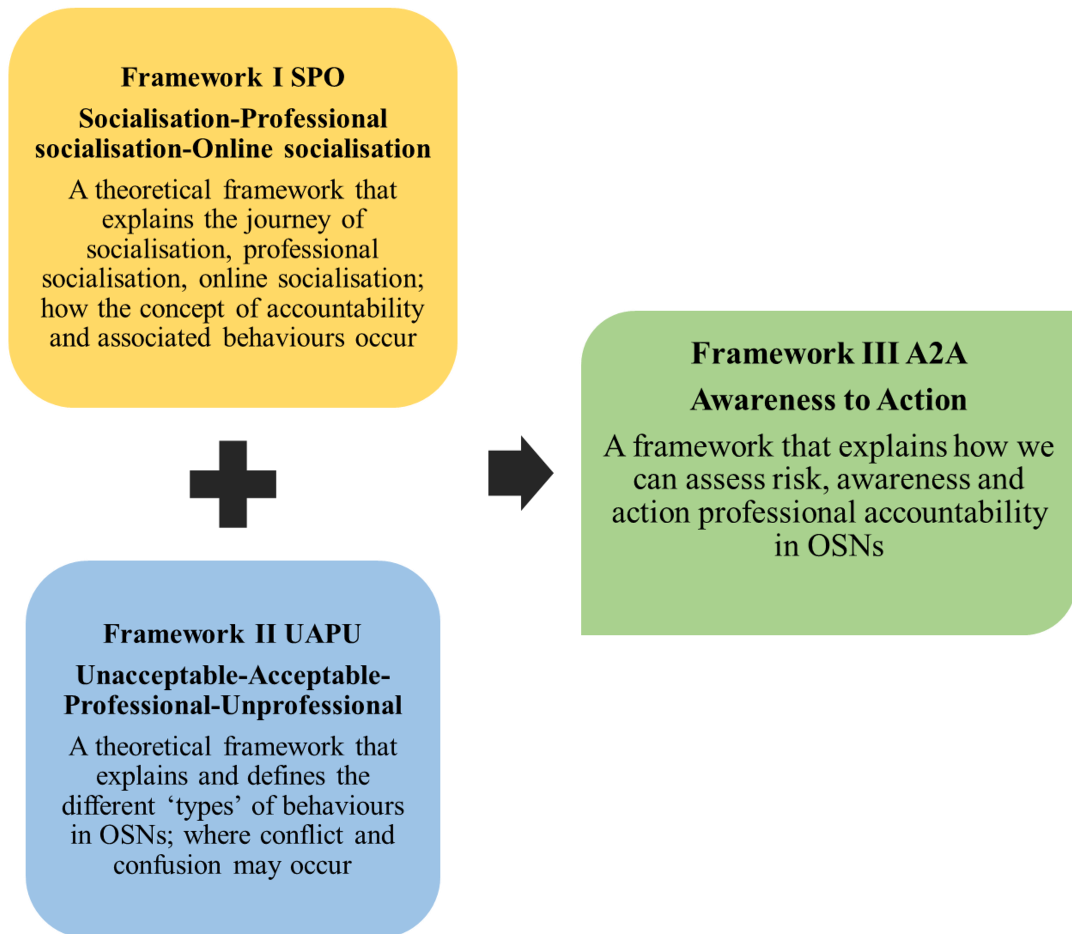
Section 5.2 Framework I: Socialisation-Professional socialisation-Online socialisation (SPO)

Section 5.3 Framework II: Unacceptable, Acceptable, Professional, Unprofessional (UAPU)

Section 5.4 Framework III: Awareness to Action (A2A assessment and decision-making framework)

The way in which these frameworks interact can be seen in figure 5-25.

Figure 5- 25 My three frameworks and how they are related



Chapter 6 will go on to summarise my research journey, confirm my response to my research question, make recommendations for practice and conclude my current research.

CHAPTER 6 CONCLUSION

6.1 INTRODUCTION

Chapter 5 has presented the results of this study and employed a critical realist analysis framework in order to identify the components of three relationships in response to my research question.

At the end of chapter 5 I confirmed three *frameworks* that explained these relationships. From this I am able to discuss how the three theory informed *frameworks* that may be employed by individual [student] nurses, employers, organisation and/or HEIs to successfully achieve professional and acceptable behaviours in the Facebook environment. This chapter will achieve my final study objective (V)[53]

A summary of this chapter's contents can be viewed in table 6-1.

[53] 'V. Present recommendations for professional practice on the use of Facebook by and for the education of pre-registration nursing students'.

Table 6- 1 Summary of chapter 6 contents

Chapter section	Content
6.1	Introduction to chapter 6
6.2	Study limitations
6.3	Response to the research question
6.4	Personal reflection: where I have been and where I am going?
6.5	Chapter summary
6.6	Thesis conclusion
Final words	

6.2 STUDY LIMITATIONS

In 4.8 p111 I discussed the concept of TAPUPASM in relation to quality and rigour. This sought to minimise the limitations to this study. However, despite critical realist researchers favouring intensive research design (appendix 11 p317) I must acknowledge that other schools of thought [such as positivism] will challenge repeatability, replicability and generalisability of my work. My cohort of semi-structured interview (n=16) and focus group participants (n=8) may not be considered to be representative of 'nursing' although I have established that they do reflect the registered nursing population demographically (section 5.2 p123). Conversely, my observation strategy sought to address this as a limitation through wider analysis of 'what is happening and why this might be'.

In keeping with critical realism, my literature review was not simply to describe the situation but was also included in my data analysis (which others do not) and hence, I do not dismiss other fields of study but view research knowledge as a baseline for moving forward and building upon, and I assert that this strengthens my study findings. I acknowledge that due to the 'open' system that is society it is never possible to be completely objective (like in experimental 'closed' systems) and hence, my modified objectivity, through use of multiple sources of data and previously established knowledge identifies the most likely conclusions. However, I also recognise that truth is *fallible* and therefore, further research will be conducted and may evolve the baseline knowledge I have presented in my study (see section 6.4.2 Where am I going? p251). At this point it may be relevant to revisit appendix 9 p312 and my defence against the challenges to critical realist research.

6.2.1 Lessons learned

Having completed this part of my research journey, I recognise that I would perhaps do certain things differently. This notable component of the process of doctoral study [training] and forms the basis of moving forward in my research and academic career. I also feel that these lessons learned should be considered alongside the possible limitations to this study.

Firstly, in my literature review (chapter 2) I used an adapted version of the GRADE criteria (appendix 2 p290) to appraise the research evidence available. My decision to use this approach back in the year 2013 was based on my research experience and training at that point, which was predominantly influenced by systematic review, clinical trials and medical research. It was also a tool I was using in a rapid evidence synthesis as part of my role as Innovation Hub Deputy in an NHS Trust service improvement project (Ryan, 2015a). Hence, the GRADE criteria were viewed as an appropriate tool for critical appraisal *at this time*. Coupled with the fact that I knew from a scoping search, that most of the research evidence was likely to be quantitative in nature, I inadvertently chose an appraisal tool which aligned more with a positivistic approach to research rather than post-positivist critical realism; which values both qualitative and quantitative approaches. The GRADE approach used would never allow qualitative research to be appraised as high quality. Upon reflection, I would now consider post-positivist principles more thoroughly in the context of conducting a literature review. Since 2013 I have conducted a range of reviews, taught critical appraisal and begun to explore approaches to realist evidence synthesis. Therefore, there are two possible appraisal tools I would use if I were starting this project again. The first would be the Mixed Methods Appraisal Tool (MMAT) (Pluye *et al*, 2011) which provides equal weighting to qualitative, quantitative and mixed methods approaches. The second would be [the very approach I used for rigour in this study], TAPUPAS (Pawson *et al*, 2003).

Secondly, my original proposal to use SCS for selecting semi-structured interview participants was perhaps well-intentioned but not feasible for this study. While the concept of SCS did

assist me to consider the diversity of the participants as I recruited to the semi-structured interviews (and once they had all been recruited), I did essentially select participants who expressed an interest in the research, rather than deliberately seeking out such individuals. Hence, the sampling approach was more reflective of 'convenience' rather than [purposive] SCS. So, while the principles of SCS assisted me to assess the diversity of my sample, it was not the primary approach to sampling.

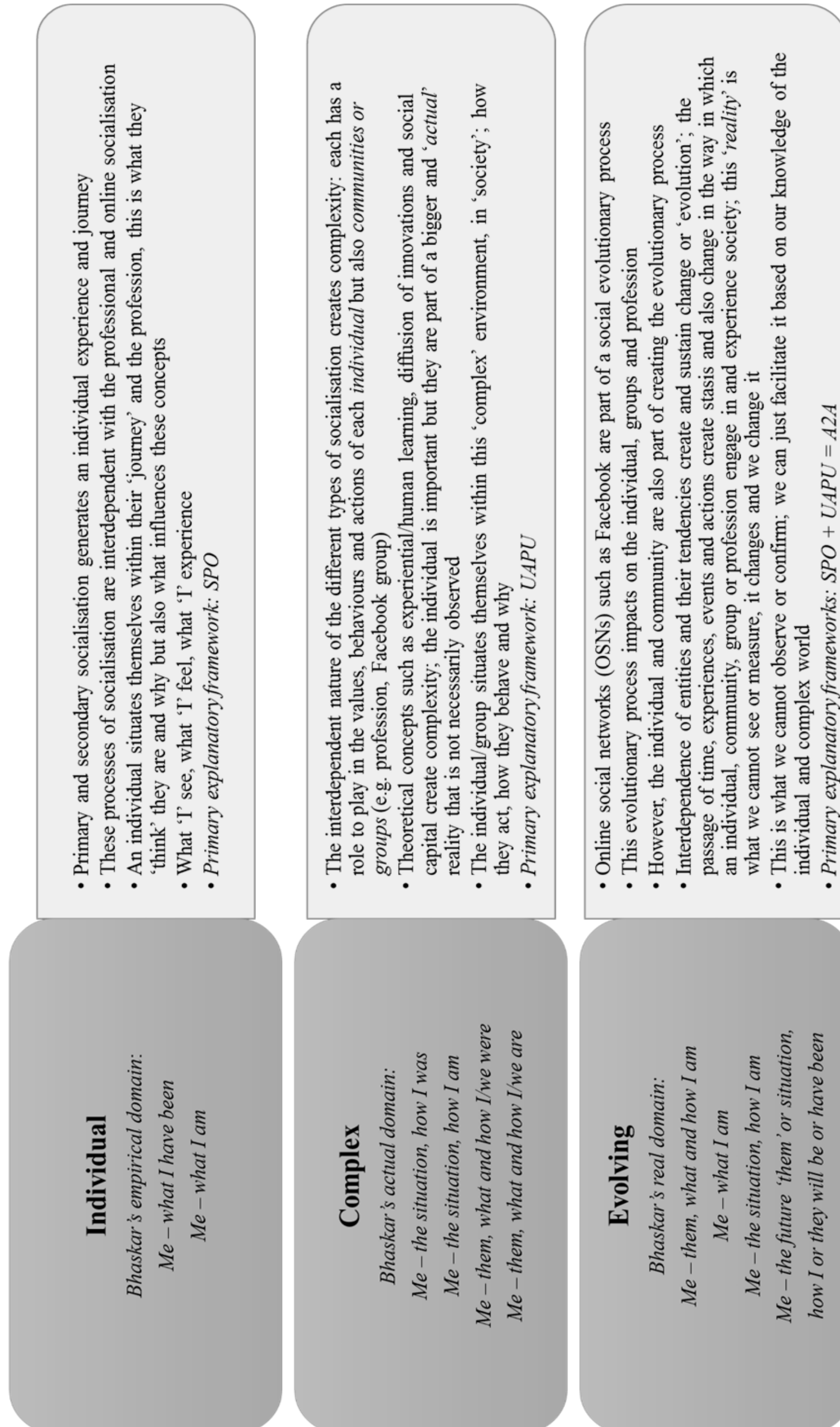
Finally, I do believe that my approaches to data collection were necessary and complementary to the principles of CRE. However, in my unstructured non-participant observations, I was not able to quote online discussions verbatim [for ethical reasons] and therefore, I have not been able to report on the rich data obtained from my unstructured observations to the level that reflects how influential this process was on my findings. If I were to take this approach again, I would need to consider how my actual approach to analysis could be reflected in the results and discussion in a more balanced way (i.e. to not allow the focus groups and semi-structured interviews dominate the presentation of the results). On approach might be to use broad examples from observations more frequently that I have done here and, to use these alongside verbatim quotations.

6.3 RESPONSE TO THE RESEARCH QUESTION

My final response to my research question is summarised in figure 6-1.

How can we explain the relationship(s) between accountability, Facebook and the pre-registration student nurse during their journey of professional socialisation?

Figure 6- 1 Response to my research question: ICE

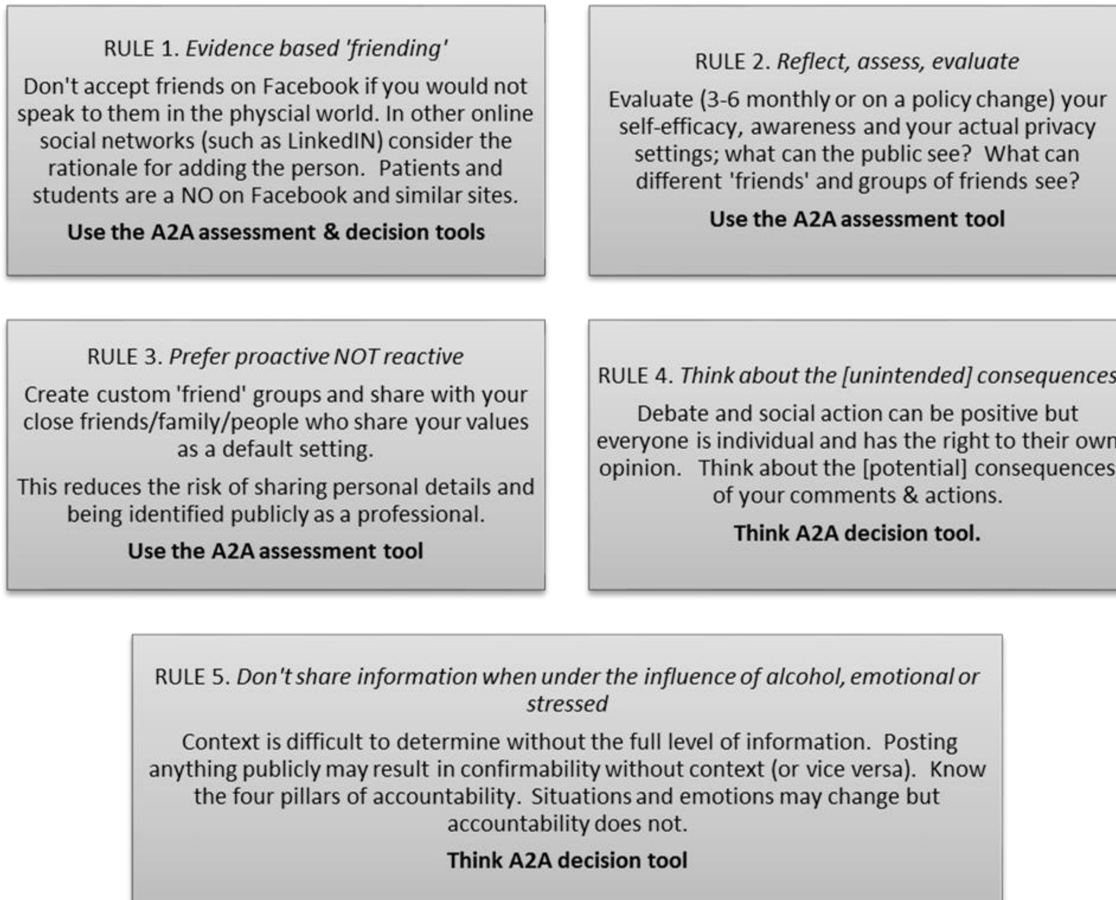


6.4 PERSONAL REFLECTION: WHERE HAVE I BEEN AND WHERE I AM GOING?

6.4.1 Where have I been? The '5 rules' revisited

In section1.1.1 I explored how I came to my research question, the experiences I'd had in my professional and personal life, and the 'five rules' by which I operated on Facebook. I now see that some of these were positive, but upon my reflection throughout this research I have realised that I also needed to make changes. I have changed my personal name on Facebook to my middle name and switched my profile picture to one that did not identify me, this resulted in some of my 'friends' removing me as they did not know who I was. While disappointed, this made me realise that if they did not know me well enough to know it was me then they probably should not have access to my personal information on Facebook! I further amended my sharing settings so that my information was only shared by default to a handful of close friends and family, people who I would see and spend time with in the offline world on a regular basis [or would like to at least]. If I want to share anything more widely (which I have realised is very rarely) then I custom that particular post to 'friends' only. An additional measure meant that I revised my public profile to make sure that it was as limited as I would like it to be. As a result, my research journey redefined my 'five rules' (figure 6-2).

