A phenomenological exploration of nursing students' experience of raising a care concern in clinical practice

Thesis submitted in accordance with the requirements
of the University of Chester for the degree of
Professional Doctorate in Health and Social Care

Elizabeth Anne Cooper

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Declaration

The material being presented for examination is my own work and has not been submitted for an award of this or another HEI except in minor particulars which are explicitly noted in the body of the thesis. Where research pertaining to the thesis was undertaken collaboratively, the nature and extent of my individual contribution has been made explicit.

Signed ……..

Elizabeth Anne Cooper

Dated: ……..

Dedication

This thesis would not have been achieved without the support of my family, friends and academic supervisors who have probably experienced the highs and lows of my journey with me.

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Definition of Terms

Term	Description
Advocacy	The act of speaking up to colleagues or peers when concerned with the treatment, care or human rights of a patient (M. Baldwin, 2003; NMC, 2018a)
Approved Academic Institution (AEI)	Organisation which has governance responsibilities for the quality of the professional education of pre-registration nursing students (NMC, 2013a)
Concern	An emotional response characterised by negative feelings
Educator	Staff member who supports the learning and teaching of pre-registration health and social care students within AEI governance and approved programmes – may be in 'the classroom' or in a workplace
Mentor	A nurse who has undertaken the NMC (2008) required preparation to support the learning, teaching and assessment of pre-registration nursing students in a placement
National Health Service (NHS)	A collective name for the range of publicly funded and privately or publicly owned health and social care service providers (DoH, 2011a)
Nursing students	A student undertaking pre-registration nurse education (NMC, 2010, 2018b)
Patient	Person who requires care, implies service user or client
Placement	A workplace which meets the required governance standards for providing a safe and effective learning environment for health or social care pre-registration students (HCPC, 2016a; NMC, 2013a, 2015, 2018c)
Placement providers	Services who care for patients/clients and have met the professional regulatory standards (HCPC, 2016b; NMC, 2013a, 2015a) for an effective, safe learning environment for pre-registration students
Practice educator	Staff member who has undergone additional education for supporting the learning, teaching and assessment of pre-registration nursing students in a placement (GMC, 2016; HCPC, 2016b; NMC, 2008)
Raising a care concern	A personal verbalising of a concern about patient care (GMC, 2018; HCPC, 2016a; NHS Improvement & NHS England, 2016; NMC, 2017a, 2019)
Safeguarding	The act of raising a care concern to an external or internal agency when abuse or neglect of a vulnerable person is suspected or known (NHS England, 2016)
Stakeholders	The public, organisations, practitioners, students and service users who are involved with the education of pre-registration nursing students (NMC, 2010)

Term	Description
Tutor or lecturer	A nurse who supports the learning, teaching and assessment of pre-registration nursing students and whose usual place of work is within the AEI (NMC, 2008, 2010)
Whistleblowing	The act of disclosure of organisational or workplace wrongdoing to either external or internal bodies (Ash, 2016; NHS Improvement & NHS England, 2016)

Abbreviations

Abbreviation	Full Title
AEI	NMC Approved Education Institute e.g. university
CQC	Care Quality Commission
DoH	Department of Health
GMC	General Medical Council
HCPC	Health and Care Professions Council
IPA	Interpretive Phenomenological Analysis
NHS	National Health Service
NMC	Nursing and Midwifery Council
PCaW	Public Concern at Work, now known as Protect (www.pcaw.org.uk)

A phenomenological exploration of pre-registration nursing students' experiences of raising a care concern within clinical practice.

Elizabeth Anne Cooper

Abstract

UK pre-registration healthcare students are expected to raise a care concern about unsafe situations whilst in clinical practice. The UK's NHS is in the midst of a change to an open, honest and transparent culture which responds to a professional's concern about patient care, to improve safety and prevent harm. Central to this change is improving the experience of registered healthcare professionals whose decision to raise a care concern is influenced by the organisational culture; this can create a difficult moral choice. The experience of nursing students who decide to raise a care concern has received little attention, and this study sought to explore this under-researched area.

A literature review was undertaken which identified that the experience of nursing students who had raised a care concern had not been previously examined. To guide this study, Clarke Moustakas' (1994) transcendental phenomenological methodology was used to explore nursing students' lived experience of raising a care concern. Ten nursing students with experience of raising a care concern in clinical practice voluntarily participated in the study. Open interviews conducted between December 2016 and October 2017 were audio recorded and transcribed, exposing individual narratives of raising a care concern in clinical practice. The transcripts were analysed to produce a composite description which summarises nursing students' lived experience, reflecting four themes or essences: 1) patient centred concern; 2) deciding how to act; 3) having emotional strength; and 4) feedback and support. These typify what it is like for nursing students to raise a care concern whilst in clinical practice.

The findings were critically examined and suggest that compassion may motivate nursing students to act when faced with an unsafe situation, seeking to stop patient harm and suffering. Recognising this moral motivation, students described the relevance of emotional strength when dealing with the emotionally complex experience of facing difficult situations, with feedback and support providing comfort plus moral and emotional satisfaction.

This study also explores the implications for professional practice, specifically the impact upon future teaching and learning approaches to facilitate nursing students' ability to detect and act upon unsafe situations; providing listening opportunities to support students in clinical practice; and valuing nursing students who raise a care concern as role models and local clinical leaders. Recommendations include a new national campaign to improve the likelihood of nursing students raising care concerns and updating UK professional guidance.

Chapter 1: Introduction

Raising a care concern has become a significant way that health and social care practitioners contribute to protecting the public, providing safer care and facilitating improvement within the UK's NHS (CQC, 2013a; Darzi, 2008; Dayan, Ward, Gardner, & Kelly, 2018; GMC, 2012; HCPC, 2018; King's Fund, 2017; McSherry & McSherry, 2015; NHS England, 2014; Nuffield Trust, 2015; NMC, 2019a). Since the Francis report (2013), the NHS has had a key strategic imperative to improve its response to concerns about care failings raised by its staff (Francis, 2015; Mannion & Davies, 2019; McSherry & McSherry, 2015; NHS Improvement and NHS England, 2016). Despite the NHS remaining a top ranked world-class service (Schneider, Sarnak, Squires, Shah, & Doty, 2017) with high patient satisfaction, good management of certain long-term conditions and being financially economical (Dayan et al., 2018), published CQC inspections of NHS providers (www.cqc.org.uk) show that organisations find it challenging to consistently meet all the targets associated with good care i.e. leadership, responsiveness, effectiveness and safety, suggesting patient care may still fall short of required standards. Failures in NHS care continue to be highlighted by public inquires and investigations (Bubb, 2014; Francis, 2013; Gosport Independent Panel, 2018; Kirkup, 2015), public disclosure by whistleblowers (Alexander, 2018; British Broadcasting Corporation [BBC], 2010; B. Cooper, 2018; Sawer & Donnelly, 2015), NHS surveys (NHS England, 2018), and internal reporting or speaking up by professionals (Cleary & Doyle, 2016; NHS Improvement, 2018). In the UK, health and social care registered practitioners are required to raise a care concern when patient care is compromised (General Medical Council [GMC], 2012; Health and Care Professions Council [HCPC], 2016a; Nursing and Midwifery Council [NMC], 2019). Within the UK, there is a renewed focus upon professionals and raising of a care concern since the recommendations of the Francis report (Francis, 2013; Hunt, 2016) were published, following a public inquiry into care failings at one NHS Trust which highlighted how improving the NHS response to raised concerns can prevent and protect patients from being harmed and improve patient safety. The focus on improving the NHS culture, through the strategic priorities of the NHS and Professional, Statutory Regulatory Bodies (PSRB) (summarised in diagram 2.2, p.28), has led to a steady increase in reported incidents (table 1.1, p.15), which suggests that raising concerns is contributing to a safer NHS (NHS Improvement, 2018). The current focus upon practitioners and raising of care concerns within the

NHS highlights speaking up and whistleblowing as a key aspect of contemporary professional practice.

Table 1.1: Concern profile: NHS patient incidents and reporting of malpractice/ misconduct of health and social care professionals since 2013

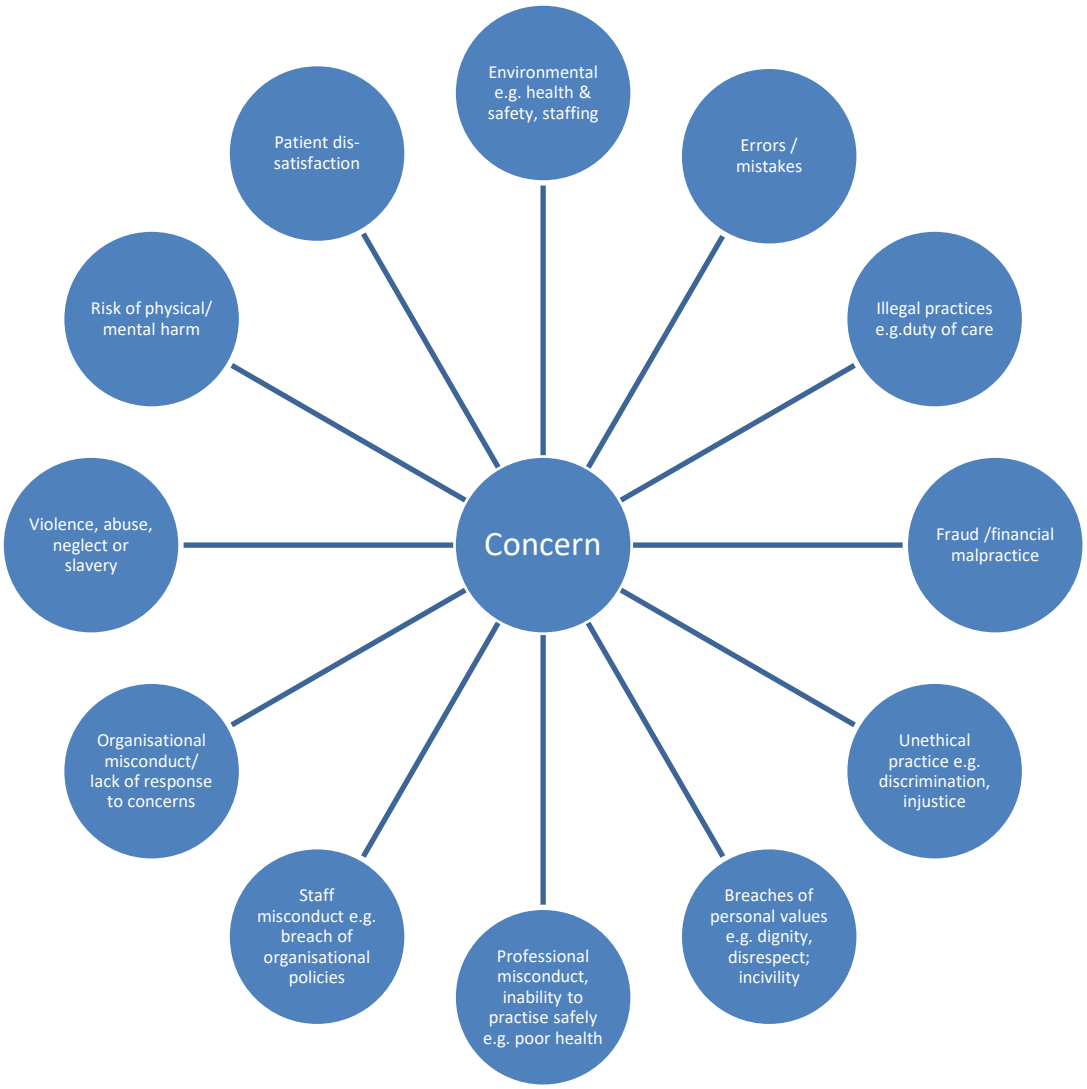
Key: ND = No data

Source	Year					
	13/14	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Incident reports	153	ND	135,356	ND	508,409	ND
NMC: Nurses & midwives	4687	5183	5415	4771	5509	5,373
GMC: Doctors	9866	9624	9418	9146	8546	ND
HCPC: Allied health professional including social workers	322,021	330,887	341,745	350,350	361661	ND

Sources: GMC, 2017; HCPC, 2018; NHS Improvement, 2018; NMC, 2014, 2015b, 2016, 2017b, 2018d, 2019b

The current NHS emphasis on raising of a care concern is associated with speaking up, which is considered an initial trigger for organisational reporting or internal whistleblowing. The phrase 'speaking up' minimises the complexity which faces a professional who whistleblows. For professional practitioners, a series of decisions and dilemmas lead to raising of a care concern (Davis & Kinoshi, 2007; Jackson et al., 2014; Jenson, 1987; Newdick & Danbury, 2015), although two main points emerge as key: judging what is a concerning situation and deciding how to respond. Concerning situations can be defined from a range of perspectives e.g. public protection and safeguarding (NHS England, 2015; NMC, 2019), organisational whistleblowing (Francis, 2015; Jubb, 1999; NHS Improvement and NHS England, 2016), illegal/ criminal acts e.g. health and safety, duty of care, fraud (Moore & McAuliffe, 2012; NHS Improvement and NHS England, 2016; Newdick & Danbury, 2015; Vinten, 2000, 2004), professional misconduct/ incompetence (GMC, 2012, 2017; HCPC, 2018; NMC, 2013a, 2015a, *2*017a, 2019a) and unethical practices (Erdil & Korkmaz, 2009; Pavish, Brown-Saltzman, Hersh, Shirk, & Rounkie, 2011); these are summarised in diagram 1.1. below. The variety of perspectives suggests that practitioners require specific knowledge e.g. of health and safety, professional competency, and a sensitivity to others' distress or abuse to recognise and judge a concerning situation.

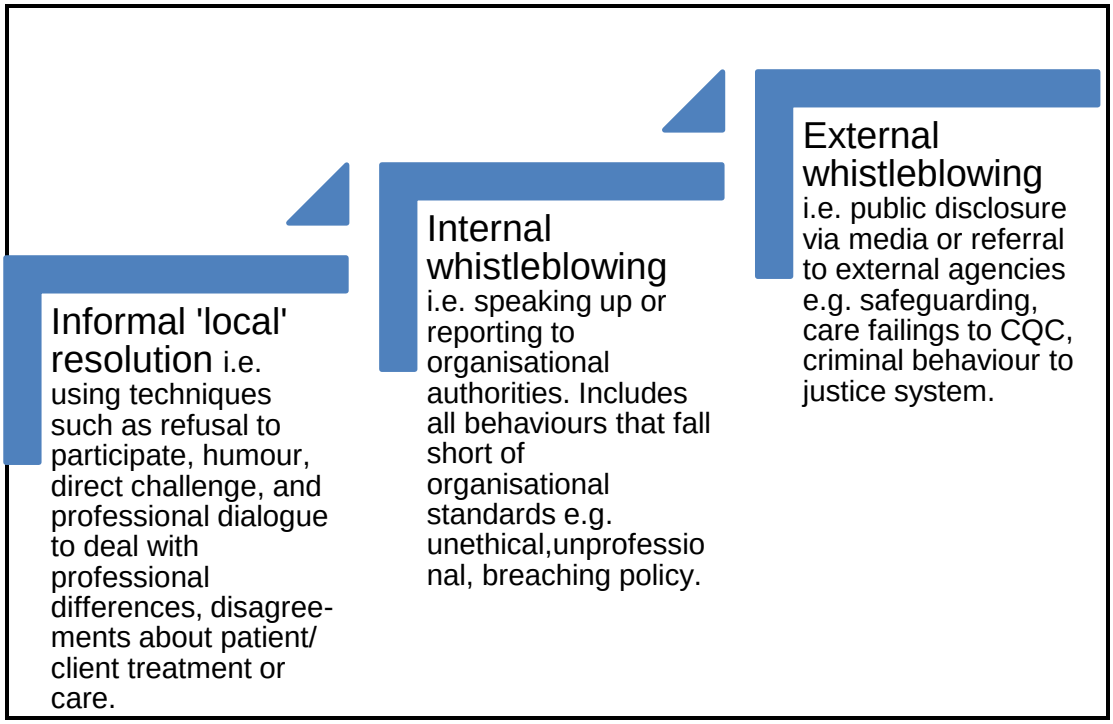
Diagram 1.1: Range of potential concerning situations in the NHS



Sources: M. Baldwin, 2003; Erdil & Korkmaz, 2009; Francis, 2015; GMC, 2012; HCPC, 2016a; 2018; Hoffman & Schwartz, 2015; NHS England, 2015, 2018; NHS Improvement, 2018; NHS Improvement & NHS England, 2016; NMC, 2017b, 2018d, 2019; RCN, 2010

Deciding how to respond to encountered concerning situations appears to be fraught with dilemmas. These arise from an initial choice of three responses summarised in diagram 1.2 below: local, informal approaches; speaking up within the organisation; or external, public disclosure to another agency. Within this thesis, the term *raising a care concern* is used throughout to capture the range of responses which may be taken by professional practitioners when encountering a concerning situation.

Diagram 1.2: Proposed escalation of responses to concerning situations



Sources: M. Baldwin, 2003; Cleary & Doyle, 2016; Department of Health [DoH], 2015a, 2015b; Dworkin & Baucua, 1998; Fagan, Parker, & Jackson, 2016; Francis, 2013, 2015; GMC, 2012; Greene & Latting, 2004; Jubb, 1999; Jones & Kelly, 2013, 2014; HCPC, 2018; McSherry & McSherry, 2015; Near & Miceli, 2016; NHS England, 2015, 2018; NHS Improvement & NHS England, 2016; NMC, 2013a, 2019; RCN, 2017a; Watson & O'Connor, 2017.

The options in diagram 1.2 are presented as an escalation model, as the practitioner usually has to choose the 'best' option, which is dependent on a range of factors. Choosing how to respond depends upon the practitioner's appraisal of the situation, including severity, perceived impact upon the patient/ vulnerable person involved, and evidence of wrongdoing (Davis & Konishi, 2007; Newdick & Danbury, 2015; Pohjanoksa, Stolt, Leino-Kilpi, Suhonen, & Löyttyniemi, 2017). The choice of whether to speak up internally or to externally whistleblow appears to be dependent on the practitioner's perception of the organisational culture, in particular the treatment of whistleblowers and the response to concerns (Berwick, 2013; Cleary & Doyle, 2016; Department of Health [DoH], 2015a, 2015b; Francis, 2013; Glasper, 2016; Hunt, 2015, 2016; Keogh, 2013; Moore & McAuliffe, 2010; Near & Miceli, 2016; Royal College of Nursing [RCN], 2017a). As NHS staff (NHS England, 2018) and independent surveys (PCAW, 2015; 2016) suggest, encountering concerning situations is part of everyday clinical practice, and raising a care concern is a contemporary topic within UK professional practice; the dilemmas and decision making associated with professional 'speaking up' therefore have implications for educators of pre-registration health and social care students, who seek to prepare

and support students to meet this aspect of NHS (Francis, 2015; NHS Improvement & NHS England, 2016) and professional practice (GMC, 2012; HCPC, 2016a; NMC, 2013b, 2015a, 2017a, 2019a).

1.1 The research problem: Professional education and raising a care concern

Professional education within the UK consists of students learning in both the classroom at the Approved Education Institution (AEI) and within clinical practice (GMC, 2016; HCPC, 2017; NMC, 2010, 2018b). In nursing, fifty percent of learning occurs within clinical practice (NMC, 2010, 2018b; RCN, 2017b), i.e. on placements within work environments (NMC, 2013b, 2015b) with the appropriate staff, learning experiences and resources to support the acquisition of professional proficiency. Currently, nursing students (NMC, 2010) enter placements within the first three months of the programme, where a network of practice-based educators but specifically a mentor (NMC, 2008; RCN, 2017a) supports transition into the workplace, facilitates learning and assesses the achievement of professional competence. In 2013, the NMC (2013a) introduced specific guidance for nursing students raising a care concern when in clinical practice, and the 2017 update (NMC, 2017a) describes a concerning situation as one which places someone at risk of harm, charging students with speaking up and seeking help:

> 8.1 Inform your mentor, tutor or lecturer immediately if you believe that you, a colleague or anyone else may be putting someone at risk of harm.
>
> 8.2 Seek help immediately from an appropriately qualified professional if someone for whom you are providing care has suffered harm for any reason.
>
> 8.3 Seek help from your mentor, tutor or lecturer if people indicate that they are unhappy about their care or treatment.
>
> (NMC, 2017a, p.4)

The introduction of this requirement posed an immediate problem for educators, both in the AEI and in clinical practice: how to prepare and support students to fulfil this professional duty.

1.2 Supporting students to raise a care concern

The implementation of the NMC guidance led to changes within my own field of practice, with strategic and local implementation. As I work at an AEI within England, local policies and procedures were implemented, with a regional collaboration creating multi-professional practice guidance consistent with

professional best practice (Glasgow Caledonian University, 2016; GMC, 2012; HCPC, 2016a; NMC, 2013b; RCN, 2017a; 2017b). Collaborative AEI and practice policies and procedures, plus academic guidance aimed to facilitate university and clinical staff to support students to raise a care concern in practice. During the initial implementation, the NHS incentive to encourage, facilitate and listen to nursing students who wish to raise a care concern became apparent, yet a range of anxieties regarding students' ability to fulfil this responsibility were expressed: insufficient knowledge to recognise unsafe patient care (Duffy, McCallum, Ness, & Price, 2012), the potential for a poor student experience stemming from the then negative view of NHS whistleblowing (Glasper, 2015, section 1.5, p.20), and fears for additional student stress or dissatisfaction (Brown et al., 2011; Cromby, Brindley, Harris, Marks-Maran, & Thompson, 2013; Hamshire, Wilgoss, & Wibberley, 2012; Kinsella, Williams, & Green, 1999; Thomas, Jack, & Jinks, 2012). All of these could lead to attrition of students from professional education, which would have negative impact on the AEI, and the NHS, which seeks to recruit the health professionals on completion of the programme.

1.3 Rationale for study

This study developed from the expectation that professional education would prepare pre-registration nursing students for raising a care concern when in clinical practice (NMC, 2013a). From the contemporary NHS perspective of raising of a care concern as internal whistleblowing, an exploration of the literature (chapter two) highlighted the decisions, dilemmas, motivations and perceived barriers deemed to affect practitioners and students, reducing the likelihood of raising a care concern when in clinical practice. This, in addition to the professional perspectives described in section 1.2, raised my curiosity to understand the experience of students who did raise a care concern when in clinical practice. The current re-emphasis upon raising a care concern across the NHS suggested that a study which explored the experience of nursing students would be timely, informative and relevant to current professional practice.

1.4 The research aim

The initial research aim for this study was to explore nursing students' experience of the phenomenon. Following the exploration of literature in chapter two, three questions arose which would guide this study: 1) what is it like for nursing students who raise a care concern in clinical practice; 2) what motivates nursing students to

do this; and 3) what helped nursing students overcome perceived barriers to raising a care concern.

1.5 Methodological and design influences

For this exploratory study of nursing students' experience of raising of a care concern, a desire to pursue an 'open', appreciative approach and a critical examination of qualitative methodologies (Creswell, 2013; Parahoo, 2014), an umbrella term for a range of designs which focus upon examining or exploring a person's perspective upon or within an experience, led to a pragmatic decision (Denzin & Lincoln, 2011) to adopt a phenomenological methodology (Creswell, 2013; Parahoo, 2014). Following an in-depth analysis of Husserlian and Heideggerian/hermeneutic phenomenological approaches (Creswell, 2013; Parahoo, 2014), and in seeking to conduct an original study which contributed to existing knowledge, Clarke Moustakas' (1994) transcendental phenomenology was chosen to influence the study's design. Moustakas' (1994) transcendental phenomenology follows the Husserlian phenomenological philosophy, producing a descriptive exploration of an experienced phenomenon.

In preparing for the study, ethical approval was gained from the Faculty Research Ethics Committee (Appendix A), and a reflective consideration of my position and pre-conceptions towards the phenomenon (epoché) was undertaken. A purposeful sample of ten nursing students voluntarily participated and were interviewed using an 'open' style with prompts from a pre-set topic guide (Moustakas, 1994). Interviews were audio recorded and transcribed. From each participant's transcript, data was phenomenologically reduced, i.e. the size of the final text was decreased through the removal or grouping of statements. The reduced text was analysed using imaginative variation, which Moustakas (1994) describes as application of different and varied vantage points to identify answers to the posed questions from the data. Analysis of individual transcripts resulted in identification of invariant qualities i.e. themes or individual statements which described the experience. To develop a composite description i.e. a compiled summary of the students' experience, repeated imaginative variation was undertaken across all data. This led to identification of sub-essences i.e. themed data groups, which were then drawn together into four essences (or components) delineating the core components of the students' lived experience: 1) patient centred concern; 2) deciding how to raise a care concern; 3) emotional strength; and 4) feedback and support. These were used

to write a composite description, providing a summary of the key features of nursing students' experience of raising a care concern when in clinical practice.

1.6 Relevance of the study

This study has implications for policy and practice within professional nurse education, clinical practice and professional regulation. The analysis of nursing students' experience in this study emphasises the moral and emotional aspects of their experience, which suggests that educators would benefit from focusing upon teaching students to respond to compassionate concern, facilitating emotional intelligence to recognise concern, sustain motivation and assist in communicating concerns when in clinical practice. This study recommends that educators support students in clinical practice to feel safe to raise a care concern; that placement staff give positive feedback to students, offering emotional comfort and moral reassurance; and that NHS organisations recognise the impact of students as local leaders in patient safety. At policy level, this study recommends an NHS student focused campaign to promote the recognition of and response to a concern using a simple 'feel it, check it and raise it' sequence, and recommends that the NMC guidance is updated requiring nursing students to ensure a response to the concern has occurred.

1.7 Structure of the thesis

This thesis is presented in a format which guides the reader through the research journey and development of new knowledge. Chapter two presents a background to the study and a critical narrative of retrieved literature in relation to professional registrants, pre-registration health and social care students and raising a care concern, from which three research questions arose; these, in conjunction with the methodological critique, guided the choice of methodology and inquiry. Within chapter three, methodological considerations are presented, critically examining a range of qualitative approaches and justifying the choice of transcendental phenomenology to guide this study. A detailed analysis of the decisions and choices made in conducting the research is presented, including the use of phenomenological epoché, phenomenological reduction and imaginative variation to gain a composite description and identify four essences of the students' experience. In chapter four, the students' experience and four essences are critically discussed, situating them within the current retrieved literature, proposing new explanations and identifying their relevance to professional practice, displaying the new knowledge in relation to raising a care concern. In chapter five, the implications for

nurse education, placement staff, and NHS and NMC policy and practice are examined. Chapter six contains conclusions, personal reflections, and recommendations for future professional practice and research.

1.8 Summary

This chapter introduces the thesis and the contemporary relevance of raising a care concern as a topic of research for professional education and nursing practice within the UK. It provides the current context of raising of a care concern as a strategic imperative for the UK NHS, which focuses upon internal whistleblowing as a key improvement and prevention strategy for care failings. For practitioners, raising a care concern is the result of clinical decision making, which focuses upon the ability to judge a concerning situation and choosing an appropriate response. Further examination of the literature surrounding the current focus upon raising a care concern as an aspect of professional practice is discussed in chapter two, specifically the NHS strategy to improve the experience of practitioners who raise a care concern and the moral dilemmas which practitioners and students associate with the decision to whistleblow. From the exploration of the literature (chapter two), the emergence of the three guiding questions for this study is discussed, which subsequently influences the choice of methodology for this study (chapter three).

Chapter 2: Review of the Literature

Introduction

This chapter provides a narrative review of the literature which addresses the key question: what are the current view and key issues within contemporary professional whistleblowing (P. Cronin, Ryan & Coughlan, 2008; Noble & Smith, 2018)? A critical narrative review of raising a care concern as internal whistleblowing is presented, following a traditional narrative approach which omits detailing the rigorous aspects of traditional systematic approaches e.g. search keywords and exclusion criteria (Aveyard, 2007; P. Cronin et al., 2008; Jahan, Naveed, & Tahir, 2016; Noble & Smith, 2018). The review provides an overview of the NHS current strategic imperative of raising of care concerns, and then focuses upon the key issues highlighted within the experiences of both registrants and health and social care pre-registration students. The review creates a picture of the current culture change being undertaken across the NHS that seeks to encourage raising of a care concern, aiming to improve NHS care and keep patients safe from harm; it also considers how organisational culture affects professionals' perception of raising of a care concern, which has been linked with a reduced willingness to speak up. Although both the organisational and educational studies indicate how to improve the likelihood of speaking up, the review suggests that further inquiry is needed, which this study seeks to address.

2.1 Narrative reviews

This narrative review presents the current perspective for raising a care concern within health and social care, providing a context for the study, my educational practice, and the interpretation of the study findings in chapters four and five. Systematic approaches advocated within nursing, e.g. PICO, SPIDER and ECLIPSE, emphasise outcome measures, are clinically focused and follow a predetermined clinical research question (Jahan et al., 2016; Noble & Smith, 2018), which was inappropriate for an exploratory study. Critiques of narrative reviews suggest that the search may be considered biased, unstructured and unsystematic, weakening the rationale for a study (Aveyard, 2007; Jahan et al., 2016) yet narrative reviews can assist in identifying the 'position' from which the research is being conducted (P. Cronin et al., 2008; Noble & Smith, 2018), setting the scene for the research, in addition to providing guidance for the research study. Although nursing narrative reviews can be presented as a mix between systematic and traditional reviews (Aveyard, 2007; P. Cronin et al., 2008; Noble & Smith, 2018; Parahoo,

2014), the narrative review presented here seeks to provide background for this study, capturing the ongoing publications and research within the topic of raising of a care concern and identifying how the questions for the study emerged from the current context of professional whistleblowing.

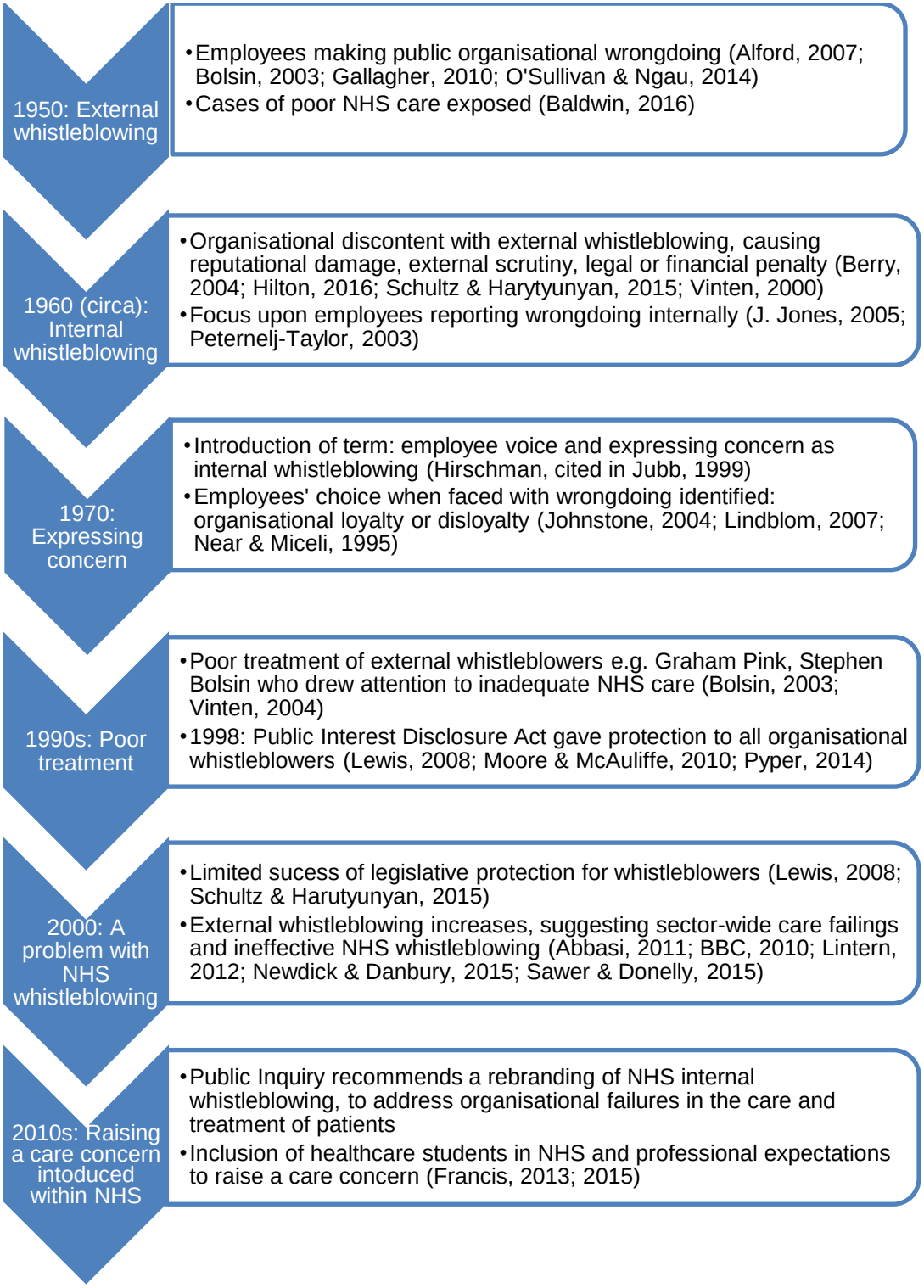
2.2 Concern raising as internal whistleblowing

A dominant view at this time of raising of a care concern is that it is a form of internal whistleblowing. The current emphasis upon raising a care concern is led by government initiatives to improve patient safety and care, in response to public inquiries where NHS care failings led to patient harm or death (Bubb, 2014; Francis, 2013; Gosport Independent Panel, 2018; Kirkup, 2015). The high profile public inquiry into care failings at Mid Staffordshire NHS Trust (Francis, 2013) was influential in changing nursing's emphasis upon raising a care concern. The Francis report (2013) led to a public perception that nurses failed to address poor care, which created damage to and a loss of confidence in the profession. Nursing's political leaders (Cummings & Bennett, 2012) and the NMC (its PRSB in the UK) (2013a) led the profession to enhance its leadership in care quality, promoted raising of a care concern as a key strategy of clinical leadership, and focused upon strengthening registrants' courage, communication and competence (Cummings & Bennet, 2012; Cummings, 2016; Oxtoby, 2016) to re-energise registrants' responsibility to prevent care failings. In order to meet the NHS aims for improving care and preventing patient harm, the emphasis upon raising of a care concern as a way of highlighting poor care within the organisation was launched as a 'speaking up' campaign (diagram 2.2, p.28; Francis, 2015).

2.2.1 Evolution of raising of a care concern as internal whistleblowing

Raising of a care concern as a form of internal whistleblowing has evolved from business/ organisational perspectives, focusing upon how concerns from employees can inform organisational practices, as illustrated in diagram 2.1. For professional registrants, raising of concerns as internal whistleblowing appears to be supported by professional literature (Bolsin, 2003; Faunce,2004; McDonald & Ahern, 2000), NHS reviews (Berwick, 2013; Francis, 2015; Keogh, 2013), NHS policies (NHS Improvement and NHS England, 2016) and UK PRSB guidance for registrants and pre-registration students (GMC, 2012; HCPC, 2016a; NMC, 2013b, 2015b, 2017a, 2019), and has evolved since the development of the term 'whistleblower' in the 1950s (Bolsin, 2003), as illustrated in diagram 2.1 below.

Diagram 2.1: Timeline illustrating the evolution of raising a care concern as NHS internal whistleblowing



2.2.2 Experience of professional whistleblowers

For professional whistleblowers, there appears to be a view that raising of a care concern or whistleblowing, whilst a professional responsibility, is fraught with potential difficulties. These focus upon the decision of whether to raise a care

concern, which presents a series of moral perspectives and dilemmas of how best to act (Ahern & McDonald, 2002 Jenson, 1987; Jubb, 1999; Peternelj-Taylor, 2003; Rennie & Crosby, 2002). Promoting raising of a care concern as a key moral professional duty (Bolsin, Faunce, & Oakley, 2005; Crisp & Slote, 1997; Duncan, 2010; Holden, 1991; Uys & Senekal, 2008) centres upon three key areas: deciding on an ethically 'right' choice, following the professional belief in putting patients first (advocacy) or upholding/ following a personal virtue or characteristic (discussed in 2.2.3). However, when in the workplace, a central aspect of the experience of professional whistleblowers is a 'moral dilemma' (Bjørkelo, Einarsen, Nielson, & Matthieson, 2011; Davis & Konishi, 2007; Faunce, 2004; Jubb, 1999; Lindblom, 2007; Mesmer-Magnus & Viswesvaran, 2005; O'Sullivan & Ngau, 2014; Pope, 2015; Vinten, 2004). The dilemma is characterised as individuals having to choose between opposing loyalties (Uys & Senekal, 2008), in particular between the organisation/employer or the patient (table 2.1).

Table 2.1: Dilemmas in professional whistleblowing: A range of moral positions within the decision to raise a care concern

Dilemma	Profession	Source
Organisational loyalty vs professional duty	Nursing	J. Jones (2005)
	Medicine	Bolsin, Pal, Wilmhirst, & Pena (2011); Faunce (2004)
Organisational loyalty vs professional autonomy	Medicine	Faunce (2004)
	Nursing	Johnstone (2004); Vinten (2000)
Loyalty to employer vs patient	Medicine	Bolsin (2003)
	Nursing: Adult & Mental Health	McDonald & Ahern (2000); Peternelj-Taylor (2003)
Outcome for the patient	Nursing	Mansbach & Bachner (2009);
	Physical Therapists	Mansbach, Bachner, & Melzer (2010)
Professional duty vs likely personal outcome	Nursing	Attree (2007); Hooper (2011)
Protecting clients/patients	Social Work	Greene & Latting (2004)
Loyalty to colleague vs professional duty to patient	Nursing: Mental Health	Peternelj-Taylor (2003)
	Psychology	Rice (2015)

The view of choice associated with loyalty, as depicted in table 2.1, simplifies what has been reported in other sources as a morally complex decision or dilemma. There are several moral decisions which are required e.g. judging what has occurred (Davis & Konishi, 2007; Jenson, 1987) and weighing up different options

(see diagram 1.1), yet the point which receives most attention is the decision of when to 'speak up'. In deciding whether to speak up, the practitioner's perception of the organisational culture i.e. the treatment of whistleblowers and the response to concerns that have been raised are key influencing factors (De George, cited in Hoffman & Schwartz, 2015; Kaptein, 2011; Mannion & Davies, 2015; Perry, 1998; Ray, 2006; Vinten, 2000). Poor treatment e.g. bullying, ostracising, job loss, and ongoing personal and family stress (Hoffman & Schwartz, 2015; Jackson et al., 2010, 2014; PCaW, 2013, 2016; Vinten, 2004; F. West, Bottomley, & Vandekerclehove, 2013) are cited as potentially dissuading people from speaking up. Poor treatment of whistleblowers, perhaps stemming from a view of whistleblowers as disloyal employees (Bolsin, 2003; Bolsin et al., 2011; Børnfelt, Aridson, Axelsson, & Ahlstrand, 2014; Dworkin & Baucua, 1998; J. Smith & Oseth, 1993), has been considered a means by which employers/organisations silenced employees, thus preventing whistleblowing and enabling the continuation of wrongdoing. For nurse whistleblowers, poor treatment has been considered a key contributor to the perception that whistleblowing decisions are difficult to make (Ahern & McDonald, 2002; Attree, 2007; Firtko & Jackson, 2005; Jackson et al., 2010, 2014; King, 1997; McDonald, 1994; McDonald & Ahern, 2000) and is associated with psychological distress (table 2.2) through generation of fears and anxieties related to potential consequences or outcomes from speaking up.

Table 2.2: Factors cited as influencing professionals' decision to whistleblow

Psychological distress	Source
Experiencing negative emotions	Pavish, et al. (2011); Peternelj-Taylor (2003)
Impact upon family or others involved	Johnstone (2004); L. Wilkes, Peters, Weaver, & Jackson (2011)
Organisational reprisal	Attree (2007); Firtko & Jackson (2005); Jackson et al. (2010, 2014); Vinten (2000)
Professional repercussions i.e. misconduct	Bolsin et al. (2011); Hooper (2011); Jackson et al. (2014); McDonald & Ahern (2000)
Not wanting to cause trouble	L. Moore & McAuliffe (2012)
Disruption to working relationships and alienation	Abbasi (2011); Jackson et al. (2010); O'Sullivan & Ngau (2014)
Needing to move workplaces	Yanchus, Derickson, Moore, Bologna, & Osatuke (2014)
Anticipate degree of regret associated with staying silent or whistleblowing	Fredin (2011)

Having spoken up and raised a concern, the other significant decision for professionals appears to be what to do if the response, by colleagues or the organisation, fails to deal with or stop the concerning situation (Attree, 2007; Francis, 2013; Mannion et al., 2018; L. Moore & McAuliffe, 2010, 2012; Whitehead & Barker, 2010). Failure or ineffective responses provide practitioners with another dilemma: whether to escalate as in diagram 1.2 (p. 15), or to stop and keep silent (Cleary & Doyle, 2016; Jenson, 1987; Mesmer-Magnus & Viswesvaran, 2005). In combination, how organisations treat those who raise a care concern and the effectiveness of the responses have contributed to the view that whistleblowing is a difficult decision, and this perception has been cited as a main reason why practitioners may not speak up (Attree, 2007; Berry, 2004; Bjørkelo et al., 2011; Davis & Konishi, 2007; Eppich, 2015; Firtko & Jackson, 2005; Francis, 2015; A. Gallagher, 2010; Glasper, 2015, 2016; Jackson et al., 2010, 2014; Lachman, 2008a; Lindblom, 2007; Mannion & Davies, 2015; Mesmer-Magnus & Viswesvaran, 2005; Monrouxe & Rees, 2012; Moore & McAuliffe, 2010; PCAW, 2016; Vinten, 2004; Whitehead & Barker, 2010). Moral strength i.e. belief in doing the right thing appears important in navigating perceived difficulties, with professionals who choose to carry on with repeated concerns or to internally whistleblow (Francis, 2013; Keogh, 2013; PCaW, 2013, 2016; Vinten, 2004) characterised as righteous, virtuous or courageous people (Cronenwett, 2001; A. Gallagher, 2011a; Lachman, 2007, 2008a; Peternelj-Taylor, 2003). However, those practitioners who perceive the organisational culture as not supportive, and choose to stay silent, experience ongoing angst which has been described as moral distress (Jameton, 1993; Rushton & Caldwell, 2016) or regret (Fredin, 2011), suggesting that practitioners face an emotional time irrespective of their decisions. There is key evidence that professional whistleblowing is a difficult time for practitioners, peppered with decisions, dilemmas, fears and anxieties, potential risk of poor treatment and consequences and distress which may deter speaking up. Thus, the findings from the Francis review (2015) may not have been a surprise; however, the care failings at Mid Staffordshire NHS Trust (Francis, 2013) and urgent care review (Keogh, 2013) acted as a political catalyst to change the experience of NHS whistleblowing.

2.2.3 Changing NHS culture

Political impetus for changing the NHS approach to whistleblowing has led to multiple strategies and systems aimed to improve the treatment of whistleblowers and enhance the listening and learning from raised concerns. The review of 'speaking up' (Francis, 2015) highlighted the internal systems and processes which

were needed to support the culture changes (diagram 2.1, p.23), with multiple approaches (summarised in diagram 2.2, p.28) focused upon providing protection for whistleblowers, enhancing communication, implementing new NHS values and beliefs, and promoting clinical leadership.

Diagram 2.2: Changes recommended to support NHS whistleblowing (adapted from Francis, 2015)

Key:
Blue: Theme
Green Principles of change
Red: Position of trainees and students

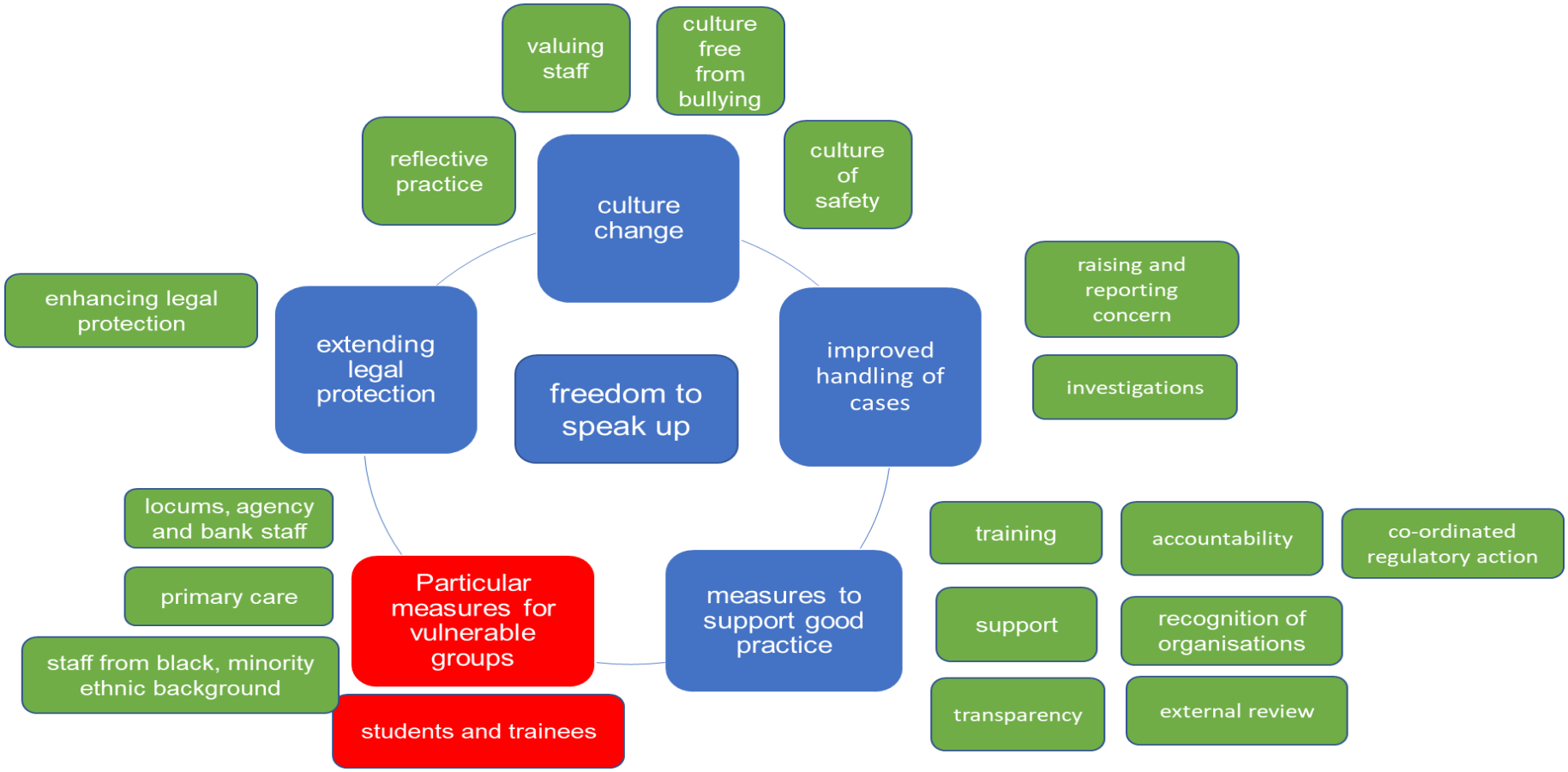
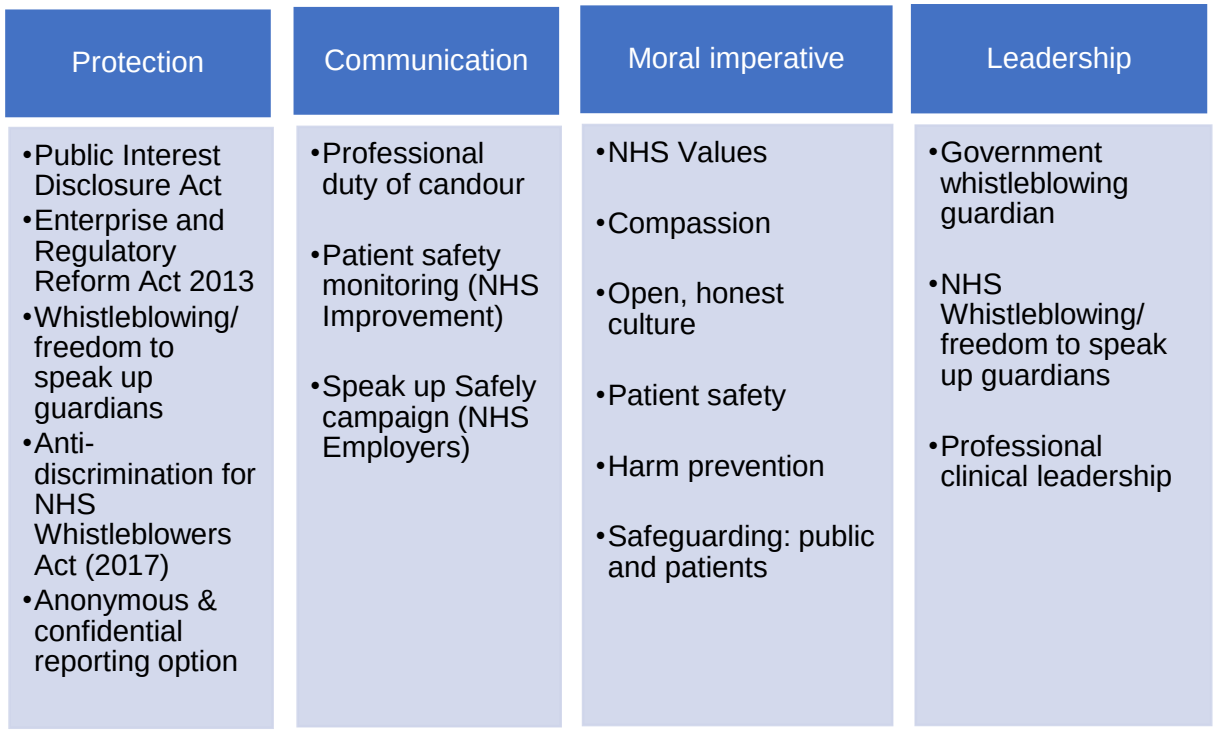


Diagram 2.3: Summary of NHS strategic changes to improve organisational culture for raising a care concern



Sources: DoH (2011b, 2015a); Hunt (2015); National Audit Office (2014); RCN (2017a); www.nhsemployers.co.uk; www.NHSImprovement.co.uk; NHS Improvement & NHS England (2016); www.improvement.nhs.uk/improvement-hub/patient-safety/.

The strategic focus upon protection, communication, values and leadership illustrated in diagrams 2.1 and 2.3 aims to decrease poor treatment, improve responses to concerns, and align organisational, professional and carers' moral imperatives, and is supported by a large body of evidence (Bolsin, 2003; Firtko & Jackson, 2005; Hoffman & Schwartz, 2015; Jubb, 1999; Kaptein, 2011; Mannion & Davies, 2015; L. Moore & McAuliffe, 2012; J. Smith & Oseth, 1993; Vinten, 2000, 2004). Through improving NHS culture, the experience of professional whistleblowers should improve, as the organisation's effectiveness in dealing with concerns leads to improved care. Since the implementation of the changes shown in diagram 2.3 (p 29), the NHS staff survey (NHS England, 2018) noted a year-on-year increase in the number of concerning situations reported by nurses (27.8% in 2018), with a 4% improvement in staff's view that the NHS treats staff who raise a care concern fairly, a 2% improvement that action is being taken (70% in 2018) and a 2% improvement (to 59.9% in 2018) in feedback being given on actions taken. These figures suggest that the treatment of whistleblowers may be improving – yet Prevent (PCaW, 2016), a charity which supports employees to raise a care concern, suggests that the change is only partially achieved, as reports of threatened job loss remained at 38% for health sector staff (compared to 50% in 2014) and bullying in the sector remained at an above average rate (39%). Despite this, PCaW's (2016) five-year review of UK whistleblowing identified an increase in staff willingness to raise a care concern, with a higher number of nurses or doctors reporting it (31% compared to 27% non-health), suggesting that professionals' likelihood of speaking up is improving. However, there appears to be some way still to go to improve the treatment of and response to all concerns. This suggests that the perception of raising of a care concern as a difficult, challenging experience may still be prevalent within the NHS.

2.2.4 Raising a care concern: Professional decision making

The decision making preceding and following speaking up is associated with practitioners' compliance with professional moral duty and responsibility (Armstrong, 2006; M. Baldwin, 2003; Bolsin et al., 2011; Crisp & Slote, 1997; A. Gallagher, 2010; Holden, 1991; Jenson, 1987; Lachman, 2008a; MacIntyre, 1981). For registrants, there appear to be three approaches evident within the literature: making an ethical choice, following professional beliefs, or utilising a personal moral virtue or characteristic, discussed below. These three approaches are subsumed within the notion of fulfilling professional responsibility, yet reflect different view of decision making, from conscious deliberate use of ethical principles/ professional

beliefs to the more instinctive responses drawn from personal virtues/ characteristics (Beauchamp & Childress, 2009; Crisp & Slote, 1997; Duncan, 2010; MacIntyre, 1981).

2.2.4.1 Ethical principles

The key ethical approaches of consequentialism and choice between biomedical principles are cited as key to choosing to raise a care concern. Consequentialist ethical principles where the anticipated outcomes of actions are weighed up – e.g. in the public's interest (Faunce & Jeffreys, 2007), best interest of the patient (table 2.1, p.24), patient safety (Francis, 2013; Keogh, 2013) or utilitarian principles i.e. acting for the greater good, which for the NHS is associated with protecting the public – are frequently cited in medicine and nursing (Bolsin, 2003; Bolsin et al., 2011; Faunce, 2004; GMC, 2018; NMC, 2019; see table 2.1, p.24). If a universal benefit from whistleblowing cannot be identified, weighing up the best course of action using principles of biomedical ethics such as non-maleficence, beneficence, autonomy and justice (Beauchamp & Childress, 2009; Duncan, 2010) and judgments of the situation e.g. serious actual or potential harm in physical, psychological or financial form, challenges to human rights, or injustice (Hoffman & Schwarz, 2015; NHS Improvement & NHS England, 2016; NHS England, 2015 Vinten, 2000) is considered an effective decision making approach. Applying ethics to concerning situations has been associated with inconsistent judgements, leading to variation and uncertainty in decision making (Attree, 2007; Beauchamp & Childress, 2009; Crisp & Slote, 1997; Druce, Hickey, Warrens, & Westwood, 2016), weakening the practitioner's ability to make an absolute 'right' choice and thus perhaps reducing the likelihood of choosing to raise a care concern. The dominance of ethical principles in modern clinical decision making may contribute to difficulties in deciding whether to whistleblow.

2.2.4.2 Advocacy: Putting patients first

Putting patients first is a belief which has been used across professions to justify raising concerns (table 1.2, p.21), particularly in nursing (Ahern & McDonald, 2002; M. Baldwin, 2003; Erlen, 1999; Mansbach, Kushnir, Ziedenburg, & Bachner, 2014), social work (Greene & Latting, 2004; Mansbach & Bachner, 2009) and physical therapy (Mansbach, Melzar, & Bachner, 2012). For nursing these beliefs have become synonymous with advocacy, an American term adopted in the 1980s to empower the profession (Abel-Smith, 1960; S. Anderson, 1990; M. Baldwin, 2003; Erlen, 1999; Hanks, 2010; Hooper, 2011; Mallik & Rafferty, 2000; UKCC cited by

Vinten, 2004). From a basis of social empowerment (Crotty, 2009), advocacy situates nurses between weak, vulnerable patients/service users/clients and powerful social structures such as hospitals to give voice to these groups (Abel-Smith, 1960; S. Anderson, 1990; M. Baldwin, 2003; Bradshaw, 1999; Negarandeh, Oskouie, Ahmadi, & Nikravesh, 2008; Watson & O'Connor, 2017), and is a core perspective within nursing's justification for raising concerns:

> Speaking up on behalf of people in your care… a professional role to report any concerns from your workplace which puts the safety of the people in your care or the public at risk. (NMC, 2017a, p.10)

Current patient empowerment strategies (Darzi, 2008; NHS England, 2017a, 2017b; Piper, 2014) suggest that advocacy perpetuates a view of patient vulnerability and disempowerment, a stance perhaps more closely aligned with contemporary safeguarding ideology which also relies upon raising of concerns (NHS, 2016). These reservations, and the focus upon local resolution e.g. avoidance, speaking with colleagues captured within advocacy practice (M. Baldwin, 2003; A. Jones & Kelly, 2013), imply that this may not be consistent with the current NHS ideology of speaking out about patient harm to initiate organisational or workplace change. Yet the belief of putting the patient first (table 2.1, p.24) as a moral justification for whistleblowing is widely acclaimed.

2.2.4.3 Virtues and good character

The importance of the presence of inherent virtuous behaviour or good character offers another aspect to professional decision making (Armstrong, 2006; T. Baldwin, 2016; Faunce, 2004; Faunce & Jeffreys, 2007; A. Gallagher, 2010; Lachman, 2007, 2008b; Lindh, Barbosa de Silva, Berg, & Severinsson, 2010), shifting towards a less conscious/deliberate decision making process. This view suggests that decisions to act are made due to a person's own virtuous, good character, choosing to act because it is consistent with personal characteristics or qualities e.g. honesty (Bolsin et al., 2011; Crisp & Slote, 1997; Duncan, 2010; MacIntyre, 1981). More recently it has been suggested that virtuous or good behaviour results from a values-based decision, choosing to act because the behaviour is viewed as 'good' (Ash, 2016; Cummings & Bennett, 2012; HEE, 2014: Law, 2014) rather than an inherent trait.

Virtuous practice is anticipated through the pre-entry expectations of students undertaking healthcare professional education (GMC, 2013; HCPC, 2017; HEE, 2014; NMC, 2010, 2018b) being open, honest and trustworthy (GMC, 2012; HCPC,

2016a; NMC, 2018a, 2018b), which support the professional duty of candour. For whistleblowing, the importance of good moral character (Armstrong, 2006; Lachman, 2007) to motivate nurses' and doctors' decisions to whistleblow (Armstrong, 2006; Bolsin et al., 2005; A. Gallagher, 2010; Lachman, 2008b) was theoretically needed, to overcome the perceived negative effects of organisational culture (Faunce & Jeffreys, 2007; Kaptein, 2011). Recent strategic imperatives (Francis, 2013; HEE, 2014) have raised the significance of virtues such as compassion for all healthcare practice (Arthur, Kristjannison, Thomas, Kotzee, Ignatowicz, & Qui, 2015; Numminen, Repo, & Leino-Kilpi, 2017), whilst caring professions (Cummings & Bennett, 2012; Oxtoby, 2016) e.g. nursing have been tasked with demonstrating the additional five virtues of care, courage, commitment, communication and competence in practice. This '6Cs' strategy (Cummings & Bennett, 2012) generated re-interest in the theoretical relevance of these virtues (Numminen et al., 2017; Simola, 2015), yet there is little practical evidence of the relevance of virtues to current professional practice and raising a care concern.

Using a moral perspective, raising a care concern is perceived as being the professional right thing to do (Beauchamp & Childress, 2009; Faunce, 2004; Holden, 1991), irrespective of which approach is used.

2.2.5 Students and raising a care concern

Students' involvement in NHS patient safety through raising of care concerns was prompted from the recommendation following the Francis public inquiry (Francis, 2013; Keogh, 2013). As with professional whistleblowing, there is an emphasis upon raising of a care concern as speaking up which instigates internal whistleblowing processes (Bickhoft, Sinclair, & Levett-Jones, 2017; Fagan et al., 2016; Francis, 2015; GMC, 2012; HCPC, 2016a; Milligan, Preston-Shoot, Pappas, & Randhawa, 2016; NMC, 2017a, 2019), an aspect of student practice which has not received much attention within professional education. The inclusion of students within NHS policies (NHS Improvement & NHS England, 2016) sought to offer them the same protection, communication, values and leadership as staff members, yet as Francis (2015) highlights, students have some specific fears and anxieties which may deter them from raising a care concern, and of which educators (in AEI and in clinical practice) should be aware and make adjustment for.