Figure 6- 2 Five 'refined' rules



These '5 rules' supported by the A2A assessment and decision tools can form the basis of organisational and professional guidelines. In my research article Ryan (2016) I acknowledge the wide variety of professional guidelines for the use of social media on an international level. My criticisms of the guidance I reviewed in Ryan (2016):

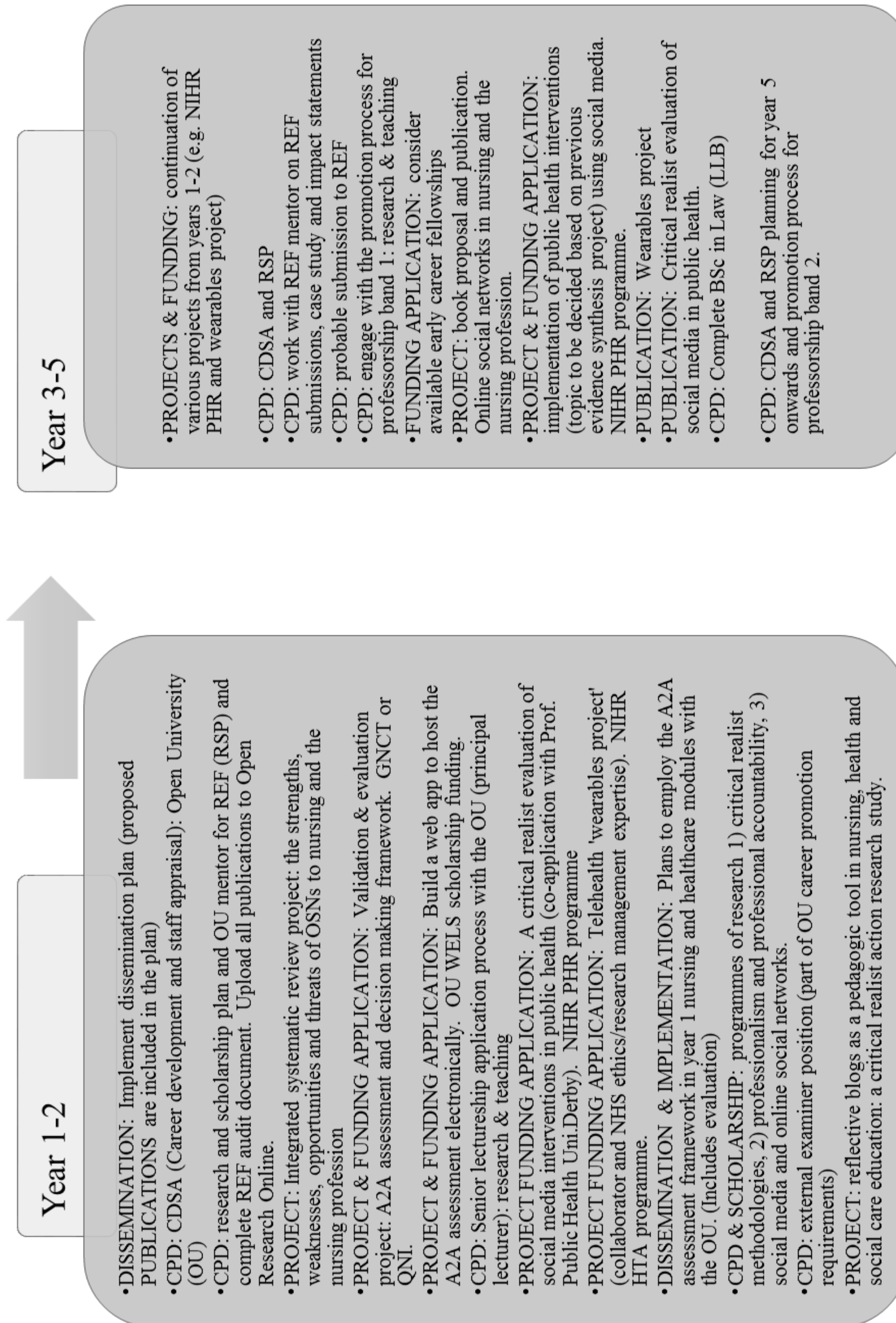
- While core professional issues were identified (e.g. confidentiality, breaching boundaries) my research here found that these are commonly known 'breaches' of professionalism and there is consensus that individuals should be held to account for them. The current guidelines focus too much on the 'obvious' and not enough on how to 'negotiate' the grey areas.
- Grey areas exist where different groups, communities and individuals hold different values and beliefs about what is 'acceptable' which creates tension and confusion (particularly for those new to being professional like student nurses).

- The guidelines are not based on high quality evidence but frequently respond in a 'knee jerk' way to media reports, incidents, or even through lack of true consensus about what really is 'unprofessional' and needs action to be taken. This is generally what I would expect when we are as a society, profession and as individuals on an experiential learning curve with a *structure* such as Facebook.

6.4.2 Where am I going?

Post-positivists, like myself believe that the truth is 'fallible'; meaning that while my research findings here are of great importance to the nursing profession and the education of pre-registration student nurses, I also acknowledge that things change and evolve. This includes me, as a person, a wife, a daughter, an academic, and as a nurse. Hence, I need to consider where this research journey will take me. As a result, I have prepared a dissemination strategy (appendix 16 p327) and a 5-year plan (figure 6-3).

Figure 6- 3 Suggested five-year plan



6.5 CHAPTER SUMMARY

This chapter has presented a discussion of my thesis limitations and a response to my original research question. It has outlined a personal reflection on my research journey, considering the original '5 rules' I presented in chapter 1, where I discussed my personal assumptions and justified the research topic. Finally, I have considered where I will now focus attention for my research career but also in furthering the knowledge generated as part of this study.

6.6 THESIS CONCLUSION

How can we explain the relationship(s) between accountability, Facebook and the pre-registration student nurse during their journey of professional socialisation?

Critical realist ethnography has been used to explore and explain the relationship(s) between the pre-registration student nurse as developing professional [professional socialisation] and their professional accountability on Facebook as an OSN. After reviewing the current evidence base in Chapter 2 I found that quantitative research dominated the evidence base on this topic and, the available qualitative literature was limited. Philosophical position was rarely stated explicitly and, either attempted to measure [positivist] or described how individuals felt and experienced OSNs [interpretivist]. With the qualitative and quantitative research combined, there was a range of evidence that only described experiences, perspectives, situations, behaviours and relationships [Bhaskar's empirical domain] but, none that *explained* what, how and why these occurred [Bhaskar's actual and 'real] domains. Furthermore, there seemed to be an assumption that OSNs were 'risky' and 'bad'. Consequently, there was little progression of knowledge that could be *used practically* for the nursing profession. The CR approach [as opposed to the alternatives discussed in chapter 3] has enabled me to develop *explanatory* frameworks along with the A2A tools which have *utility* in nurse education and practice. It has also enabled me to go beyond a description of what the situation is or what individuals 'believe' it to be, but *explain* the wider context of the pre-registration nurse in both the physical and online world.

My objectives for this study were to,

I. Employ a model of professional socialisation to critically analyse the perceptions, behaviours and actions of those who influence the pre-registration student nurse as a developing professional [in the context of Facebook]

II. Critically explore pre-registration student nurse understanding of the concept of professional accountability in the context of Facebook

III. Critically analyse the pre-registration nursing student's behaviours and publicly accessible information on Facebook in the context of professional accountability

IV. Critically analyse and explain underlying causal mechanisms which impact the relationship(s) between Facebook, professional socialisation and the behaviours and actions of the pre-registration student nurse on Facebook

V. Present a practical framework for use in nurse education and make recommendations for future practice.

In order to achieve my aims and objectives I have presented six chapters (summarised in table 6-2). This table outlines where I have achieved my study objectives chapter 1: 16) and outcomes for the DHSci. (DMU, 2012: 51)[54]. Appendix 21 p354 summarises the design, data collection, analysis and results process I have employed.

This research journey has led me to a response to my research question; that the relationships between accountability, Facebook and the pre-registration nurse during their journey of professional socialisation is **individual, complex and evolving**.

In order to achieve *utility* and meet the full complement of learning outcomes for my professional doctorate (DMU, 2012: 51) I have presented the A2A framework (assessment and decision-making tool) (appendix 20 p332) that can be used as part of an ongoing professional socialisation journey for pre-registration student nurses, developing shared values and accountability in online social networks. It also enables educators, academics, managers and employers to assess and make decisions about whether an action and behaviour in the online environment is unacceptable or unprofessional with suggestions about what action could be taken in each circumstance.

[54] I. An understanding of research methods appropriate to the vocational area of the named award; II. Critical investigation and evaluation of the area of study; III. Originality either in the development or application of knowledge.

Table 6- 2 A summary of this thesis and how it meets my study objectives and DHSci programme outcomes

Chapter	Title	Summary	Study Obj.	Prog. Outcome
1	BACKGROUND & RATIONALE	This chapter provided an outline of the reasons for, context and scope of this project with an introduction to underpinning theory. Professional accountability is a core component of the nursing profession. Without accountability, approach to care, care quality and care delivery is affected. Pre-registration nursing students undertake a programme of study that intends to produce competent practitioners. Along with this they are socialised into the nursing profession, developing understanding of the core values and social 'norms' of nursing. Professional socialisation is inherently linked to professional accountability. OSNs such as Facebook pose a new dilemma for nurses and the nursing profession. There are risks but also genuine benefits associated with its use. It is known that nurses can be held to account for unprofessional behaviours in the online environment and that these can reflect poorly on the nursing profession, particularly if presented in the media. Conversely, there are a range of behaviours that may not be unprofessional but may still reflect poorly on the individual. At this point of my study, it was unclear what were the influencing factors and mechanisms that lead pre-registration nurses to use Facebook, how they use it and how they make decisions about what to share and with whom. Without well defined values in this context, I concluded that it was difficult for educators and professionals to 'socialise' student nurses into the accepted professional values in the online environment.	I	II.
2	LITERATURE REVIEW	A review of research literature on the topic of Facebook use, healthcare professionals and e-accountability/professionalism found that the fluid nature of life mode boundaries in OSNs compared to those found in the physical world has implications for information sharing and management of relationships across life domains. E-professionalism or e-accountability is to understand and demonstrate professionally acceptable behaviours in the online environment, with friends, family and acquaintances as well as in the clinical and physical contexts and it is no longer possible to completely segregate these. I identified limited research on Facebook and healthcare professional accountability. The majority of the published research was of quantitative and survey design which only described the potential issues and perceptions of healthcare professionals including nurses. Similarly, the few qualitative studies found also described the situation as we currently know it and did not provide any suggested resolution or framework of action to support those new to nursing or becoming 'socialised' as a professional, nor were there well defined professional values amongst those who were registered nurses/healthcare professionals. My literature search outlined issues associated with professional accountability and awareness of publicly accessible personal information. There is some evidence to suggest that health professional students need further guidance and input from educators. Furthermore, while there is some research evidence suggesting discrepancy between perceived behaviours versus actual behaviours [e.g. privacy settings, information sharing] utilised by university/healthcare students, much of this is quantitative or based on survey design. This limits conclusion to data which is entirely self-reported or that which attempts to measure awareness via observation of content only. While the NMC (2012; 2016) published guidance on the professional use of social networks such as Facebook, there is still limited research evidence to explain 'how' to manage this, 38 reported competency hearings that mention or use evidence of Facebook [mis]use by the NMC over a short four year period and much of the literature presents anecdotal, reactive perspectives rather than explanation as to how and why we can use Facebook and still be professional.	I	II.

Chapter	Title	Summary	Study Obj.	Prog. Outcome
3	STUDY DESIGN & JUSTIFICATION	This chapter discussed the rationale for employing an underlying research philosophy: • To guide the inquirers beliefs about what is truth, reality and knowledge • To conduct rigorous research in the eyes of their scientific community; transparency, credibility, trustworthiness, reflexivity • To direct the selection of appropriate research methods for data collection, analysis and use of theory in order to explore the phenomena I presented the argument for employing Bhaskar's 'Critical Realism under the post-positivist paradigm. The primary reasons for this are also threefold: • It acknowledges the complexity of OSN social structures through the principle of stratified reality • It acknowledges that due to the nature of social structures and the changeable nature of OSNs there can never be one confirmed truth of what is real • It enables me to theories and explain what might happen, the way it does and in what circumstances [causal powers] by using appropriate evidence & sources available at this time Methodological considerations for post-positivism were considered. My justification for selecting critical realist ethnography was presented along with a discussion of relevant leaders in this field and an illustration of how Rees & Gatenby (2014) rather than Porter (1993; 2002), Porter & Ryan (1996) and Hammersley (1992; 1995) influenced the design and methods of this study. Primarily, critical realist ethnography shares commonalities with more traditional ethnography however, with a critical realist approach to data collection and analysis it enables more depth of explanation about the social structures that impact on behaviours and actions. I also proposed that critical realist ethnography serves to negotiate the conflict between positivist-post-modern perspectives about ethnographic inquiry while maintaining a detached approach to observation that is not typically afforded in critical ethnography.	II III	I.
4	RESEARCH METHODS	This chapter took the philosophic and ethnographic principles from Chapter 3 and applied them to research methods. Here, I proposed the use of semi-structured interview, focus groups and observation in the Facebook environment in order to achieve the study aims and objectives. These data collection methods and the strategic sampling method discussed sought to complement the intensive research design that is typical of critical realist research. I highlighted the importance and relevance of retroductive analysis as opposed to traditional ethnographic approaches to analysis. In the absence of detailed analysis methods available in CRE I proposed a six-stage process with further detail on the processes and procedures to be employed at each of these stages e.g. identifying components. In section 4.10 I outlined the TAPUPAS(M) model to highlight how I have taken into account scientific rigor in my approach to research method and conduct.	II III	I. III

Chapter	Title	Summary	Study Obj.	Prog. Outcome
5	FINDINGS AND DISCUSSION	This chapter presented my findings. It discussed three relationships in response to the research question, the theories that may inform these and three explanatory frameworks: • Socialisation, Professional socialisation, Online socialisation (SPO): explaining the interdependence of the types of socialisation and the influencing characteristics and structures that create stasis or change to an individual. • Unacceptable, Acceptable, Unprofessional, Professional (UAPU): this explained the complex nature of 'being' professional but also being a 'person' and 'online'. It explains the difference and complex nature of social norms and professional norms in the online environment. • Awareness into Action (A2A) assessment and decision-making tool: This takes the two previous explanatory frameworks and presents a practical set of tools to proactively help new (or registered) nurses to assess their self-efficacy and current 'actual' actions online. It makes recommendations based on 'risky' types of behaviours and facilitates critical discussion if used in small groups. However, it is also useful to individuals. A2A acknowledges the experiential learning and evolving nature of the individuals circumstance but also society, technology and the profession as a whole. The decision making tool may be practically applied in a reactive way, facilitating rational and evidence based decisions about actions and/or behaviours in OSNs and what action (e.g. disciplinary) should [or should not] be taken. This may be used by academics assessing fitness to practice, employers, managers and professional bodies. It may also be used by moderators and administrators of professionally linked Facebook groups when making decisions about whether to remove or block posts and/or comments.	IV V	I. II. III.
6	CONCLUSION	This chapter reflects on my research journey. Revisiting my initial assumptions and 'five rules' and then looking to the future. I present a response to my original research question: the relationships are individual, complex and evolving (figure 6-1.) I have recognised the limitations my study may present but also form a plan for my research career and recommendations for the continuation of my research in this field. There is also an summary (table 6-2) and dissemination strategy (appendix 16) in order to demonstrate potential 'impact' for my research on my own and others practice.	V	III.

FINAL WORDS

In section 1.2 p10 I discussed my assumptions and beliefs about professional accountability. I was and am passionate about 'being' professionally accountable. I had witnessed and experienced poor-quality patient care, and was frustrated that nurses were not held to account over their omissions in practice, nor did they demonstrate the ability to 'be' accountable. During my research, I have found that there does seem to be confusion and lack of clarity about what 'being' accountable means, both pre-registration student nurses and registered staff found it challenging to define the concept. While examples of unprofessional behaviours could be identified, I am disappointed that the concept of professional accountability has negative associations with when you have done [or not done] something wrong and/or caused harm. I now attest that professional accountability is a positive thing, it keeps us current, up to date and challenges us to think about the decisions we make. Being professionally accountable is **not** just about admitting you have done something wrong and/or caused harm, it's about **being** a nurse and demonstrating our values in everything we do, retaining the shared professional **pride**, it's not just about being **aware** but also **doing**.

At the start of my journey one of my initial questions was *if we can't be accountable in practice how can we be accountable on Facebook?* I further questioned whether there was even a 'problem' with Facebook. There was part of these questions that had originated from my negative experiences, however, what my research has found is that we [nurses and academics] take our understanding of professional accountability for granted, in essence if we cannot articulate and define it confidently, and with consensus, then the students we support in education and practice are also going to struggle to do so. And this is indeed what I have observed in my research. Furthermore, the evolving nature of technology and online social networks means that not only is society changing but so are we [individuals] and so is the

profession of nursing. This evolution creates complex circumstances, life domain overlap and conflicts in values for the individual and for the communities in which we exist. Conversely, it presents opportunity and potential to improve our profession and enable us to understand the positive values we share in all life domains.

I assert,

"Online social networks are not a problem, people are the problem".

Our challenge is to facilitate a working understanding of professional accountability but also how this works in the online and offline world. This is not only true for pre-registration nurses but also registered nurses and professional organisations; our shared values and principles are what keep us accountable, what uphold the professions reputation and should be strong enough to resist trolling, mass media and political influences. We need to be pro-active and provide clarity on what our shared values and 'norms' are within the online environment, and not be afraid to use it to our advantage within the parameters of our professional code. Currently, I assert that we are so unclear on how OSNs impact on nursing and we focus so much on the negatives[55] that we are missing the very opportunities it brings.

We also need to acknowledge that our pre-registration student nurses are the profession of the future, these values and skills will be embedded in our [the professions] future; we need to start to define 'what' and explain how to do the 'right' thing as a person and a professional; it's not just about **being** it's about **doing**. Awareness is not enough, we need to action it and at the moment I do not believe as educators, registered staff and resultantly, our students are. Hence, I

[55] In my early supervisions, I was challenged by my second supervisor Dr Mohammed Begg because he felt that chapter 1 was so negative I would enter my research with preconceived ideas. And I'm glad he did, because it made me see the bigger picture and include my assumptions about why OSNs present opportunity!

propose a potential role for implementing the principles of critical realism in the way in which we educate our students: critical realist pedagogy.

While we need to acknowledge that there will always be a minority of individuals whose values and actions are unprofessional, where there are clear breaches. I contest that it is the persons values and subsequent actions that should be brought into question and not that of Facebook. Facebook actions simply bring them to the forefront and surely this is a positive thing, these individuals clearly do not share our values and pride in our profession. Without Facebook, we may never know that such values and behaviours exist and hence, I believe this is damaging to the profession; I want to make our evolving society and technological advances a positive thing, embrace the challenges and make best use of the opportunities. My A2A assessment and decision-making framework does this where others have not.

Hence, this study proposes a practical framework that will:

1. Assess and raise awareness, self-efficacy and professional accountability not only online but also in the physical domain
2. Improve confidence and competency in the use of online social networks such as Facebook not just for digital natives but also groups of registered professionals
3. Facilitating active and reflective experiential learning for the novice (pre-registration student nurses and digital immigrants) through to ‘experts’ (academics and registered nurses and digital natives)
4. Supporting rationale, evidence based and objective decisions about reported incidents and/or whether to report or refer incidents to other agencies (e.g. employer, NMC, fitness to practice procedure in education).

5. Enabling critical reflection and discussion in order to negotiate the ‘grey’ areas where currently there is some conflict between what is unprofessional or simply unacceptable; it sets clearer boundaries by consensus
6. Use in education during the journey of professional socialisation; forming a consensus of values for our future nurses and profession
7. Form an evidence base for professional practice, the development of policy and professional guidance on the use of social media, not just for nursing but for wider health and social care professions
8. Be transferrable and modifiable for implementation internationally, to form a modifiable evidence base for local policy, practice and guidance and, as experience, individuals, professions and technology evolve and change.

In a WordPress blog (Ryan, 2016b), I reflected on and shared my research journey with my MSc research students through ‘what I learned this week’ (WILTW) of which they also participated by sharing their journey, I concluded,

“Don’t be so blinded by the challenges that you underestimate the benefits”

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LIST OF APPENDICES

Appendix 1 - Theoretical framework for professional socialisation (Weidman *et al*, 2001) 2889

Appendix 2 - Literature review search terms and selection criteria (Healthcare Specific) ... 290

Appendix 3 – A summary of included literature ... 291

Appendix 4 – Boundary management (Ollier-Malaterre *et al*, 2013) ... 306

Appendix 5 – NMC competency hearings scoping search (2004-2014) ... 307

Appendix 6 – Summary of philosophical paradigms ... 309

Appendix 7 – Typology of theory ... 310

Appendix 8 – Comparison of inductive, deductive and retroductive reasoning ... 311

Appendix 9 – Defence against the challenges of critical realism ... 312

Appendix 10 – Facebook demographics ... 316

Appendix 11 - Intensive versus extensive research design and methods ... 317

Appendix 12 – Semi-structured interview schedule of prompts ... 318

Appendix 13 – Focus group inclusion, exclusion criteria ... 319

Appendix 14 – Focus group schedule of prompts ... 320

Appendix 15 – Ethical approval ... 321

Appendix 16 – Dissemination strategy ... 327

Appendix 17 – Semi-structured interview participant characteristics ... 328

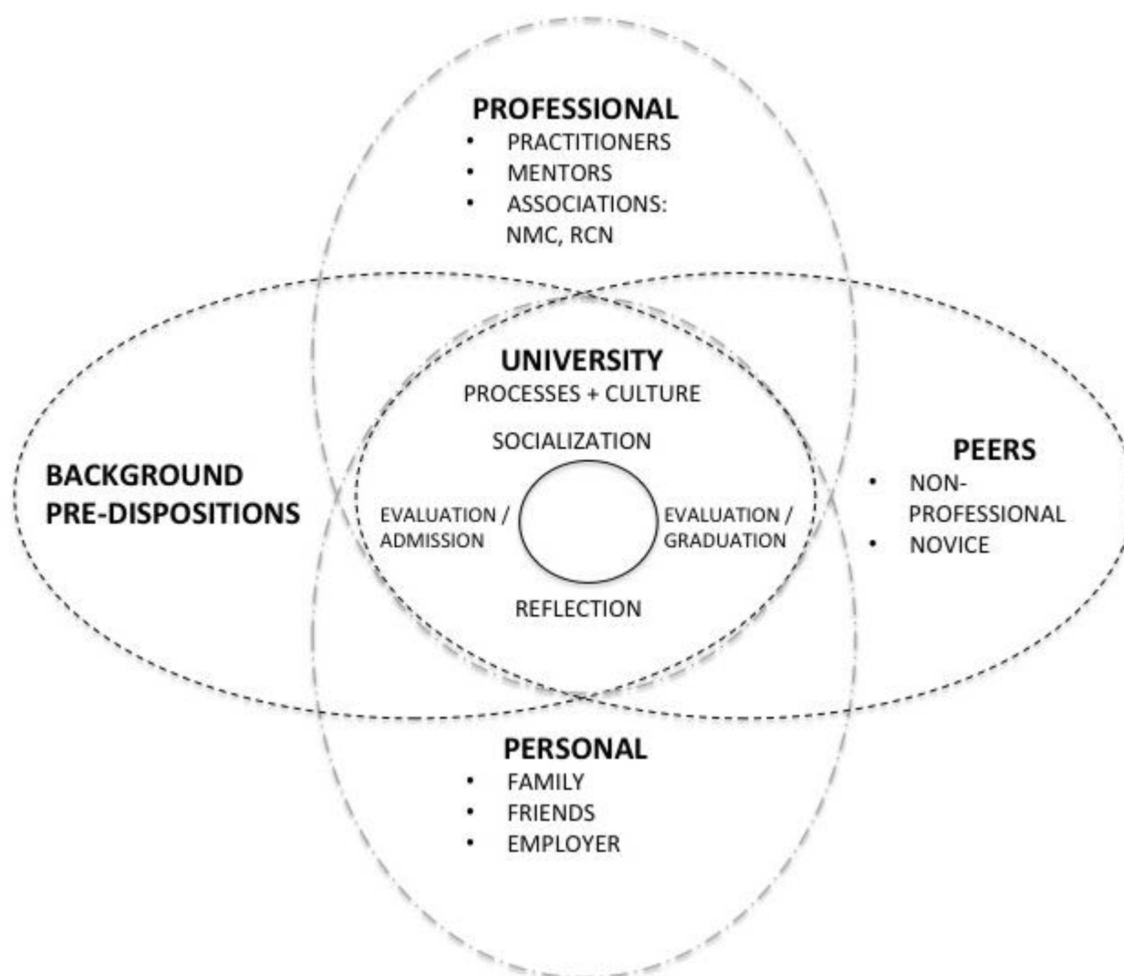
Appendix 18 – Focus group participant characteristics ... 330

Appendix 19 – Components found in the data ... 331

Appendix 20 – Framework III: Awareness to Action assessment process ... 332

Appendix 21 – Summary of research process ... 354

APPENDIX 1 - THEORETICAL FRAMEWORK FOR PROFESSIONAL SOCIALISATION (WEIDMAN *ET AL*, 2001)



APPENDIX 2 - LITERATURE REVIEW SEARCH TERMS AND SELECTION CRITERIA (HEALTHCARE SPECIFIC)

Table 1 - Search terms

Social media; Facebook; online social network[s]; online social media; social network[s];
AND
Healthcare profession*; health profession*; doctor; medic; pharmac*; nurs*; occupational therap*; physiotherapy*; student; trainee; surgeon; foundation year; psych*; biomedical; radio*; staff grade; residen*; guidance; guidelines; dent*

Table 2 - selection criteria

Inclusion	Exclusion
• Must have OSNs as a focus and include Facebook in the method, analysis and discussion • Published 2004 onwards (when Facebook was released) • Refers to and/or has a focus on healthcare professions including: medicine, nursing, students, allied health	• Does not make reference to Facebook • Not published in English language • Is not a research publication (e.g. no clear methodology section or states 'discussion paper')?

Table 3 - Adapted Grade approach to quality with added assessment for utility in practice (Ryan, 2015a)

Underlying methodology	Quality rating
Randomized trials, double upgraded observational studies, high quality systematic review/meta-analysis. Practical application of results.	High
Downgraded randomized trials or upgraded observational/survey studies. Systematic review and evidence syntheses.	Moderate
Double downgraded randomized trials, observational/survey studies or case reports, case control, cohort studies. Mini reviews. Philosophically guided qualitative research and mixed methods studies. Some possible practical application and utility.	Low
Downgraded observational & survey studies. Small scale qualitative research. No obvious practical application or utility.	Very Low