Students' fears and anxieties largely focus upon the personal consequences that raising a care concern may have. As Francis (2015) highlighted, the students' role as a learner may place them in a vulnerable position, whereby fears and anxieties

pertaining to their education may inhibit raising of a care concern. The fears and anxieties which have been reported by health and social care students support the view that students may have specific difficulties which require addressing prior to and on speaking up. Undertaking research which focuses upon raising a care concern, without stipulating 'whistleblowing', would therefore be beneficial to enhance understanding of students' experience of this phenomenon.

2.2.5.1 Students' moral decision making

Within the literature, there appears the assumption that students are motivated by similar professional morals as registrants. There is a mixed picture which emerges from the literature, which lacks clarity, and appears to interplay professional duty and responsibility with moral components of professional practice. Undertaking raising a care concern as a professional responsibility appeared to be a general term used to cover a range of ethical and professional belief positions i.e. ethical principles, deontology and advocacy. Brief mention of ethical principles in one medical study (Druce et al., 2016), and of the deontological positions (i.e. doing one's duty) in three nursing studies (Andrews & Monsour, 2014; Ion et al., 2015, 2016) suggest that there is an attempt to view raising a care concern as a dispassionate decision, yet even within these studies, there is an intimation that decisions for raising a care concern may also involve moral components i.e. 'doing the right thing' (Ion et al., 2016, 2017). The broad sense of something not being right, a stance connected to Aristotle's theory of virtuous practice (Beauchamp & Childress, 2009; Duncan, 2010) and associated with breaches of personal morals and principles, has been provided as a general principle for triggering concern of medical, nursing and allied health professional students when in clinical practice (Erdil & Korkmaz, 2009 Monrouxe et al., 2012, 2014, 2015; Rees Monrouxe, & McDonald, 2014). A generalist approach to moral motivation was adopted in Australian research by Bickhoft, Levett-Jones, and Sinclair (2016) which went on to attribute nursing students' desire to raise a care concern to the principle of professional advocacy. As with registrants, advocacy captures the belief in putting the patient first, which appears to have international, multi-professional acceptance for motivating raising of care concerns (Bickhoft et al., 2016; Cimino, Rorke, & Adams., 2013; Erdil & Korkmaz, 2009; Mansbach et al., 2009, 2012, 2013, 2014). In addition to these perspectives, the consideration of ethical principles such as consequentialism i.e. an outcome for improved patient safety was cited in several North American educational studies (Duhn, Oluwasbusola, Edge, Ginsburg, & VanDenKerkhof, 2012; Kent, Anderson, Ciocca, Shanks, & Enlow, 2015; Espin &

Meikle, 2014) and one UK clinically based study (Bellefontaine, 2009). The weighing up of biomedical ethical principles to guide the decision to raise a care concern was intimated in a medical study by Druce et al. (2016), suggesting a deliberate decision making approach was needed rather than reacting to a moral sense. The range of perspectives offered within the literature as motivating or aiding students' decisions on whether to raise a care concern suggest there is little known about students' decision making in this situation, and that further research may be beneficial.

2.2.5.2 Experience of students and raising a care concern

Students' experiences of raising of a care concern as internal whistleblowing have led to negative perceptions, and are associated with fears and anxieties which may deter speaking up. As with registrants, speaking up presents a limited view of actions which students may take when faced with a concerning situation (Milligan et al., 2016), and has been associated with a range of potential fears, anxieties and barriers which may inhibit them (Duffy et al., 2012; Jones & Kelly, 2013). Feelings of stress have been attributed to raising of concerns (Galvin et al., 2015); these appear to centre upon fears about personal outcomes, such as educational non-achievement, speaking up to people in authority and negative placement experiences. Negative changes to placement relationships, especially with practice educators, supervisors or mentors, were considered as inhibiting medical, nursing and allied health professional students from taking action when faced with breaches of health and safety, patient dignity and respect, and poor treatment of fellow students (Monrouxe et al., 2012, 2014, 2015; Rees et al., 2014). Similarly, fear of not belonging to the placement team is offered by Levett-Jones and Lathlean (2009) as an explanation for students not wishing to 'rock the boat' by raising care concerns. Fears about negative personal consequences due to educational failure, being chastised and developing a reputation for raising concerns, and concerns about future employment and careers, were reported by some nursing students across several research studies (Andrews & Monsour, 2014; Bickhoft et al., 2016; Ion et al., 2015, 2016) and medical studies (Druce et al., 2016). Speaking to people with authority appears to be another specific fear, with having to verbalise concern to a person with perceived educational responsibility such as mentors, supervisors or university staff (Bellefontaine, 2009; Cimino et al., 2013; Druce et al., 2016; Galvin et al., 2015; Monrouxe et al., 2012, 2014, 2015; Rees et al., 2014) or organisational authority (Espin & Meikle, 2014; Kent et al., 2015) being particularly difficult. These fears have been associated with inaction by multi-professional students (Monrouxe et al., 2012, 2014; Rees et al., 2014) and especially by females

(Monrouxe et al., 2015), leading to moral distress. Studies of social work, physical therapy, physiotherapy and nursing students by Mansbach et al. (2009, 2010, 2012, 2013, 2014) noted a statistically significant decrease in willingness to raise a care concern if this required speaking outside of the placement, as is required by internal and external whistleblowing policies. There appeared to be a consensus within the literature that raising a care concern to someone in authority, as required by their PSRB (GMC, 2012; HCPC, 2016a; NMC, 2013a, 2017a, 2019a), may actually reduce students' likelihood of speaking up.

Being a pre-registration learner appears to contribute other variable factors when deciding whether to raise a care concern, specifically the recognition and assessment of a situation, choosing how to respond, degree of personal confidence and exposure to learning opportunities. The range of concerning situations which students need to recognise is reflected across the literature. Two educational studies suggest that nursing students are able to recognise a concerning situation which features patient physical or psychological harm (Duhn et al., 2012; Kent et al., 2015). This is supported by the scenario studies by Mansbach et al. (2009, 2010, 2013, 2014) and social worker case studies by Cimino et al. (2013). One educational study suggests nursing students are unable to determine potential harm and have limited knowledge of the scope of professional practice, which restricts their ability to recognise professional malpractice (Espin & Meikle, 2014). Other studies suggest that students rely upon knowledge of policies to determine misconduct (Andrews & Monsour, 2014; Killam et al., 2013; Monrouxe et al., 2012, 2014; Rees et al., 2014) whilst interpreting a breach of ethical principles (Erdil & Korkmaz, 2009) or of values e.g. dignity within patient care (Cimino et al., 2013; Killam et al., 2013; Monrouxe et al., 2012, 2015) may be employed to determine if practitioners are practising competently. Other studies suggest students may rely upon instinctual responses of feeling uncomfortable (Killam et al., 2013; Monrouxe et al., 2014) as an internal indicator that something may not be right. Failing to recognise concerning situations remains a possibility for all health and social care pre-registration students, due to potential differences in knowledge of professional practice, difficulties in assessing risk of harm and difficulty in applying ethical principles to practical situations (Druce et al., 2016; Espin & Meikle, 2014). The literature reflects the difficulties in recognising a concerning situation, which as illustrated in diagram 1.1 can be determined from a range of perspectives, suggesting that students may not always recognise when a situation should elicit raising of a care concern.

Knowledge of how to respond to a concerning situation may prevent students choosing the right action to take. There is evidence to suggest that students, as with registrants (diagram 1.2., p 15), may choose a variety of ways to deal with a concerning situation such as documentation, speaking to a colleague and reporting to other agencies, showing concern for the wronged person, indirect verbal challenges, acts of resistance i.e. non-participation, debriefing, direct verbal challenge or whistleblowing (Espin & Meikle, 2014; Rees et al., 2014), which may be employed in preference to speaking up. Whilst these approaches may be used due to not knowing the correct polices or processes to follow (Bellefontaine, 2009; Druce et al., 2016; Duffy et al., 2012; Milligan et al., 2016), this may not be as relevant since the publication of PSRB guidance for raising a care concern (GMC, 2012; HCPC, 2016; NMC, 2013a, 2019a). Limited role modelling in clinical practice has been suggested in a few international educational studies (Duhn et al., 2012; Erdil & Korkmaz, 2009; Kent et al., 2015) as a reason that students do not have sufficient knowledge to recognise and respond to a concerning situation within a negative culture with a negative view of whistleblowing (Druce et al., 2016; A. Jones & Kelly, 2014). It should be acknowledged that the availability of role modelling and therefore opportunities for learning how to raise a care concern in clinical practice may be limited, suggesting that educators need to seek other ways to prepare students for this important aspect of current professional practice.

2.2.5.3 Improving students' likelihood to raise a care concern

Ways to positively influence students to raise a care concern are evident in recent discussions. Student feedback on how to improve support in clinical practice identified the importance of anonymity, protection, reporting to a person unconnected to education and local knowledge of how to raise concern (Glasper, 2015; RCN cited in Milligan et al., 2016). Students' awareness of how to raise a care concern may be addressed through educational preparation (Duhn et al., 2012; Espin & Miekle, 2014; Kent et al., 2015) and through enhanced awareness of policies and practices when in clinical practice (Bellefontaine, 2009; NMC, 2015b). The improvement of NHS culture towards speaking up may alter nursing students' perceptions (Duffy et al., 2012; Jones & Kelly, 2014), enhance exposure to role models (Bickhoft et al., 2016) and support students' learning of patient safety (Duhn et al., 2012). Removing the fears associated between educational failure and raising of a care concern to mentors or supervisors may also be helpful, and the recent NMC (2018e) standards to support students' supervision and assessment in practice have identified a new independent person for nursing students to raise a

care concern with: the nominated person, although the NMC (2019a) guidance for raising of a care concern has yet to be updated. Although protection and anonymity remain areas of debate, the most recent NMC guidance (2019a) seeks to aid protection, including ways to raise a care concern which are anonymous and confidential. Although the legal strategies outlined in diagram 2.3 (p 29) enable whistleblowers to be protected in finding new employment, how this translates to students is unclear. Besides strategic approaches to encourage students to raise care concerns, the presence of self-confidence i.e. “a feeling of self-assurance arising from an appreciation of one's own abilities or qualities” (https://en.oxforddictionaries.com/definition/confidence) combined with having personal strength, ambition, determination to succeed (Fagan et al., 2016; Ion et al., 2015, 2016), and willingness (Mansbach et al, 2010; 2013) have been suggested as important personal qualities facilitating raising a care concern. How students gain confidence is less widely evident within the literature, although specific university based educational intervention about patient safety has been cited (Bellefontaine, 2009; Duhn et al., 2012; Kent et al., 2015). When in clinical practice, early studies suggest that fostering a sense of belonging and effective mentor/ student relationships may be a positive influence on students’ confidence and likelihood to raise a care concern (Bellefontaine, 2009; Levett-Jones & Lathlean, 2009), with Bickhoft et al. (2016) suggesting that effective role models and positive feedback from placement staff may enhance students’ confidence and courage to raise care concerns. Although there is an emerging association between personal confidence and raising of a care concern, the literature appears to focus upon what factors may deter students from acting. Although within the NHS there has been much attention on how to improve registrants’ experiences of raising of a care concern, the literature suggests that the impact of these changes upon pre-registration students has not been examined.

There remains an opportunity to undertake research into the topic of raising of a care concern from the perspective of health and social care students.

2.3. Implications for study

From the review of the literature, the topic of raising of a care concern as a form of internal whistleblowing appears to be a current perspective within professional practice. Although the association with internal whistleblowing presents a limited definition of how professionals and students may respond when faced with a concerning situation, this perspective is consistent with the current UK focus of

raising of a care concern. From this perspective, the dominant view sees raising a care concern as a stressful, difficult professional decision, with many dilemmas caused by fears of poor treatment and choices between professional and organisational priorities. For students, the difficulty appears linked to the potential barriers of lack of knowledge/failures of recognition, how to respond to concerning situations, and fears of educational disadvantage caused by speaking up. The phenomenon of raising of a care concern appears to be under researched (Milligan et al., 2016), with an emphasis upon examining external factors which influence students. This suggested that exploring students' experience of raising of a care concern since the introduction of changes to NHS culture may be timely and insightful, and inform changes to education and the profession. Therefore, this study aimed to provide insight into students' experience, and sought to focus upon students who had raised a care concern whilst in clinical practice. Using their perspective, the inquiry aimed to provide insight into what motivated students and what helped them overcome the barriers to action i.e. the personal fears which appeared to be part of their experience.

2.4. Research aim and questions

The phenomenological question reflects the aim of the study, i.e. to explore the experiences of nursing students who have raised a care concern in clinical practice. This was split into three questions to help establish the research agenda and focus the investigation:

1. What is the experience of nursing students who raise a care concern in practice?
2. What motivates nursing students' decisions to raise a care concern?
3. How do nursing students overcome perceived barriers to raising a care concern in clinical practice?

2.5. Chapter summary

From the literature reviewed in this chapter, the topic for investigation in this transcendental phenomenological research study was identified: the experiences of nursing students who have raised a care concern whilst in clinical practice. The systematic retrieval and critical appraisal of twenty-four primary studies identified the international relevance of the topic, although healthcare students' lived experience of raising a care concern when in clinical practice remains an under-explored area, justifying the need for further research. The critical review suggested that examining nursing students' experiences would address a gap in current

knowledge. For educators, understanding what motivates nursing students and how students who do raise a care concern overcome the barriers to whistleblowing may inform future professional practice and policy. The study's research methodology and design will now be discussed in chapter three.

Chapter 3: Research Methodology and Design

This chapter details the choices of methodology and design of the study, made in order to meet the research aim and questions (Creswell, 2014; Lincoln et al., 2011; Parahoo, 2014). Methodological choices drew upon influences from nursing research and my philosophical beliefs, and were selected from a range of qualitative methodologies which explore the subjective experience of participants. The study was influenced by Clarke Moustakas' transcendental phenomenology (1994), and this approach guided the practical completion of the study, from recruitment, sampling and data collection to data analysis and findings. The influence of ethics and the need to produce a trustworthy study are also documented, evidencing the decision making made throughout the study. From these processes, a composite description and the essences of students' lived experience of raising a care concern were identified, and are presented in chapter four.

3.1 Research methodology

The choice of research methodology i.e. the set of beliefs which guide the practical conduct of the study (Denzin & Lincoln, 2011) was influenced by my researcher position and the research aim and questions (p.39). Following a specific methodology provides a framework for the novice researcher and helps demonstrate the trustworthiness of the research (Boswell & Cannon, 2017; C.A.S.P, 2017). The choice of methodology for this study, transcendental phenomenology, was made following consideration of the researcher's position, a critical review of a range of interpretive qualitative methodologies, and consideration of five phenomenological approaches.

3.1.1 Researcher position

The researcher position in this study reflects my philosophical beliefs towards research and the topic, which led to a pragmatic decision for the choice of methodology. Within contemporary nursing and educational research, interpretivist approaches acknowledge that the researcher's position (i.e. beliefs) is influential upon the choices made (Denzin & Lincoln, 2011; Gray, 2014). An insider position is acknowledged as being the prompt for this study, as my curiosity about nursing students' experiences of raising care concerns arose from my field of professional practice: nurse education. The insider position embedded within nursing research (Braun & Clarke, 2013; Parahoo, 2014; Polit & Beck, 2012) assumes that the researcher makes pragmatic decisions, choosing between quantitative or qualitative

methodologies according to their suitability to address the posed research questions.

This study's aim was interpreted as the exploration of a real-world, lived experience. This position arose from my educational practice, where experiential learning describes the individual (learner) as separate to, yet interacting with, a real world i.e. a world which exists external to the person, and which influences / generates learning (Crotty, 2009; Denzin & Lincoln, 2011; Howell, 2013; Kolb, 1984). A focus upon a real-world experience, driven by the reviewed literature and research questions (p.39), suggested that the chosen methodology should encourage exploratory, open inquiry conducted without pre-determined ideas or theories (Gray, 2014; Parahoo, 2014). This discounted consideration of naturalistic, descriptive and quantitative methodologies, which utilise deductive reasoning i.e. the research seeks to prove ideas, theories or relationships between a range of factors (Creswell, 2013; Denzin & Lincoln, 2011; Gray, 2014; Guba & Lincoln, 1985; Robson & McCarten, 2016; Saldowski, 2010 cited in Parahoo, 2014). Thus, a qualitative methodology which utilises an inductive reasoning approach i.e. seeks answers from participants' perspectives, and explores new or under-researched areas or topics which are difficult to define or measure, was deemed most appropriate for this study (Gray, 2014; Parahoo, 2014).

3.2 Qualitative methodologies

The choice of an appropriate qualitative methodology was made following consideration of several approaches which could be used to explore an individual's experience. Qualitative research focuses upon exploring experience through the collection of verbal accounts, which are analysed to explore the events, thoughts, feelings, meaning or understandings held by participants (Parahoo, 2014; Polit & Beck, 2012), which suited the aim of this study. For this study, qualitative methodologies which appeared common to the discipline of Nursing i.e. action research, case study, critical ethnography, ethnography, grounded theory, phenomenology, and narrative and discourse analysis (Braun & Clarke, 2013; Creswell, 2014; Holloway & Wheeler, 2010; Parahoo, 2014) and which were appropriate to examine a real-world experience were critically examined. A summary of the critical analysis is presented in table 3.1, identifying phenomenology as the methodology of choice.

Table 3.1: Critique of qualitative methodologies

Type of methodology	Purpose of methodology	Previous use of methodology within the topic area, as evidenced within reviewed literature	Suitability for study
Action research (Crotty, 2009; Howell, 2013; McAteer, 2013; McNiff, 2013)	Critical methodology: using research to empower participants or groups through participation in social change	Nil	Study not associated with active change project – rejected
Case study	Typical or unusual case (Barbour, 2008; Stake, 2005)	Cimino et al. (2013)	Single case study suggested lack of credibility in knowledge generation for professional practice – rejected
	Exploration of societal/cultural aspects within specified complex social situations (C. Cronin, 2014; T. Moore, Lapan, & Quartaroli, 2012)	Levett-Jones et al. (2009)	Societal/cultural focus was not aligned with research questions – rejected
Critical ethnography (Creswell, 2014; Howell, 2013)	Critical methodology: to create social challenge and change by participatory research focusing upon socially disadvantaged/vulnerable groups	Nil	View of nursing students as a vulnerable group (Francis, 2015) not consistent with professional stance (NMC, 2018b, 2018c) – rejected
Ethnography (Barbour, 2008; Creswell, 2014; Gobo, 2011; Parahoo, 2014)	Examination of the influence of societal/ cultural or environmental factors within a real-world experience which impact upon a person's behaviour or views, based upon the researcher's direct observation	Nil	Limited by practical constraints and the sensitivity of the topic area – rejected
Grounded theory	Generation of theory from analysis of participants' real-world experiences, from either an outsider perspective (Glaser & Strauss cited in Polit & Beck, 2012) or insider perspective (Charmaz, 2014)	Galvin et al. (2015)	Generation of theory through abstracted analysis not consistent with seeking nursing students' actual experience – rejected

Type of methodology	Purpose of methodology	Previous use of methodology within the topic area, as evidenced within reviewed literature	Suitability for study
Narrative methodology & discourse analysis (Burr,1996; Potter, 2011; Riessman, 2011; Wang & Geale, 2015)	Examination of life stories or events, focusing upon deconstructing language to highlight cultural or social influences	Monrouxe et al. (2012, 2014, 2015); Rees et al. (2014)	Not aligned with personal philosophy of experience or research questions – rejected
Phenomenology (Braun & Clarke, 2013; Holloway & Wheeler, 2010; Parahoo, 2014;	Examination of people's experience of real-world situations, events or concepts	Bellefontaine (2009)	Purpose aligns with this study's research aim and focus upon students' experience, and thus was chosen as suitable approach

The suitability of using a phenomenological approach is discussed in the following section.

3.3 Phenomenology methodology

Phenomenology is a broad term which encompasses a range of approaches which may be adopted to examine a person's lived experience of a real-world situation, event or concept. Lived experience has become synonymous with exploring a person's subjective experience i.e. psychological interpretations, meanings, thoughts, ideas or perceptions of a real-world occurrence (Braun & Clarke, 2013; Creswell, 2014; Parahoo, 2014; Shaw & Conelly, 2012). Phenomenological research is credited to the writings of Edmund Husserl in his *Cartesian Meditations* (Husserl, 1973) which suggested that research could give an insight into the real world through describing an individual's experience. Thus, Husserlian methodologies were considered to directly represent the view of real-world experience, as a combination of events, situations and psychological phenomena e.g. empirical phenomenology (Moustakas, 1994). Later phenomenological research, influenced by Martin Heidegger's existential ideas and application of hermeneutic beliefs e.g. Gadamer (1979, 2000), Palmer (1969), and Ricoeur (Charalambous, Papadopoulos, & Beadsmoore, 2008; Ricoeur, 1991, 1994) considered individuals' experience as a psychological phenomenon i.e. as constructions or interpretations, and thus research gave insight into how people viewed the world (Crickshanks, 2003; Gray, 2014; Palmer, 1969). Further existential, anti-foundational beliefs i.e. disputing the existence of a real world (e.g. Sartre) focused upon exploring how people constructed their interpretations/ meaning of the world, rather than discovering a real world (Howell, 2013; J. Smith, Flowers, & Larkin, 2009). Although there are different philosophical interpretations of phenomenology (Braun & Clarke, 2013; Creswell, 2013, 2014; Crotty, 2009; J. Smith et al., 2009), phenomenology research is typically identified as concerning the 'lived experience' (Fendt, Wilson, Jenkins, Dimmock, & Weeks, 2014; Parahoo, 2014) from which insight into other people's worlds, meanings and/or interpretations may be achieved. Thus, phenomenology was applicable to providing insight into nursing students' experience of raising a care concern when in clinical practice.

My choice of methodology concurred with the conclusions from the Milligan et al. (2016) commissioned literature review, that exploring students' lived experience using a phenomenological methodology would offer a unique method of inquiry and address a significant gap within current literature. The adoption of phenomenology

as a methodology would also contribute to the knowledge underpinning professional practice, fulfilling in part the requirement of this thesis to offer an original piece of new knowledge.

A familiar methodology within nursing and nurse education (e.g. E. Anderson & Kiger, 2008; Baglin & Rugg, 2010; Bradbury-Jones, Sambrook, & Irvine, 2011; Chesser-Smyth, 2005; May & Veitch, 1998; F. Murphy, Rosser, Bevan, Warner, & Jordan, 2012; Ohrlung & Hallberg, 2000), phenomenology encompasses different philosophies and practices (Creswell, 2014; M. Dowling, 2007; Holloway & Wheeler, 2010; Parahoo, 2014) which have been applied diversely across nursing research. This diversity of application of phenomenology, perhaps due to the professions' use of bricolage i.e. research methods used according to researcher choice (Kincheloe, McLaren, & Steinburg, 2011; Reiners, 2012) or pragmatism i.e. research methods used according to the identified problem or questions (Creswell, 2014; C. Dowling & Cooner, 2012), led to criticisms of Nursing research i.e. a lack of methodological rigour and implied weakened trustworthiness within phenomenological studies (Finlay, 2009; Giorgi, 2008; McNamara, 2005; Paley,1997, 1998; Yegdich, 2000). These criticisms were addressed in this study through the adoption of a phenomenological methodology which guided the conduct of the study.

3.3.1 Choice of Moustakas' transcendental phenomenology

A range of phenomenological methodologies which were cited in current qualitative or nursing research were critically reviewed: the methodologies' ability to address the posed research questions, the identified researcher's position in relation to knowledge production, and the type of description produced by the method were appraised prior to selection and are summarised in table 3.2 (p.47).

This study aims to explore nursing students' experience of raising a care concern whilst in clinical practice, and as such the researcher's position in relation to the research process i.e. knowledge generation was a key factor in choice of methodology. As illustrated in table 3.2 (p.47), there are two key researcher positions presented within the reviewed methodologies: insider and outsider. The outsider terminology originates from Nursing's assumed positivist ideology (M. Dowling, 2007; C. Dowling & Cooner, 2012; Giorgi, 2012; Moustakas, 1994), whereby the researcher is an observer or external to scientific experiments and was applied to early Husserlian based phenomenology. Insider positioning reflects the involvement of the researcher within the research process, and has been associated with Heidegerrian phenomenological methodologies (Braun & Clarke,

2013; M. Dowling, 2007; C. Dowling & Cooner, 2012; Finlay, 2009; Giorgi, 2012; Moustakas, 1994). Within contemporary interpretivist research, some phenomenological methodologies provide practical steps which aim to assist the researcher to promote an outsider position i.e. distance between researcher and participant (Creswell, 2014; Finlay, 2009; Lopez & Willis, 2004**)**, whilst others employ the insider position i.e. researcher and participant as co-researchers / co-producers of knowledge. These differing perspectives are reflected in the reviewed phenomenological methodologies below, which included approaches favoured in Nursing, from the Utrecht school i.e. Moustakas, Van Manen (Creswell, 2014; Lopez & Willis, 2004) and North American school i.e. Giorgi, IPA, Colazzi (Parahoo, 2014; Finlay, 2009). As this study aimed to explore nursing students' experience, a methodology which reduced the researcher's influence through promoting an outsider positioning was advocated, and was a key factor in the choice of methodology for this study.

Table 3.2: Overview of phenomenological methodologies (adapted from Finlay, 2009)

Methodology	Philosophical foundation	Dominant researcher position	Extent of interpretation	Description of experience
Descriptive Transcendental (Creswell, 2014; Moustakas,1994)	Husserl	Outsider through the use of phenomenological epoché	Through development of analytic themes i.e. experiential essences	Description of events, situations and psychological components i.e. feelings, thoughts within the lived experience
Descriptive Psychological (Giorgi, 2000a, 2012)	Husserl	Outsider through the use of bracketing	Through development of analytic themes	Description of participants' meanings – psychological components of lived experience
Descriptive Colazzi (Holloway & Wheeler, 2010)	Husserl	Insider through the use of personal experience	As above	Description of meaning – psychological components of lived experience
Interpretive Hermeneutic (Parahoo, 2014; Van Manen, 1997)	Heideggerian Gadamer	Insider through awareness of personal/external views and influences	Co-production of meanings during data collection	Description of shared new interpretations of an experience
Interpretive Phenomenological Analysis (IPA) (Parahoo, 2014; Smith et al., 2009)	As above plus Sartre	Insider through co-productive relationship	Co-production of meanings during data collection	Description of cultural/social constructions of meaning of an experience

Sources: Braun & Clarke, 2013; Creswell, 2014; M. Dowling, 2007; C. Dowling & Cooner, 2012; Giorgi, 2000a, 2000b, 2008, 2012; Moustakas, 1994; Paley, 1997; Parahoo, 2014; Smith et al., 2009; Smith & Osborn, 2003; Van Manen, 1997.

As summarised in table 3.2, three methodologies suggested an insider positioning i.e. Colazzi, Van Manen and IPA. Colazzi's approach was identified as inappropriate due to the requirement that the researcher uses their own real-world experience as part of the research data (Holloway & Wheeler, 2010), a requirement I did not meet. Van Manen and IPA, which originated from Heidegerrian phenomenological ideology, favoured an insider positioning to construct knowledge through a dialogic approach to data collection whereby co-production or shared understanding and meaning is achieved through interviewing (Gray, 2014; Smith et al., 2009; Van Manen, 1997). The co-production relationship advocated in Van Manen's Heidegerrian approach was difficult to uphold due to my position as a lecturer with perceived power implications (table 3.4, p.53). The production of new meanings in Van Manen's approach (1997) detracted from what may have happened during the participants' actual experience which was not consistent with the aim of this study. Within IPA, insider positioning is used to construct and then analyse the cultural/ social influences constructing the meaning of the experience (Smith et al., 2009). The aim of IPA was not consistent with this study's research questions, which sought descriptions of nursing students' real-world experiences, gaining insight into motivations and ways of overcoming perceived barriers. Thus, the methodologies which advocated the researcher insider position were rejected due to practical requirements, and the inability to address the aim of this study.

Two methodologies described ways for the researcher to adopt an outsider position through utilising processes whereby personal beliefs, ideas or thoughts are deliberately withheld whilst collecting data (Englander, 2012; Parahoo, 2014; Vagel, 2014)*.* The outsider positioning appeared more suited to this study, enabling nursing students' descriptions of a real-world experience to be at the forefront of the research process. Both methodologies derived from Husserlian ideologies, which are considered to focus most directly on describing people's intentionality i.e. perceptions, meanings and understanding of their real-world experience (Husserl, 1962, 1973; Kockelmans, 1994)*.* Husserl describes 'experience' as having both physical ('noema') and psychological ('noesis') components, and that participants' perceptions accentuate components (which become essences) which hold meaning or significance for the individual within the experience (Husserl, 1962, 1973; Kockelmans, 1994). Research derived from Husserl's view of an individual's real-world experience would appear to address the questions posed by this study (Crotty, 2009; M. Dowling, 2007; C. Dowling & Cooner, 2012: Lopez & Willis, 2004),

as understanding the significant components of nursing students' experience of raising a care concern would provide a description which would address research question one (p.38), and provide opportunity to explore any potential motivations or strategies employed to overcome any perceived barriers, addressing research questions two and three (p.39). Of the two Husserlian methodologies, both Giorgi and Moustakas offered practical ways to gain an understanding of the key essences of nursing students' experiences (table 3.2, p.47). Giorgi's methodology (Giorgi, 2000a, 2000b, 2008, 2012; Parahoo, 2014) has been favoured by nursing researchers to examine patients' experience of living with a disease/illness (Crotty, 2009; Paley, 1997; Parahoo, 2014), focusing upon describing the thoughts, feelings and meaning held within participants' lived, real-world experience. The psychological emphasis portrayed in Giorgi i.e. seeking to understand the meaning within lived experiences (Parahoo, 2014) sees a move away from examining the breadth of a real-world experience i.e. physical and subjective components (C. Dowling & Cooner, 2012; Howell, 2013; Paley, 1997; Reiners, 2012; Robson & McCarten, 2016) advocated in Husserl's view of experience (Husserl, 1962, 1973; Kockelmans, 1994). Thus, Giorgi's approach may not capture the physical events/ interactional components of a real-world experience, which the literature review infers are part of the influence of clinical practice upon nursing students when contemplating raising a care concern (Chapter 2). Moustakas' transcendental phenomenological methodology (1994) outlined ways in which both physical (i.e. situations, events, people) and psychological occurrences (i.e. thoughts, feelings, ideas) could be explored as part of the research process. This ability to capture the breadth of a real-world experience offered within Moustakas' methodology (1994) therefore appeared best suited to this study's exploration of nursing students' experience of raising a care concern.