APPENDIX 3 – A SUMMARY OF INCLUDED LITERATURE

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
Alber et al 2016	USA	Examined social media self-efficacy related to areas of responsibility	Health education specialists	QUANTITATIVE Cross sectional n= 353	Statistically significant differences in SM self-efficacy existed by age, $F(2, 289) = 6.54$, $p = .002$. Experience ($\beta = 1.43$, $t = 11.35$, $p < .001$) was a predictor of self-efficacy	Moderate
Alsuraihi et al 2016	Korea/SA	Most common SM resources used in education	Medical students	QUATITATIVE SURVEY DESIGN N=657	21% incomplete questionnaires. YouTube most common (42.3%, n=185); males preferred using Twitter and Wikis (p=0.001). 95.8% (n=419) of the students believed SM useful for learning. Females stated that SM helps them link basic and clinical science (p=0.003).	Very low
Asiri et al 2016	Saudi Arabia	What is the impact of Twitter and Facebook on nursing practice and education?	Facebook, twitter and nursing	SYSTEMATIC REVIEW	Three themes: (1) using social media to enhance students' confidence and /or self-efficacy, (2) characteristics of nurses who use social media, and (3) preferred modes of communication.	Moderate
Cain et al 2009	USA	Assess pharmacy student activity on fb and opinions on accountability and e-professionalism	Pharmacy students	QUANTITATIVE SURVEY 21 item questionnaire n=299; pilot n=128 + 3 peers; 21-28 years old	More than half of the students reported that they would change some of their settings/behaviours as a result of an e-professionalism presentation 69% said that students should be accountable for illegal acts discovered through fb 78% said they use privacy settings No difference in this demographically Females more likely to think people should be held accountable for professional or legal violations 65% of students believed online persona reflected them as a professional 69% said that professional students should be held to higher standards	Low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
					After a presentation on e-professionalism 47% said they would make no change, 38% said they would be more cautious. Disconnect between opinions of fair use of Facebook compared to the open access nature. 57% believed it was unfair to view profiles for viewing them as professionals. Difficulty grasping new paradigm of personal-public online environment Privacy concerns do not necessarily reflect the privacy behaviours online – awareness does not = use Differing views on 'appropriate' use Faculty members need to be aware	
Call et al 2017	USA	Review of online postings	Orthopaedic surgeons	QUATNTITATIVE Unprofessional content recorded and reviewed N=1021	Of the 1,021 Orthopaedic Surgeons sampled, 82% have professional websites, 4% have professional blogs, 21% have professional Facebook accounts, 14% have professional Twitter accounts, 26% have professional LinkedIn accounts, and 14% have professional YouTube accounts. Unprofessional content was identified in 3.5% of all surgeons sampled who have some form of content on the Internet.	Very low
Campbell & Craig 2014	USA	How HPS are using the internet and online activity + motivations for using OSNs	AHPs, nursing, pharmacy, biomedical sciences, medical students	QUANTITATIVE SURVEY N=187 out of 4370; Online survey designed around the uses and gratifications framework	Fb most commonly used. 54% use for academic and personal. 37.4% for personal only Little interest in interacting with clients online due to privacy and liability. 80% had fb account and 53% accessed at least once daily Need to modify curricula	Very low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
Chretien et al 2009	USA	Assess the experience of US medical schools with online posting of unprofessional content by students and existing policies	Deans of student affairs	QUANTITATIVE SURVEY N=78 60% RESPONSE Anonymous online survey	78 [60%] responded 60% reported incidents with posting of online content Violations of patient confidentiality, profanity, discriminatory language, depiction of intoxication, sexually suggestive material	Very low
Clyde et al 2014	USA	Examine how medical doctors sns profiles impacted on patient perceptions of professionalism	N=250 Students from education courses	QUANTITATIVE QUESTIONNAIRE Participants viewed one of 6 profiles which were populated with 1) professional material 2) healthy personal material 3) personal that included unprofessional behaviour and measure with first impressions of medical professionalism scale	Female profiles received consistently higher professionalism ratings The physicians profile can affect patient perceptions of character and professionalism Wider profession perception is not affected by an individual post – viewed as individual Women are likely to be viewed more favourably (? Because females more cautious Cain et al) Sharing some personal info for ‘personability’ with others but ‘healthily’ Personal health profiles are viewed most favourably Need to carefully monitor content and use of privacy settings	Very low
Craig et al 2013	USA	Healthcare professionals current use of social media Motivations for interacting online	Healthcare professionals	QUANTITATIVE SURVEY DESIGN N=180/4269	Little interest in online interaction with patients [privacy and liability] Use for professional self-expression, social entertainment & conveniences Facebook most popular followed by twitter Concerns about privacy and liability if communicating with patients HCPs view as a personal rather than professional outlet tool Need training opportunities	Very low
Deen et al 2013	USA	Understand mental health providers practices and attitudes to social media MISSING COPY	Psychiatrists, psychologists	QUANTITATIVE SURVEY DESIGN N=130	70% felt they were familiar with social media Those with fewer years practice were more likely to use fb in their personal lives, those with more years were more likely to use skype for professional use Different use with different levels of experience	Very low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
				24-point multiple choice survey + free text about use and attitudes towards the internet		
Farooqi et al 2013		Evaluate the effect of fb on the social life, health and behaviour of medical students	Medical students Pilot with 15 for reliability	QUANTITATIVE SURVEY DESIGN Cross sectional survey + interview 1050 distributed 1000 usable responses	400 female, 600 male 18-25 years, mean 20; 640 used fb daily; 359 said they were equally active in real life as they are on fb 36%; Few believed their social life became worse after using fb 372 37%; 39% considered shy in real world but fun loving on fb 60%; asked about health effects of fb	Low
Ferguson et al 2016	AUSTRALIA	To explore first year nursing student experiences with social media in supporting student transition and engagement into higher education.	1st year student nurses	QUALITATIVE N=10 focus group Thematic content analysis	Three key themes emerged that illustrates the experiences of transition and engagement of first year student nurses using social media at university. (1) Facilitating familiarity and collaboration at a safe distance, (2) promoting independent learning by facilitating access to resources, and (3) mitigating hazards of social media	Very low
Finn et al 2010	UK	How medical students perceive professionalism and the context it is relevant	Medical undergraduate students	QUALITATIVE SOCIAL CONSTRUCTIVISM INTERVIEWS N=72 13 semi-structured focus groups Analysed using grounded theory approach Social constructivism	Seven themes: Context, role modelling, leniency, professional identity, switching on professionalism, sacrifice [from freedom as an individual] Switching on professional identity when dressing for work and acting as students when at work Identity in virtual world Being able to keep things completely separate. Having limited medical friends on fb. Know it can affect career later Nature of being a 'developing' professional in that mistakes may be made and that they are 'learning' about what it means to be professional	low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
					Conflicting nature of fb – what to post, different students had different views. Had seen posts re: clinical placements and experiences. Had observed what they deemed to be unprofessional behaviour – comments about anonymous patients. People have posts about course/experience as status Confusion about what professionalism means as a student. Resentment about being judged. Professionalism is most relevant in clinical context – student perception, also reflected in the way literature and professional guidance is written. Role modelling in the clinical context is important for professionalism learning. Focus on communities of practice as professional socialisation. State that they themselves distinguish between personal and professional identity but that others didn't. Influence of peers on their own perceptions – manage fb posts but others do not. Recommends further research.	
Ford 2011	UK	Evaluate if nurses breach online rules in SM	Nursing times readers	QUANTITATIVE SURVEY Online poll 915 readers	41% said colleagues had used OSN inappropriately; Discussion of staff members 75%; Service users 32%; Photos 12%; 3% pursuit of relationship with patients; 59% use form of SM every day; 32% felt nurses shared too much about work; 35% aware of policy in workplace; 36% did not know; Higher profile of education needed on OSNs	Very low
Fuoco & leveridge 2014	Canada	Understand the attitudes and practices of urologists regarding social media use	Urologists	QUANTITATIVE SURVEY Survey sent to members of Canadian Urological Association by email and mail. Likert scales used to assess engagement in social media, attitudes towards responsibilities, privacy and patient interaction	504 surveys sent, 229 completed [45.4%]; Frequent/daily personal and professional use of media 26%/8%; 76% Fb users Most common roles of social media in health; interprofessional communication 67%, information, 14% online patient interaction Fewer than 19% had read guidance on this	Very low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
Garner & O'Sullivan 2010	UK	Investigate how undergraduate medical students use fb and identify any unprofessional behaviours online	Medical students	QUANTITATIVE SURVEY Online survey link emailed to 180 students	31% response rate n=56; 96% had fb account; 90% said that they had privacy limits on their account; 19% accepted friend requests from people they did not know/know well; 52% admitted photos which would be embarrassing; 54% reported seeing unprofessional behaviour Conflicting beliefs – professionalism should be a concern but believe personal life is an entitlement too but 36% said they aren't separate	Very low
George 2011	USA	Evaluate a 3 part continuing education course	Health professionals	QUALITATIVE OBSERVATIONAL USING FIELD NOTES N=15 Field notes taken during 3 classes exploring how hcp may use social media	Course on social media including Facebook. Individuals were assessed throughout the 3-hour long courses over 1 week. Positive results – several tools potentially useful in professional lives – google alerts, fb if used responsibly Need for institutions to promote IP conversations on SM use	Very low
Ginory et al 2012	USA	Psychiatry residents use of fb and potential prof and boundary violations	Psychiatry residents	QUANTITATIVE SURVEY N=182/619 Online survey	89% had fb; 96% still had the profile; Privacy concerns/lack of interest for never having profile; 19% had public profile of these 53% said it inappropriate for a patient to access it; 10% had received friend requests from pts and 4% from former patient;1 accepted; 19% had searched for pts on Fb; 36% said it unethical, 51% had never thought about it, 14% said it unnecessary/uncomfortable; Privacy and confidentiality concerns expressed; Importance of separating personal and professional lives; One explained suicidal threat on Fb	Very low
Giordano & Giordano 2011	USA	Investigate social media use in healthcare professional students	Health profession students	QUANTITATIVE SURVEY N=644 1st years N=413 graduating Survey via survey monkey to investigate media preferences, how respond to advertisements	Most students use fb 77% 1st years, 80% graduating. Students prefer online media as primary source of information	Very low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
				Biotechnology, couple and family therapy, medicine, nursing, OT, physical therapy, public health, radiology & imaging, pharmacy		
Gray et al 2010	AUS	Medical students use of fb to support learning	Medical students	QUANTITATIVE SURVEY Survey of the extent and key features of fb use N=759 62.1% response rate	87% had fb account; 90.5% accessed more than once a week; 25.5% used for educational purposes	Very low
Guraya 2016	Saudi Arabia	Aims to determine the medical students' extent of usage of SNSs for educational purposes.	Medical students in education	SYSTEMATIC REVIEW AND META-ANALYSIS	10 articles: Majority (75%) of the respondents admitted using SNSs, whereas 20% used these sites for sharing academic and educational information. No single study explored the impact of the SNSs on the academic performance.	High
Hall et al 2013	UK	Use and views on SNS of pharmacy students	Undergraduate pharmacy students	QUANTITATIVE SURVEY Electronic survey consisting of 21 questions N=377	91.8% of respondents reported using SNS; 98.6% use fb; Female more likely than male to agree that they had been made aware of professional behaviours expected of them; 76.3% agree that students should have same professional standards whether on placement or SNS; Training may be useful to improve awareness and ability to apply codes of conduct	Very low
Henry & Molnar 2013	USA	Accessibility, amount and type of unprofessional content on fb	Dental professionals and students	QUANTITATIVE DESCRIPTIVE/CONTENT ANALYSIS Evaluated online publicly accessible profiles; existence of profile, current privacy settings, access to identifiable information Sample evaluated for unprofessional content	61% students used fb; Dental hygiene students more likely to have than dental students. ; 4% open to public; Less than 2% allowed non-friends to access personal info; 14 instances of unprofessionalism found – substance abuse; Nearly half had some kind of personal information that could potentially share with the public	Low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
Jain et al 2014	USA	Ascertain what medical students, doctors and public felt was unprofessional for medical students to post on fb	Medical students, attending physicians, non-health care employees	QUANTITATIVE SURVEY DESIGN N=1421 Online survey investigating perceptions and viewing mock screenshots of fb profiles. Rated on Likert scale for appropriateness	Faculty and public groups rated less appropriate and having students as future doctors; Females and older individuals were less permissive	Low
Kakushi & Evora 2016	Italy	Use of social networking in nursing education	Nurses	INTEGRATIVE SR/LITERATURE REVIEW	14 articles included Most studies were published after 2013 (57%), originating from the United States and United Kingdom (77.8%). Use of social networking among nursing students, postgraduate students, mentors and nurses, in undergraduate programmes, hybrid education (blended-learning) and in interprofessional education. Facebook (42.8%), Ning (28.5%), Twitter (21.4%) and Myspace (7.1%), by means of audios, videos, quizzes, animations, forums, guidance, support, discussions and research group.	Moderate
Kind et al 2010	USA	Social media policies in US medical schools	Medical school websites	QUANTIATIVE DESCRIPTIVE Searched for policies relating to social media Online presence on fb and twitter	126/132 had Fb presence; 72 had student Fb presence via groups; 97% had public guidance/policy	Very low
Kumar 2014	AUS	What constitutes medical professionalism online: e-professionalism	Medical students, faculty members, doctors, non-healthcare employees/public	QUANTITATIVE SURVEY DESIGN IN TWO PHASES Medical students n=237 Medical faculty/doctors n=206 Public n=978 Online survey gather self-reported sm use. Attitudes to online professionalism, 29 mock medical students postings [responses]	Top purposes for using Fb=keeping in touch with friends, sharing pics, communicating with classmates/colleagues Medical students more likely to use Fb for fun Public more likely to use for networking 65% medical student's fb for communication compared to 30% of faculty. Public expressed more conservative view of appropriateness of content. Female participants consistently rated images a less appropriate	Low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
Kung et al 2012	USA	Evaluation of a small group reflective practice session to heighten awareness of SM	Radiology residents	QUANTITATIVE SURVEY DESIGN 25 responded to online survey about use 21 attended session using case based examples for discussion	66% responded to a survey, 40% using Fb daily, 50% witnessed unprofessional posting Reporting more awareness of privacy and confidentiality following session, would take more active role in ensuring professional use of social media as it relates to patient care Reflective sessions positive way for education	Very low
Lagenfeld et al 2016	USA	Current approach of education directors to online professionalism in surgical education	Education directors of medical students	QUANTITATIVE Survey design	A total of 110 responded to the survey (110/259,42.5% response rate). Social media usage was high among (Facebook 68% and Twitter 40%). Deans frequently viewed the social media profiles of students, residents, and faculty. 11% reported lowering the rank or completely removing a residency applicant from the rank order list because of online behaviour, and 10% reported formal disciplinary action against a surgical resident because of online behaviour. 68% agreed that online professionalism is important, should receive instruction on the safe use of social media.	Very low
Lahti et al 2017	Turkey	Describe nurse educator students' use of social media and the ways in which their educational needs are related to social media.	Nurse educator students	QUANTITATIVE Survey design N=49	(53% use it every day) and YouTube (17%). YouTube (6% use it every day) and Facebook (4%) most often as support in their studies. The most common educational needs of nurse educator students include receiving more in-depth information about how to use social media, plus more practice in using it.	Very low
Landman et al 2010	USA	Use of OSNs and further need for developing guidelines	Surgical residents and faculty	QUANTIATIVE DESCRIPTIVE/OBSERVATIONAL/CONTENT ANALYSIS N=88 N=127 Search subject’s online profiles. Existence of a profile, public or private, status update posted in last month, last 24hrs, work related postings	64% residents had Fb, 22% faculty; 50% public, 31% work related postings, 14% patient specific, some inappropriate; Faculty 2% posted in 24hrs, 29% in previous month; Of public profiles: 44% residents had 30 days, 25% in previous 24hrs	Very low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
				Appropriate posts		
Langenfeld et al 2014	Nebraska, Canada	Evaluate the publicly available Facebook profiles of surgical residents to determine the incidence and degree of professional conduct	Surgical residents N=319	QUANTITATIVE DESCRIPTIVE/OBSERVATIONAL/CONTENT ANALYSIS American college of surgeon's website used to identify general surgical residents in Midwest. Facebook then searched to see which had publicly accessible information	319 had identifiable fb profiles; 235 had no unprofessional content; 45 had potentially unprofessional content; 39 had clear unprofessional content e.g. binge drinking, sexually suggestive photos, health insurance portability, accountability act violations; No differences between gender or postgraduate year status	Very low
Levati 2014	UK	To explore the use of Facebook by RNs in Italy and the UK, focusing on the disclosure of personal and professional information	RNs Italy and UK N=124	QUALITATIVE CONTENT ANALYSIS N=124; qualitative content analysis of unrestricted profiles. Used categorisation system developed by Macdonald et al. Looked at info page, wall page and photo page.	Few cases of unprofessional content were observed. Italy and UK showed similar patterns of information sharing. There is a blurring of professional and personal boundaries evident between posts and info shared. Workplace affiliation e.g. Vulnerability online and still accountable to profession in any environment – consider some other studies which state that students see it as a 'personal' space.	Very low
Mabvuure et al 2014	UK	Uptake and usage of website and social media by UK consultant plastic surgeons	Plastic surgeons in the UK	QUANTITATIVE DESCRIPTIVE/CONTENT ANALYSIS Searched profiles on Facebook, twitter, LinkedIn, real self, YouTube, ResearchGate.	82% were on at least one platform; LinkedIn was most used 52%; 4% used Facebook; 11% twitter; Appropriate usage guidance required	Very low
Macdonald et al 2010	NZ	Examine nature and extent of use of fb by medical graduates and use of privacy settings	Medical graduates	QUANTITATIVE SURVEY DESIGN/CONTENT ANALYSIS N=338 65% had fb accounts 63% had some activated privacy options	Educators and regulators need to consider how to advise students about online professionalism Lots of info available to the wider public which could be deemed as unprofessional e.g. drinking alcohol Other showed sexual orientation, religious views and relationship status publicly	Very low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
Maloney et al 2014	AUS	Health professional student use and behaviours with SNS	Physiotherapy students	QUANTITATIVE SURVEY Online survey 20 items, demographic data, current use and opinions	N=142; 2 people not current users; 97% of participants had used fb for educational purposes; 85% felt it could benefit educational experience; Need for separation between personal and professional life modes	Very low
Muhlen & Mochado 2012	USA	Clinician use of SM [health care professions]	Healthcare professions use of social media	SYSTEMATIC REVIEW	370 articles, 50 included: Students showed highest use 64-96% Profs less 12.8%-46.7%; Professional conduct: concerns regarding misuse and need for practical guidance and education	Very low
Nason et al		To assess the level of online professionalism on Facebook profiles available for public viewing of students from a dental school.	Dental students	QUANTITATIVE Observational study	287 students in the dental school. 62% (n= 177) had a Facebook account. Three per cent (n = 6) had a public account (fully accessible) whilst 97% (n = 171) had a private account (limited access) ; 36% (n = 63) of students mentioned the dental school/hospital on their profile; 34% (n = 60) had questionable content on their profile whilst 3% (n = 6) had definite violations of professionalism on their profile; and 25% (n = 44) had unprofessional photographs on their profile. Of those with unprofessional content, 52% (n = 23) of these had a documented affiliation with the dental school also visible on their profile.	Very low
Ness 2013	USA	Use patterns of social media in graduating pharmacy students	Graduating pharmacy students	QUANTITATIVE SURVEY DESIGN N=5516 sent survey to obtain views and opinions about behaviour on social media among students seeking employment	N=212. 93% had social media profile; 74% felt they should edit this prior to applying for a job; Growing awareness of presenting professionalism online as approaching graduation	Very low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
Nyangeni et al 2015	South Africa	To explore and describe the perceptions of nursing students regarding responsible use of social media.	Nursing students	QUALITATIVE descriptive and explorative N = 12 semi structured interviews	The results of this research study demonstrate that nursing students use social media irresponsibly. Nursing students experience blurred boundaries between personal and professional lines and lack accountability when using social media.	Very low
O'Sullivan et al 2017	Ireland	This multidisciplinary study aimed to examine health science students' opinions on the use of social media in health science education and identify factors that may discourage its use.	Health science staff and students 8 universities 7 countries	QUANTITATIVE Survey design 1640 students	N=1640, 1343 (81.89%) use social media in their education. 462/1320 (35.00%) respondents have received specific social media training, and of those who have not, the majority (64.9%, 608/936) would like the opportunity. Users and nonusers reported the same 3 factors as the top barriers to their use of social media: uncertainty on policies, concerns about professionalism, and lack of support from the department. Nonusers reported all the barriers more frequently and almost half of nonusers reported not knowing how to incorporate social media into their learning. Among users, more than one fifth (20.5%, 50/243) of students who use social media "almost always" reported sharing clinical images without explicit permission.	Low
Osman et al 2012	UK	To assess fb use, publicly accessible info and awareness of privacy guidelines and online professionalism	Students, foundation year doctors, senior staff grades	CROSS SECTIONAL SURVEY	All 42 students and 20 FDY had Fb; 30% of SpR did; 41% students had public info available; 50% of SpRs; 75% FDY; 88% students reported colleagues acting unprofessionally online; 80% of FDY; 76% students felt professionalism was threatened online; 90% FDY, 33% SpR; 26% students, 50% FDY, no SpR aware of guidance available; Lack awareness of vulnerability online; Not carefully restricting public access to information; Not mindful enough of professionalism/guidance	Very low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
Ponce et al 2013	USA	Determine the frequency of social networking, degree of information publicly exposed, any unprofessional content	Medical students applying for orthopaedic surgical residency	QUANTITATIVE SURVEY DESIGN/CONTENT ANALYSIS N=431 Review of fb profiles Evidence of unprofessional content based on professional guidance	46% had Fb; 85% did not restrict online access; 16% identified unprofessional content; Those with unmarried relationship status	Very low
Ross et al 2013	Canada	Medical students views about professionalism in a digital world	Medical students	QUANTITATIVE SURVEY DESIGN Online survey n=236 Understanding of professionalism and perceptions of professionalism in online environments	43% felt that students should act professionally at all times. 64% free text comments identified that 'free time is private time' 'professionalism is unrealistic as a way of life' 'professionalism should be a way of life' Curriculum should be targeted to help understand professionalism on online environments and communicate realistic expectations Disconnect between what students understand by professionalism and what they feel is appropriate in online and real-life behaviour	Very low
Santillan 2013	Spain	Evaluate the impact of diffusion of the blog evidence based nursing through Facebook	Nursing profiles N=2132	QUANTITATIVE SURVEY DESIGN Cross sectional study carried out via wed link to an online survey.	75.9% had personal profiles on Facebook; 46.5% read the EBP blog occasionally, 17.1% regularly, 35.7% do not read blog; 75.75% said that improved knowledge of EBP	Very low
Shceherbakova & shepherd 2013	USA	To determine what extent Texas community pharmacists, use txt, email, Facebook, twitter	Community pharmacists	QUANTITATIVE SURVEY 25 item survey was mailed to random sample of community pharmacists	23.7% response; 284 unusable; 91% familiar with term social media; 5% n=14 use fb to communicate with healthcare professionals	Very low
Smith & Knudson 2016	USA	Explored differences in student nurses' unethical behaviour by age (millennial vs no millennial) and clinical cohort, the relationship of unethical behaviour to the utilization of social media, and	Nursing students	MIXED METHODS N=55 students (quantitative) N=8 faculty members (qualitative interview)	Findings indicate a significant correlation between student nurses' Unethical behaviour and use of social media (p = 0.036) and a significant	Low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
		analysis on year of birth and unethical behaviour.			Difference between student unethical conduct by generation (millennials vs non-millennials (p = 0.033)) and by clinical cohort (p = 0.045).	
Thompson et al 2008	USA	Measure frequency and content of OSN among medical students and residents	Medical students and residents	QUANTITATIVE DESCRIPTIVE/CONTENT ANALYSIS Students n=501 Residents n=312 Evaluated profiles Existence of profile, private, personally identifiable info, photo content, social groups and personal info	44.5% have account; Medical students used frequently 64.3%; 84.3% accounts had 1 form of personal info; 37.5% were private; Some had potentially unprofessional material Reduced use as training progressed from yr1 to yr3/4 Competencies must address intersection of personal/professional lives	Low
Tower et al 2015	Australia	The aim of the study was to develop a Facebook forum that utilised peer learning, to build self efficacy related to learning, of students commencing into the second year of a three-year nursing programme.	Nursing students	Observation of a Facebook forum and thematic analysis	Analysis suggests that Facebook forums may be a useful peer learning strategy to build students' self-efficacy related to study in the second year of nursing study. Students shared mastery experiences, provided modelling experiences, and used verbal persuasion to reframe problems which suggested that it helped build students' self-efficacy, and alleviated some of the physiological response associated with stress.	Very low
Usher et al 2014	Australia	Understand the use of social media by health profession students	Health profession students	QUANTITATIVE SURVEY DESIGN N=637 1st year n=451 final year Cross sectional survey to identify use and media preferences for sourcing information	80% used internet as preference to source information; Facebook use was high among all students 93% 1st years, 91% final years; As age increases in final years, fb use reduces	Very low

Author, year	Country	Aim	Pop.	Method	Results/conclusions	Quality
White et al 2013	Canada	Explore attitudes and experiences of healthcare professional students using fb	Healthcare professional students; medicine, nursing, pharmacy, salt, ot, physical therapy, dentistry, dental hygiene, medical lab	MIXED METHODS Mixed methods, semistructured interviews and online survey N=14 N=682	Most considered the following behaviours online as unprofessional: Use of alcohol/drugs, crime, nudity/sexual content, patient/client information, criticism of others 44% reported seeing this material posted by a colleague 27% said they posted such content themselves	Low

APPENDIX 4 – BOUNDARY MANAGEMENT (OLLIER-MALATERRE *ET AL*, 2013)

		Preferences for segmentation versus integration *Segementors* – like to keep life modes separate *Integrators* – like to view their life modes as their single 'identity' or persona	
Motivations of individuals posting information *Self-verifiers* – these individuals wish to seek confirmation of their own preexisting self-concept. They share information that is positive or negative to others as long as it fits with their own self-concept *Self-enhancers* – these individuals are more likely to share information that helps manage impressions of others on their identity. They want people to see them in the most positive light		Integration	Segmentation
	Self-verification	*Open boundary management behaviours:* • Mostly connected with peers and personal contacts • Preference to integrate professional and personal identities • Fully enact themselves to a broad audience • Little to no 'active' boundary management online • Takes little time and effort to manage this type of behaviour	*Audience boundary management behaviours:* • Not completely comfortable integrating life modes • Do not like unsolicited contact and will ignore friend requests from colleagues if on a personal profile E.g. setting up private profiles or lists where only professional colleagues can see certain information and family can only see certain information such as emotions, family photo's
	Self-enhancement	*Content boundary management behaviours:* • Individuals control boundaries through the content they share • Audiences may be from all life modes but content posted is limited and 'appropriate' for all	*Hybrid boundary management:* • Preference to keep all life modes separate • Boundaries are managed through controlling audience and content • A desire to actively construct an online image and manage inappropriate personal information disclosure in the professional life mode • The wish to be seen positively in all life modes • This method is difficult to manage and control; resource intensive and susceptible to failure when emotionally challenged or under the influence of alcohol for example e.g. Facebook friends are likely to be added to lists, with controlled privacy settings for each

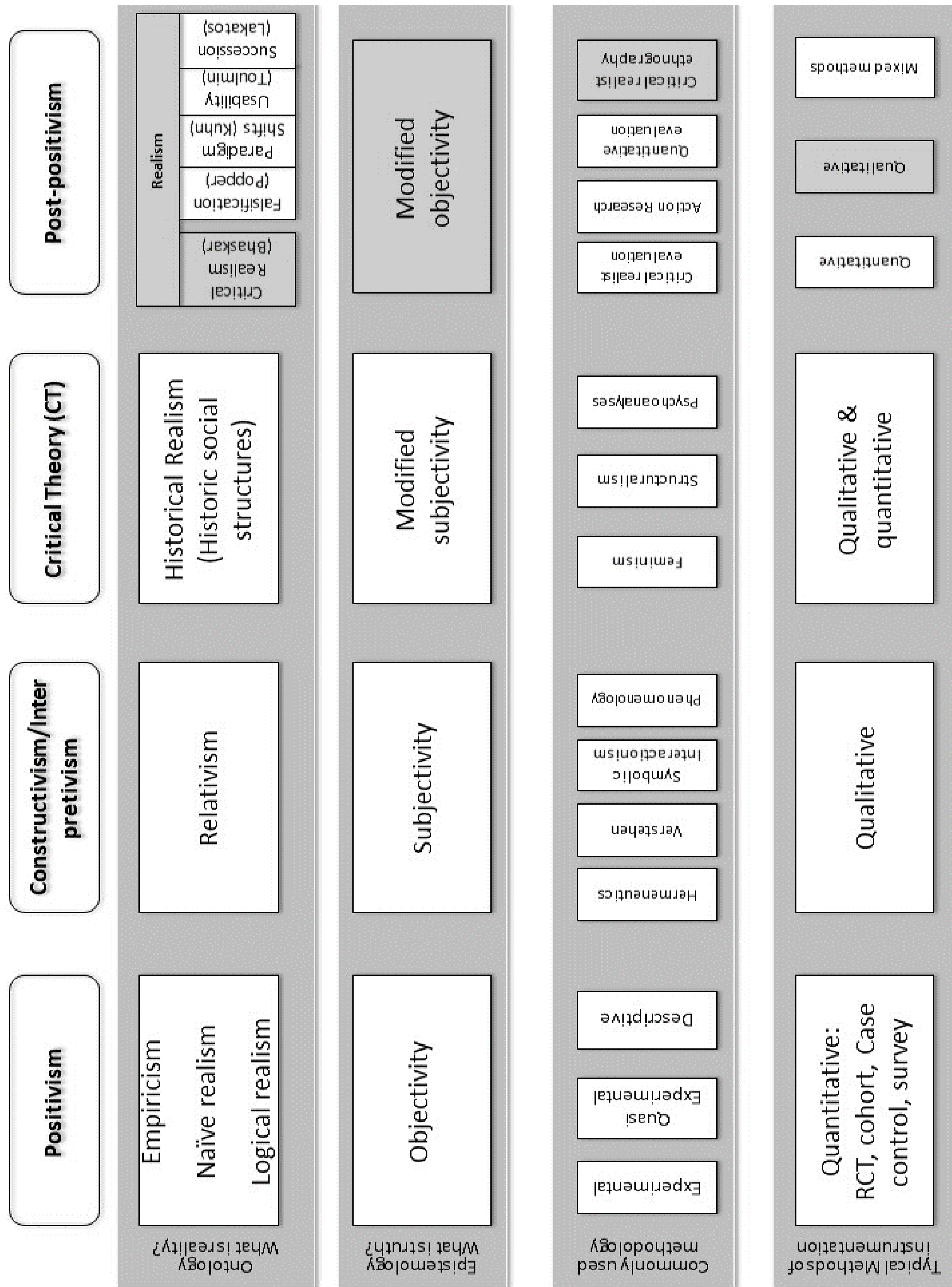
APPENDIX 5 – NMC COMPETENCY HEARINGS SCOPING SEARCH (2004-2014)

Summary of findings linked to breach of professional accountability (n=38)

Professional	Legal	Ethical	Employer
Communicated with patient through Facebook	Comments about a police caution	Inappropriate comments about patients but not identifiable	Facebook posts being dishonest about work
Communicating with patient through Facebook	Violence and aggression outside of the workplace	Contacted former patients on Facebook	Photography of being asleep on duty
Communicating with patients through Facebook	Communicated with a minor on Facebook	Taking advantage of female patients on Facebook	Posted aggressive comments to a preceptor on a Facebook page
Professional boundaries with colleagues, inappropriate posts/messages	Posted a picture of a patient on Facebook	Adding a patient on Facebook	Sharing comments about students and staff on Facebook using inappropriate language
Failure to maintain professional boundaries with patients	Communicating with a minor and sharing inappropriate pictures with a minor	Contacted patients on Facebook	Making inappropriate comments about colleagues
Professional boundaries with patients	Breach of patient confidentiality	Contacted and then had a relationship with a patient on Facebook	Travelling on holiday while on sick leave and sharing this through Facebook
Inappropriate comments on public websites	Trying to entrap a colleague in illegal activity through Facebook	Using a false name to use Facebook to breach professional boundaries	Inappropriate comments about colleagues on Facebook
Violence and aggression against an instructor	Breach of patient confidentiality	Inappropriate communication with a patient with dementia and was filmed by another patient and posted on Facebook	Accessed Facebook during a shift when they were meant to be with a high dependency patient
Correspondence with patients on Facebook		Instigated relationship with patient	Contacted a colleague to request that they did not attend a disciplinary hearing

Professional	Legal	Ethical	Employer
A witness posted on Facebook and this impacted on their professional credibility as a witness		Instigated relationship with patient	Posted comments about the workplace and a student nurse
Communicating with patient through Facebook		Found and added a mother of a patient on Facebook	Posted comments about the organisation and poor practices
		Made inappropriate comments about religion, homosexuality, disabled people as patients	Posted information about managers following dismissal
			Threatening comments about an employer and colleagues
			Comments about an employer
			Derogatory comments about team on Facebook

APPENDIX 6 – SUMMARY OF PHILOSOPHICAL PARADIGMS

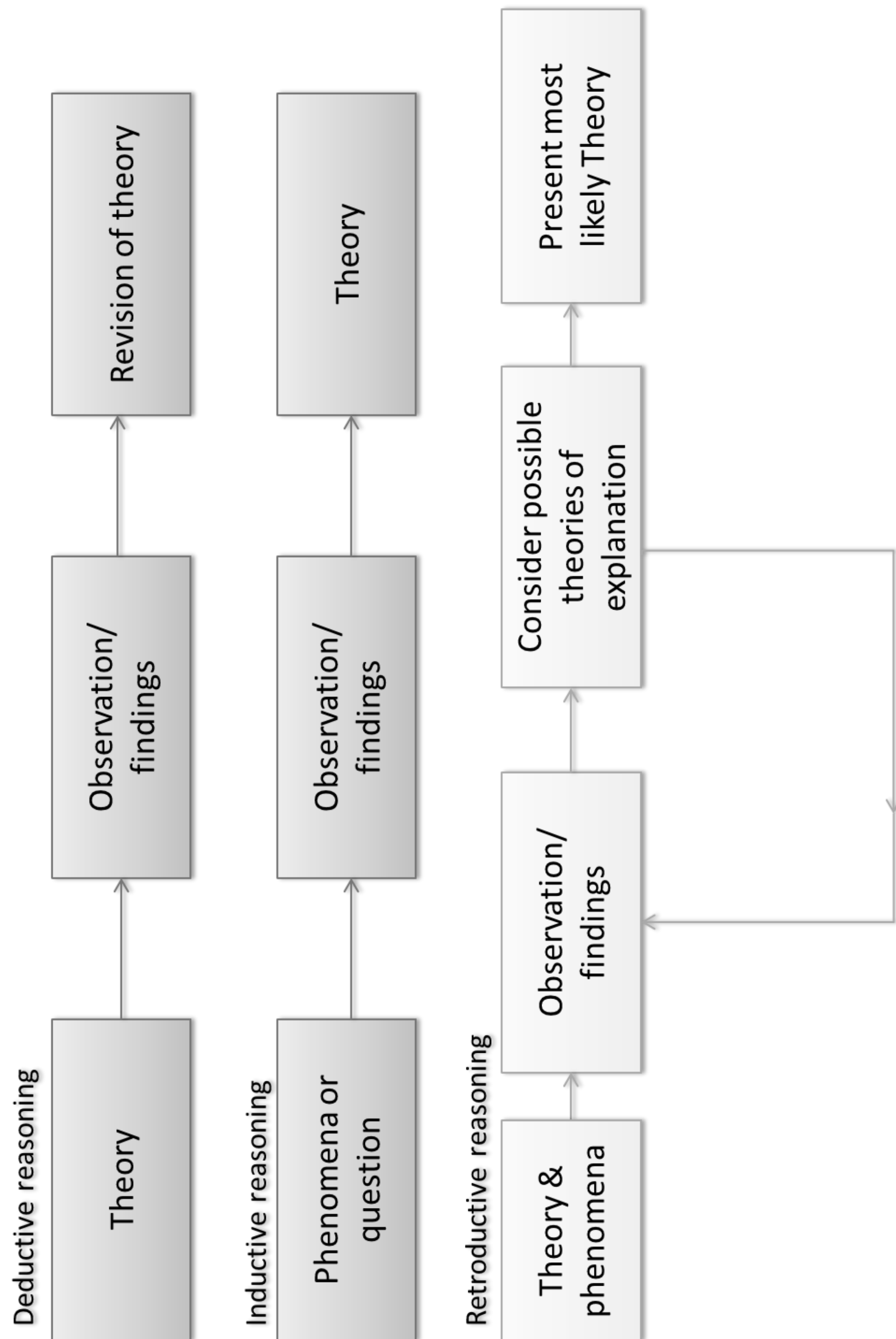


APPENDIX 7 – TYPOLOGY OF THEORY

Adapted from Howell (2013:27)

Types of theory	
Personal theorizing	Reflection on individual experience in relation to wider notions or rationales
Substantive theory	From data analysis, conceptualisations of specific situations
Models/frameworks	Simplified presentations of phenomenon researched
Meso theory	Middle range theory that draw on substantiated substantive theory and models/frameworks
Grand theory and philosophical positions	Sweeping explanations of phenomena and existence

APPENDIX 8 – COMPARISON OF INDUCTIVE, DEDUCTIVE AND RETRODUCTIVE REASONING



APPENDIX 9 – DEFENCE AGAINST THE CHALLENGES OF CRITICAL REALISM

a) If there are multiple truths because of different beliefs about what is true then surely this is relativism?

No, I would argue that *beliefs* should not be confused with *truth*. Regardless of philosophical perspective the object of study is just that. The object of study does not change; it is only the theory and perspective applied to it that changes. The reality of the overall context is the same whichever angle it is viewed from. Hence, while there is an aspect of relativism in what is observed, there are not multiple realities, only one. Therefore, this is not truth but a *belief that something is true* when in fact, I would argue that we can never know the definitive *truth* of *reality*, merely present the best knowledge we have at a given time.

b) How can you acknowledge subjectivity in that researchers allow values to influence their research but claim modified objectivity in inquiry, surely this is subjective by definition and also introduces bias? And surely bringing about change in this way fosters bias?

Any intervention with humanity and society may bring about change, even by participation in research participants will experience discussion or observe something that may change their opinion, behaviour or values. I would argue that [unlike critical theory] the ultimate goal of CR [often misinterpreted] is not necessarily social change but explanation and new knowledge that might lead to it.

I would further argue that *bias* is not the same as *subjectivity*. While, I do not disagree that there is evidence that some researchers have allowed their values to influence the way findings of research are analysed and presented, it is not logical to then propose [*that it is true that*] all researchers allow this to affect their process of inquiry. To say that values do not influence [social science] research is unrealistic given that we are unavoidably part of humanity and often investigate phenomena that are steered by our own values of what is important or of personal interest. This is even true of empiricists who claim objectivity; they are ultimately driven by something internally to conduct inquiry of a particular focus and with a particular hypothesis. This does not then mean we will be *bias*. Bias is about conduct and integrity of process with the best knowledge we have at the time of inquiry.

Phillips & Burbules (2000) give the example of the IQ test. This may have been developed with middle class, Caucasian children and therefore, be bias to this group. We would argue that this was not the primary intention of the individuals who developed this test but once made aware of

the issue they should act upon it to progress our knowledge and acknowledge new evidence. The absence of this action would then demonstrate bias toward the Caucasian population.

Conversely, I would contend that the scientific community within which the researcher sits determines the concepts of bias or quality and hence, the researcher seeks to generate new knowledge within this community based on what they would view as *bias* and *high quality*.

Therefore, I place importance on:

1) Being willing to improve, progress and change if new knowledge is produced,

2) Be transparent about any values or philosophy that have influenced your decisions

3) Having an underlying philosophy providing principles to guide the research process

c) Surely there is no intransitive knowledge in the social sciences (Cruickshank, 2007; Michel, 2012)?

While intransitive knowledge in the social sciences is not a fixed as that in natural sciences. I would argue that 1) there are natural factors that impact on social actions and structures. For example, genetics create the person in combination with nurture. And 2) not all social structures are obvious, observable or consciously employed. For example, people who get married and have 2.4 children do not do so to create the nuclear family, but *objective inquiry* of this does tell us something about the patterns in society at that time.

d) Fallibilism creates an internal contradiction.

> *Hammersley (2009: 3) argued that "as fallibalists, we should distinguish between factual knowledge claim being true and our belief that it is true…if some factual claim be true we ought to believe it…it does not follow automatically from the fact that I have come to the conclusion that statement X is true that others ought to believe it…it might be argued that there is a scientific method whose guarantees true conclusions…once we recognize that we can never have absolute truth of this kind…the argument fails"*

This statement is suggesting that fallibilism in itself is fallible as a principle. Yes, in some ways this may be possible [as a CR I am open to the presentation of new evidence and argument]. However, I would argue that this is the best option, for me and the object of my inquiry (as a result of perspectives presented in chapter 3). And this [fallibilism] might or might not be *true*

but in the absence of a definitive truth and an ability to find it we need to make decisions about the approach to take with inquiry, otherwise we would never progress scientific knowledge. I believe mine is well justified and guided by philosophical principles. I would ask *in what way is what you **believe** to be true more than what I **believe** to be true, rather than different perspectives on the nature of the reality of social structures that both add knowledge to the field of social science research?* It is not about what is more or less true but what evidence is available and what it adds to our progression of knowledge about an object of inquiry; all sources are evidence of some kind (Phillips & Burbules, 2000) and this is the very essence of evidence based practice: research, expert knowledge & the patient.