Further exploration of Clarke Moustakas' methodology within primary research demonstrated that this was a credible approach within several health related professions e.g. family therapy (Fendt et al., 2014), midwifery (Linhares, 2012; Masterson & Brenner, 2016), counselling (McGlasson & Rubel, 2015) and in social science (Creswell, 2014; Moerer-Urdal & Creswell, 2004). The methodology was not reflected within key nursing texts e.g. Braun and Clarke (2013), Holloway and Wheeler (2010) or Parahoo (2014), nor had it been used to investigate the whistleblowing experiences of registered health professionals (Jackson et al., 2014; Whitehead & Barker, 2010) or healthcare students' experiences of raising a care concern (Ion et al., 2017; Milligan et al., 2016), suggesting this was an original

method of inquiry within the topic area. Thus, Moustakas' methodology was adopted to guide this study, offering an appropriate design which would address the posed research questions through an original method of inquiry.

3.4 Research design

This study followed the phenomenological research described by Clarke Moustakas' transcendental phenomenology (1994), which focused upon gaining a summarised description of nursing students' experience of raising a care concern. The final, summary description addresses the first research question through identifying the commonly occurring essences i.e. "the condition or quality without which a thing would not be what it is" (Moustakas, 1994, p.100). When the final description is deconstructed, four essences are present which address the second and third research questions: what motivates nursing students, and what may help them overcome perceived barriers? The essences 1) patient centred concern, 2) making the decision, 3) emotional strength, and 4) feedback and support were identified through following Moustakas' guidance on preparation, data collection and analysis, which includes the processes of phenomenological epoché, phenomenological reduction and imaginative variation (Creswell, 2013; Moustakas, 1994). This process is discussed below.

3.4.1 Preparation

Prior to completing the study, Moustakas (1994) identified preparation required by the researcher which entails psychological and practical activity. Psychological preparation focuses upon phenomenological epoché which moves towards a supposition-less state prior to planning and conducting the research (Moustakas, 1994) and prepares the researcher for distancing themselves from the data. Practical preparation also focused upon meeting the international standards for ethical and quality research (section 3.4.1.2, p.52).

3.4.1.1 Phenomenological epoché

Phenomenological epoché is used to prepare the researcher for "deriving new knowledge; [making a] new start… not being hampered by the voices of the past" (Moustakas, 1994, p.85). For Moustakas, epoché is transcendental preparation, whereby the researcher undergoes a self-analysis of views held about the phenomenon. Through the process of self-examination, an openness towards the topic under investigation emerges as the researcher uses purposeful contemplation to remove the *natural attitude* i.e. the researcher's own preconceived thoughts

(Moustakas, 1994) prior to relooking at the phenomenon under study. The removal of the researcher's natural attitude has been associated with the process of 'bracketing' (Englander, 2012; Gearing, 2004), trying to achieve an objective distance from the topic being studied. Within current phenomenological research, the achievement of objectivity through bracketing has been disputed (Gearing, 2004; Giorgi, 2012; Vagel, 2014), and currently the achievement of an attitude of openness, which leaves the researcher able to explore new perspectives, meanings or views which describe a phenomenon, is advocated. In seeking to achieve this attitude, whereby I am receptive to new ideas relating to raising a care concern (Moustakas, 1994), Moustakas (1994, p.88) suggests I undertake a contemplation: "..what is before me increasingly comes into meaning as I remain with it, as I linger in its presence, as I open myself to it, as I focus on its manifold appearances, its dimensions and as a whole". A range of perspectives emerged from this deliberate reflection on the topic, identifying my 'natural attitude' towards raising a care concern; these are summarised in table 3.3 (p.52).

By identifying my natural attitude, these ideas could be deliberately set aside prior to the conduct of the study, so I could adopt an attitude of open-mindedness and uphold an outsider position towards the research. It should be noted that although the thesis focuses upon the decision making aspects of professional whistleblowing, this stance was adopted after the analysis phase of the research (Gearing, 2004; Jacelon & O'Dell, 2005), following an authentic inductive approach to knowledge generation advocated within qualitative methodologies (Gray, 2014).

Table 3.3: Phenomenological epoché: My 'natural attitude' towards raising a care concern

Perspective	Evidence in thesis
Professional education promoting raising a care concern as a professional responsibility	NMC guidance (2013b) and premise of educational role in pre-registration nurse education (Section 1.2., p 16)
Organisation: Raising concern as internal whistleblowing	Original interpretation of raising a care concern from own experience of implementing NMC policy, terminology and relevance to NHS strategy (Section 2.2., p.22)
Professional: raising a care concern as a negative emotional experience	Table 2.2 (p.25)
Organisation: Students as a vulnerable group when whistleblowing	Organisational analysis by Francis (2015) *Freedom to speak out* report (Diagram 2.2. p28).
Professional: raising a care concern as professionally motivated act based upon ethical and moral imperatives	Apparent from exploration of the opinions of, and literature pertaining to, healthcare professionals and whistleblowing (section 2.2.4).
Connotations of protection, safeguarding & advocacy	Derived from professional background (section 2.2.4.2., p.32)
Raising a care concern requiring virtues of courage, commitment, compassion and care	Strategic position for nurses (section 2.2.4.3., p.32)
Students' assumed professional moral Imperatives	Section 2.2.5.1. p.34
Students' use of moral courage to raise a care concern	Bickhoft et al. (2016) paper
Students raising a care concerns a difficult prospect	Section 2.2.5.2., p.35

3.4.1.2 Ethical considerations

This study sought to fulfil the international requirement for ethically sound research, through meeting its obligations for confidentiality, anonymity, data management, health and safety, and upholding ethical values of non-maleficence, beneficence, equality and autonomy (British Educational Research Association, 2011; Parsell et al., 2014; Universities UK, 2012). Raising a care concern is a potentially risky ethical topic due to organisational, professional or emotional sensitiivies (Section 2.2., p 22). Ethical dilemmas during the conduct of this study may have arisen due to my role as a nurse and an educator and through undertaking research within my place of work (Bradbury-Jones & Alcock, 2010; Lindorff, 2010; B. Murphy, 2003; Parahoo, 2014); steps taken to mediate or manage any unexpected situations are presented in table 3.4, and were agreed through the receipt of ethical approval at the Faculty Ethics Committee (Appendix A). Health Research Authority approval was not

sought, as the research was not conducted in an NHS environment, and did not require access or use of employee or patient data (Health Research Authority [HRA], 2017). There was no occurrence of unforseen ethical dilemmas, instigation of Faculty processes for undisclosed concerns, nor withdrawal/termination of participation during this study.

Table 3.4: Ethical considerations relating to the researcher and student relationship

Nature of ethical issue	Action taken to address
Potential disclosure of unethical conduct of placement staff/student	Participant Information Sheet (Appendix B) & informed consent: the potential termination of participation and instigation of the Faculty's 'Raising a care concern' policy on new or inadvertent disclosure
Student may inadvertently disclose an area of 'concern' which has not been reported	
Students who discuss a concern which they have knowingly not reported	As above, plus potential professional 'Fitness to practise' (NMC, 2010) process
Student may disclose poor practice within the Faculty	Researcher may instigate Faculty processes if required
Potential distress due to disclosure of concerning event **Stress due to time required and the academic and practice workload** **Relaying experience may be a way of gaining therapeutic benefit**	Recruitment strategy: Recruit students at either beginning or end of academic year, in years 2 and 3, who have adjusted to the programme using voluntary self-selection Option of withdrawal from study (without penalty) if necessary Refer student for pastoral support from Personal Academic Tutors/University counselling as appropriate
Conflict of interest: **Students may consider involvement as a way of seeking favour from the researcher as a member of academic staff** **Students undergoing 'Fitness to practise' proceedings**	Recruitment from students not taught by the researcher Suitability of students checked on their response to invitation to participate
The potential for emotional impact may compromise the researcher's position during data collection, detracting from the study and delaying completion	Researcher has support of supervisor for pastoral issues, or issues with time management of data collection

Sources: Bradbury-Jones & Alcock, 2010; Lindorff, 2010; B. Murphy, 2003; Parahoo, 2014

3.4.1.3 Trustworthiness indicators

This study demonstrates trustworthiness (Guba, 1990; Lincoln et al., 2011; Sorrel & Redmond, 1995) through its alignment with the indicators of credibility, confirmability and dependability. Credibility i.e. conducting the study in alignment with Moustakas' transcendental phenomenology (1994) is described in the remainder of this chapter,

confirmability i.e. producing authentic findings derived from participants' data (sections 3.4.3, p.58 & 3.4.4, p.59) whilst dependability is demonstrated through an account of the decisions made during the completion of this study (Koch, 2006). Transferability of the study to the reader's own field of practice (Boswell & Cannon, 2017; Gray, 2014) can be made through weighing up the methodological details of the study, which are in the remaining part of this chapter.

3.4.2 Recruitment to the study

The study's sample was recruited from the population of undergraduate pre-registration nursing students within a North West of England university which delivered an NMC approved programme covering four nursing fields: Adult, Children's, Learning Disability and Mental Health (NMC, 2010). This approach was chosen as it provided opportunities for nursing students' own perceptions of raising a care concern to be paramount, reducing potential limitations to recruitment which might have occurred if recruiting students whose concerns had been formally reported to placement or were undergoing organisational investigation. Recruiting students who had raised concerns to the NHS, CQC or via the safeguarding process was rejected as impractical considering the restricted time available for recruitment due to the study's duration and the complex ethical issues of sensitivity, confidentiality and disclosure which surround NHS data (HRA, 2017); there was also concern that this failed to recruit students who may have used informal, local resolution to deal with concerning situations (Diagram 1.2., p.15). Recruiting from within my University, the population of nursing students would be aware of NMC approaches to raising of a care concern, and of clinical practice environments in both NHS and non-NHS organisations which have met the NMC (2015a) standards for pre-registration nurse education, including recognition of NMC guidance for staff (including students) on raising a care concern. The University's pre-registration nursing population are UK citizens (due to the recruitment policy at the time of recruitment to the study), and predominantly female and Caucasian, representing the national picture of nursing students in the UK.

For a credible phenomenological study, participants needed to fulfil two essential criteria: a) be a current nursing student and b) have had an experience of raising a care concern whilst in clinical practice (Creswell, 2014; Englander, 2012; Moustakas, 1994). Purposive sampling was not feasible due to the difficulties in identifying nursing students who had raised a care concern when in clinical practice, and potential breach of students' or placement confidentiality through targeting

students whose care concern was recorded within University records (Chu & Hsu, 2011; Funtasz, 2012; Parahoo, 2014; Ursa & Koehn, 2015). The decision to recruit through voluntary self-referral was made (Bornsheuer-Boswell, Garza & Watts, 2013). Voluntary participation meant participants had to personally identify their ability to meet the study's essential criteria, and one participant required clarity before agreeing to participate.

Recruitment followed a pragmatic, convenient approach (Parahoo, 2014) inviting, via email, year 2 and year 3 nursing students to maximise the likelihood of suitable participants being recruited (Englander, 2012; Moustakas, 1994). Year 1 students were excluded due to concerns about additional stress and workload evoked by participation (Chesser-Smyth, 2005; Gale, Ooms, Newcombe, & Marks-Maran, 2015; Thomas, Jack, & Jinks, 2012) and a pragmatic choice to focus upon students who would have had more opportunity /chance to be exposed to concerning situations on placement as a nursing student. The email invitations, with attached participant information sheet (Appendix B) and consent form (Appendix C), offered equal opportunities for participation across the identified pre-registration population, whilst limiting the influence or generation of ethical issues (table 3.4, p.53). However, this strategy did not recruit any participants, therefore the researcher met with specific cohorts to invite students to participate and sent them a follow-up invitation email with the same attachments. Using this approach, the study successfully recruited a sample of ten nursing students to the study.

3.4.2.1 Sample

A sample of ten participants was achieved, which met the requirements identified by Creswell (2014) and was consistent with studies using Moustakas' (1994) methodology (Bornsheuer-Boswell et.al., 2013; Chu & Hsu, 2011; Linhares, 2012; Masterson & Brenner, 2016). Although ensuring a minimum sample number is not necessary within a phenomenological study as data analysis and generalisability are not statistically dependent, a sufficient sample is needed to produce a 'plausible generality' (Englander, 2012, p.23) of the experience. Whilst there remains a debate upon the ideal number of participants for phenomenological research (Englander, 2012; Kvale, 1994; Moustakas, 1994), during data collection repetition emerged within the ten narratives which according to Moustakas (1994) should satisfy the researcher that a sufficient sample has been achieved to produce a generalised description of the experience.

The details of the study's sample are presented in table 3.5, which indicates each student's pseudonym, field of nursing and when in their studies the experience occurred. Details of a study's sample are useful to determine the dependability and transferability of the findings to other groups or contexts (Parahoo, 2014).

Table 3.5: Sample details

Participant identifier	Field	Year when experience occurred	Synopsis of concern
Abi	Learning Disability	2	Described a shift, where she was caring for a young boy with severe learning disabilities, whose prescribed and personal care were not delivered
Bea	Adult	1	Described two events: one when she worked with her mentor and found that routine medication had not been administered to a group of patients, and a second when a concern was raised about her behaviour to University, and she potentially faced being reprimanded for not knowing a policy, despite a task being delegated to her
Carly	Adult	Not disclosed	Described finding a healthcare assistant taking money from a patient's personal belongings
Diane	Adult	1	Described occasion of visiting a nursing home, where care of patients was not following best evidence nor prescribed plan. Failure to improve over a few days led to the student raising concerns, and safeguarding notification under the supervision of her mentor
Eve	Learning Disability	1	Described concern at seeing a mentally ill patient who was not responding to treatment and who was isolated due to aggressive bursts, making staff fearful. She investigated the treatment and escalated concern to medics to get a review of the patient's treatment undertaken
Fay	Adult	2	Described two concerns. One was working in a placement when a healthcare assistant treated a patient with disrespect and lack of dignity. She escalated this until an internal investigation was started. Two: reports from patients that an agency nurse had been bullying and uncaring to her group of patients. Action was taken, but outcomes remain unresolved
Gina	Adult	1	Described witnessing a medication error with her mentor, and having to report this to the ward manager
Heidi	Adult	2	Raised concern about a mum and a baby who may have been a failure to thrive due to concerns about breastfeeding. The student raised concerns which were ignored and had to escalate until intervention occurred. Her assessment was negatively affected by this situation
Ida	Adult	Not disclosed	Raised concern when staff on her placement were expected to complete 'first aid' to a patient who had fallen despite not having the correct competence. She intervened to ensure the care was delivered safely
Joy	Adult	1	Described witnessing a member of staff shouting at a patient, escalating to the manager yet having to support the patient and her husband

The sample participants were recruited from across the University's local delivery sites, yet represented only two nursing fields i.e. adult and learning disability. The participants were all female, with limited ethnic diversity i.e. nine Caucasian participants, and reflected a typical cross-section of ages consistent with the University's population of nursing students.

3.4.3 Data collection

Data collection for this study adopted an open style of inquiry (Moustakas, 1994), allowing each participant's lived experience of raising a care concern when in clinical practice to be told. A topic guide (Appendix E) was devised by the researcher (Bornsheuer-Boswell et al., 2013; Moustakas, 1994; Singh, Meng, & Hansen, 2014), drawn from the reviewed literature and reflecting the study's phenomenological approach. The interview was conducted as a conversation (Englander, 2012; Giorgi, 2008; Vagel, 2014): after the initial open question was posed, the researcher probed deeper through the use of natural prompts – e.g. 'Can you expand on that?' 'Can we go back to…?' – to gain a full and detailed description. Following the ethos of epoché (table 3.3, p.52), the conversation focused upon participants' accounts and the researcher consciously did not use influencing questioning, or introduce language reflecting her own personal or professional opinions into the conversation. Overall, the interviews elicited a detailed and reflective account of their lived experience, suggesting that the participants felt 'safe' to disclose the personal and potentially sensitive experience (Englander, 2012). Only Eve appeared to struggle with reflecting upon the experience in depth, and required repeated prompting to give deeper insight into her experience. The open style face-to-face interviews provided ten accounts of raising a care concern when in clinical practice which addressed the posed research questions and from which the findings were derived.

Interviews were audio taped and transcribed for easier data analysis (Moustakas, 1994; Parahoo, 2014). Transcription focused upon typing all audible words and sounds of the conversation, to capture the participants' natural emphasis. The data was managed in line with the Data Protection Act requirements: with audiotapes and transcripts stored anonymously, on a secure, password protected computer, and due to be destroyed after completion of the viva (when audiotapes do not need to be heard) and following completion of the thesis (Parahoo, 2014). Transcripts were returned to participants to ensure accuracy of the data, to enable any points which participants wished to clarify to be identified, and to confirm authenticity i.e.

that the interview was a truthful account of their lived experience (Giorgi, 2008; Holloway & Wheeler, 2010; Moustakas, 1994). No participants responded with any clarifications.

3.4.4 Data analysis

Data analysis was undertaken following the Moustakas (1994) analysis framework, and utilising the principles of phenomenological reduction i.e. reducing the full account to key themes and statements and using imaginative variation i.e. seeking the key components or essences which bring together the separate participant accounts into essences and a composite description. Three potential analytic processes were described by Moustakas (1994): Modified Steen-Colazzi-Keen (SCK); Modified Van-Kaam (MVK); and Moustakas' (1994) own approach. SCK was discounted due to the inclusion of the researcher's experience within the analysis (Holloway & Wheeler, 2010), and MVK was also discounted due to a focus upon the psychological meanings within the text and use of 'structures' which lacked clarity (J. Anderson & Eppard, 1998; Creswell, 2013; Liersch-Sumskis, 2013). Moustakas' (1994) approach was adopted (table 3.6, p.60), although modified slightly as indicated in the table, as this appeared to provide a clearer process for the generation of answers to the posed research questions (Creswell, 2013).

Table 3.6: Moustakas' (1994) processes of transcendental phenomenology

Processes	Definition
Phenomenological reduction	Bracketing the topic
	Horizonalisation: Every statement has equal value
	Delimited horizons or meanings: Horizons which stand out as invariant qualities of the experience
	Invariant qualities and themes: Non-repetitive, non-overlapping constituents clustered into themes
	Individual textual descriptions: A description gained by an integration of the invariant constituents of each participant's data
	Composite textual description: An integration of the individual textual descriptions into a composite textual description [1]
Imaginative variation	Vary possible meanings
	Vary perspectives of the phenomenon: from different vantage points such as opposite meanings and various roles
	Free fancy variations: consider freely the possible structural qualities or dynamics that evoke textual qualities
	Construct a list of structural qualities of the experience
	Develop structural themes: Cluster the structural qualities into themes
	Employ universal structures as themes: Time, space, relationship to self, to others, bodily concerns, causal or intentional structures
	Individual structural descriptions: for each co-researcher, integrate the structural qualities and themes into an individual structural description
	Composite structural description: An integration of the individual structural descriptions into a composite structural description[1]
Final composite description	Intuitively and reflectively integrate the individual textual and structural descriptions to develop a synthesis of the essences of the experience

(Adapted from Moustakas, 1994, pp.120–154)

[1] Completed in conjunction with final composite description.

3.4.4.1 Phenomenological reduction

Phenomenological reduction is the initial part of data analysis which seeks to bring forward themes, phrases and statements which represent the core components of the participants' accounts (Moustakas, 1994; Polit & Beck, 2012: Silverman, 2011). Moustakas (1994) identifies the product of phenomenological reduction as the invariant qualities which represent "the nature or meaning of the experience" (Moustakas, 1994, p.90), where the nature of the experience includes 'material' objects such as people (noema) and the meaning of the experience is captured through reported thoughts and feelings (noesis) (Husserl, 1973; Moustakas, 1994). Through the reduction of the participants' transcribed experiences, the nature and meanings of the experiences are revealed more clearly through exposure of their invariant qualities i.e. themed phrases or statements which, through the next phase of analysis (imaginative variation), are grouped to reflect the essences or core aspects of the experience.

To complete phenomenological reduction, the researcher needs to bracket the topic (an application of phenomenological epoché) by becoming solely focused upon the described experiences (Moustakas, 1994), allowing the researcher to undertake sustained, deliberate and ongoing engagement with the data (Moustakas, 1994).This focused engagement is similar to the position of data immersion needed for inductive qualitative analysis (Silverman, 2011). Bracketing requires the researcher to adopt an open, empathetic stance or sensitivity to the data (Giorgi, 2012; Silverman, 2011; Vagel, 2014) and the researcher experiences what Moustakas attributes to Husserl's "shift in expectation horizon" (1994, p.94), i.e. a move into the participants' experience, lessening the impact of personal pre-conceptions. This, coupled with phenomenological epoché, means the researcher makes a conscious attempt to not add pre-determined or pre-identified labels or codes to the presented text (Moustakas, 1994; Van Manen, 1997). To illustrate how failure to engage in phenomenological epoché and bracketing may affect data analysis, an example of Abi's transcript with researcher derived coding/labelling is presented in table 3.7.

Table 3.7: Example of interpretive coding – application of researcher defined 'codes' to Abi's transcript to illustrate change in data

Interview with Participant 1 (6.10.16) 25:47

1. **Interviewer:** OK, as we've described we're just going to erm...listen to what you want to tell me about your experience of raising concern in practice. So I'm just going to let you talk.
2. **Participant 1:** OK.
3. **Interviewer:** And introduce as you want to.
4. **Participant 1:** OK erm...so in my...the end of my second year of my nurse training erm...I was in a situation where I felt like a child was being neglected erm...the...the whole kind of set up of the day was I was in charge of this one particular child.
5. **Interviewer:** Yeah.
6. **Participant 1:** Erm...and he had autism and moderate learning disabilities erm...and I was also assigned a health care worker.
7. **Interviewer:** Yeah.
8. **Participant 1:** And my mentor wasn't on shift that day until the night time.
9. **Interviewer:** Hmm.
10. **Participant 1:** And throughout the day I was...in the morning I was starting to feel like I was becoming slightly abandoned by my health care staff.
11. **Interviewer:** Right.
12. **Participant 1:** Erm...and I started to get a bit worried because I just kept reading the care plan over and over again to make sure that there was nothing that I had missed out.
13. **Interviewer:** Yes.
14. **Participant 1:** Erm...because obviously I then felt like all the onus was on me because I had been put in charge of this child and that if anything went wrong then it would come back on me.
15. **Interviewer:** Yeah.
16. **Participant 1:** Erm...and...so...when was that...let me have a look...so...so in the morning

elizabeth Cooper
Safeguarding

elizabeth Cooper
Vulnerable patient

elizabeth Cooper
personnel

elizabeth Cooper
personnell

elizabeth Cooper
Feelings

elizabeth Cooper
feelings

elizabeth Cooper
feeling of PERSONAL responsibility

elizabeth Cooper
feelings of personal responsbility

From initial readings of the transcripts, the practical reduction of the text into themed groups and statements is undertaken, requiring horizonalisation and text reduction. According to Husserl (1973), a horizon is a frame or boundary within a person's experience, and therefore each transcribed statement reflects a 'horizon' i.e. something sensed or experienced by the participant. In Moustakas' (1994) application of horizonalisation, each statement is given equal value and consideration, focusing the researcher on the participant's description, maintaining bracketing, epoché and inductive reasoning, and developing authentic findings (Gray, 2014).

As illustrated in the excerpt from Abi's interview in table 3.8, the transcribed interview generates the initial statements from which data analysis began:

Table 3.8: Excerpt from full transcript – Abi

Interviewer:	***OK, as we've described we're just going to erm… listen to what you want to tell me about your experience of raising a care concern in practice. So, I'm just going to let you talk.***
Abi:	***OK*.**
Interviewer:	***And introduce as you want to.***
Abi:	***OK erm… so in my… the end of my second year of my nurse training erm… I was in a situation where I felt like a child was being neglected erm… the… the whole kind of set up of the day was I was in charge of this one particular child.***
Interviewer:	***Yeah.***
Abi:	***Erm… and he had autism and moderate learning disabilities erm…and I was also assigned a healthcare worker*.**
Interviewer:	***Yeah*.**
Abi:	***And my mentor wasn't on shift that day until the night time*.**
Interviewer:	***Hmm*.**

The removal of interviewer statements reduced the volume of text and brought the participant's statements to the fore confirming the authentic origin of the data analysis. Table 3.9 demonstrates the reduction of text following the removal of the interviewer statements from Abi's transcript.

Table 3.9: Removal of interviewer statements – Abi

…I was in a situation where I felt like a child was being neglected erm… the… the whole kind of set up of the day was I was in charge of this one particular child. ***He had autism and moderate learning disabilities*** ***I was also assigned a healthcare worker.*** ***And my mentor wasn't on shift that day until the night time.*** ***And throughout the day I was… in the morning I was starting to feel like I was becoming slightly abandoned by my healthcare staff.*** ***I started to get a bit worried because I just kept reading the care plan over and over again to make sure that there was nothing that I had missed out.*** ***because obviously I then felt like all the onus was on me because I had been put in charge of this child and that if anything went wrong then it would come back on me.*** ***in the morning he was due to have his nebulizer which one of the nurses came and put on*** ***one nurse was off sick that day so there were only two nurses when there should have been. There should have been four. One was in training and two were on the floor***

Following this reduction, repetitive 'verbatim' statements, i.e. repeated words, comments or sentences, were removed (table 3.10) which reduced the text still further:

Table 3.10: Removal of repetitive statements – Abi

I was in a situation where I felt like a child was being neglected ***the whole kind of set up of the day was I was in charge of this one particular child.*** ***He had autism and moderate learning disabilities*** ***I was also assigned a healthcare worker.*** ***And my mentor wasn't on shift that day until the night time.*** ***In the morning I was starting to feel like I was becoming slightly abandoned by my healthcare staff.*** ***I started to get a bit worried because I just kept reading the care plan over and over again to make sure that there was nothing that I had missed out.*** ***because obviously I then felt like all the onus was on me because I had been put in charge of this child and that if anything went wrong then it would come back on me.*** ***one nurse was off sick that day so there were only two nurses when there should have been four. One was in training and two were on the floor*** ***In the morning he was due to have his nebulizer*** ***to my common knowledge a nebulizer should have only lasted until either the liquid's gone out or around about ten, twenty minutes and it was on for about forty minutes*** ***this child was getting very distressed*** ***I was alone in the room and I didn't know what to do.*** ***obviously couldn't leave him,***

Final reduction of the text was conducted through identification of the invariant qualities i.e. textual statements which capture elements of the reported experience (Moustakas, 1994). This was achieved by reviewing the remaining statements and, if appropriate, clustering statements together in a theme. The researcher's immersion through bracketing is required to ensure the clustering reflects the presented data (table 3.11), and is not coding (table 3.7). Themes were generated through examining the statements relating to the physical (i.e. events, people) or subjective (i.e. feelings, thoughts or ideas) aspects within the text, and where appropriate grouped under one statement which retained the participant's language and voice from the data (Moustakas, 1994, p.129). An example of clustered theme generation is illustrated from Abi's text in table 3.11:

Table 3.11: Clustering of text – Abi

Situation: Child being neglected
I was in a situation where I felt like a child was being neglected, the whole kind of set up of the day was I was in charge of this one particular child. ***he had autism and moderate learning disabilities,*** ***In the morning. He was due to have his nebulizer which one of the nurses came and put on, and so he had his nebulizer on, this child was getting very distressed.*** ***to my common knowledge a nebulizer should have only lasted until either the liquid's gone out or around about ten, twenty minutes and it was on for about forty minutes***
Situation: Low staff numbers
one nurse was off sick that day so there were only two nurses when there should have been four. One was in training and two were on the floor
Feeling alone
I was also assigned a healthcare worker. ***And my mentor wasn't on shift that day until the night time.*** ***In the morning I was starting to feel like I was becoming slightly abandoned by my healthcare staff.*** ***I was alone in the room and I didn't know what to do.***
Sense of responsibility
the whole kind of set up of the day was I was in charge of this one particular child. ***I started to get a bit worried because I just kept reading the care plan over and over again to make sure that there was nothing that I had missed out.*** ***because obviously I then felt like all the onus was on me because I had been put in charge of this child and that if anything went wrong then it would come back on me***

Through the clustering process, the text was reduced to themed statements which reflected a group of statements (table 3.12.) or individual statements or quotations

which are identified as invariant qualities of the experience. Table 3.12 illustrates Abi's invariant quality of 'responsibility'.