We should be more concerned about what knowledge we add, where the differences are [if any], what these might mean and whether this was conducted through a transparent and rigourous process rather than discussions about whether what I believe is more or less true than what you believe to be true. Hammersley (1992: 32) himself argues:

> *"[discussion and theoretical] debate can easily become a distraction: swapping one set of problems for another"*

e) We should not assume that true knowledge claims are generated in any fundamentally different way to those with false knowledge claims (Hammersley, 2009)?

I would not disagree for the most part. However, Bhaskar's critical realism is simply not about verification or falsification of truth given that we do not believe there to be a definitive truth merely the best available evidence at a given time. This would be a more appropriate criticism of Popper.

Conversely, if one would argue that there are certain methods of inquiry that are more likely to produce truth I would challenge how we know this to be definitively *true*?

f) Aren't value assumptions needed to interpret values?

I do not deny the role of value assumptions in the interpretation of social science. Collier (1994), Danermark *et al* (1997) and Phillips & Burbules (2000) advocate inquiry into perceptions and values of participants in order to understand how social structures may be interpreted. However, this data needs to be taken in context of the object of inquiry and is not *truth,* merely those individual perspectives on these social structures we seek to uncover and explain further.

Conversely, I have previously admitted that values do play a role in the process of inquiry. However, with clear, structure methods of data collection and analysis along with adherence to transparent quality criteria (chapter 4) such as being transparent about my perspective and assumptions (chapter 1 & 3) participant verification and triangulation of data sources, the influence of my values as a researcher can be kept to a minimum.

g) Critical realism moves away from the object of study in favour of a reality that can be definitively discovered under specific conditions (Schostak, 2002).

Bhaskar does not advocate this in such a simple manner; this statement attempts to simplify that which we view the stratified world. Firstly, it has never been the claim of critical realism that the truth about reality can be definitively discovered by humanity, just that there is the existence of one reality – remember, we believe that truth is fallible. We do attest to an unobservable *real domain* but as humans we are unable to ever know the definitive *truth* of this *real domain*, however we seek to explain (*actual*) what mechanisms might occur in order to generate the *events* we *experience* in the *empirical domain*.

APPENDIX 10 – FACEBOOK DEMOGRAPHICS

Percentage of users by age, gender and ethnicity (e.g. 93% of 16-24-year olds use Facebook)

Demographic	Percentage of users in each group	
Age (years)	16-24	93%
	25-34	90%
	35-44	80%
	45-54	68%
	55-64	49%
	65+	28%
Gender	Male	70%
	Female	74%
Ethnic group	White	71%
	Black	67%

Distribution of Internet use by age and gender

Age (years)	Gender	
	Male	Female
16-24	98.8%	98.9%
25-34	98.6%	98.6%
35-44	97.1%	97.5%
45-54	93.7%	93.6%
55-64	86.5%	86.6%
65-74	73.0%	68.4%

APPENDIX 11 - INTENSIVE VERSUS EXTENSIVE RESEARCH DESIGN AND METHODS

Adapted from Danermark et al (2013: 165)

	Intensive (CR)	**Extensive**
Research questions	Explores relationships and processes. What happens, why and in what circumstance?	Explores regularities, patterns and describes features. Considers distribution of characteristics and representation.
Typical methods	Qualitative, quantitative and preferably mixed methods to examine individuals within the context of interest. Triangulation of different data sources is important.	Large scale, randomised controlled trials, survey design or experimental, case control or cohort studies. Favours statistical analysis.
Limitations	Representation is not of paramount importance and comes under critique from other paradigms due to this. Some studies may have very small numbers (e.g. case studies) but they will be applicable to the context that is being investigated.	Tends to focus on representation but do not explain what is happening and why. Not usually theoretically driven so current evidence is not used to best effect. Does not acknowledge, make best use of or necessarily value knowledge that has gone before or that is seen to be 'inferior'. What is observed, measured or found is what describes 'reality'
Findings	Explanatory account of what is happening and why this might be. Theoretically informed. Utility of findings in practice is important rather than generalisability.	Descriptive account of what is happening and/or what has been observed. Statistically or thematically informed. Generalisable to large populations but may not be knowledge that is easily transferrable to practical situations.

APPENDIX 12 – SEMI-STRUCTURED INTERVIEW SCHEDULE OF PROMPTS

Participant ID: _______ Date: ______________ Gender: Male Female

Age: _________ Year of Programme: 1 2 3 Field: MH Adult

Ethnic group:

Topics for discussion:

Understanding of professional accountability

Accountability and Facebook, professional guidance, professional code. Personal or professional?

Implications? Patients searching/adding?

Use of Facebook: when, how, why, privacy settings, management of information shared, types of use, context of 'friends'

Who is acceptable/not acceptable to be added as a friend? 'Rules' for management

Acceptable/non-acceptable behaviours

Professional versus acceptable behaviours. Are they the same? Why?

Observed behaviours: friends/family, public, work. Online versus offline persona

Log into Facebook and consider privacy and security settings & discuss awareness

a. Who can see my stuff? Future posts all posts limit old posts
b. Who can contact me?
c. Who can look me up? Email phone search engine
d. Who can post on my timeline?
e. Review posts
f. Who can see things on my timeline?
g. Tags
h. Restrictions & blocking

Review previous activity and discuss any posts, wall information, feelings about posts, what this may mean for accountability

Open wall/activity log

Discuss types of activity, friend requests, shared posts, blocked/hidden posts, photo's & content of photos. Shared with 'public'

Timeline prior to nursing. Explore possible changes in perceptions, influencers on posts, 'regrets', conflicts, decisions Download public profile data (with consent)

APPENDIX 13 – FOCUS GROUP INCLUSION, EXCLUSION CRITERIA

Inclusion criteria

- Registered professional with the Nursing and Midwifery Council currently employed by the University of Derby to deliver pre-registration
- Willing to provide informed consent

Exclusion criteria

- Members of staff who deliver post-registration programmes only

Focus groups: registered professionals

Inclusion criteria

- A nurse, midwife, health visitor or similar registered with the Nursing and Midwifery Council
- Willing to provide informed consent

Exclusion criteria

- Individuals who are registered allied health professionals e.g. pharmacists, occupational therapists, radiographers

APPENDIX 14 – FOCUS GROUP SCHEDULE OF PROMPTS

Topics for discussion:

Understanding of professional accountability/how students know?

Accountability and Facebook, professional guidance, professional code. Personal or professional? How known?

Implications? Patients searching/adding? Publicly viewable information

Use of Facebook: when, how, why, privacy settings, management of information shared, types of use, context of 'friends'

Who is acceptable/not acceptable to be added as a friend? 'Rules' for management

Any difficult/emotional responses or experiences with Facebook? Posts which you removed or regretted? Why? What led to this?

Acceptable/non-acceptable behaviours/appropriate/not – is it clear? How, why, where?

Professional versus acceptable behaviours. Are they the same? Why?

Observed behaviours: friends/family, public, work/professional or unprofessional/student/colleagues – anything unprofessional/unacceptable – why do you know? When would you take action? Different result online/in real world/practice?

Online versus offline persona

Professional 'values'/profession deemed acceptable/not?

Is it just 'normal'? Not 'normal' if you don't use Facebook.

APPENDIX 15 – ETHICAL APPROVAL

HLS FREC Ref: 1322

17th March 2014

Gemma Sinead Ryan
DHSci Candidate

Dear Gemma,

Re: Ethics application – Exploring the nature of online social networks and impact on development of professional accountability in pre-registration nursing students? (Ref: 1322)

I am writing regarding your application for ethical approval for a research project titled to the above project. This project has been reviewed in accordance with the Operational Procedures for De Montfort University Faculty of Health and Life Sciences Research Ethics Committee. These procedures are available from the Faculty Research and Commercial Office upon your request.

I am pleased to inform you that ethical approval has been granted by
Chair's Action for your application. This will be reported at the next Faculty Research Committee, which is being held on 27th March 2014.

Should there be any amendments to the research methods or persons involved with this project you must notify the Chair of the Faculty Research Ethics Committee immediately in writing. Serious or adverse events related to the conduct of the study need to be reported immediately to your Supervisor and the Chair of this Committee.

The Faculty Research Ethics Committee should be notified by e-mail to hlsfro@dmu.ac.uk when your research project has been completed.

Yours sincerely,

M. Grootveld

Professor Martin Grootveld
Chair
Faculty Research Ethics Committee
Faculty of Health & Life Sciences
De Montfort University

Email: hlsfro@dmu.ac.uk
Web: http://www.dmu.ac.uk/research/ethics-and-governance/faculty-specific-procedures/health-and-life-sciences-ethics-procedures.aspx

Research & Commercial Development Office, Faculty of Health and Life Sciences
1.25 Edith Murphy House, The Gateway, Leicester LE1 9BH. **T:** (0116) 257 7765 **E:** hlsrcogeneralenquiries@dmu.ac.uk

Approval processes

Ethical approval was sought through DeMontfort University Health & Life Sciences Ethics committee and the University of Derby School of Health research ethics committee. This appendix outlines some of the main considerations.

Semi-structured Interviews & Focus Groups

Informed consent and access

All participants are over the age of 18 [the sample population does not currently consist of students under the age of 18]. A participant information sheet will be provided and individuals will be provided with the opportunity to ask any questions they wish prior to consent. Informed consent will be re-confirmed prior to interview as there may be up to a month between initial consent and a mutually acceptable time to meet.

All participants will be informed of their right to withdraw, both in the participant information sheet (PIS) and verbally. This will not affect their education or programme in any way and they will not be required to give a reason. Where a participant withdraws consent during the research process their data will not be retained. This would be disposed of immediately by deleting digital files and shredding of field notes.

Data will be disposed of through the ‘confidential waste disposal’ system in University of Derby.

Confidentiality and anonymity

All data collected will be stored securely, under lock and key or electronically through encrypted hard drive or password-protected files in accordance with University of Derby. The PI will be the only person who is able to access this documentation. Trust computers have encrypted login access and files will also be password protected and kept on a separate hard drive.

Participant names and contact details will not be stored with the data collection forms and not be held electronically for the purpose of the study. They will be linked to data collected through ‘unique study number’ only. Names and addresses will remain on the electronic study record database.

During the project, no personal data will be recorded. Participants private or restricted Facebook profile wall, discussion forum or friends will not be recorded or analysed in any way.

This part of the semi-structured interviews is simply examining the type of information shared in the profile details section and relevant privacy settings only.

No participant will be identifiable as part of this process. Names and personal details will not be shared as part of the research study. This will mean that the person transcribing the data will not be able to identify the participant from discussions. All data will be kept in accordance with Data Protection Act (1998) and will only be accessible to the researcher.

Digitally recorded data

Digitally recorded data will be deleted from the digital recorder following transcription. Participants will not be identifiable from this data. Once consented to the research they will be referred to by their unique participant number allocated during the recruitment process. The digitally recorded data will be transferred to a hard drive, secure server within the University of Derby [encrypted file]; along with this electronic portable document files [pdf] of the raw transcribed data will be stored in this manner.

The digitally recorded data will be transcribed by an experienced individual, employed within the University of Derby. They will not be able to identify the participant from this data.

Data will be retained for 5 years from project end in concurrence with DMU policy.

Transcriptions

Hard copies of transcriptions will only be accessible to the principal investigator [PI] and academic supervisors within DeMontfort University. The PI will carry out the analysis of the data. Where required and appropriate the data may be shared with the academic supervisor. Transcribed data will be stored within the parameters of the Data Protection Act (1998) on site, at the University of Derby, accessible only to the PI.

Research Documentation & Participant Information

Research documentation such as completed consent forms, EOIs, screening logs, enrolment logs, risk assessments and other associated documentation in the investigators research file will be stored in a separate [locked] cabinet to that of the data. This too will be kept within accordance to the Data Protection Act (1998) and only be accessible to the PI.

All research documentation and data will be stored for 5 years from the end date of the project in accordance with DMU policy. They will be archived on site at University of Derby in accordance with the University research policy and will only be accessed by the principal investigator for the purposes of this research project.

Protection of participants

All interviews will be conducted on the University of Derby campuses. University of Derby policies and procedures will therefore be followed throughout the research process. When interviews are being carried out there will be a clearly identified appointment, detailing time, location and purpose in the PIs Outlook Calendar and be made accessible to their line manager and an appropriate person also on-site [personal safety].

This project is considered to be low risk to participants and the PI. Any Adverse Events (AEs) will be considered and acted upon within 7 days of the PI becoming aware. Serious Adverse Events (SAEs) will be responded to within 48 hours of the PI becoming aware. Where appropriate the personal tutor, stage lead or programme lead relating to the particular participant will be informed and involved in the management of such an event. The academic supervisor for the PI may also be consulted. Where the research process identifies areas where the participant may be exposed to a previously unknown safety, security or privacy risk relevant advice and support will be given to address this.

Participants are unlikely to become distressed as part of the discussions within this research. However, there are sections of the interview that have low risk of causing emotional distress as a result of not knowing what may be accessible online. If this does occur, they will be asked if they wish to stop the research process. There are several actions that may be taken as a result of distress during the research process:

- The recording and process is stopped
- Students may be referred to the on-site Student Well-being & counselling service
- Students may be referred to their on-site personal tutor or vice versa for a follow up meeting
- The PI may refer the student to the University of Derby learning technology team learningtechs@derby.ac.uk for advice and support relating to privacy and security changes they may wish to make in line with University of Derby Policy, NMC and RCN guidance [copies of these documents will also be made available for students to take away]

Individual personal profile posts, comments and discussions will not be viewed during this process. If any professional conduct issues arise as a result of what is observed or discussed during the research process, referral and discussion with the participant's personal tutor will determine appropriate course of action. The student will be informed of any referral and the PIS

will clearly state that they may be instances where this action will be required e.g. disclosure of criminal activity.

Secrets

Given the nature of this research and its focus on professional accountability I have considered the guidance documents published by University of Derby and the NMC (2012; 2015) on the appropriate use of social media. A standard operating procedure associated with potential fitness to practice issues has been developed for use in this research study. This details the procedure to be taken if I observe or a participant discloses behaviour or actions that would breach organizational or professional policy. In the participant information sheet, on the informed consent form and verbally prior to data collection I will inform the participant of the need to report behaviours and actions that may be deemed to be unprofessional or a breach of University policy. They will agree to this by initialling and signing the informed consent form and will be given the opportunity to view the standard operating procedure for reporting unprofessional behaviour if they wish to.

Observation

Considerations for conducting observation in the online environment

There has been varied ethical debate on the observation of participants in the online environment, particularly for publicly accessible data. Gatson (2011) and Gatson & Zweerink (2004) outline the boundless nature of online observation with respect to whether the researcher is passive, deceptive or simply disguised. This is of particular relevance when discussing the observation of publicly accessible information, such as Facebook group pages to be observed in this study. It is further argued that as a researcher I am already ‘in’ the community of study, already observing, reading, ‘lurking’ and participating either active or passively just by being a member of Facebook and engaging in Facebook activity (Gatson, 2011; Busher & James, 2007; Turkle, 1995). I would also contest that open groups or groups open to membership from all are publicly accessible and participants engage with it on the understanding that their comments are open to a national or even international community. The challenge of deciding whether observing these forums without disclosure is appropriate, deceptive or simply disguised.

The British Psychological Society (2013) discuss the notion of publicly available information and that observation in the public domain need not require ethical approval as long as participants are not identifiable. Furthermore, Bryman (2008) presents a case where a

researcher sought consent prior to observing public forums and this limited the responses from participants. This researcher then returned to an alternative forum and conducted covert observation; obtaining more rich and realistic insights. Hence, being completely overt about your observations as a researcher could well impact on the dynamic and activity within a group.

The practicalities of obtaining consent from many hundreds of Facebook users is unrealistic, particularly as the observations I plan to undertake are 1) in the public domain and 2) will not identify individuals, obtain personal information (even if it is shared publicly) nor use direct quotations or verbatim comments. For this part of the study I am more interested in the dynamics and topics of discussion rather than an individual's personal data per se. Hence, the risk of harm is minimal. Gatson (2011) argues that participants should be informed that they are being observed. When presented with both sides of the debate, and on further consideration of the Facebook (2015) security and privacy policy I suggest that my approach is more 'disguised' than 'deceptive' (Gatson, 2011). I argue that observation of publicly accessible pages in the online environment is different [ethically] to observing public behaviours in the physical world. Some would argue that this is not the case. However, I would argue that participants can be far less 'identifiable' online, particularly in this study where names and personal information is not the phenomena of interest; observations are to be used to explore and clarify topics and themes and not 'quote' individual participants. I will not be engaging in discussion but merely observing topics of discussion. Hence, I would agree with Fine (1993) that the public nature of Facebook groups and the associated digital footprint forces us to redefine the parameters and ethics of ethnographic observation based on the time, context and focus of the observation.

Reimbursement for participation

Participants will be offered a £15 amazon e-voucher for their time spent contributing to the research. This will be provided to the participants once data collection is completed. This is not intended to persuade individuals to take part but to acknowledge the time spent participating, given that it is likely to mean an additional visit into campus and also over an hour of their time (involve, 2013).

APPENDIX 16 – DISSEMINATION STRATEGY

Method/activity	Suggested timeline
Presentation at professional academic conferences	
o *RCN International research conference: Critical realist analysis & final frameworks*	*March 2017*
o *RCN Education forum: final framework impacting on pre-registration student nurses*	*April 2017*
Book proposal:	February
o Making the best of social media for nursing and the nursing profession	2018-2019
Publication in academic journals:	
o *International perspectives on social media guidance for nurses: a content analysis*	*December 2016*
o From theory to practice: a method of critical realist ethnographic data analysis	October 2017
o Socialisation, professional socialisation and online socialisation: how student nurses become professionally accountable	October 2017
o E-professionalism on social media: defining the boundaries with a critical realist assessment framework	December 2017
o *Applying and assessing scientific rigour in critical realist ethnography: a practical example*	*Under review*
Application in practice:	
o Use of my published literature and findings in curriculum design and content delivery for pre-and post-registration nursing programmes	Ongoing
o Advising and informing organisational policy on use of social media and assessment of incidents	Ongoing
o Supporting students to complete assessments and reflect on their online activity	Ongoing
o Supporting peers and colleagues to complete assessments but also implement the frameworks from my study	Ongoing
o Supervision of under graduate, post graduate and doctoral students	Ongoing
o Workshops and presentation at internal professional development days	Ongoing
o Clinical practice and mentoring student nurses	
Summary (lay) report:	
o Produce a short summary of my findings for dissemination through professional groups on social media including those representing student nurses, educational institutions, professional bodies and healthcare organisations such as BUPA, NHS heads/assistant heads of nursing	Summer 2017 onwards
Social media (public, professionals, students & international):	
o Share summary report through my own profiles: Facebook; LinkedIn; Twitter; Tweet to mass media	Summer 2017 onwards
o Share academic publications and links: Research gate; Facebook; LinkedIn; Twitter; University research archives	
o International student and professional group pages/Twitter profiles	
Personal networks:	
o Universities in Australia, across the UK and in Ireland	Summer 2017 onwards
o BUPA	
o NHS organisations in the East Midlands including R&D departments	
o Academic health science network (AHSN)	
o Academic colleagues in health and social care and medical networks	
o Lead by example: Apply the approaches to my own social media profiles	

N.B. items in italics have been submitted

APPENDIX 17 – SEMI-STRUCTURED INTERVIEW PARTICIPANT CHARACTERISTICS

Participant	Age (years)	Gender	Year of study	Field of study	Ethnic group	Site [56]	Stated level of public profile privacy	Observed level of public profile privacy
01	32	Female	3	Adult	White British	2	Private. Existence on Facebook is visible but other information is not	Partly private: Profile photos, Facebook banner photos & comments. Professional workplace (incorrect). Friends
02	27	Female	2	Adult	White British	2	Private. Existence on Facebook is visible but other information is not	Partly private: Profile photos, Facebook banner photos & comments. Professional workplace; some wall pictures and comments. Friends
03	21	Female	2	Adult	White British	1	Private. Searchable but with only a profile picture	Private. Searchable but with a profile picture only. Middle name used so that they were not at the top of the search results.
04	27	Female	3	Adult	White British	1	Private. Searchable but with only a profile picture	Private. Searchable but with a profile picture only.
05	24	Male	3	Adult	White British	1	Private. Searchable but with a profile picture only.	Fully public. Incorrect/old workplace (health related).
06	38	Female	1	Adult	White British	1	Private. Searchable but with a profile picture only.	Partly private: Profile photos, Facebook banner photos & comments. Professional workplace; some wall pictures and comments. Friends
07	39	Female	2	Mental Health	White British	1	Private but profile pictures are visible. Shares 'student mental health nurse'. Marital status, location.	Partly private. Profile pictures, banner pictures and comments shared. Shares 'student mental health nurse'. Marital status, location. Friends are shared.
08	39	Female	3	Adult	White British	2	Private. Searchable but with a profile picture only.	Partly private: Profile photos, Facebook banner photos & comments. Professional workplace; some wall pictures and comments. Friends. These were posted before privacy settings were changed.

[56] Site 1 – Main university campus; site 2 – North of the region, satellite/2nd site.

09	21	Female	3	Mental Health	White British	1	Private. Searchable but with a profile picture only.	Partly private. Location. Profile pictures, banner pictures, comments. Does not share friends. Some old status posts prior to applying new privacy settings.
10	20	Female	3	Adult	White British	1	Private. Searchable but with a profile picture only. Possibly previous profile pictures.	Partly private. Location. Profile pictures, banner pictures, comments. Shared photos about NHS pay. Does not share friends. Some older status posts prior to applying new privacy settings.
11	29	Female	1	Adult	White British	2	Private. Searchable but with a profile picture only. Possibly previous profile pictures.	Partly private. Hospital as workplace and University of study. Friends. Profile pictures and comments. Some personal pictures. Education history, work history. Life events e.g. in a relationship with…
12	46	Male	1	Adult	White British	2	Private. Searchable but with a profile picture only. Possibly previous profile pictures.	Partly private. University of study. Posts and comments. Likes and shares.
13	25	Male	2	Adult	White British	1	Private. Searchable but with a profile picture only.	Not searchable. Not visible
14	42	Male	2	Mental Health	Black African	1	Private. Searchable but with a profile picture only. Possibly previous profile pictures.	Private. Searchable but with a profile picture only. Possibly previous profile pictures.
15	20	Female	2	Adult	Mixed Caribbean	1	Private. Searchable but with a profile picture only.	Partly private. Location. University of study. Workplace (hospital). Profile pictures, banner pictures, comments. Does not share friends. Some old status posts prior to applying new privacy settings.
16	40	Male	2	Mental Health	Black British	1	Private. Searchable but with a profile picture only (an old profile picture from childhood) with African name. Then a separate profile for use with the cohort.	Private. Searchable but with a profile picture only (an old profile picture from childhood) with African name. Then a separate profile for use with the cohort. Some personal pictures and comments (not in English) on the personal profile. Also uses a middle name to make it difficult to search.

APPENDIX 18 – FOCUS GROUP PARTICIPANT CHARACTERISTICS

Table 1 - Registered, practicing staff focus group characteristics

	Gender	Areas of specialty	Length of time registered
PSI	**F**	Mental health Learning disability	3 years
PSII	**F**	Adult	26 years
PSIII	**F**	Mental Health Learning disability	4 years
PSIV	**F**	Adult	22 years

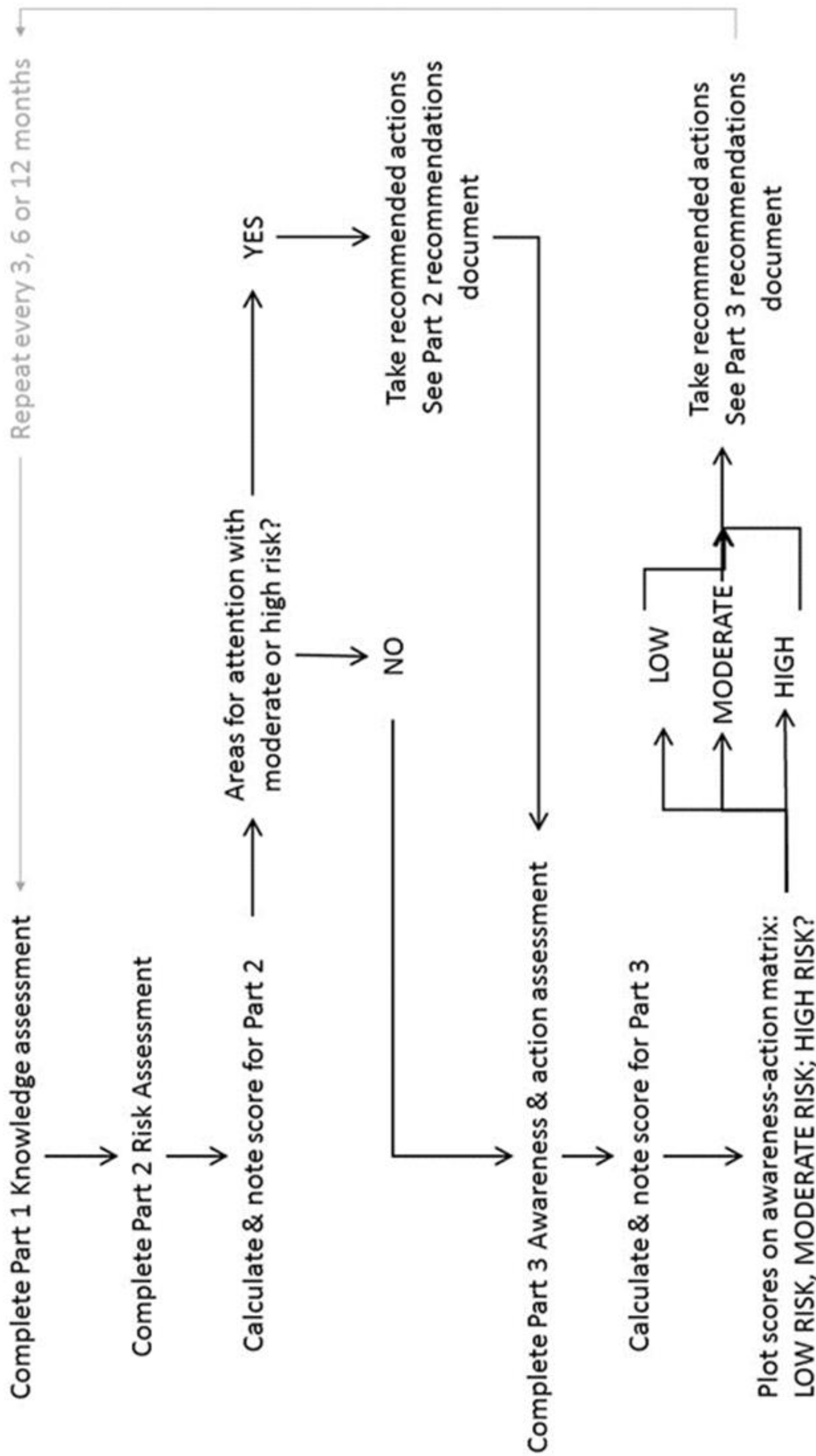
Table 2 - Academic focus group characteristics

	Gender	Areas of specialty	Length of time registered
ASI	**F**	Adult Health visiting	31 years
ASII	**F**	Adult Health visiting	27 years
ASIII	**F**	Mental health	20 years
ASIV	**M**	Adult nursing	15 years

Appendix 19 – Components found in the data

Component	Coding themes
Entities Things, people, places that are involved in 'reality'	Laws, guidance, regulations & standards; policies & procedures; organisations; employers & workplaces; NHS; NMC; academic staff; family; friends; public; patients; peers; Facebook friends; Facebook friends of friends; Facebook acquaintances; university; placement; nurses; mentors; Facebook; online (virtual); offline (physical); politicians; Facebook groups; Facebook functions/features; other professional groups/professions
Tendencies Things that characterise 'entities'	Personal values, morals, ethics; personal attributes; age; maturity; professional values, morals, ethic; being current and up to date; student nurse concept of identity; concept of nurse identity; levels of accountability; levels of awareness; willingness and motivation to learn; awareness of concepts; personal awareness; being a parent; emotions; willingness to share positive experiences; confusion; perceptions of Facebook; 'me and them'; 'them and us'; confusion; conflict of opinion and perception; political affiliation; spiritual beliefs; professional & personal pride; belonging & acceptance; knowledge and understanding of accountability
Events Things that happen to entities	Positive and negative experiences; process of training; lectures; education; placement experiences; repeated exposure to concepts; events in the media; events in politics; events on Facebook; being tagged in photos or comments; being given an NMC PIN; having a 'bad day' or negative event; positive events; political changes; changes in the NHS; changes in education; conflict in political opinion; having patient contact through social media
Actions The behaviours and actions of entities	Taking care of physical appearance; challenging practice; reporting concerns or practice; performance at work/placement; appropriate actions; inappropriate actions; professional actions; unprofessional actions; removing or deleting friends; adding friends; making work related comments; frequency of use of Facebook; sharing photo's, videos, comments; sharing social action events; private messaging; changing security/privacy settings; deleting content; de-tagging content;
Outcomes Things that happen and that can be observed	Being professional; displaying accountability; consequences to patients; consequences to self; consequences to others; consequences to profession; wider consequences; disconnect between online-offline; online-offline complementary; positive consequences; negative consequences; unintended consequences to self and others; realising levels of self-awareness, skill & knowledge; being an outsider;
Morphostatic Structures Things that enable a situation to remain the same or that creates continuation of tendencies and/or actions	Bonding social capital; Religion; limited or lack of experience; personal awareness; dissonance between awareness and behaviours; need and motivation for belonging; compassion;
Morphogenic Structures Things that enable change or that create dis-	Passage of time; experience; age; stasis of information on Facebook; social capital (linking, bridging, bonding); context of the university environment; reflection; Facebook security and privacy; political events; Facebook functions/features

APPENDIX 20 – FRAMEWORK III: AWARENESS TO ACTION ASSESSMENT PROCESS



Part 1 - Initial knowledge (awareness) assessment: Awareness into Action assessment framework (proposed v1.0)

	Have you ever or do you have an online profile that others may be able to view e.g. Facebook profile; LinkedIn; Twitter account?	Yes	No	Don’t Know				
	Do you review your privacy settings from a *public perspective* at least once monthly?	Yes	No	Don’t Know				
	Do you review content posted or shared by other people before sharing or accepting it onto your profile?	Yes	No	Don’t Know				
	Have you read the privacy and security policy on the site that you use most frequently?	Yes	No	Don’t Know				
	Is your profile searchable on google?	Yes	No	Don’t Know				
	Personal							
	Do you use your real name on this profile?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you have a profile or outwardly facing picture from which you are identifiable? (i.e. the picture is of you)	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share your birthday?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share your home location/location?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share any educational information? (e.g. student nurse)	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share any workplace or employment information?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share your relationship status?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share your sexual orientation?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share your friend list?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share your phone number?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share your email address?	Public	All friends	Some friends	Custom	No-one	Not sure	

	Do you share your family relationships?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Have you got an 'about me' and/or list of interests/activities?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you share previous profile pictures?	Public	All friends	Some friends	Custom	No-one	Not sure	
	Do you have friends/followers/or people in your network who you would not speak to in person?	Yes	No	Don't Know				
	Who do you have in your network?	Family	Close Friends	Friends of friends/ family	Friends	Peers/ Work Colleagues	Strangers/ people I have not met	Professional networks
	Do you review your friends/following/network at least once monthly?	Yes	No	Don't Know				
	Do you remove friends/followers/people in your network?	Yes	No	Don't Know				
	Do you feel 'obliged' or 'required' to accept friend requests?	Yes	No	Don't know / sometimes				

Professional (public)

Please answer this section in relation to your publicly accessible information/public profile

	Are you identifiable as a healthcare professional/trainee on your public profile?	Yes	No	Don't Know				
	Is your workplace/place of study shared?	Yes	No	Don't Know				
	Do you share any photo's pictures or content that identifies you as a healthcare professional?	Yes	No	Don't Know				
	Do you share any content that may identify your political beliefs or opinions?	Yes	No	Don't Know				
	Do you share any content that may identify your religious beliefs or opinions?	Yes	No	Don't Know				
	Do you share any content that may identify your opinions on sexual orientation?	Yes	No	Don't Know				
	Do you share any content that may identify your opinions on disabilities, diseases or disorders? (e.g. mental health)	Yes	No	Don't Know				
	Do you share the groups and pages that you follow?	Yes	No	Don't Know				
	Do any of these groups and pages share opinions on political, religious or other views mentioned above?	Yes	No	Don't Know				

	Is there content that could be viewed as illegal or criminal behaviour?	Yes	No	Don’t Know				
	Is there content that shows evidence of drinking alcohol?	Yes	No	Don’t Know				
	Is there content that shows evidence of smoking tobacco?	Yes	No	Don’t Know				
	Is there evidence of offensive language?	Yes	No	Don’t Know				
	Is there evidence of nudity, promiscuity or sexual references?	Yes	No	Don’t Know				
	Is there any content that expresses your opinions or experiences in your workplace?	Yes	No	Don’t Know				
				Regulatory				
	Can you name and source the guidance for use of social media/digital profiles for your profession?	Yes	No	Don’t Know				
	Can you name and source the guidance/policy for your employer/workplace?	Yes	No	Don’t Know				

Part 2 Awareness assessment: Awareness into Action assessment framework (v1.0)

Review the online profile and compare the original with the actual observed profiles

Score 0 = part 1 and part 3 answers the same; 1 = part 1 answer was don't know/unsure; 2 = part 1 and part 3 answers were different

Score

Is your profile searchable on google?	Yes	No	Don't Know			
Personal	***Public***	***All friends***	***Some friends***	***Custom***	***No-one***	***Not sure***
Do you use your real name on this profile?						
Do you have a profile or outwardly facing picture from which you are identifiable? (i.e. the picture is of you)						
Do you share your birthday?						
Do you share your home location/location?						
Do you share any educational information? (e.g. student nurse)						
Do you share any workplace or employment information?						
Do you share your relationship status?						
Do you share your sexual orientation?						
Do you share your friend list?						