Table 3.12: Abi's invariant quality of 'responsibility'

her feeling of responsibility for the patients' care *"nothing that I had missed out,… because obviously I then felt like all the onus was on me because I had been put in charge of this child and that if anything went wrong then it would come back on me.* ***felt like a child was being neglected…, the whole kind of set up of the day was I was in charge of this one particular child, he had autism and moderate learning disabilities.*** ***I felt the onus of anything that… I felt accountable. I felt like anything that was gonna happen from that… from that morning was gonna come back on me.*** ***I couldn't leave him because I felt like if I left him that was it. So I felt like I had to stay with him*** ***I can remember saying, I said to my mentor.., I feel like this is what it's like to be a qualified nurse… and I've lost that side and everything, just piled on each other and then I did feel like crying, because it was just horrible.***

Following the phase of phenomenological reduction, which identified the invariant qualities, a textual description was produced, which presents a summary of the experience. The individual textual description was derived from the original data, and thus illustrated authentic and confirmable findings. An excerpt from Abi's textual description, illustrating the invariant qualities (bold type), is provided in table 3.13:

Table 3.13: Excerpt from textual description – Abi

Abi described several experienced situations which occurred over the course of a day (shift). One situation focused upon proposed neglect of a child where she "*felt like a child was being neglected… the whole kind of set up of the day was I was in charge of this one particular child, he had autism and moderate learning disabilities and was getting very distressed"*. The situation was explained due to low staffing, and the situation of "*one nurse was off sick that day so there was only two nurses when there should have been four. One was in training and two were on the floor."* **She identified that feeling alone became an increasing issue: "I *was also assigned a healthcare worker… my mentor wasn't on shift that day until the night time… In the morning I was starting to feel like I was becoming slightly abandoned by my healthcare staff."*** **The staff and patient situation led to feelings of worry associated with a sense of responsibility for the patients' care: *"…the whole kind of set up of the day was I was in charge of this one particular child… I started to get a bit worried because I just kept reading the care plan over and over again to make sure that there was nothing that I had missed out… because obviously I then felt like all the onus was on me because I had been put in charge of this child and that if anything went wrong then it would come back on me…".* These feelings were magnified by other factors: "*I was alone in the room… and I didn't know what to do… obviously couldn't leave him."***

Moustakas (1994) advises at this stage that researchers develop a composite description from all participants' textual descriptions. Drawing upon guidance from the MVK approach (Moustakas, 1994, p.121), the composite description for this study was completed following completion of individual textual/structural descriptions (next section) which prolonged engagement with the data and thus clarified development of a composite description.

3.4.4.2 Imaginative variation

The next phase of analysis was the application of imaginative variation (IV), whereby the researcher seeks the essences i.e. broader ideas or descriptions which bring together the invariant qualities of the experience. Moustakas (1994, p.99) suggests an initial application of universal structures such as time, space, materiality (objects e.g. people, occurrences), causality, relationship to self (comments relating to self) and relationship to others (comments relating to others) to group the invariant qualities. This starts to provide a new structure to the data, and from it the researcher can begin to search for answers to the posed research questions, using these as additional vantage points from which to understand the data. Thus IV, according to Moustakas (1994), requires the researcher to engage in transcendental thinking, moving beyond the text to try to see what may have contributed to the experience, generating a "…structural description of an experience, the underlying and precipitating factors that account for what is being experienced" (Moustakas, 1994, p.98).

Initial application of universal structures, produced a table for each participant, as illustrated in table 3.14 for Abi, and illustrates how using the universal structures gave new insights or thoughts from the data. For example, the structure *time* suggested a pattern of escalation, *space* suggested that being alone was significant for Abi, and *materiality* highlighted the potential significance of other students and placement staff in Abi's experience. *Causality* identified contextual factors e.g. low staffing, as well as personal incentives e.g. wanting to improve the situation. *Relationship to self* captured a range of emotions which dominated the experience, whilst *relationship to others* identified connections between Abi, her patients and placement staff, such as concern for patients; fears associated with facing other people.

Table 3.14: Abi's initial list of invariant qualities aligned to universal structures

Time: time line applied	**Space: locality**
***Unplanned situation*: neglect of child** **Not knowing** ***Acting:* Unplanned concern raising escalation** **Feedback from placement staff** ***Aftermath*: no feedback following reporting, ongoing emotional state, sense of personal loss**	**Being alone** **Seeking help** **Uncertainty**
Materiality: physical objects **None which were outside of other structures i.e. self and others.**	**Causality** Placement staffing Failure to complete care as planned Wanting to improve the situation Not participating in poor care Missed listening opportunities Expecting action Hindered by fear
Relationship to self **Emotional build up** **Feeling concerned** **'No choice'** **Being in charge** **Personal responsibility** **Accountability** **What it's like to be a qualified nurse** **Personal limitations** **Frustration of being a student** **Breaking point** **Fear of the unknown** **Verbalising concern** **Going out of comfort zone** **Hoping for a solution** **Personal loss**	**Relationship to others** *Patient* Witnessing distress Concern of neglect (causality also) 'If I left him that was it' *Staff: negative* Part of the problem Unhelpful Fear of unknown staff Fear of formal escalation Fear of manager Feeling that things have changed: staff views towards student *Staff: positive* Helpful & supporting Feeling better Relief at being listened to Waiting for feedback

Using these universal structures, new aspects of the participants' experience were highlighted, which gave insight into what the overall experience was like, addressing question 1 of this study. Moving further with the use of IV, research questions 2) 'what motivates nursing students', and 3) 'what may help overcome perceived barriers' were also employed as 'structures'. This started to regroup the data again. This emerging focus upon motivation is illustrated in the excerpt from Abi's structural description in table 3.15, where *time* identifies three structural points within the experience and where motivation as a pre-cursor to acting i.e. decision

making and subsequently verbalising the care concern starts to emerge. Motivation as a precursor brought together the universal structures of time (prior to acting to raise the concern), causality (what led to action), relationship to self (emotional focus), and relationship to others (effect of seeing patient neglect /distress).

Table 3.15: Excerpt from Abi's combined structural analysis

Within Time, Abi's account suggests that *prior to acting* a sequence of unexpected situations involving her patient led to feelings of concern and worries about not knowing. *Acting* appeared to occur and involved speaking with various other staff, but their inaction culminated in escalation of the concern to the mentor. After sharing her experience with staff (nurses, physiotherapist, mentor, placement director and University staff), the student felt relief, and had hope for a solution. Abi describes an *aftermath* during which she awaits feedback, portraying an ongoing personal journey of emotional distress, a sense of personal loss, a perceived change in staff relationships, loss of current income through bank working, and a future job and career.

Within the individual analysis, the final stage is the production of a textual/structural (t/s) description for each participant. As illustrated in table 3.16, this t/s description brings together structures and the invariant qualities, providing different perspectives of the participants' experience and starting to identify answers to the posed research questions. In table 3.16, the excerpt from Abi's t/s description is presented where the structures (in brackets), derived from the universal analysis (table 3.14) and the research questions i.e. description of the experience, motivation, barriers and overcoming barriers (p. 39), the invariant qualities (bold) and direct text quotations (italics), together illustrate the essence of patient centred concern and decision making emerging from Abi's experience.

Table 3.16: Excerpt from Abi's individual textual/structural description

Abi described a sequence of events (Time), which suggested a precursor to action (motivation) as an unexpected *clinical situation* that appeared to involve student's concern for her patient: The clinical situation was caused by: *low staffing, "One nurse was off sick that day so there was only two nurses when there should have been four. One was in training and two were on the floor";* concern about her patient, *the neglect of a child she was caring for, through thoughts of "felt like a child was being neglected …child was getting very distressed. …So that kind of left me with a very distressed young boy who had had autism, he had a routine to stick to…*"; and acknowledgment that there had been a *failure to complete care as planned* (causative/motivation*), "I read the care plan and it said he needed chest physio every morning cause he had repeat episodes of pneumonia and that hadn't been completed because I was with him all morning and then I read in the notes that were completed by her that afternoon that she'd done it, she'd done the chest physio…. The… healthcare… had written it who I was supposed to be with…*". **Abi described several potential issues (rel to self; barriers) prior to deciding to raise the concern, a sense of *not knowing what to do;* of *being alone*, *"my mentor wasn't on shift that day until the night time… I was starting to feel like I was becoming slightly abandoned by my healthcare staff…. I was alone in the room, no-one was around to help me and it's at this point I felt a bit trapped"* and a *sense of responsibility* (rel to self/overcome barrier), *"I then felt like all the onus was on me because I had been put in charge of this child and that if anything went wrong then it would come back on me… I felt accountable… I couldn't leave him because I felt like if I left him that was it, so, I felt like I had to stay with him",* which appeared to offer a conflicting emotional time prior to acting upon her concern.**

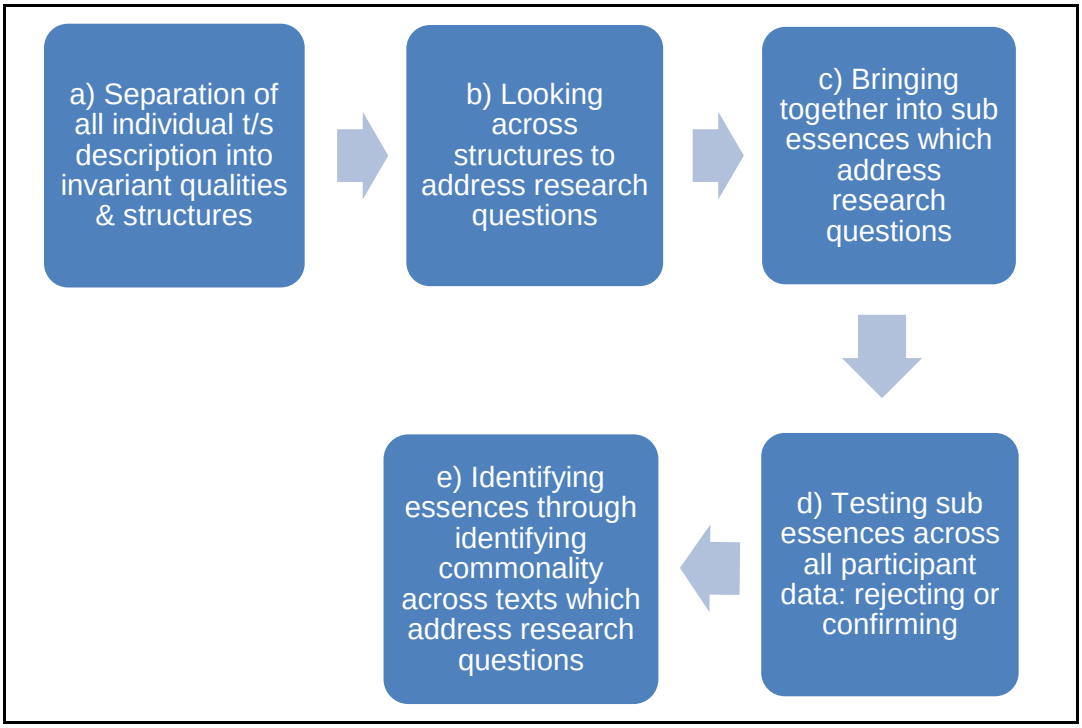
Following the completion of each individual's t/s descriptions, the generation of a composite description and identification of core components or essences of the experience was completed.

3.4.5 Composite description

In formulating the composite description, a synthesis of the individual t/s descriptions is undertaken, whereby the wholeness of the experience is captured within one account. The intuitive and reflective skills of the researcher are required for this stage of the analysis (which are explained by Moustakas, 1994, p.181), to identify the essential components of the experience (essences) and a final composite description. The development of the composite description requires the researcher to remain bracketed in the data, to look across all t/s descriptions and bring together commonalities into groups or essences. As can be seen in diagram 3.1, the researcher drew upon the original invariant qualities and the universal structure lists as these contained the relevant participants' data, and sought to

address the study's research questions using structures of potential motivation, barriers and how barriers were overcome.

Diagram 3.1: Process undertaken to develop final essences and composite description



Adapted from Moustakas (1994, pp.118-119)

Following the process identified above, the researcher re-employed IV, using insights gained from developing the individual t/s descriptions, and referring back to original text, invariant qualities and structures (step a, diagram 3.1). Initial deconstruction of Abi's individual t/s description is presented as table 3.17 below.

Table 3.17: Deconstruction of individual t/s description (Abi)

Text statement	Invariant quality	Structure	Emerging idea to address research questions
"one nurse was off sick that day so there was only two nurses when there should have been four. One was in training and two were on the floor"	Low staffing	Time – prior to action	Situational context – motivation
"And throughout the day I was… in the morning I was starting to feel like I was becoming slightly abandoned by my healthcare staff"	Feeling abandoned	Time – prior to action	Situation – motivation

Table 3.17 (cont.): Deconstruction of individual t/s description (Abi)

Text statement	Invariant quality	Structure	Emerging idea to address research questions
"he was due to have his nebulizer which one of the nurse came and put on, and so he had his nebulizer on, this child was getting very distressed"	Patient's distress	Relation to self – concerned response	Motivation
"And my mentor wasn't on shift that day until the night time." "I was alone in the room"	Feeling alone	Relationship to self – worries, anxieties	Perceived difficulty
"no-one was around to help me and it's at this point I felt a bit trapped"		Causality – linked with need to act	Perceived difficult situation

In following steps b) and c) in diagram 3.1, an iterative process (Alvesson & Skoldberg, 2009; Vagel, 2014) of repeated engagement with and across all data was undertaken. The different invariant qualities which arose from individual's data, required the researcher to go back to the original text at times to check the meaning i.e. if a motivator or barrier was consistent with the context of the participants' experience. The iterative process requires IV, whereby the researcher actively uses inter-subjectivity: "…everything I know about your conscious life is really based on my knowledge of my own lived experience." Moustakas (1994, p.38) to offer new structures or perspectives from within the data. Within this study, the researcher sought to bring together textual / structural aspects which addressed the posed research questions. This offers one interpretation or analysis of the data, as "…the essence in any experience are never totally exhausted" (Moustakas, 1994, p.100). In developing the final composite description, a re-grouping of the invariant qualities across all texts was required (step c), seeking to describe the experience, to identify potential motivations and identify how perceived barriers were overcome. In bringing together of all t/s data, the invariant qualities were regrouped together according to shared meanings or understandings which addressed the research questions, as illustrated in table 3.18; this led to the formation of sub-essence groupings (steps d and e).

Table 3.18: Collation of Abi's invariant qualities to form composite sub-essences and essences

Invariant qualities	Sub-essence	Final essence – research question
Low staffing	Contributory – unexpected situation	Patient centred concern – motivation (research question 2)
Patients' distress	Trigger for motivation – feeling concerned	
Worry		
Not knowing what to do – what was best for patient		
Feeling abandoned		
Staff not completing care as they should/was planned	Checking concern	
Common knowledge		
Care unable to be given		
Reflecting on the care		
Sense of responsibility	Motivation/Being professional	Deciding how to act – motivation and overcoming role barriers
Responding to lack of basic needs care		
Querying care		
Writing the report – feeling better		
Feeling like being qualified		
Reaching breaking point	Point of action motivation	
Student status limitations – reliance	Perceived barriers – boundary of student role	
Student status limitations and facing being on own		
Only a student		
Refusing to participate	Acting on concern	
Intervening to get care done		
Relaying concern to person in charge		
Sensing relief at handing over to person in charge		
Second relaying to person in charge		
Fear of talking to the person with authority	Facing perceived difficulty	Emotional strength – overcoming perceived difficulties
Facing non-helpful staff		
Speaking with person in authority – facing fears		
Feeling abandoned – no physical help with patient care		
Looking for other help		
Feeling alone	Needing comfort – perceived barrier	Feedback and support – overcoming emotional barriers
Emotional recollection		
'I cannot wait for my mentor to come in. Cause I just need to cry'		
Comfort listening	Receiving support/comfort – overcoming barrier	
Relaying to mentor		
Relaying it to PAT		
The real action will start when I tell my mentor		
Feeling looked after by mentor		

Invariant qualities	Sub-essence	Final essence – research question
Reflecting upon experience ruined my placement	Unresolved feelings – aftermath and unfinished business	
Unsure if had raised a concern **Unresolved outcome of the concern**		
After raising concern – not able to work there		
After raising the concern – feeling like a bad person		
After raising concern – feeling weak		
Regret about the situation		

The emerging sub-essences from the individual t/s descriptions were compared across all texts (step d, diagram 3.1), and an understanding of what may have motivated students or assisted with overcoming perceived barriers emerged. The regrouping of data into sub-essences was achieved through identifying a shared understanding, as illustrated in table 3.19. The sub-essences were then grouped together into four areas which were considered the essences i.e. the components which constitute the experience and which were common across all participants (step e, diagram 3.1), achieved through further imaginative consideration of how to address the research questions (p.38).

Table 3.19: The meanings which bring sub-essences together to form final essences

Sub-essences		Final essence and meaning
Title	**Meaning**	
Unexpected situation	Identified initial incident	**Patient centred concern:** triggered/motivated action
Emotional response to situation	Suggestive of feeling concern – compassion	
Confirming the concern	Seeking assurance of feeling concerned	
Bound by student role	Position as learner and situation affected consideration of what to do	**Deciding how to raise a care concern:** sustained motivation and key to overcoming concerns about student role
Being professional	Theories and ideas which underpin nursing practice	
Realising personal autonomy	'Aha' moments when students respond to concerns, perceptions and judgement, leading to verbalising concern	
Relaying concern to others	Reflects the purposeful verbalising of concern directly to personnel	
Emotional journey	The occurrence of emotions throughout the students' descriptions	**Emotional strength**: helped overcome the perceived emotional work and perceived difficult situation
Concern for others (involvement or potentially affected)	No action, just feeling/consideration – overridden or used to justify acting – had to be 'dealt with'	
Facing difficult situations	Interaction with others which had to be faced as part of the experience or to get the concern heard	
Getting help, advice, support	Positive descriptions of interaction with various others	**Feedback and support:** helped to improve emotions/positive view of experience, or ongoing negative emotions/negative view of the experience
Not receiving help, advice, support	Negative descriptions of interaction with various others	
Aftermath	Time following reporting – further discussions with others, personal making sense, emotional catch-up	

3.5 Presenting the findings

In completing the analysis, how to present and make sense of the findings for professional practice was considered. Moustakas' (1994) suggestion of a composite description, i.e. a summary of the analysis descriptions, would concisely address research question one from this study, describing what it was like for nursing students who raised a care concern when in clinical practice. Papers describing transcendental phenomenological methodology used various presentation styles: textual themes and verbatim quotes (Funtasz, 2012; Lloyd, Sailor, & Carney, 2014); themes with verbatim quotes (structural and textual descriptions) (Bornsheur-Boswell et al., 2013; Masterson & Brenner, 2016; McGlasson & Rubel, 2015; Ursa & Koehn, 2015), textual themes and composite description (Sailor, 2013); textual and structural attributes (McNamara, 2005); and horizonal analysis through to theme categories (Linhares, 2012) which would have variable familiarity to a nursing audience (Parahoo,2014; Polit & Beck, 2012). However, the development of the essences is an example of qualitative thematic analysis (Parahoo, 2014), which the professional audience of nurse educators, clinicians and nursing students are familiar with, and therefore the findings relating to research questions two and three are presented in a thematic format in chapter four.

3.6 Summary

This chapter has presented a rationale for the choice of Clarke Moustakas' transcendental phenomenology to guide this study's design and conduct. My philosophical beliefs in experience as a real-world occurrence influenced the pragmatic decision to undertake a qualitative phenomenological exploration of nursing students' experience of raising a care concern when in clinical practice. The findings are analysed in relation to professional practice in chapter four, which discusses how this study may inform further professional policy and practice.

Chapter 4: Analysis and Discussion of Findings and Application to Professional Practice

This chapter presents an analysis and critical discussion of the findings from the phenomenological exploration of nursing students' lived experience of raising a care concern, within the context of contemporary nursing practice. The findings addressed the three research questions posed at the beginning of this study:

1. What is the experience of nursing students who raise a care concern in practice?
2. What motivates nursing students' decisions to raise a care concern?
3. How do nursing students overcome perceived barriers to raising a care concern in clinical practice?

The findings are a summation of the nursing students' voices and give a deep insight into their lived experience. To illustrate the lived experience, the findings are presented as a composite description, whereby the key essences – 1) patient centred concern; 2) deciding how to act; 3) emotional strength; and 4) feedback and support – identify motivational factors and suggest inter-linking elements which may help nursing students decide to raise the care concern and overcome perceived barriers. Following the composite description, a deeper analysis of the essences is presented. The essences are critically discussed within the context of contemporary literature, drawing upon moral theory, emotional labour and emotional intelligence (EI) to help understand the relevance of the findings for current and future education, the NHS, and professional nursing policy and practice (discussed in chapter five).

4.1 What is it like? A composite description

This study provides understanding of what it is like to raise a care concern whilst in clinical practice, addressing a key question which arose from a critical review of retrieved research papers (chapter two). In summarising students' experience, new insights are presented into the moral motivations and the influences upon students, and the role that emotional strength, feedback and support play in assisting students to overcome perceived difficulties. This section adds to the current knowledge within professional nursing, as it recognises a potential new motivator in essence 1) patient centred concern and compassion, supported by essence 2) deciding how to act: the motivational potential of professional endorsement and the skill of autonomous decision-making which appear to assist students to navigate role boundaries. This description identifies the emotional journey experienced by

nursing students when overcoming perceived barriers, suggesting that 3) emotional strength and 4) receipt of feedback and support may be influential in promoting their moral and emotional satisfaction and wellbeing, during and following what appears to be a difficult experience.

The composite description of nursing students' lived experience is presented below: **bold type** are essences, and *italics* illustrate underpinning sub-essences which are discussed in subsequent sections addressing the two remaining research questions: what motivates nursing students (4.3) and what helps them overcome perceived barriers (4.4):

When encountering a potentially unsafe situation, students describe feeling a **patient centred concern**, expressed as an emotional response to the perceived patient's immediate distress or potential harm. The concern arose from *unexpected situations* which occurred whilst being involved with a learning opportunity or undertaking nursing work. Students described a concern focused upon the patient or person seeking healthcare advice, arising from a range of situations including inappropriate care, theft, incorrect advice or discontentment with treatment. As well as a feeling, students appeared to *confirm the concern,* through activities of comparison e.g. what should be happening [via a care plan/prescription chart], expectations of 'good' behaviour, perceptions of 'good' care, and prior knowledge from classroom, placement or external additional resources. This appeared to provide the motivation for students to consider taking some action to stop or prevent patient harm or distress.

Following this, **deciding how to raise a care concern** emerges, whereby being professional and realising autonomy appeared relevant to overcoming the perceived boundaries of the student role and to relay concern to others. *Being professional* captures the overarching awareness of themes which underpin nursing practice, such as responsibility, accountability, duty, needing to be like a nurse and behaving professionally whilst in the workplace. This appears to strengthen students' motivation, helping them to overcome *boundaries of the student role* through weighing up the perceptions of how others think they should act, and their reliance on staff and mentors for placement success, before deciding how to respond. When considering these factors, *realising personal autonomy* captures the consequence of personal judgements, emotional frustration and concern at unresolved situations which result in an awareness of personal responsibility to take action to deal with the unsafe situation. Students describe a variety of strategies to try and stop wrongdoing e.g. seeking physical help, advising, prompting, verbalising worries or anxieties, or querying the situation, which brought concerns to the attention of others. The need to verbalise the care concern continued as students describe ongoing concern, especially when other strategies were unsuccessful which eventually led to purposefully *relaying concern to others.* The purposeful verbalisation to an available member of the staff, e.g. a mentor, person with expertise, manager or someone they felt would do something with the information, continued until students felt an appropriate response has been made.

Having emotional strength emerges as a self-reported quality necessary to deal with the experience of raising a care concern. During and after verbalising concern, students described navigating *an emotional journey*, moving between negative and positive emotions. Strength was needed to deal with emotions and

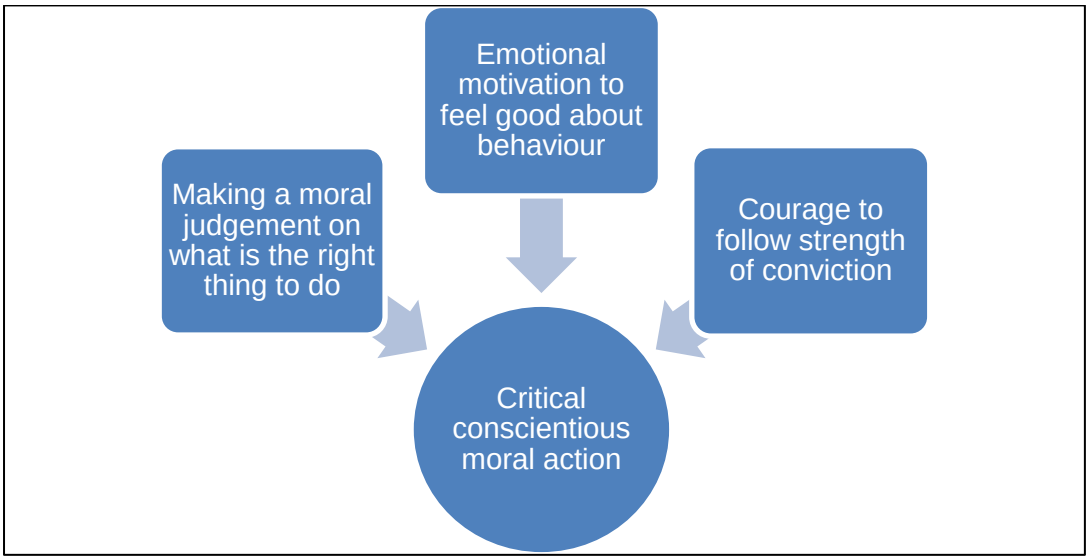
face the perceived difficult situations such as direct verbalising to practice or senior staff, carrying on working with staff involved with the situation, and dealing with negative responses from practitioners**.** For some students, managing additional feelings of *concern for others* was an additional emotional consideration; these others included fellow students who may attend the placements or staff involved in the situation.
As well as personal emotional strength, **feedback and support** gained through interactions with other staff, students and the organisation appeared important for students' emotional and moral wellbeing during and after the raising of the care concern. Following the action, students' personal reflection concluded with either a positive or negative evaluation of the experience, which was typified by a sense of *moving on* due to receiving feedback, or a sense of *unfinished business.*
Descriptions of *needing comfort and support* which were addressed through *receipt of support* from various staff e.g. mentors, managers, academic tutors and other professionals were associated with positive feeling, whilst the latter was provoked by awaiting formal feedback, having unanswered questions, still working through emotional upset, wanting to find out what happened and thinking of future practice.

From the composite description, the motivational component for nursing students appears to be focused upon the distress/suffering/harm of the patient or person receiving care, with little regard for personal risk. This perspective has associations with the previously discussed views of whistleblowing as a moral decision i.e. being loyal to one's own beliefs, values or virtues, which have been subsumed within the idea of raising a care concern as a professional responsibility (section 2.2.4.,p 30). A moral motivation arising from the essence of patient centred concern (Crisp & Slote, 1997) suggests a potential new application of compassion within current nursing practice. The strength of moral motivation, in addition to decision-making capability, emotional strength, and external feedback and support, appears integral to nursing students' ability to raise a care concern and overcome perceived barriers.

4.2 Motivated by compassionate concern

The essence of patient centred concern suggests that the trigger of witnessing patient harm or distress may motivate nursing students to raise a care concern. Whilst whistleblowing has been attributed to professional moral decision-making (Ahern & McDonald, 2002; Bolsin et al., 2011; Holden, 1991) (diagram 4.1), the importance of personal beliefs in motivating practitioners to raise a care concern has become interlinked with upholding a professional responsibility (section 2.2.4.,p 30).

Diagram 4.1: Professional moral decision making



(Adapted from Holden, 1991)

Moral judgement, depicted in diagram 4.1, has become associated with the professional decision of whether to raise the care concern (section 2.2.4.,p 30), yet the choice of moral codes is diverse and includes ethical principles, professional beliefs, personal qualities and virtues (section 2.2.4.,p 30). The drive for healthcare students to raise a care concern has been assumed to come from professional origins (section 2.2.5.1.,p 34), but this study suggests a new perspective of compassion as a potential moral motivation for nursing students to raise a care concern.

In this study, nursing students did not accentuate a moral dilemma i.e. choosing between different loyalties or moral positions, yet described a trigger moment when a feeling of concern suggested something not being right. Checking activities appeared to confirm the potential or actual patient suffering or harm, and this appeared to motivate nursing students to take some form of action. Feelings of concern appeared linked to nursing students' recognition of patient harm, highlighting an additional perspective to that which is proffered within the retrieved literature (section 2.2.5.1. p 34). Alford's (2007) research parallels the findings in this study, that for those nursing students who raised a care concern, motivation was based upon a moral response to do the right thing when faced with perceived patient harm, rather than a deliberate, conscious decision. This implies that suspected or actual patient harm may trigger a compassionate response i.e. to relieve another's suffering (Bein, 2013), providing a moral motivation for raising of a care concern (MacIntyre, 1981; Slote, 1997). The moral decision suggested by nursing students in this study identifies the crucial role that feeling concerned may

play in triggering students' response and motivating interventions which culminate in the verbalising of a care concern.

4.2.1 Concern as moral discomfort

Findings from this study highlighted the significance of nursing students recognising a feeling of concern, triggered by patient distress or suffering, prompting a feeling of moral discomfort i.e. something not being right (Beauchamp & Childress, 2009). In this study, moral discomfort was described as patient centred concern which had three contributory elements: a) unexpected situations, b) concern about the patient, and c) confirming the concern. These all appeared significant to the students' judgement that here was a situation in which actual or potential patient harm had occurred and intervention was required.

Being in an unexpected situation appeared to highlight an initial trigger of concern, as illustrated by the following text extracts:

a) Unexpected situation

Participant	Quote
Abi	"she said she was going to go and sort out his lunch and about an hour later it hadn't happened"
Bea	"I was just asking general questions to the mentor saying as staff coming over from somewhere else, where do we stand on that?"
Carly	"cause like this my first time seeing happening."
Diane	"I thought I dread to see what I'm gonna find today"
Eve	"it was new to me anyway cause I'd never been on an in-patient unit and obviously seeing the behaviour she was displaying was new as well"
Fay	"the difference of care between one corridor and another was such a large contrast it was quite shocking"
Gina	"There was no questions about how often this baby was feeding,… there was no offer of support to her about feeding positions maybe that could have been looked at."
Heidi	"I remember my mentor didn't say anything, they weren't really paying attention, So the alarm bells started ringing"
Ida	"I was on shift when an elderly lady fell. I wasn't quite happy with how the situation went."
Joy	"my mentor being quite rude to a patient… then she said that my mentor had shouted at her again"

Motivation appeared influenced by the students' emotional concern for the patient and this led to a deepening sense of something not being right, of identifying another's suffering through feeling personal emotional angst which contributed to the recognition that the situation was harmful and therefore wrong:

b) Patient centred concern

Participant	Quote
Abi	"So that kind of left me with a very distressed young boy" "I was in a situation where I felt like a child was being neglected"
Bea	"it seemed to be a general lack of care. There were things that should have been in there and that wasn't done."
Carly	"So I said no, this is not right because this patient is vulnerable." "I couldn't go home having it in my mind"
Diane	"the patients weren't getting looked after… there was lots of safeguarding issues" "…all the patients who we were seeing were vulnerable" "So that's what made me… say look, these are all the issues, but this needs sorting because… it's just so wrong."
Eve	"it was quite upsetting to see how she was such an independent person – now she's showing none of that"
Fay	"the lady ended up so distressed and upset and I was very distressed and upset as well from seeing that."
Gina	"for somebody to kind of not listen to what that mum wanted or the mum's needs"
Heidi	"I acted with the patient's best interest in mind"
Ida	"I was uncomfortable… if it was my family member I would have wanted it dealt with properly and quickly"
Joy	"I felt it was important that how she was feeling wasn't being heard" "…she seemed quite shaken by the situation… I felt it was too far"

Further actions were taken to confirm the nature of the concern, including a verification of wrongdoing which appeared to support students' sense of something not being right and feeling of concern. The excerpts below indicate how students used a range of ways to gain conviction in their judgement of concern, such as patient documentation, previous experience prior to or during their educational programme, and an awareness of professional beliefs i.e. patients' best interests.

c) Confirming the concern

Participant	Quote
Abi	"I read the care plan and it said… and that hadn't been completed because I was with him all morning"
Bea	"what care they should be receiving… we'd asked all the patients"
Carly	"I wanted to be sure if I'm right or wrong. It happened to be two bags on the patient's wardrobe and one is the bathing soap, you know the one for going to the bath" "Actions were not of someone doing something right"
Diane	"it's not the standards of care what the NMC, you know, teach nurses to provide?"
Eve	"I think because it had been mentioned in a class and it had been mentioned by other doctors in MDT meetings that I'd been to"
Fay	"I've worked in care before and I've worked in a similar care environment where it was very good care… Whereas some people with no care experience might actually think that is the way to look after someone."

Participant	Quote
	"from feedback from other patients…and I never asked, I never probed or anything, I just asked how the night was. They'd say oh that nurse was very nasty or abrupt or rude."
Gina	"I've got a background in breastfeeding support and I support nationally over the phone. I'm up to date, I go to conferences, I'm constantly being updated with information"
Heidi	"Reported with the patient's best interests – what's been drilled in to our head from day one" "any drug error is dangerous"
Ida	"My A&E and my minor injury training background"
Joy	"the ways that I was being taught as a student nurse… this nurse didn't create that"

In this study, patient centred concern suggested that an emotional concern may be an indicator of something being wrong, provoking moral discomfort. The findings are discussed below in relation to 'concern' within whistleblowing and current nursing practice, proposing that the virtue of compassion may have a role in motivating nursing students to raise a care concern.

4.2.2 Concern as a basis of whistleblowing practice

The term *concern* is used universally to indicate the trigger for internal whistleblowing (PCaW, 2013; RCN, 2017a; Vinten, 2000, 2004), and within organisational whistleblowing (NHS, 2015; RCN, 2017a) appears to be associated with general recognition of illegal, judicial or ethical wrongdoing. Within professional practice, the recognition of wrongdoing in the decision making of whistleblowers has received less attention (Attree, 2007; Davis & Konishi, 2007; O'Sullivan & Ngau, 2014; Pohjanoksa, et al., 2017), although these four studies imply that feeling concerned in isolation is not sufficient for taking action: practitioners should take time to find evidence of suspected wrongdoing. Deciding if wrongdoing has actually taken place poses another potential delay to raising a care concern; and the focus upon rational, logical, evidence-based decision making within nursing (Banning, 2008; Boswell & Cannon, 2017; Stubbings, Chaboyer, & McMurray, 2012), plus organisational legal requirements for evidence-based investigations (NHS, 2015; RCN, 2017a), may have contributed to a lack of confidence in speaking up about feeling concerned. Within contemporary clinical decision-making approaches, multiple factors may influence a practitioner's judgement of an unsafe situation (Duffy et al., 2012; Edwards, 1999; Stubbings et al., 2012): sufficient previous experience to identify differences in behaviour patterns (Carper, 1978; Pardue, 1987; Stubbings et al., 2012; Zander, 2007) and professional knowledge including theory e.g. ethical and legal parameters, policies, processes and principles (Benner,

2001; Benner, Tanner, & Chesla, 2009; Boswell & Cannon, 2017, Zander, 2007). The complex considerations within clinical judgement may contribute to uncertainty in deciding whether to raise a care concern formally using internal reporting mechanisms (Attree, 2007; Ion et al., 2015), which for nursing students may bring concerns over the knowledge needed to identify an unsafe situation (Duffy et al., 2012). Educationalists (Duhn et al., 2012; Espin & Meikle, 2014; Kent et al., 2015) appear to utilise a knowledge/evidence-based approach to teach and appraise students' ability to recognise potentially unsafe clinical situations (section 2.3.3.1, p.50), which may have overlooked the value of feeling concerned as an initial indicator that something may be unsafe or causing a patient harm. Similarly, unsafe situations have been described as those which are unethical (Erdil & Korkmaz, 2009), acknowledging ethics as a branch of moral practice (Callister, Luthy, Thompson, & Memmott, 2009; Lacobucci, Daly, Lindell, & Griffin, 2012; Park, 2014), and adding ethical decision making into the recognition of patient harm, which Druce et al. (2016) suggest adds difficulty for medical students when in clinical practice. This study suggests a refocusing upon how feeling concerned about patients' wellbeing could act as a trigger for students, may ease the perceived moral difficulty of deciding to raise a care concern (section 2.2.5, p.23), and could be used to identify a compassionate imperative behind feeling concern.

4.2.3 Compassionate concern

In this study, emotional concern felt by nursing students appeared to trigger interventions which sought to relieve harm, suggesting a compassionate moral motivation. Concern as an indicator of unsafe situations has not received much attention in professional practice (section 2.2.4.,p 30; section 2.2.5.2.,p 33), although Killam et al. (2013) noted nursing students' feelings of discomfort when encountering unsafe practice. This study further suggests that patient centred concern, as an emotional response and as a sign of moral discomfort i.e. a sense of something not being right (Duncan, 2010), may be instrumental in helping nursing students recognise and then respond to an unsafe situation. Compassion, described as "an attentiveness to suffering and satisfaction, coupled with a will to bring about the alleviation or cessation of suffering and the continuation and multiplication of satisfaction" (Bein, 2013, p.88), offers a moral motivation for nursing students' actions (Bein, 2013; Dutton, Worlines, Frost, & Lilius, 2006; Law, 2014; Simpson, Clegg, & Pitsis, 2014), with emotional concern felt by nursing students an important motivational trigger. This suggests that students' compassionate nature, to respond to another's distress, may be important to raising a care concern, acting as a moral

incentive (Crisp & Slote, 1992; Beauchamp & Childress, 2009; Duncan, 2010; MacIntyre, 1981). As well as being important for quality nursing care (Cummings & Bennett, 2012; DoH, 2015; Oxtoby, 2016), this study suggests that compassion may hold potential relevance to patient safety, aiding the recognition of and response to unsafe situations.

Compassion has been intrinsic to modern nursing, as Florence Nightingale's Christian background (Bradshaw, 2011; Straughair, 2012a) influenced her belief in nursing as a force of moral goodness i.e. caring for patients with the intention to do good, and that compassion i.e. the relief of suffering was a key moral quality for nurses to possess. This early connotation of compassion as a natural quality which promoted an altruistic, self-sacrificing aspect to nursing practice (Boehm, 2012; Bradshaw, 2011; Law, 2014; Straughair, 2012a) relied upon pre-existing virtue and instinct. Altruistic compassion diminished as a component of nurse decision making during nursing's drive for professional status (Abel-Smith, 1960; Bradshaw, 1999; Carper, 1978; Straughair, 2012b) which promoted the credibility of logical and rational critical thinking and evidence based practice (EBP). More recently, care failings within the NHS have partially been attributed to a lack of compassion (diagram 1.1;Hunt, 2013), and subsequent re-interest in promoting authentic compassion i.e. an ability to emotionally connect with patients (Burridge, Wench, Kay, & Henderson, 2017; Cummings, 2016; Henshall, Alexander, Molyneux, Gardiner, & McLellan, 2018; Tierney, Sears, Tutton, & Reeve, 2017) to deliver kind and person-centred care has arisen. Extending Faunce's (2004) view of professionals' emotional involvement with patients as being a contributor to whistleblowing, this study suggests that a compassionate emotional connection may act as a trigger for nursing students' concern about unsafe situations.

Whilst expressions of compassion such as communication and kindness are integral to good patient care (Cummings, 2016; NHS, 2014), the practitioner's emotional response to distress and suffering has identified compassion as an emotional burden, requiring workplace strategies to prevent 'compassion fatigue', stress and burnout (Curtis, 2014; Wilkinson, Whittington, Perry, & Eames, 2017; Willis, 2012). Within professional practice, the emotional burden is partially mediated through the use of professional empathy (Holden, 1991; NMC, 2018a; Papadopoulos & Ali, 2016). Professional empathy is a skill which enables a distanced, detached intellectual appraisal of another's emotional distress or suffering (Batt-Rawden, Chisholm, Anton, & Flickinger, 2013; Holben, 1991; Papadopoulos & Ali, 2016), reducing emotional involvement, and making clinical decisions logical and rational.

Although in practice compassionate and empathetic responses may be identical, two studies of medical and nursing students (Curtis, 2014; Goldie, Schwartz, McConnachie, & Morrison, 2003) suggest that empathy and compassion may feel different to the practitioner, which may affect the sense of concern (Bein, 2013; Halpern, 2001). In identifying a potential role for compassion as a motivation for raising a care concern, the findings from this study suggest that education could focus upon promoting a compassionate perspective to raising a care concern, focusing upon students' recognition of emotional concern as moral discomfort and a trigger in unsafe situations (chapter five) as well as developing students' empathy to patient harm (Halpern, 2001), and in practising moral response behaviours (MacIntyre, 1981).

4.3 Deciding how to raise the care concern: Influencing factors

The essence of deciding how to raise a care concern included factors which may have sustained students' moral motivation and helped overcome perceived boundaries of the student role. Within moral decision making, strengthening moral conviction is purported to lead to positivity i.e. feeling satisfied, which reinforces motivation and helps give courage to stay true to one's moral desire (Holden, 1991). Within this section, being professional appeared to sustain students' moral strength, helping them to navigate the perceived role boundaries of being a student in clinical practice until realising autonomy led to their decision to verbalise the concern directly to placement staff, seeking to resolve the unsafe situation and remove patients from harm. Thus, students' desire to be professional appeared to add to the motivation to respond to concern.

d) Being professional

Participant	Quote
Abi	"I felt accountable… I saw it all unfolding."
Bea	"It was patient safety – I'd do it again"
Carly	"So you look at it at the point of that's your professional because… is your right to protect them" "As a nurse you've already taken an oath to protect patients and be there for them"
Diane	"you have to because that's your duty of care"
Fay	"it was lack of care and compassion. She just didn't care for the people and their dignity" "She said are you aware of the safeguarding procedure and what I'm gonna do next"
Gina	"You hear all these stories and well-known stories where there's a jigsaw piece and I didn't wanna be that missing jigsaw"

Participant	Quote
Heidi	"…being warned that nurses are being sued, it's about patient safety and accountability and I was there and I was witness to that."
Ida	"People should be challenging and questioning practice, you're doing it because you want to provide the best care for that patient" "I think that really, as a nurse, once you're qualified… your first concern is providing the best care"
Joy	"I'm not quite sure whether that was the right thing to do or not… just trying to be professional about the situation"

Nursing students were aware of the boundaries of the student role within the clinical situation including doing what was asked, not being sure, not wanting to disrupt or be a trouble, and the potential personal consequences for educational achievement. Students in this study appeared to navigate around these boundaries to reach a goal of stopping patient distress, suggesting that a moral motivation and autonomous decision making were central to overcoming the perceived barriers of being a student in clinical practice.

e) Bound by student role

Participant	Quote
Abi	"I managed to grab her and I said look, I'm only a student and I don't really… I'm not too sure" "I cannot do this myself as a student. I need someone else, I rely on someone else."
Bea	"I was just told to go and get it and it was a bit hectic and to be fair I don't think I was thinking properly either and I just ran up and got it, to path lab, and come back."
Carly	"because it might affect your team work. I'm just a student and it just struck me that they might not pass me on my placement, you know."
Diane	"It is quite a difficult thing to do as a student… because you don't wanna fail as a student nurse." "I felt like it could jeopardise my place as a student nurse."
Eve	"being new to the ward… being a first year student it wasn't always to go and run to that person. It wasn't something that I wanted to go and do." "I think it was more a case of you're a student nurse, I'm a doctor, you're just here to learn."
Fay	"I was so scared because all I wanted to do was please everyone and pass and the last thing I wanted to do was get in any form of mither cause all you want to do is keep your head down and, you know, study and then pass your placement." "I just decided that nothing negative was gonna come from it. It could only impact the patient positively."
Gina	"I was also a student nurse – it's maintaining my boundaries…. It was really frustrating as well because I could have helped her [patient]." "Prompted an issue with my student assessment… saying I caused conflict. I only asked a question but…That was shock."
Heidi	"I feel like I've ruined that relationship between me and my mentor" "because I didn't have keys to his locker to go in and check… so that's another reason that I needed another member of staff involved"

Participant	Quote
Ida	“So I was reassured that nothing bad was gonna come from it and I could go back to the ward and everything would be fine.”
Joy	“But again, it’s really intimidating as a student to raise a care concern at the beginning of the year thinking like if I see anything wrong report it cause I want to be the change in the NHS… in a way you’re right down the pecking order” “…it’s such a role problem where you rely on them so much, so there is always that worry” “a patient making a formal complaint, I felt more managerial role than mine”

There was evidence of ‘aha’ moments when students recognised the need for them to act, specifically to relay the concern verbally to a member of placement staff. This reflected the students’ awareness of personal responsibility to act and ensure that the situation was addressed.

f) Realising autonomy

Participant	Quote
Abi	“I’m gonna have to do it because someone has to” “I can remember saying, I said to my mentor I said, I feel like this is what it’s like to be a qualified nurse”
Bea	“I was just asking general questions to the mentor” “… but because of what I saw in practice I come in to the University on the Monday”
Carly	“as a nurse... This is what you need to do when something goes wrong. You need to report it”
Diane	“that’s why I said to the nurse I was with I want to hand over” “And I wasn’t sure at first – and then I thought right, that’s it, I’ve had enough”
Eve	“so in the MDT meeting I mentioned about the prolactin levels.” “I can see that you’re more than capable of doing this by yourself and went off.”
Fay	“She went oh, it’s OK, I’ll have a word…. I didn’t think just a word was good enough…. I was like this needs to be formal.”
Gina	“I went to a breastfeeding champion in that area. I spoke to her about it”
Heidi	“that’s when I decided yeah, I do have to report this.”
Ida	“I decided to raise the issue with the nurse that was looking after the patient”
Joy	“…responsibility to make a change” “So I gave the patient the number to call and the name of the nurse who it was… they were welcome to say I’d witnessed it.”

Nursing students described how they relayed concerns to various academic and practice staff, but for some there were occasions when concerns were not heard or responded to by the staff they spoke with. The repeated relaying of concern implies that a sustained moral strength to stop the perceived patient harm was needed and exhibited by nursing students. This also suggests that nursing students did not necessarily start out with the intention to formally raise the care concern; however,

failure to be heard or get the situation resolved eventually led to students realising the need to purposively speak up which included formally reporting the concern.

g) Relaying concern to others

Participant	Quote
Abi	"I almost felt like ooh, you know. I've told her, that's all I can do now and I kind of left her [person in charge] to it" "And then I had a PAT meeting with Uni, with my PAT obviously… and it all came out and things."
Bea	"like when I said about the process of why… where do we stand on giving the drugs now and she [mentor] said if it's still written up in the prescription chart we still have a duty of care to give."
Carly	"So I went to the staff nurse, I said listen, there is something I saw, which I think it wasn't right. just want to report about it" "she has to escalate it…to a proper person in charge. So she [staff nurse] will take it from there"
Diane	"so I had to raise that concern to my mentor" "raising a care concern as a way to stop the distressing situation"
Eve	"When I questioned the nurse about it she didn't know off the top of her head." "I didn't think it was resolved until I'd gone back to community and spoke to another doctor"
Fay	"So I tried to gently prompt her [carer] in that way and then I asked her when we finished doing her care round" "So after that I was like this needs to be formal and when I said that to my mentor she was very supportive, she asked me to do a very formal procedure, write things down, which is what I expected the day before really."
Gina	"that I wasn't confident that she'd [mentor] follow it up… So I raised it elsewhere to somebody who had been trained more in that area"
Heidi	"if I'd have told my mentor I couldn't have been sure that it would have been reported correctly…. I've always been told you have to escalate by level… is the sister who happens to be the ward manager as well and that's why I felt like I had to go to her next…. I wanted something to happen with the information that I was then giving"
Ida	"she [manager] asked if it was OK if the matron of the division came in. The matron sort of reassured me."

4.3.1 Strengthening moral motivation

Being professional within this study appeared to provide additional justification for raising a care concern, strengthening students' compassionate motivation to relieve patients' distress. Strengthening moral motivation through a deepening sense of conviction or certainty (Attree, 2007; Davis & Konishi, 2007; Pohjanoksa et al., 2017) has been cited as important for professional whistleblowing decisions. Certainty has implications for evidence based decisions, and may be partly due to organisational recognition that raising a care concern is acceptable if made with good intentions and with sufficient evidence of wrongdoing (Hunt, 2015; NHS, 2015; RCN, 2017a). The situation for healthcare students is slightly different, as professional bodies suggest raising concern with a supervisor, mentor, practice

manager or member of academic staff (GMC, 2012; HCPC, 2017; NMC, 2019), suggesting that certainty is not an essential requirement prior to speaking up. Yet nursing students appeared to utilise the additional desire to be professional to justify the need to act, suggesting that professional knowledge may contribute to the motivation to act and to confirm that raising the care concern was the right thing to do.

Contrary to the studies of professional whistleblowing, putting patients' needs first was not the only motivational belief (Ahern & McDonald, 2002; Jameton, 1993; table 2.1., p.24) cited in this study: the use of professional knowledge, described as being professional, suggested that students utilised a range of perspectives associated with nursing practice to justify their decision to act and influenced how they responded to the patient's distress. This valuing of professional perspectives by nursing students appears to agree with Andrews and Monsour's (2013) view that a sense of professional responsibility may contribute to the likeliness of their raising a care concern. The influence of nursing students' desire to be professional suggests that the professional endorsement of raising a care concern (NMC, 2017a; RCN, 2017a) is important in helping students to sustain the moral motivation to address the situation and secure a satisfactory outcome (section 4.5, p.101). A strong motivation appeared to prompt students to navigate through perceived boundaries of the student nurse role whilst sustaining the imperative to intervene.

4.3.2 Motivational strength: Navigating student role boundaries

Whilst nursing students in this study acknowledged the boundaries of the student role in dealing with unsafe situations, the study suggests that moral motivation may help minimise the fears and anxieties nursing students associated with whistleblowing. As discussed, professional knowledge helped to justify students' decision to act (section 2.2.5.3.,p 37), and thus may strengthen their belief that intervening is doing the right thing (Holden, 1991). Moral motivation suggests integrity i.e. staying true to the belief, as nursing students uphold a commitment to personal belief (Crisp & Slote, 1997), and within the literature, this has been seen as important to overcome the negative, challenging and difficult portrayal of professional whistleblowing (section 2.2.2., p. 23). Moral integrity is difficult to uphold when faced with an unsupportive organisational culture (Kaptein, 2011), and the professional attributes of autonomy, critical thinking and decision making (Benner et al., 2009; Bolsin et al., 2005; Holden, 1991) have become important in projecting whistleblowing as a powerful professional act. Contemporary strategies

and polices (diagram 2.3, p.29) seek to diminish this view of whistleblowing being a major challenge; however, a sense of personal risk posed by raising a care concern has filtered into the experience of healthcare students, as reticence to speak out (section 2.2.5.2.,p 35). Within the retrieved literature (section 2.2.5.1.,p34) there has perhaps been an assumption that healthcare students act as autonomous, critical thinkers whilst in clinical practice, yet the need for belongingness (Levett-Jones & Lathlean, 2009), support (Bellefontaine, 2009), and fears of personal repercussions (Monrouxe et al., 2012, 2014, 2015), imply that healthcare students including nurses may be reluctant to raise concern. This study offers an alternative view, that professional endorsement may strengthen their compassionate motivation, helping to sustain the motivation to navigate role boundaries and continue taking action until the situation is resolved.

4.3.3 Feeling good – maintaining motivation

Choosing to act in a way consistent with one's moral beliefs i.e. integrity is considered to promote feelings of satisfaction, which sustain the moral motivation to undertake difficult decisions such as raising a care concern (Bolsin et al., 2005; Holden, 1991; Jameton, 1993; Lindblom, 2007). Positive feelings experienced by professional whistleblowers, however, are less evident in the literature (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005; Pauly, Varcoe & Storch, 2012), and did not feature in the papers reviewed prior to this study. There is a sense that whistleblowing disclosure is a wholly negative experience (section 2.2.2., p.23), with little reward for the professional. Feeling unable to follow one's preferred moral choice e.g. having to remain silent when faced with wrongdoing has been associated with feelings of moral distress (Burston & Tuckett, 2012; Jameton, 1993; Lamiani, Borghi, & Argentero, 2015; Pauly et al., 2012; Sasso, Bagnasco, Binchi, Bressan, & Carnevale, 2016), suggesting that individuals who encounter an unsafe situation experience negative feelings regardless of staying silent or speaking up. The negative portrayal surrounding healthcare students' moral decisions upon raising a care concern is perpetuated in the retrieved literature (section 2.2.5., p.33). This study highlights moments of positive feelings (section 4.5.3, p. 104), yet these occur after the verbalising of concern. This study did not uphold the model view (diagram 4.1, p.93) that upholding one's moral integrity generated positive feelings which contributed to nursing students' motivation; rather, the students' perceptions of patients' ongoing distress appeared to maintain the motivation for students to keep taking action until the realisation of autonomy, to verbalise concerns, occurred.

4.3.4 Moral courage – acting on motivation

Moral courage has become associated with a person's inner strength to follow moral beliefs, overcoming difficult or challenging situations (Simola, 2015). Whilst courage has recently re-emerged as a virtue for UK nurses since the 6Cs campaign (Cummings & Bennett, 2012), its use within professional literature has been diverse (Black, Curzio, & Terry, 2014; Lindh, Severinsson, & Berg, 2009; Lindh, da Silva, Berg, & Severinssen, 2010; Numminen et al., 2017; Simola, 2015), suggesting a continued lack of clarity on its meaning and relevance to professional practice. Courage has been suggested as a missing virtue within professional whistleblowing (Armstrong, 2006; A. Gallagher, 2011a; Lachman, 2007) where the transformation of Aristotelian virtues into physical courage – i.e. when people choose to take a difficult action, rather than doing nothing or taking unnecessary risks – has been applied (Simola, 2015). This physical description of courage (Armstrong, 2006; Christensen, Barnes, & Rees, 2007; A. Gallagher, 2010, 2011a; Lachman, 2007, 2008a), as described in the 6Cs (Cummings & Bennett, 2012), perpetuates the view of whistleblowing as a risky act, with the need for individuals to draw upon personal strength to raise a care concern.

A moral view of courage defines a person's inner strength to adhere to personal beliefs despite their perceived difficulty (Simola, 2015), but there appears little evidence of the direct consideration of moral courage within professional whistleblowing (Armstrong, 2006; A. Gallagher, 2010; Lachman, 2008a; Numminen et al., 2017). Whilst the Bickhoft et al. (2016) study of nursing students' descriptions of moral courage agreed that adhering to professional advocacy beliefs i.e. putting patients first contributed to raising a care concern, there remains little exploration of the personal attributes which may define contemporary 'moral courage'. Within non-healthcare approaches, moral courage has been associated with an inner resolve (Christensen et al., 2007), whilst studies of healthcare students have focused upon dimensions of confidence e.g. determination and self-belief (section 2.3.2.4, p.53) which may be interpreted as courage when related to raising a care concern. Though the participants in this study did not directly mention courage, some students were aware of risks and continued to relay concern until an acceptable outcome was perceived to have occurred. This has connotations of physical or moral courage, but may be perpetuating the sense of difficulty and hardship associated with whistleblowing (section 2.2.2.,p 23;section 2.2.5.2.,p 35). Within this study, the interplay of compassion, professional endorsement and conviction appears to contribute to students' ongoing attempts at trying to stop the unsafe

situation. Rather than one episode of courage where students spoke up, the relaying of concern appeared to need to be sustained and repeated, challenging the traditional view of courage. This study suggests that focusing on ways to maintain students' moral motivation (discussed in section 4.5) may promote students' likelihood to raise a care concern, and that using 'compassion' to redefine and encourage staff and students to raise concern may promote the more positive stance advocated in current NHS strategies (diagram 2.3, p.29).

4.3.5 Realising autonomy: Personal responsibility

For several students there emerged one point where the decision to relay concern verbally to others occurred, and in realising autonomy a personal responsibility for dealing with the unsafe situation arose. The importance of students' realising the need to take individual responsibility, and to stop relying on others to report or respond to the concern, notes an interesting stage in the nursing students' experience and of learning to be professional. This stage indicated a point where students undertook critical thinking i.e. contemplation of what to do (Ahern & McDonald, 2002; GMC, 2016; HCPC, 2016b; NMC, 2010, 2018b), and were exhibiting characteristics comparable with professional competence. Inherent within the discussion about professional whistleblowing is the practitioner's autonomous decision making (section 2.2.4.,p 30), and this study challenges the assumption that when in clinical practice nursing students consistently feel able to exercise independent decision making. The complexity of ethical decision making was noted by medical students as problematic when deciding how to react to unsafe situations (Druce et al., 2016), whilst a competing need to belong (Levett-Jones & Lathlean, 2009) or supervisory power (Monrouxe et al., 2012, 2014, 2015; Rees et al., 2014) may inhibit students' independence in clinical practice. Moral strength has been considered integral to whistleblowing (A. Gallagher, 2011b; Lachman, 2008b, 2016), and the compassionate motivation suggested in this study may have contributed to nursing students reaching a point of autonomous decision making. The realisation of autonomy described in this study implies that nursing students recognised that previous actions had not changed the situation nor addressed the cause of patients' distress, and therefore personal, deliberate intervention was needed i.e. verbalising the concern directly.

In section 4.3, there is a suggestion that a strong compassionate motivation is achieved by students' awareness of a desire to be professional, yet a continued moral strength sustains nursing students to navigate the boundaries of the role and

reach a point when personal autonomy occurs. This suggests seeking ways to strengthen students' motivation when in clinical practice (section 4.5) may be helpful in facilitating nursing students to respond when faced with an unsafe situation (sections 5.1, 5.2 and 5.4).

4.4 Overcoming perceived barriers: Having emotional strength

What helps students overcome perceived barriers to raising a care concern? In answer to this final research question, this study highlights three new perceived difficulties for nursing students: a complex emotional journey, clinical situations and feelings of concern for others such as students and placement staff. Carly used the term *emotional strength* to capture how she responded to and coped with these difficulties, and the notion of emotional strength appears to capture a type of endurance required by nursing students throughout and after the experience. The emotional journey apparent within nursing students' experiences is illustrated in the text excerpts below:

h) Emotional journey

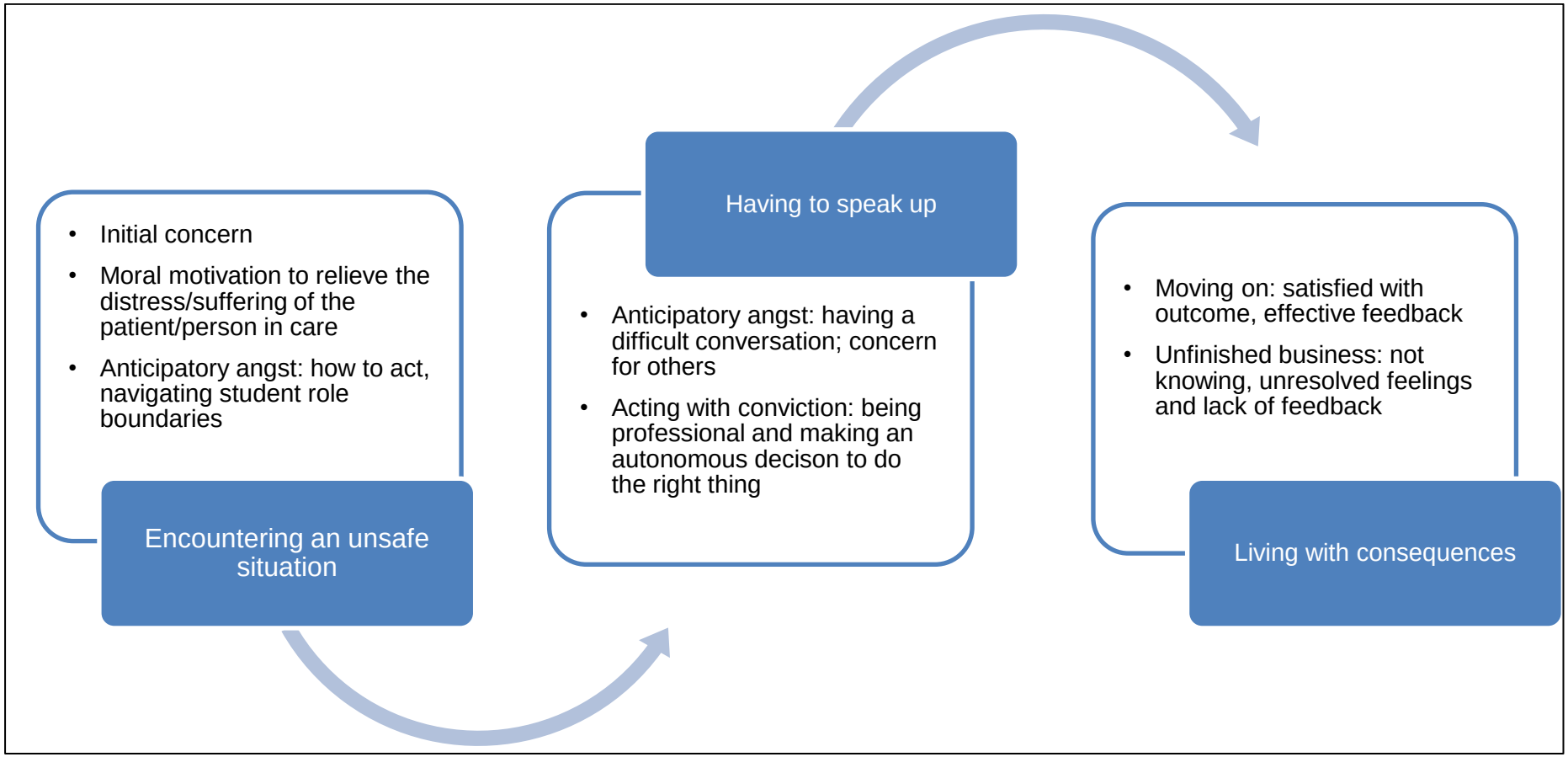
Participant	Quote
Abi	"no-one was around to help me and it's at this point I felt a bit trapped" "I cannot wait for my mentor to come in. Cause I just need to cry" "And I just said I've had a really horrible morning and I've got so much to tell you" "she was really scary and I thought the last thing I wanna do is go in and talk to her."
Bea	"and I actually sat there and started crying." "to university just to discuss… everything that happened really, for my own peace of mind" "cause I thought here do I stand on this now, am I gonna get thrown off my course, am I going to ever qualify as a nurse, whether I'd get a job in the future, is this gonna go against me?"
Carly	"my surprise it was only a carer… I was shocked, I was terrified… I didn't know what to do at that moment." "I'm OK with it. I'm emotional strong and everything"
Eve	"it was quite upsetting to see how she was such an independent person" "I didn't feel she made it as urgent as what I felt it should have been" "I suppose listen to my gut feeling" "I just had to deal with the fact that I'd been shut down"
Fay	"the lady ended up so distressed and upset and I was very distressed and upset as well from seeing that." "It was the right thing to do at the time for the client but I was very scared." "It felt amazing and uplifting and I remember asking her… so I knew that I could actually speak to her about something like that." "I knew that she [mentor] would do something about it. Whereas the other nurses I didn't get that feeling." "I'm quite glad now." "I acknowledge that I need to learn it before I qualify but it worries me that… will I have time to learn that with everything that will be going on… and that worries me… coming close to qualifying."