Do you share your phone number?							
Do you share your email address?							
Do you share your family relationships?							
Have you got an ‘about me’ and/or list of interests/activities?							
Do you share previous profile pictures?							
Do you have friends/followers/or people in your network who you would not speak to in person?	Yes	No	Don’t Know				
Who do you have in your network?	Family	Close Friends	Friends of friends/ family	Friends	Peers/ Work Colleagues	Strangers/ people I have not met	Professional networks
Do you review your friends/following/network at least once monthly?	Yes	No	Don’t Know				
Do you remove friends/followers/people in your network based on your current/changing circumstances?	Yes	No	Don’t Know				
PERSONAL SCORE							
Professional (public) ***Please answer this section in relation to your publicly accessible information/public profile***	***Yes***	***No***	***Don’t Know***				
Are you identifiable as a healthcare professional/trainee on your public profile?							
Is your workplace/place of study shared?							

Do you share any photo's pictures or content that identifies you as a healthcare professional?			
Do you share any content that may identify your political beliefs or opinions?			
Do you share any content that may identify your religious beliefs or opinions?			
Do you share any content that may identify your opinions on sexual orientation?			
Do you share any content that may identify your opinions on disabilities, diseases or disorders? (e.g. mental health)			
Do you share the groups and pages that you follow?			
Do any of these groups and pages share opinions on political, religious or other views mentioned above?			
Is there content that could be viewed as illegal or criminal behaviour?			
Is there content that shows evidence of drinking alcohol?			
Is there content that shows evidence of smoking tobacco?			
Is there evidence of offensive language?			
Is there evidence of sexual references, promiscuity or nudity?			

Is there any content that expresses your opinions or experiences in your workplace?			
PROFESSIONAL SCORE			
Regulatory	***Yes***	***No***	***Don't Know***
Can you name and source the guidance for use of social media/digital profiles for your profession?			
Can you name and source the guidance/policy for your employer/workplace?			

Awareness score TOTAL:

Part 3 - Risk assessment: Awareness into Action assessment framework (v1.0)

Score: 0 for each green response; 1 for amber; 2 for red

Question						
Have you ever or do you have an online profile that others may be able to view e.g. Facebook profile; LinkedIn; Twitter account?	Yes	No	Don't Know			
Do you review your privacy settings from a *public perspective* at least once monthly?	Yes	No	Don't Know			
Do you review content posted or shared by other people before sharing or accepting it onto your profile?	Yes	No	Don't Know			
Have you read the privacy and security policy on the site that you use most frequently?	Yes	No	Don't Know			
Is your profile searchable on google?	Yes	No	Don't Know			
Personal						
Do you use your real name on this profile?	Public	All friends	Some friends	Custom	No-one	Not sure
Do you have a profile or outwardly facing picture from which you are identifiable? (i.e. the picture is of you)	Public	All friends	Some friends	Custom	No-one	Not sure
Do you share your birthday?	Public	All friends	Some friends	Custom	No-one	Not sure
Do you share your home location/location?	Public	All friends	Some friends	Custom	No-one	Not sure
Do you share any educational information? (e.g. student nurse)	Public	All friends	Some friends	Custom	No-one	Not sure

Do you share any workplace or employment information?	Public	All friends	Some friends	Custom	No-one	Not sure	
Do you share your relationship status?	Public	All friends	Some friends	Custom	No-one	Not sure	
Do you share your sexual orientation?	Public	All friends	Some friends	Custom	No-one	Not sure	
Do you share your friend list?	Public	All friends	Some friends	Custom	No-one	Not sure	
Do you share your phone number?	Public	All friends	Some friends	Custom	No-one	Not sure	
Do you share your email address?	Public	All friends	Some friends	Custom	No-one	Not sure	
Do you share your family relationships?	Public	All friends	Some friends	Custom	No-one	Not sure	
Have you got an 'about me' and/or list of interests/activities?	Public	All friends	Some friends	Custom	No-one	Not sure	
Do you share previous profile pictures?	Public	All friends	Some friends	Custom	No-one	Not sure	
Do you have friends/followers/or people in your network who you would not speak to in person?	Yes	No	Don't Know				
Who do you have in your network?	Family	Close Friends	Friends of friends/ family	Friends	Peers/ Work Colleagues	Strangers/ people I have not met	Professional networks
Do you review your friends/following/network at least once monthly?	Yes	No	Don't Know				
Do you remove friends/followers/people in your network?	Yes	No	Don't Know				
Do you feel 'obliged' or 'required' to accept friend requests?	Yes	No	Don't know / sometimes				

Professional (public)

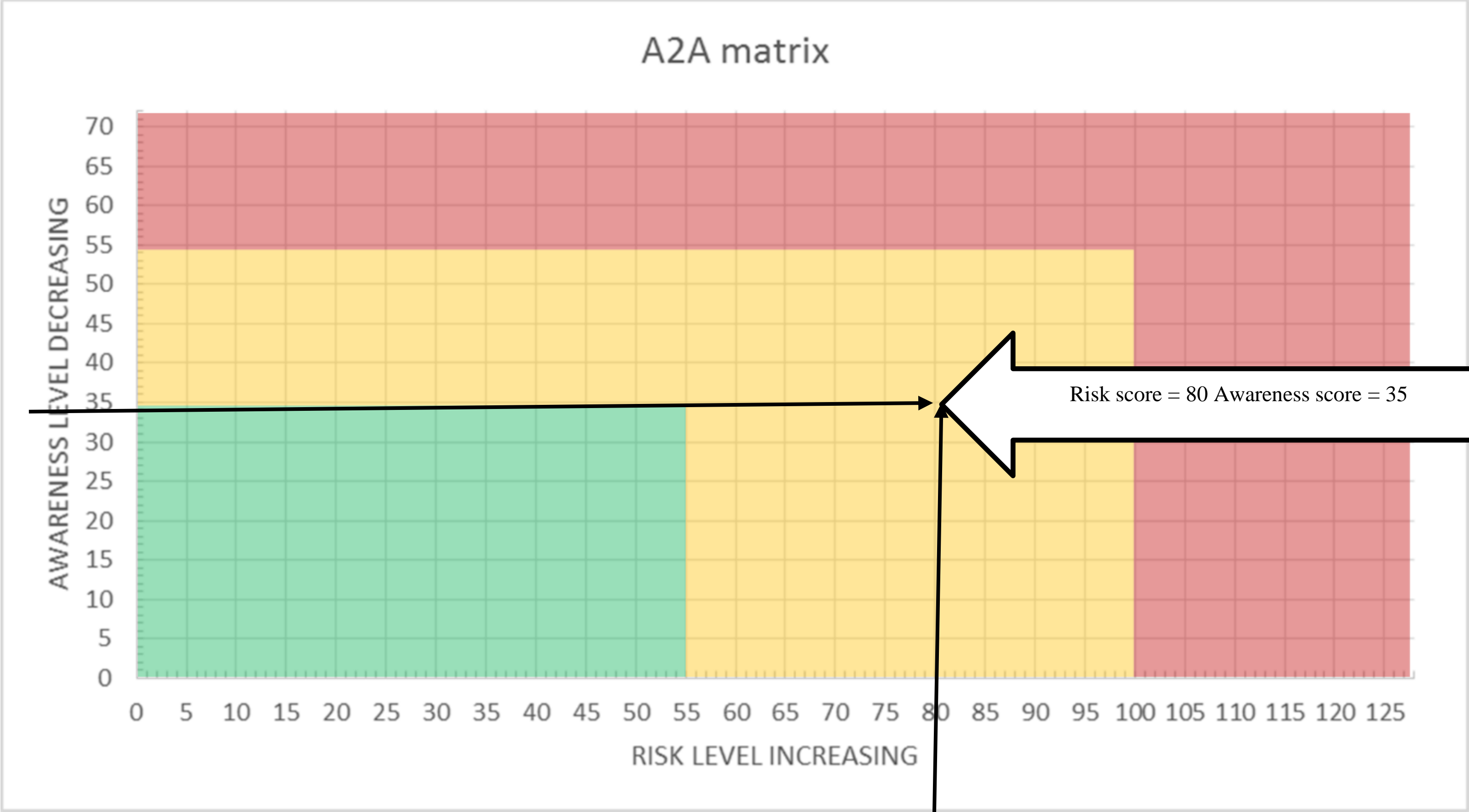
Please answer this section in relation to your publicly accessible information			
Are you identifiable as a healthcare professional/trainee on your public profile?	Yes	No	Don't Know
Is your workplace/place of study shared?	Yes	No	Don't Know
Do you share any photo's pictures or content that identifies you as a healthcare professional?	Yes	No	Don't Know
Do you share any content that may identify your political beliefs or opinions?	Yes	No	Don't Know
Do you share any content that may identify your religious beliefs or opinions?	Yes	No	Don't Know
Do you share any content that may identify your opinions on sexual orientation?	Yes	No	Don't Know
Do you share any content that may identify your opinions on disabilities, diseases or disorders? (e.g. mental health)	Yes	No	Don't Know
Do you share the groups and pages that you follow?	Yes	No	Don't Know
Do any of these groups and pages share opinions on political, religious or other views mentioned above?	Yes	No	Don't Know
Is there content that could be viewed as illegal or criminal behaviour?	Yes	No	Don't Know
Is there content that shows evidence of drinking alcohol?	Yes	No	Don't Know

Is there content that shows evidence of smoking tobacco?	Yes	No	Don’t Know
Is there evidence of offensive language?	Yes	No	Don’t Know
Is there evidence of	Yes	No	Don’t Know
Is there any content that expresses your opinions or experiences in your workplace?	Yes	No	Don’t Know
Regulatory			
Can you name and source the guidance for use of social media/digital profiles for your profession?	Yes	No	Don’t Know
Can you name and source the guidance/policy for your employer/workplace?	Yes	No	Don’t Know

Risk assessment score TOTAL:

(minimum 0; maximum 128)

Plot the risk awareness score (x-axis) against the awareness assessment score (y-axis) like the example shown. This would indicate a moderate overall risk of unprofessional behaviours and there are actions that can be taken to reduce this risk using the recommendations document.



Part 2 & 3: Awareness into Action assessment recommendations document (v1.0)

Score

Is your profile searchable on google?	Amend settings	No action	Check and amend if required			
Personal	***Public***	***All friends***	***Some friends***	***Custom***	***No-one***	***Not sure***
Do you use your real name on this profile?	Consider use of a middle name or other given name					Check
Do you have a profile or outwardly facing picture from which you are identifiable? (i.e. the picture is of you)	Consider public acceptability and professional nature of the picture	Consider social acceptability of the picture	Consider social acceptability of the picture			Check and then refer to respective group recommendations
Do you share your birthday?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary			Check and then refer to respective group recommendations
Do you share your home location/location?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary			Check and then refer to respective group recommendations
Do you share any educational information? (e.g. student nurse)	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary			Check and then refer to respective group recommendations
Do you share any workplace or employment information?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary			Check and then refer to respective group recommendations
Do you share your relationship status?	Remove this from your public profile	Consider who your 'friends' are and	Consider who your 'friends' are and			Check and then refer to respective

		whether this is necessary	whether this is necessary		group recommendations
Do you share your sexual orientation?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary		Check and then refer to respective group recommendations
Do you share your friend list?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary		Check and then refer to respective group recommendations
Do you share your phone number?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary		Check and then refer to respective group recommendations
Do you share your email address?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary		Check and then refer to respective group recommendations
Do you share your family relationships?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary		Check and then refer to respective group recommendations
Have you got an 'about me' and/or list of interests/activities?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary		Check and then refer to respective group recommendations
Do you share previous profile pictures?	Remove this from your public profile	Consider who your 'friends' are and whether this is necessary	Consider who your 'friends' are and whether this is necessary		Check and then refer to respective group recommendations
Do you have friends/followers/or people in your network who you would not speak to in person?	Consider removing them or restricting your posts to a 'custom' group of	No	Review friends list Consider restricting your posts to a 'custom' group of		

	close friends and family		close friends and family					
Who do you have in your network?	Family Review posts as you make them to ensure they only include family Check profile viewed by different people on different lists every 3 months or after a change of policy	Close Friends Review posts as you make them to ensure they only include family Check profile viewed by different people on different lists every 3 months or after a change of policy Also consider if these people are still close friends or not	Friends of friends/ Family Consider what type of 'friends' they are. Are they people you would speak to if you met them in the street? Consider restricting your posts to close friends and family	Friends Consider what type of 'friends' they are. Are they people you would speak to if you met them in the street? Consider restricting your posts to close friends and family	Peers/ Work Colleagues Consider why this is the case for this platform and either remove these individuals or restrict your posts to a 'custom' group of close friends and family	Strangers/ people I have not met Consider why this is the case and either remove these individuals or restrict your posts to a 'custom' group of close friends and family	Professional networks Consider why this is the case for this platform and either remove these individuals or restrict your posts to a 'custom' group of close friends and family
Do you review your friends/following/network at least once monthly?	Yes Good practice	No This should be done at least 3 monthly to ensure that sharing information is restricted appropriately	Don't Know You should check this and take respective action				
Do you remove friends/followers/people in your network based on your current/changing circumstances?	Yes Good practice	No This should be done at least 3 monthly to ensure that sharing	Don't Know You should check this and take respective action				

		information is restricted appropriately	
Professional (public) Please answer this section in relation to your publicly accessible information	***Yes***	***No***	***Don't Know***
Are you identifiable as a healthcare professional/trainee on your public profile?	Sharing this information is not recommended in Facebook and Twitter but may be shared in professional networks such as LinkedIn	Good practice	You should check this and take respective action
Is your workplace/place of study shared?	Sharing this information is not recommended in Facebook and Twitter but may be shared in professional networks such as LinkedIn	Good practice	You should check this and take respective action
Do you share any photo's pictures or content that identifies you as a healthcare professional?	Sharing this information is not recommended in Facebook and Twitter but may be shared in professional networks such as LinkedIn	Good practice	You should check this and take respective action
Do you share any content that may identify your political beliefs or opinions?	Sharing this information is not recommended in Facebook and Twitter but may be shared in professional networks such as LinkedIn	Good practice	You should check this and take respective action

Do you share any content that may identify your religious beliefs or opinions?	Sharing this information is not recommended in Facebook and Twitter but may be shared in professional networks such as LinkedIn	Good practice	You should check this and take respective action
Do you share any content that may identify your opinions on sexual orientation?	Sharing this information is not recommended in Facebook and Twitter but may be shared in professional networks such as LinkedIn	Good practice	You should check this and take respective action
Do you share any content that may identify your opinions on disabilities, diseases or disorders? (e.g. mental health)	Sharing this information is not recommended Delete this information	Good practice	You should check this and take respective action
Do you share the groups and pages that you follow?	Sharing this information is not recommended Change your settings	Good practice	You should check this and take respective action
Do any of these groups and pages share opinions on political, religious or other views mentioned above?	Sharing this information is not recommended Consider unfollowing the group, person or page or change your sharing settings	Good practice	You should check this and take respective action
Is there content that could be viewed as illegal or criminal behaviour?	This is both unprofessional and unacceptable and should be removed	Good practice	You should check this and take respective action

Is there content that shows evidence of drinking alcohol?	This may be considered unacceptable and unprofessional in some circumstances. You should change your settings to not share this information outside of a custom group of people and ensure that any 'tags' of photos and comments are reviewed by you before sharing on your profile using the security and privacy preferences	Good practice	You should check this and take respective action
Is there content that shows evidence of smoking tobacco?	This may be considered unacceptable and unprofessional in some circumstances. You should change your settings to not share this information outside of a custom group of people and ensure that any 'tags' of photos and comments are reviewed by you before sharing on your profile using the	Good practice	You should check this and take respective action

	security and privacy preferences		
Is there evidence of offensive language?	This may be considered unacceptable and unprofessional in some circumstances. You should change your settings to not share this information outside of a custom group of people and ensure that any ‘tags’ of photos and comments are reviewed by you before sharing on your profile using the security and privacy preferences	Good practice	You should check this and take respective action
Is there evidence of sexual references, promiscuity or nudity?	This may be considered unacceptable and unprofessional. You should change your settings to not share this information outside of a custom group of people and ensure that any ‘tags’ of photos and comments are reviewed by you before sharing on your profile using the	Good practice	You should check this and take respective action

	security and privacy preferences		
Is there any content that expresses your opinions or experiences in your workplace?	This is considered unacceptable and unprofessional. You should change your settings to not share this information outside of a custom group of people and ensure that any ‘tags’ of photos and comments are reviewed by you before sharing on your profile using the security and privacy preferences	Good practice	You should check this and take respective action
Regulatory	***Yes***	***No***	***Don’t Know***
Can you name and source the guidance for use of social media/digital profiles for your profession?	Good practice	You should source this now and read the recommendations	You should source this now and read the recommendations
Can you name and source the guidance/policy for your employer/workplace?	Good practice	You should source this now and read the recommendations	You should source this now and read the recommendations

Action plan

Level of risk/issue /lesson learnt	Action(s) required	By when	Review date	Rationale	Comments

APPENDIX 21 – SUMMARY OF RESEARCH PROCESS