Participant	Quote
Heidi	“By this point I was getting more panicky” “then I came back and I remember feeling just dread” “I wanted the ground to swallow me up” “I had to go back and work with my mentor – it was awkward”
Ida	“I was quite anxious about bringing the situation up initially” “I felt quite unsure about the situation” “I was uncomfortable with the fact that if it was my family member I would have wanted it dealt with properly and quickly” “I was worried that people would think I was over-stepping the mark.” “I was quite anxious about it” “Someone obviously that high up it was worrying anyway.”
Joy	“then it’s kind of the guilt of why am I thinking about me so much” “Quite a bit embarrassed that I didn’t know the policy.” “So I’d felt uncomfortable just standing there” “I could have done possibly more.”

The emotional journey described by nursing students in this study included coping with initial concerns, anticipatory anxieties, facing difficult situations and – having raised the care concern – living with the emotional consequences of the decision and outcome. This is illustrated in diagram 4.2 (p.96).

Diagram 4.2 (p.96) reflects the phases and range of emotions associated with the experience of raising a care concern by the nursing students in this study, exposing a deeper level of angst than has perhaps been illustrated in studies of professional whistleblowing (table 2.2, p.25), and revealing an aspect of nursing students’ experience previously hidden.

Diagram 4.2: The emotional journey within the experience of raising of a care concern



The emotional journey included particular situational difficulties: the reactions of other people, either those involved in the unsafe situation or those listening to the students' concern, and the students dealing with their own anticipatory emotions about speaking to people in authority i.e. those on higher bands/ward managers who students had to face.

i) Facing difficult situations

Participant	Quote
Abi	"she [person in incident] got a bit angry." "And I just said I've had a really horrible morning and I've got so much to tell you…"
Bea	"she [manager] was really going for it and I actually sat there and started crying and she was like what you crying for cause this is your fault and I went but why is it my fault?"
Carly	"the girl [person in incident] has been walking around, we've been doing things… but I don't think what I supposed to do" "I'm OK with it. I'm emotional strong and everything."
Diane	"I felt awful for doing it but I think I humiliated the sister, not in a disrespectful way," "I'd have to just give up being a nurse if I stayed quiet"
Eve	"being a first year student it wasn't always to go and run to that person. It wasn't something that I wanted to go and do." "… it might not be the right thing that I'm saying but if one person isn't gonna listen then maybe another will."
Fay	"I could see she [person in incident] was getting impatient with me cause she was huffing and puffing and tapping her foot like she hadn't got time but I knew we had time." "a bit more courage as a person… to go no, I'm not content with that and I will take it further"
Gina	"I don't want to upset anybody and I question my actions all the time and how I say things and that's just me, I'm a worrier." "I didn't feel comfortable questioning something that could upset a qualified person… but to me in that circumstance, especially with that weight loss, what else do you do?"
Heidi	"I had to carry on working with my mentor – it was awkward – she'd obviously been crying" "…most awkward thing was being on shift while all this was happening"
Ida	"I was quite anxious about bringing the situation up initially" "she asked if it was OK if the matron of the division came in… that high up it was worrying anyway"
Joy	"But again, it's really intimidating as a student to raise a care concerns" "…felt the manager was taking the mentor's side."

For a few students, a feeling of concern towards other people, including the person involved with the unsafe situation, other patients/people in care, and other students who may inadvertently encounter the same situation was described. This added to the students' emotional load, as they were sometimes unable to react to these concerns (i.e. the person involved in the situation) as the focus upon the patient in the unsafe situation was the priority.

j) Concern for others

Participant	Quote
Bea	"I'll use my experience to advise them [students] not to do something they shouldn't be doing without training" "which is something I try to say to the students in the years below me now cause I've obviously been through it."
Carly	"Was she [member of staff involved] lose her job? Maybe this why she needs her money, you know? I was feeling that kind of thing."
Diane	"hurts me to see that people are left like that, that really bothers me." "I did actually feel sorry for her [manager], that the staff weren't as educated"
Fay	"I would have still been thinking in the back of my mind that she's been left alone with vulnerable people and that is just a horrible, sickening feeling."
Ida	"I think as well I was worried about repercussions for the ward"
Joy	"but this nurse could have been telling other people who might not have spoken out"

The essence of emotional strength derived from the nursing students' ability to cope with and overcome the changing emotions experienced in feeling concerned, deciding how to act, facing difficult situations and perhaps unresolved concern for other people. The statements within emotional strength suggest that raising a care concern involves emotional work.

4.4.1 Emotional work

Emotional work i.e. the engagement and effort used to manage or cope with personal and other people's feelings (Erickson & Grove, 2008; Riley & Weiss, 2016) was described in this study, and illustrated an additional aspect of students' experience whilst in clinical practice. Healthcare work has been recognised as being emotionally intensive due to requirements to maintain moral/ethical integrity (Bennett & Chamberlin, 2013; Riley & Weiss, 2016) and effective team/leader relationships (Theodosius, 2008) whilst being at the forefront of leading and delivering compassionate care (Bolton, 2000), yet emotional work remains a largely hidden aspect of professional practice. This study suggests that raising a care concern is one aspect of placement experience where students' emotional work may be intensive.

Whistleblowing has been associated with personal emotional distress when detecting wrongdoing (initial moral distress), after making moral decisions i.e. moral residue, dealing with the outcome or response, or with lack of response i.e. ongoing residual moral distress causing ongoing angst (Burston & Tuckett, 2012; Fredin, 2011; Jameton, 1993; Lamiani et al., 2015; Pauly et al., 2012; Sasso et al., 2016). Anticipatory fears and anxieties have been attributed to the perception or belief of

how the organisation would treat the whistleblower (Angie, Connelly, Waples, & Kligyle, 2011, table 2.1., p. 24), whilst studies in Australia (Jackson et al., 2010; L. Wilkes et al., 2011) suggest that the emotional experience of professionals who whistleblew was intense, long lasting and affected informal support networks i.e. family and friends. For healthcare students, the emotional journey has been implicit across various studies (section 2.2.5.2., p.35): anticipatory anxieties (Fagan et al., 2016; A. Jones & Kelly, 2014); feelings of initial discomfort (Killam et al., 2013); stress when faced with difficult/challenging conversations (Galvin et al., 2015); moral distress as a consequence of feeling unable to raise the concern (Monrouxe et al., 2012, 2014, 2015; Rees et al., 2014); and post-reporting emotional ambiguity (Ion et al., 2015, 2016). This study has provided a clear picture of nursing students' emotional angst and difficulties: dealing with concerning situations (section 4.2); maintaining moral strength and motivation (Austin et al., 2005; Kälvemark et al., 2004; Kozlowski, Hutchinson, Hurley, Rowley, & Sutherland, 2017; Pauly et al., 2012); facing difficult situations and living with the consequences of decisions (Bennett & Chamberlin, 2013; Riley & Weiss, 2016), suggesting a high degree of emotional work occurs during the experience of raising a care concern (diagram 4.2, p.96). This varied picture suggests that the combination of moral decision making and managing the situations within clinical practice required the use of emotional strength.

4.4.2 Emotional strength to manage moral and situational conflicts

Having emotional strength appeared to assist nursing students in this study manage conflicting emotions and concerns associated with moral decision making and dealing with other people within clinical practice (Epstein & Delago, 2010; Pauly et al., 2012; Pianalto, 2012). Practitioners' moral distress and emotional angst over whistleblowing has been attributed to organisational mis-treatment or inaction (section 2.2.2., p.23), whilst the retrieved literature suggests healthcare students' distress is linked with reporting of other students, supervisors or mentors, verbalising concern and sustaining effective workplace relationships (section 2.2.5.2.,p 35). This study suggests a range of situational events which could promote moral distress e.g. dealing with placement staff's emotional responses, receiving no response and having to report other staff's poor performance whilst remaining within the workplace. The elements described in this study suggest that an extended and previously underappreciated area of personal capability may help nursing students overcome the moral and situational angst involved in raising of care concerns: emotional intelligence [EI].

4.4.3 Emotional intelligence as strength

EI is a personal capability to predict and manage one's own and other's emotional responses to situations (Kaya, Şenyuva, & Bodur, 2017; Montes-Berges & Augusto, 2007; Orak, Farahani, Kelishami, Seyedfatemi, Banihashemi, & Havaei, 2016), and has been considered as a way to mediate negative emotions and maintain personal relationships through intuitive communication and interaction. The students' descriptions within the essence of emotional strength suggest they have the ability to manage personal emotions (in conjunction with moral decision making) as part of staying strong whilst deciding upon and verbalising concerns. Managing the emotional experience of raising a care concern warrants further examination, as left unresolved negative emotions can lead to stress, burnout, disengagement, lack of care and potentially attrition (Curtis, 2014; Hamric, 2012; Por, Barriball, Fitzpatrick, & Roberts, 2011; Wilkinson et al., 2017). The emerging discussions of the emotional angst associated with being concerned for others (Wilkinson et al., 2017), and making and living with moral decisions (Corley, 2002; Hamric, 2012; Lachman, 2016), indicates that EI may be an explanation for the emotional strength described in this study.

4.4.4 EI and moral awareness

EI may also benefit improved moral decision-making (Beauvaris, Brady, O'Shea, & Griffin, 2011; Kaya et al., 2017) as self-awareness may make the recognition of a concern easier (Montes-Berges & Augusto, 2007). As discussed in section 4.2.1 (p.81), emotional components of professional decision making have been reduced due to the growth in EBP. Self-awareness may assist students in recognising when concern acts as a motivator (Montes-Berges & Augusto, 2007; Por et al., 2011) or when concern has moved into moral or psychological stress or distress (Hamric, 2012; Kolyva, Butt & Eames, 2018; NMC, 2018b), acting as a trigger to seek support. One of the main fears expressed by healthcare students within the literature was verbalising concern (Fagan et al., 2016), perhaps as at this moment the decision to raise a care concern became public and consequences e.g. alterations to relationships or responses from mentors/supervisors would have to be faced. In anticipation of negative responses, EI allows individuals to alter their communication, both verbal and non-verbal, aiming to minimise another's discomfort and to manage and maintain effective relationships (Por et al., 2011; Salovey & Mayer, 1990). EI may therefore help in understanding why and how nursing students navigate role boundaries and the different ways used to relay concern to others (section 4.3.2, p. 90). The proposed influence of EI, in conjunction

with the new NMC (2018b) requirements for pre-registration education to include EI, self-awareness and students' ability to maintain their own health and wellbeing, suggests new approaches to how educators prepare and support students to raise a care concern may be timely. Some ideas are discussed in chapter five.

4.5 Overcoming perceived barriers: Feedback and support

The type and volume of comfort, support and feedback received by nursing students in this study appeared important for the degree of emotional and moral discomfort, distress and ultimate satisfaction they felt following raising of a care concern. This study suggests that receipt of comfort, support and feedback from a variety of sources may influence nursing students' emotional health and wellbeing, reinforce students' decision making, and end or prolong the emotional disquiet felt by nursing students after having raised a care concern. Students described various times of needing comfort and support, and that feedback had a positive effect on settling moral and emotional angst, promoting a sense of satisfaction.

k) Needing comfort and support

Participant	Quote
Abi	"I felt myself getting really hectic when everyone else around me was being so calm and I felt like I was over-reacting but I felt like this was such a big deal." "I cannot wait for my mentor to come in. Cause I just need to cry."
Bea	"Requiring further answers from University, just wanted to discuss for my own peace of mind" "Not sure of who to contact"
Diane	"It's hard because you don't get a lot of support"
Eve	"I didn't feel she made it as urgent as what I felt it should have been." "Should the nurse have interacted with the doctor and, can we just look at this" "I wasn't aware that I could do anything more"
Fay	"She [mentor] had very poorly patients and sitting down to go through safeguarding procedure with me wasn't appropriate at that time"
Gina	"emotions were all over the place cause this had just happened."
Heidi	"because my mentor was there…. I felt like I couldn't tell her"
Ida	"I spoke to the healthcare in that bay about it… She did agree that something needed to be done" "I felt quite unsure about the situation"
Joy	"Quite a bit embarrassed that I didn't know the policy… but I wasn't on the best terms with my mentor to speak to her about it myself" "felt the manager was taking the mentor's side"

Students described moments when placement staff, managers or academics had provided support, either as emotional reassurance, advice, positive coaching or practical support in relation to preparing for a formal investigation within the organisation. Positive interactions with staff suggest they have an important role in

mediating the negative emotions which are felt by nursing students whilst raising a care concern.

l) Receiving support

Participant	Quote
Abi	"And she [practitioner] kept putting the emphasis on you're doing a great job, don't worry" "she's [mentor] there to look after you"
Bea	"Helpful academic staff." "Reassured by working with mentor"
Carly	"reassurance of doing the right thing." "Receiving advice [from PEF]" "Receiving advice for writing the statement [from personal tutor]"
Diane	"I got on really well with her [mentor], I felt that she was supporting me in the right way."
Eve	"Mentor did support me to go and speak to the doctor." "Dr… I felt satisfied that he'd actually bothered to listen to me."
Fay	"feeling assured it would be dealt with"
Gina	"we [student and practitioner] sat down and we looked in to it together, whether it was just to calm me down" "so I felt really supported with my personal tutor; just a big hug and a you did the right thing." "speaking with personal networks"
Ida	"The matron sort of reassured me and said you know, don't worry about it, it's good that you came to us."

4.5.1 Comfort as emotional support

Receiving comfort i.e. the easing of a person's feelings of grief or distress (www.merriam-webster.com/dictionary/comfort) suggests an additional support valued by nursing students in this study during and after having raised a care concern. Responses from placement or academic staff to students' verbalisation of concern were multi-faceted, yet feedback offering emotional comfort appeared to ease the emotional angst highlighted in this study (section 4.4., p.96). Whilst the emotional distress of students in clinical practice is well documented (Elcigil & Sari, 2007; Evans & Kelly, 2004; Hamshire et al., 2012; Leduq, Walsh, Hinsliff-Smith, & McGarry, 2012; O'Mara, McDonald, Gillespie, Brown, & Miles, 2014; Thomas et al., 2012), raising of a care concern could add to this distress. In this study, comfort appearing to be integral in mediating the extent of unresolved distress. Comfort has not been identified as a component of work based professional relationships (NMC, 2008; Papathanasiou, Tsaras, & Sarafis, 2014). Within nursing, emotional support has been a 'hidden' role of the mentor (Gidman, McIntosh, Melling, & Smith, 2011; P. Smith & Gray, 2001; Z. Wilkes, 2006) with an overt reliance upon students' social support systems i.e. family, friends and peers (Crombie, Brindley, Harris, Marks-

maran, & Thompson, 2013). As well as providing hidden emotional work for mentors (Gidman et al., 2011), an emotional relationship i.e. a connection between student and mentor may jeopardise the robust assessment of students' fitness for registration (Black et al., 2014; Duffy, 2004; Elliot, 2016; Jervis & Tilki, 2011), continuing fears and debate about the competency of newly registered nurses. In promoting a professional relationship for student assessment, the emotional or comfort needs of students when experiencing a distressing situation may be overlooked, leading to unaddressed student stress.

Seeking comfort from placement staff via words of reassurance and positive regard appears valuable in supporting students during the experience of raising a care concern. Relationships between students and mentors/placement team have been considered both helpful (Bellefontaine, 2009; NMC, 2017a) and potentially inhibitory (section 2.2.5.2.,, p. 35) in supporting raising of a care concern. This study suggests that emotional comfort may be an aspect of placement relationships which is particularly beneficial for students who have raised a care concern, as positive regard i.e. the creation of a safe psychological environment (Rogers & Freiberg, 1994; NMC, 2008) has been seen as central to the relationship which underpins nurse/patient relationships and therefore may be part of the 'natural' instinct of placement staff. Although emotions may complicate the mentor/student relationship (Duffy, 2004; P. Smith & Gray, 2001; Z. Wilkes, 2006), students' unresolved emotional angst may contribute to mental ill health – an aspect of student experience which is currently receiving priority attention within higher education (Department of Education [DoE], 2018). The positive influence of interactions of placement staff with students during the experience of raising a care concern appears to be valuable in offsetting negative feelings. The need for comfort and support when raising a care concern described in this study suggests that positive interactions may be important for easing nursing students' emotional distress, and that educators and placement providers should acknowledge and try to provide elements of comfort within placements (see section 5).

4.5.2 Feedback as support for moral decision making

Whilst making the decision to raise a care concern has been cited as a difficult choice, this study suggests that feedback from placement staff may promote a positive feeling and thereby maintain moral motivation and support students' evaluation: that it was the right thing to do. As discussed in section 4.3.3 (p.91), though there has been little emphasis upon positive feelings within healthcare

students' experiences (section 2.2.5.2., p.35) or in the experience of professional whistleblowers (section 2.2.2., p.23), positivity has a potentially valuable role to play in promoting and maintaining personal moral decision making (Duncan, 2010; diagram 4.1, p.80). The retrieved literature (Section 2.2.5.3.,p.37) suggests support for students' choice to raise a concern should focus upon addressing knowledge deficits, role modelling and promoting confidence This study suggests that feedback which positively reinforces students' choice at the point of raising the care concern promotes the feel-good emotions needed to justify moral decision making. Whilst support strategies are built into professional guidance (GMC, 2012, 2018; HCPC, 2016b; NMC, 2017a, 2019) such as reporting to mentors, supervisors, placement managers or academics, Milligan et al. (2016) suggests there is little evidence of their effectiveness in facilitating students to raise a care concern, and the retrieved literature of this study suggests these staff may add to students' perceived barriers when in clinical practice (section 2.2.5.2., p. 35). In nursing, mentor (NMC, 2008; Rogers & Frieberg, 1994) and team relationships (Carmeli, Brueller, & Dutton, 2009; Newman, Donohue, & Eva, 2017) have been assumed to promote psychological safety by being open, honest, respectful, positive and based on mutuality. This has been deemed as positive for support (Bellefontaine, 2009; NMC, 2017a), yet not necessarily support for raising of a care concern (Eppich, 2015; Levett-Jones & Lathlean, 2009; Mannion et al., 2018). This study suggests that, irrespective of their role, personnel offering positive feedback can have a beneficial impact on the students' moral motivation and promote a sense of satisfaction.

Being in clinical practice and receiving positive feedback appeared to support nursing students in this study, providing a new perspective on the importance of positive responses from placement staff when students try to verbalise a concern. As in this study, data from both Ion et al. (2015) and Bickhoft et al. (2016) included placement staff's positive responses within descriptions of nursing students' experiences. This study extends this discussion by suggesting that positive feedback from practice staff may offer comfort and support students' moral decision making, which practice partners should encourage when seeking to promote nursing students to raise care concerns (section 5.5).

4.5.3 Feedback for emotional and moral satisfaction

This study highlights a time period after nursing students have raised a care concern when one of two situations emerged: ongoing or resolved emotional or moral distress, resulting in varying degrees of post-event satisfaction. Feedback on

the outcome since raising the concern, from placement or organisational sources, appeared important for students' ultimate sense of satisfaction and resolution of emotional or moral angst. For some students, moving on was enabled due to a positive evaluation, suggesting a sense of satisfaction which was linked with the informal receipt of feedback:

m) Moving on

Participant	Quote
Bea	"Making sure not to do this again." "Helping other students to realise."
Carly	"After I raise the concern – seeing a change in placement procedure." "I'm not really worried about the transitional placement because I'll be there"
Diane	"After I raised that issue – situation improved." "After raising a care concern I felt like quite proud of myself to be honest."
Eve	"He then went to the other doctor and her medication was changed." "…maybe she could go back to the community, back to the way she was and be happier than being on the ward and being distressed every day."
Fay	"I felt awful guilt because… the last thing I wanted is for someone to lose their job… And I heard that she was on her last warning anyway and then I kind of felt like actually I'm quite glad I did it all now." "It does comfort me knowing that she's not working within the trust."
Gina	"No. It did get raised. I think it went as high as CQC …maybe I was right then if it went that high." "that was another thought that I'd had through reflection"
Ida	"The only thing they wanted to look further in to was the specific nurse's first aid training…. And since then I have been back to the ward."

The examples from unfinished business described the ongoing emotional angst for some students, which is linked with insufficient feedback and uncertainty on the outcome of having raised the care concern:

n) Unfinished business

Participant	Quote
Abi	"Unsure if have raised a concern." "so I feel like a bad person. Even though I know that I'm not. But to them or the staff members, well to her [member of staff involved], I would be." "I'd feel like that'd be a barrier to me working there… Which I hate to admit because I feel weak." "I think the only thing is I would have liked to have known what happened"
Bea	"she wasn't in uniform anymore and she's not been in uniform for some time since that incident. So I don't know if she's just been put on to administrative work."
Carly	"Still waiting to hear the outcome".
Fay	"no one else told us cause you're not allowed to, it's supposed to be confidential… rumours went round that she was let go." "Which still to this day isn't good enough for me cause I don't know where this nurse is."

Participant	Quote
Gina	"So it made me question me as person, did I say that horribly, how could I have said it again?" "Imagine if I hadn't said something…" "I just said I don't think I'll ever find out the response… It was a worry about the baby because of the weight loss"
Heidi	"…I suppose any drug error's dangerous, this is still what I'm playing with in my head, they played it down very much so cause he was fine"
Ida	"a little bit anxious if nobody on the ward had the skill to do it" "how long was it gonna take for her to be treated properly."
Joy	"…unless the patient ever raised it… if the manager would have done anything about it."

This study offers insight into the student experience after decision making, when feedback on the outcome of the raised care concern was a key factor for students' evaluation of the experience and their future professional practice. Organisational response to raised care concerns is a central point for professional whistleblowers, as this suggests the concerns were 'heard' and should elicit an intervention to stop the wrongdoing (L. Moore & McAuliffe, 2010; Vinten, 2000), prompting a sense of satisfaction (Holden, 1991). For professional whistleblowers, feedback from organisations to employees has not been well documented, yet remains a core requirement of an effective system (Whitehead & Baker, 2010; Jackson et al., 2014; Jubb, 1999; Near & Miceli, 2016; RCN, 2017a). According to Firtko and Jackson (2005), for the individual, evidence of a successful outcome from having raised a care concern vindicates the decision, yet the experience of moral decision making may leave the practitioner with some degree of angst connected to moral dis-stress (Jameton, 1993) i.e. failure to change the situation, or moral residue i.e. emotional dis-stress following moral decision making (Por et al., 2017). Nursing students' continuing angst following encountering an unsafe situation was identified by Ion et al. (2015), and this study highlights the importance of feedback upon nursing students' after they have raised the care concern.

The emotional evaluation i.e. either a positive or negative view of the raising of a care concern appeared connected to nursing students' perception of the outcome, based upon the receipt (or not) of formal or informal feedback. Providing nursing students with evidence of the outcome following a raised care concern appeared to aid a positive evaluation of the experience. Organisational feedback for students whose concern had been escalated was largely unreceived, even several months after the event. The *Freedom to speak up: Raising concerns (whistleblowing) policy* (NHS Improvement & NHS England, 2016), which includes healthcare students

within its definition of employees, identifies that feedback to those who raise a care concern is bound by confidentiality (Jubb, 1999; Lewis & Vandekerckhove, 2015; Near & Miceli, 2016; RCN, 2017a), but should occur. The dilemma about confidentiality, employee rights, the whistleblowers' right to feedback (NHS Improvement & NHS England, 2016; RCN, 2017b) and the temporary nature of students' attendance within organisations (NMC, 2010) may contribute to the paucity of investigatory feedback given This study implies a gap in communication between organisations and students who raise a care concern, which may affect students' evaluation of the experience and leads to students' relying upon informal feedback on the outcome of the raised care concern e.g. observing staff changes or local changes to practice. Regardless of the source of feedback, for some nursing students positive evaluations signified completion of the experience, whilst for others an ongoing angst was clear (Abi's account in Appendix H). Ongoing angst appeared connected to a range of contributory factors such as incomplete feedback, moral residue, emotional stress and continued moral/emotional angst. There is an intimation that the positive or negative evaluation of an experience may influence future willingness or likelihood to raise a care concern (Ion et al., 2015; Mansbach et al., 2009, 2012, 2014), which suggests that the communication to nursing students following an organisational investigation, and support during the period of self-evaluation after the concern is raised, maybe relevant to employers and future professional practice (discussed in chapter five).

Sections 4.3, 4.4 and 4.5 have provided new insight into the emotional experience for nursing students who have raised a care concern whilst in clinical practice. These new perspectives suggest that EI and feedback and support may have renewed importance in relation to education, placement providers and UK professional guidance; this will be discussed in chapter five.

4.6 Limitations and transferability of the findings

Prior to considering the implications for professional practice (chapter five), a critical consideration of the study's limitations was undertaken to establish the transferability of the findings. Using the C.A.S.P. (2017) tool, the limitations focus upon methodological decisions, namely the local and contextual nature of this qualitative study, use of voluntary recruitment and low response for confirmability checking. This study addressed the doctoral requirements for exploring an aspect of my own professional practice and this focused my work upon locality: participants were from my own institution, yet attended placements across a large area of the

North West of England. The commonality of nurse education based upon NMC standards (NMC, 2008, 2010, 2018b) implies there may be contextual transferability across the UK, and internationally in countries which adopt similar educational principles. The phenomenological methodology sought to find the commonality across nursing students' experiences, and this also suggests potential transferability to other nursing student populations, as the use of clinical practice and the requirement to raise care concerns appeared internationally relevant.

The use of voluntary recruitment whilst recruiting an appropriate sample for this study prohibited the targeting of specific representatives missing from previous studies i.e. males, students of Black, Minority and Asian ethnic origin, and the nursing fields of learning disability and children's nursing. The necessity for participants to have experienced the phenomenon under study was prioritised over their representativeness, to ensure the trustworthiness of the data (Boswell & Cannon, 2017). Further studies (section 6) will be needed to address the populations which remain under-explored. The initial low response to confirmability checking led to changes to email correspondence, signifying that no response (date limited) implied agreement with the content of the transcribed interview, as a pragmatic way to maintain the time line of the thesis. Whilst further research is needed, the limitations discussed imply that the study findings have implications for professional practice.

4.7 Summary

This chapter presented the findings in answer to the research questions of this study. The composite description summarises four essences which are common to the nursing students' experience of raising of a care concern when in clinical practice. Within essence 1, *patient centred concern*, feelings of compassionate concern may trigger and sustain students' motivation to raise a care concern, with the impetus to relieve patient's suffering and distress. In essence 2, *deciding how to raise the care concern* may be influenced by students' wanting to be professional, which sustained the motivation to navigate role boundaries and may have contributed to the realisation of using personal autonomy to verbalise the concern to other staff when other options were ineffective. Essence 3 identified the potential role of *emotional strength* that students needed to overcome and deal with a complex emotional journey, face perceived difficult situations and deal with concern for other staff. Important to emotional and moral strength, essence 4 identified the potential significance of *feedback and support* to comfort nursing students, provide

moral reassurance and promote a sense of satisfaction as a lasting evaluation of the experience. The findings have a range of implications for nurse education, clinical practice, and professional and government policies which are discussed in chapter five.

Chapter 5: Recommendations for Professional Practice

This chapter critically examines the implications of the study's findings for nursing and nurse education. As advocated by Moustakas (1994), implications are evidence of my personal application of the findings across the layers of professional practice: starting within professional education, my role as an academic leader and manager led to consideration of the recommendations for student experience i.e. teaching and learning, support in clinical practice, faculty processes, students' contribution to patient safety, and recommendations for NMC guidance.

5.1 Teaching and learning

This section focuses upon teaching students the fundamentals of a compassionate moral motivation i.e. the recognition of feeling concerned, and the practical boundaries and difficult situations which have to be navigated and faced in order to be a professionally responsible practitioner (NMC, 2018a) and raise a care concern. The teaching strategies draw upon ideas from EI, emotional awareness and simulated practice learning experiences to reflect the findings from this study. In light of the new NMC educational standards (NMC, 2018b), these approaches are pertinent for the current curriculum development being undertaken to prepare for the validation of new nursing programmes from 2020, having direct influence upon my own professional practice and leadership.

5.1.1 Self-awareness and feeling concerned

Feeling concerned suggested students need to be emotionally aware and able to recognise when a situation may be unsafe or causing patients' harm. Whilst compassion has been cited as a moral motivation from this study, compassion (as with empathy) relies upon sensitivity to another's distress; and although the personal experience of these concepts is different (section 4.2, p.79), professional education should seek to prepare nursing students to recognise 'concern' as an emotional indicator of moral discomfort (section 4.2.1, p.81), triggering compassion or an empathetic response. Drawing upon the awareness of emotions within EI (section 4.4.3, p.100), the introduction of teaching strategies for raising students' emotional awareness may help in recognising concern as a motivator for responding to potential patient distress/suffering (Freshwater & Stickely, 2004; Morris, Urbanski, & Fuller, 2005).

Within the preparation for clinical practice, classroom teaching can utilise a range of strategies to foster understanding of patients' potential distress and suffering, and

the appropriate responsiveness required for effective nursing practice. By adopting a model of 'concern and response' for raising of a care concern, empathetic concern can be promoted by experiential teaching and learning strategies (Johns, 1995; Kolb, 1984; Martin, 1989; Moon, 2013), i.e. using students' memory and previous experience to recognise concerning or unsafe situations. Recognition of others' suffering or distress may also be promoted by creating situations which give rise to emotional concern, and creative arts i.e. use of drama, poetry and literature is one strategy which can offer ways to support students' deep emotional learning within a 'safe' university environment (Morris et al., 2005; Robinson, 2007). The use of strategies such as film, plays, poems and patient stories, real or fictional, can portray the patients' view of healthcare, promoting the person-centred foundations of modern care (Darzi, 2008; DoH, 2011b, 2015a, 2015c; NMC, 2018a, 2018b). Focusing upon learning from patient experiences, the facilitation of feeling concerned as a motivator for taking action brings together the emotional/moral aspects of recognising an unsafe situation. Learning how to respond may benefit from other pedagogic strategies.

5.1.2 Practising moral decision making

To aid nursing students' association between concern and response, presenting raising a care concern as a compassionate act draws together strategic imperatives i.e. putting patients at the heart of the service, leading change and adding value (Cummings, 2016; NHS England, 2016), and patient protection (NMC, 2018a, whilst providing a practical example of compassion in action (Straughair, 2012b). Using a practical learning scenario may be beneficial, such as use of psychological fidelity simulation i.e. re-enacting a scenario within a mock real-world environment to give a sense of reality, involving practical decision making and managing challenges which may occur when in clinical practice (Khan, Pattison, & Sherwood, 2011; Krautscheid, 2017; Papathanasiou, Kleisiaris, Fradelo, Kakou, & Kourkouta, 2014; Parker & Myrick, 2012; Ricketts, 2011). Simulation provides a psychologically supportive environment (Krautscheid, 2017) where 'teachers' use 'de-briefing' i.e. reflective deconstruction of the students' performance to facilitate learning points such as overcoming perceptions or anxieties or fears. Simulation and debriefing offer opportunities to facilitate EI capability through deep reflexive learning (Moon, 2013) within the university, and using reflexive practice may help students learn the affective components of professional practice more effectively (Martin, 1989; Reece, Walker, & Walker-Greaves, 2013), preparing them for managing emotionally difficult situations such as raising a care concern. The use of varied applications of

reflection i.e. academic, personal learning, organisational learning (Rolfe, Jasper, & Freshwater, 2011) within debriefing would bring together strategic imperatives such as patient safety (Usher et al., 2018) and students' own practice and patient experience, making relevant links for students' learning. Although scepticism remains regarding the relevance of simulated learning in clinical practice (Cook et al., 2011; Sinclair & Ferguson, 2009), it offers opportunities for students to practise moral decision making and responsive behaviours, preparing them for the complexity of clinical practice (Ion et al., 2015; Khan, Pattison, & Sherwood, 2011; Lachman, 2016; Mansbach et al., 2009, 2012, 2014).

5.1.3 EI and difficult conversations

The use of EI to enable nursing students to prepare for emotional distress (section 4.4.2, p.99) or difficult conversations (section 4.4.3, p.100) should be facilitated through simulated practice. Although EI has been seen as a gender determined and therefore naturally occurring quality (Benson, Martin, Ploeg, & Wessel, 2012; Kaya et al., 2017; Stiglic et al., 2018), facilitating self and empathetic awareness can assist in enhancing EI capability (Montes-Berges & Augusto, 2007; Opie & Parkes, 2015). Teaching and learning strategies (section 5.1.1, p.100), such as creative arts, facilitated purposeful learning from previous experiences, role play, simulation and/ or clinical practice can enhance student self-awareness, empathy and raise awareness of potential staff responses on hearing of a care concern. In anticipating others' response, practising sensitive yet clear communication in difficult situations (Freshwater & Stickley, 2004; Katz & Sosa, 2015) may enable nursing students to develop an adaptive approach to verbalising of care concerns. Using adaptive communication derived from EI capability may assist in promoting nursing students' ability to overcome the perceived barrier of verbalising a care concern to university or placement staff.

5.2 Student support

Implications for student support focus upon how professional education may improve students' experience when in clinical practice, focusing upon facilitating listening to concerns, and offering compassionate support to promote the emotional wellbeing of students.

5.2.1 Listening in clinical practice

Academic and practice-based support for raising a care concern can be improved by this study's findings. The emotional and moral needs accompanying students'

experience of recognising and responding to a care concern (sections 4.2–4.4, pp.79- 100) are highlighted in this study. These findings suggest that university and placement staff have a key role in supporting nursing students' moral decision making, providing comfort and positive feedback during raising of a care concern, and therefore a change to the strategic support offered by the University and placement staff is recommended (NMC, 2018b), with a focus upon providing listening moments and responding to emotional/moral distress.

Creating opportunities whereby time is made for listening to concerns may enhance students' sense of support. Academic support in practice within my HEI focuses upon Practice Education Lecturers (PEL) and academics acting as link lecturers (NMC, 2008), yet the unexpected nature of concerning or unsafe situations makes support at the specific time of raising a care concern unlikely. As the educational support in relation to raising a care concern is also under-researched (Milligan et al., 2016), this study's findings have led to recommending the creation of 'listening moments', where academic or practice supervisors may listen to students' concerns (NMC, 2018b), facilitating a solution focused approach and enabling a response to patient care concerns from placement staff in a timely manner. Listening moments, which help nursing students engage with academics who can support the speaking-up of concerns to placement staff (http://www.listeningintoaction.co.uk/), offer an adaptation of listening-in-action approaches whereby concerns are openly discussed, listened to and responded to by employers, who can make a change happen. The creation of specific listening moments with academic staff may offer time for positive feedback for nursing students who have recognised unsafe situations, facilitate raising of care concerns to placement staff, and offer learning to others. Within either an individual or group listening moment, the moral and emotional comfort and support, plus positive reinforcement by feedback, may be optimised, increasing students' motivation to verbalise patient care concerns. A listening moment group could provide opportunities for creating an open, honest culture in which problem solving, improvement and innovation for patient safety is practised (Berwick, 2013; Carmeli et al., 2009; Newman et al., 2017), providing explicit support for NHS culture change (section 2.2.3., p.26) and demonstrating to students their involvement and importance in patient care.

5.2.2 Compassionate support

The provision of compassionate support through kindness and comfort for nursing students who raised a care concern is suggested from this study's findings (section

4.5.1, p.102). Adopting compassionate support may promote students' wellbeing and enhance students' perception of raising a care concern, which in turn may assist with improved student learning experiences, enhance student retention (DoE, 2018; Universities UK, 2015) and contribute to the future NHS workforce holding a positive view of internal whistleblowing (Francis, 2015). The need for comfort suggested that compassionate relationships – that is, treating others with kindness and consideration (King's Fund, 2017; NHS Improvement, 2015; M. West, 2016, 2018) – with practice or academic educators may be supportive of students, especially when a care concern has been raised. Within nurse mentorship models (NMC, 2008), comfort appears antagonistic to the assessor role (Bray & Nettleton, 2009; Duffy, 2013), yet new standards to support nursing students' education (NMC, 2018b; Willis, 2012) suggest that distancing between supervision and assessment roles may be beneficial to enhancing student wellbeing and compassionate support within clinical practice. Employing compassionate leadership i.e. professionals use of concern, empathy, and EI to recognise and respond to colleague's distress (Henshall et al., 2018; Massie, 2016), to mediate workplace stress and promote wellbeing, may be extended to include nursing students, promoting the inclusion, sense of belonging and compassionate support (Levett-Jones & Lathlean, 2009; NMC, 2018b; Willis, 2012, 2015) required to improve the experience of future NHS whistleblowers (Section 2.2.3., p.26) and to address nursing students' emotional welfare during placements.

5.3 Faculty policies and processes

A key point for faculty policies and processes was the suggested importance of feedback on the outcome of the concern for nursing students (section 4.5.3, p.104), which may impact upon the students' emotional wellbeing and future willingness to raise a care concern (Mansbach et al., 2014). Part of recommended good practice, organisational feedback on investigations (RCN, 2017a; Near & Miceli, 2016; NHS Improvement & NHS England, 2016), as well as informal feedback on the outcome of the students' concern, would appear to require revisiting. Whilst strategically nursing students' are included within NHS policies (NHS Improvement & NHS England, 2016), campaigns and practical implementation appears to broadly focus upon NHS employees (http://www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-whistleblowing). A review of partnership agreements to include the sharing of outcomes from care concerns raised by students may be timely, promoting a collaborative approach to patient safety, and providing nursing

students with appropriate confidential feedback on outcomes and lessons learnt from raised concerns.

5.4 Improving NHS patient safety: Students as role models and clinical leaders

This study suggests nursing students who raise a care concern offer the NHS an opportunity to contribute to promoting a patient safety culture (Hancock, 2018), through being local role models and workplace leaders. Integral to effective patient safety is a culture where concerns are listened and responded to (section 2.2.3, p.26) with nurse leadership within the workplace playing a significant part in establishing and maintaining this culture (Cummings, 2016; Cummings & Bennett, 2012). The recognition of future nurse leaders (Kolyva, Butt & Eames, 2018; NHS Employers, 2014; NHS Improvement, 2015, 2017) and role models within clinical practice (section 2.2.5.2, p.35) are important for promoting raising of a care concern and the patient safety ethos. This study suggests that nursing students who raise a care concern exhibit the personal attributes i.e. compassion and emotional and moral strength, and the professional capability i.e. are critical, autonomous decision-makers, required for leading workplace change and organisational culture to fulfil the NHS vision for safe, compassionate care (HEE, 2014).

Raising the prominence of nursing students who have raised a care concern, by making them peer role models, may be a way of positively promoting how students can and do contribute to patient safety whilst in clinical practice. Although role modelling can be considered as an opportunistic learning event (Boud, Cohen, & Sampson, 2013), deliberate recognition of nursing students' contribution to patient safety through peer debate, learning and critical analysis, using strategies such as clinical supervision i.e. individual or group discussion about personal or workplace practice (CQC, 2013b) or Schwartz Rounds i.e. workplace forums (National Institute for Health Research, 2017), could provide a clear integration between students and practitioners, and education and clinical practice. Inclusion within patient safety initiatives would also start to change the view of students from dependent, passive learners towards active, prospective clinical leaders, consistent with the vision for future nurse leaders (Kolyva, Butt & Eames, 2018; NMC, 2018b; Willis, 2015).

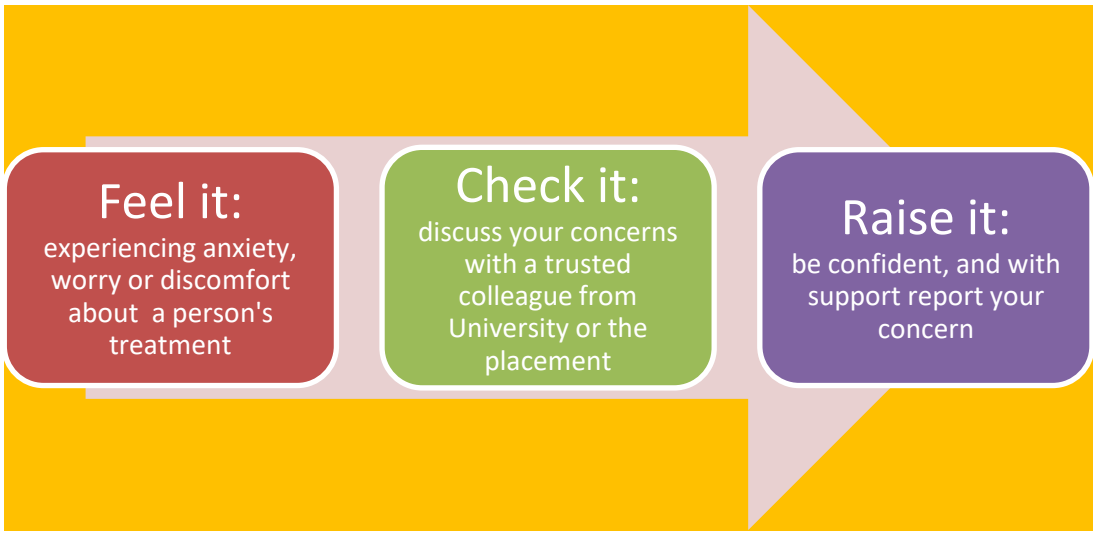
A strategic emphasis upon valuing nursing students who raise a care concern within clinical practice, such as recognition in the recruitment of new registrants, may assist in meeting the strategic vision of an open, honest NHS culture (diagram 2.2., p.28). The need for workplace leaders and role models who are compassionate,

influential, emotionally intelligent and who value patient safety has been cited as key to improving NHS patient care (Geller, 2000; Massie, 2015, 2016; NHS England, 2014; West, 2016, 2018), yet nursing students remain an untapped resource in relation to this agenda. This study suggests that nursing students who raise a care concern appear to demonstrate professional clinical leadership capability, and as a potential asset to the NHS could have a stronger influence in clinical practice if spotted as a future talent during recruitment campaigns. Developing a transparent way to respond to concerns, acknowledging students' contribution to patient safety and valuing students who have raised a care concern when recruiting new staff may assist in enhancing students' experience, start to empower students within placement, and help recruit registrants with the leadership capability required for a safe, compassionate NHS.

5.5 National compassion-led campaign for raising a care concern

The need for a new national campaign to promote nursing students to raise a care concern is a proposal of this study. Key campaigns have been developed for NHS employees (NHS England, 2015) and managers to enhance the workplace culture and value raising of a care concern (www.england.nhs.uk/ourwork/whistleblowing/raising-a-concern/; http://www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-whistleblowing). Although these strategies will improve the workplace environment, the impact upon nursing students is unclear, and this study suggests that there may be some different influences i.e. compassion (section 4.2.3, p.84), workplace support and feedback (section 4.5.3, p.104) upon nursing students' likelihood to raise a care concern. From this study, a proposed campaign introduces a simpler process for the recognition of and response to potential or actual patient harm, using key stages identified within this study (section 4.2, p.79): concern, conviction and verbalising of concern. Relabelling raising of a care concern as a compassionate act, where being concerned is sufficient trigger for a discussion, aims to remove the perceived barriers identified within the retrieved literature (section 2.2.5.2, p.35) and focus upon patient safety. The compassionate model of raising a care concern was presented at the Networking for Education Today conference (E. Cooper, 2017), where members of the NMC and peers discussed the components of compassion and the verbalisation of concerns. From this discussion and the findings, a proposed national compassionate campaign for nursing and potentially other healthcare students and raising of a care concern is illustrated in diagram 5.1.

Diagram 5.1: Healthcare students campaign: Process for compassion-led raising of a care concern



From this proposal (diagram 5.1), changes to UK professional nurse guidance are suggested.

5.6 Professional guidelines

Promoting a new perspective within the NMC guidance for nursing students and raising of a care concern (NMC, 2019) should be considered in light of this study, for all placement staff and student supervisors (NMC, 2018a, 2018b) to be prepared for listening and responding to patient care concerns. In this study, nursing students acknowledged that various placement staff were approached, and that role or status i.e. as mentor or placement manager did not always enable the students to verbalise concern. In this study, a safe outcome for the patient appeared to be a priority over waiting to report to the NMC identified person(2017a, 2019a). This study recommends that guidance for nursing students acknowledges that a timely response or outcome is the appropriate time to stop reporting. Escalation of concerns, if students are not satisfied with the outcome, should be included to enable all AEIs and placement providers to work together to ensure that when nursing students raise a care concern the outcome is a patient free from harm.

5.7 Summary

As a nurse researcher and leader within nurse education, this phenomenological study addressed an under-researched aspect of nursing students' clinical practice, that of raising a care concern. The in-depth exploration of ten nursing students' experiences suggested that raising a care concern may be motivated by a

compassionate concern, which if coupled with professional endorsement and autonomous decision making, provides a moral imperative which helped students navigate the boundaries of the student role and to verbalise concern. Sustaining this moral imperative, possessing emotional strength and receiving comfort and positive feedback and support from placement staff were integral to students' emotional and moral wellbeing, satisfaction and positive views of the experience.

From these findings, recommendations for improving the education of nursing students in preparing to raise a care concern, enhancing their support when in clinical practice and working with practice partners to value nursing students who raise a care concern have been made. This study also recommends a national strategy for nursing students, highlighting the emotional, compassionate nature of raising a care concern, and improvement to NMC guidance.

Chapter 6: Reflections, Conclusions and Recommendations

This chapter draws together and concludes the thesis, presenting an overview of the key original contributions to knowledge produced from this study, a critical reflection upon my learning throughout the doctoral journey, and recommendations for my future areas of research.

6.1 Key contributions to knowledge

This thesis has detailed the research process, influenced by Clarke Moustakas' transcendental phenomenology, to produce a new contribution to knowledge regarding UK nursing students' experience of raising a care concern when in clinical practice. In chapter one, the importance of raising a care concern for achieving good care for all, improving patient safety and preventing harm was made. A focus upon professional whistleblowing suggested that it remained a key personal and professional dilemma when in clinical practice, influenced by organisational culture and a myriad of potential moral choices on whether to raise a care concern (sections 1.5 and 1.6). Whilst current professional regulators advocate raising a care concern as a key professional responsibility, this dilemma poses potential challenges for educators and for students who were also included in the call to speak up and raise patient care concerns.

Reviewing twenty-four papers relating to healthcare students' experiences of whistleblowing (chapter two), the paucity of knowledge regarding the experience of students who had raised a care concern when in clinical practice was highlighted. The reviewed literature identified an assumption that students followed professional morals, ethics or beliefs and this raised the question: what motivated students to raise a care concern? From this review, a range of potential perceived barriers to raising of a care concern were identified: lack of knowledge, fears about personal repercussions, changing relationships, challenging others and variable levels of confidence. From this perspective, the additional question arose: How do nursing students overcome perceived barriers to raising a care concern in clinical practice?

The choice of research approach (chapter three) was influenced by my professional nurse background, focusing upon a pragmatic choice of qualitative methodology to explore nursing students' experience of the phenomenon of raising a care concern. After a review of qualitative methodologies (section 3.1), Clarke Moustakas' transcendental phenomenology which applied Husserlian philosophy within its methodology was chosen to guide the conduct of the study. Choosing this

methodology provided an original method of inquiry, according to the retrieved literature and nursing research sources, and sought to gain a description of nursing students' lived experience of raising a care concern (section 3.2). The phenomenological process of epoché i.e. developing awareness of and distancing myself from my preconceptions, obtaining ethical approval from the Faculty Ethics Sub-committee, and consideration of research quality were completed in preparation for the research. Ten nursing students, all female yet representing some ethnic diversity and two nursing fields, voluntarily participated, and the narratives of their lived experiences were recorded, transcribed and analysed. Analysis followed Moustakas' advice for phenomenological reduction and imaginative variation of separate transcripts, and was repeated across all transcripts to develop essences i.e. core components and a composite description of the experience.

In response to the posed research questions, four essences were identified which captured what is was like for nursing students who raised a care concern (chapter four). 1) Patient centred concern suggesting compassion provided a moral motivation for action, whilst 2) Deciding how to act identified that the strengthening of moral motivation was by professional endorsement and this helped students navigate the boundaries of their role, realise their autonomy and eventually verbalise concern to others. The relevance of having 3) emotional strength and 4) receiving feedback and support for comfort and emotional/moral satisfaction was highlighted, presenting a new aspect of students' experience and contributing new knowledge about raising a care concern whilst in clinical practice.

For professional practice, the recommendations from this study were wide ranging (chapter five). The new relevance of feeling concern as a moral trigger for compassionate motivation provided new emphasis upon moral decision making, emotional awareness, empathy and EI as personal capabilities to be fostered through education, exploring the use of creative arts and simulation to assist students in developing these capabilities. New ways to support nursing students whilst in clinical practice were recommended, seeking to offer a culture of openness and honesty, supported by academics and peers. For clinical practice, clearer feedback to nursing students who have raised a care concern is warranted, as well as utilising an opportunity to share nursing students' good practice through role modelling and seeing the potential of nursing students to provide local leadership, supporting the NHS cultural change towards patient safety and providing good care. At a national level, this study offered recommendations for a campaign aimed at nursing or healthcare students which seeks to make raising a care concern simpler,

and for a change to professional guidance, accentuating the importance of practice supervisors and not giving up until a satisfactory outcome is felt to have been achieved.

6.2 My doctoral journey

Through the completion of this doctorate, I have developed in many ways. The sustained level of study, engagement and inquiry has enhanced my problem-solving skills, and proved my determination and resilience to complete the task in hand. The biggest effect has been upon my professional practice (Costley & Lester, 2012), as the opportunity to study aspects of nurse education in depth, including practice placement experiences, simulation pedagogy and research methodologies, has seen a blending of scholarly endeavour with my growth as an academic leader and researcher. Engagement with academic and practice staff during two recent conference presentations of my initial findings (E. Cooper, 2017) and recommendations (E. Cooper, 2018) have seen peer debate influence my work, developing my confidence in becoming a nurse researcher and contributing to the knowledge within my professional field. This developing confidence has transferred into my current practice, whereby leading and influencing others in developing their own research capabilities through personal mentorship, line management and facilitating academic discussions of practice learning and curriculum appear more natural, which I feel embraces the true work of an academic – the creation and dissemination of knowledge. Being a nurse has meant that my teaching practice started with a focus upon professional knowledge, yet during the course of this doctorate my transition towards an educator and more importantly to an academic educator has begun. The main aspect I have begun to appreciate is the limitations of my knowledge; and that through ongoing academic endeavour, my own knowledge will progress and through research, I can contribute to the future of nurse education. Both of these will uphold my educational belief of contributing to good patient care through the provision of high quality education of healthcare students.

6.3 Recommendations for future research

During the completion of this study, I have moved to a new role where I have more influence over nurse education within my AEI, preparing for a new curriculum (NMC, 2018b, 2018c; 2018e) and leading on faculty and departmental policy and practice. Within this new role, I aim to continue my scholarship into raising of a care concern, seeking ways to influences nursing practice and policy.

Key questions for future studies emerged from my analysis. The suggestion that compassion may be a motivator for nursing students to raise concerns would benefit from further confirmation across other professions and at differing points in the students' educational journey. The discussion highlights that empathy, which remains a key professional 'tool' for appraising patients' distress, may not be as effective in triggering a moral response such as intervening when distress occurs. Examination of students' perception of patient distress as a trigger for raising concerns may provide further evidence of how the development of students' self-awareness/personal insight may motivate them to act with compassion, enhancing nursing care and professional practice.

Emotional intelligence, which includes a personal awareness of one's own and others' emotions, has not been explicitly applied to behaviours such as raising a care concern. Although EI has been associated with distress, feeling concern has not been specifically acknowledged within nursing literature. Building from the theoretical understanding suggested in this study, future research could seek to gauge/ measure students' awareness of personal concern as a motivator for taking action. Exploring if experiences of concern can be measured or graded to indicate when students should raise the concern may also be worthy of future extended investigation.

A key purpose of EI, which has been intimated through this study, is that EI may make having difficult conversations such as raising a care concern less stressful, and allow it to be approached using different yet appropriate communication. The inclusion of EI and its application to raising of a care concern can become a reality within nursing curricula (NMC, 2018b). Conducting research which seeks to examine nursing students' approach to challenging situations following EI instruction would be an achievable next stage of research.

This study only examines one perspective within the experience of raising of a care concern. Further examination of the experience of other participants, namely the clinical staff who listen to the concern and the decision to escalate it (or not), may help to understand the differing responses experienced by nursing students in this study, and help to identify some of their personal factors which may still be inhibiting concerns being raised effectively within the NHS (Mannion et al., 2018; McSherry & McSherry, 2015). The role of academics in raising concerns also remains under-explored. Despite them being a key aspect of the support for students (NMC, 2019), previous studies (Bellefontaine, 2009; Druce et al., 2016) suggest that students do

not feel able to raise concerns to University staff. Exploring if this view remains, and examining factors which students perceive inhibit approaching University staff, would be important to professional educators, and may change HEI practice or professional guidance on the role of academics in raising of care concerns. Additionally, exploring academics' views or experiences of receiving and responding to student concerns about patient care would complement the examination of the students' experience of raising of a care concern.

Encouraging practice partners to include nursing students in patient safety and quality improvement initiatives is a recommendation of this study. Within my own institution, I am pursing this key change in practice, working with a local Trust to plan and implement a project whereby nursing students work closely with quality improvement teams on real world concerns and problems. Through adopting an action research approach, the findings from this project will inform local practice learning experiences, and will have wider appeal to nurse education as the new NMC proficiencies for pre-registration nurses are implemented.

6.4 Concluding remarks

During this doctoral journey, the relevance of healthcare students raising a care concern in practice has become embedded within educational and NHS practice. It has also become part of my professional practice, presenting a new perspective on how students and educators should contribute to the NHS and support patient care. Thus, a simple change in professional regulation, plus my doctoral programme, has given me a new vision for my educational career. Things will never be the same again.

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Appendix A: Ethical Approval Letter

AM/bh

28th April 2016

Liz Cooper
4 Greenbank Road
West Kirby
Wirral
CH48 5EP

University of Chester

Faculty of Health and Social Care

Tel 01244 512600
Fax 01244 511270

Dear Liz

Ethical Approval Granted

FH&SC Ethics Number:	RESC0216-701
Course of Study:	Professional Doctorate in Health & Social Care
Supervisor:	Dr. Sandra Flynn, Prof. Elizabeth Mason-Whitehead
Student Number:	0413192

I am pleased to inform you that the Research Ethics Sub Committee of the Faculty of Health and Social Care approved your project ***"Exploring nursing students' experiences of raising a care concern with a mentor"*** on 28th April 2016.

Approval is subject to the above and following conditions:

1. That you provide a brief report for the sub-committee on the completion of your project.
2. That you inform the sub-committee of any substantive changes to the project.

We approve your application to go forward to the next stage of the approval process. For studies taking place in the NHS, Trust permission must be obtained before data collection can commence. If you are applying to IRAS and require a sponsorship letter and insurance documentation please contact Barbara Holliday.

If you have any questions or require any further assistance please contact Barbara Holliday on 01244 511117 or by email b.holliday@chester.ac.uk

Yours sincerely

Dr. Andrew Mitchell
Chair, Faculty Research Ethics Sub-Committee

cc Research Knowledge Transfer Office
cc Academic Supervisor

Appendix B: Participant Invitation

Study Title: Exploring nursing students' experiences of raising a care concern.

Dear student,

You are invited to participate in a research study within the Faculty of Health and Social Care. I am undertaking this research as part of my thesis to complete my Professional Doctorate in Health and Social Care. I am seeking to interview up to 10 nursing students, who have had to raise a care concern to a mentor during their time on the programme.

If you have had such as an experience, please read the attached participant information sheet which provides more detail on the study. If you would like to participate, please complete the consent form, on the attachment to this email and return it to l.cooper@chester.ac.uk.

If you have any further queries relating to the study after reading the information, please email me at l.cooper@chester.ac.uk.

I look forward to hearing from you. I will be selecting participants on a first come first served principle.

I look forward to hearing from you,

Liz Cooper

Doctoral student

Faculty of Health and Social Care

University of Chester

Appendix C: Participant Information Sheet

Title of study: Exploring nursing students' experiences of raising care concerns with a mentor.

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

Thank you for reading this.

- What is the purpose of the study?

The purpose of the study is to explore nursing students' experiences of raising care concerns with a mentor whilst on placement. The concern should be related to witnessed care within the practice area which was reported to a nurse mentor.

- Why have I been chosen?

As a researcher, I wish to gain the views of nursing students who have been in placement since the NMC published their raising and escalating concerns guidance in 2013. Year 2 and year 3 students who are currently undertaking their BN (Hons) programme will be invited to participate in this study. I am particularly interested in students who have raised concern with a mentor and therefore have invited students who have undertaken several placements. You should only agree to take part if you have raised a care concern in practice, if you have not done this, you do not need to continue reading this document.

- Do I have to take part?

No, taking part is voluntary

- What will happen to me if I take part?

If you agree to take part, you will be asked to read and sign a consent form. I am happy to respond to any queries to help you decide, my email address at the end of this letter. You will be asked to talk about your experience/s of raising a care concern to a mentor whilst in a placement. It is anticipated that interviews will last approximately an hour. We will negotiate a time and place when we can meet within the next four weeks. The discussion will be recorded. The discussion will be typed onto a Word document and kept on a secure computer for storage. Once the interview has been written up, you will receive a copy for checking that the content reflects our discussion. At this point you may add any points for clarification. Once the study has been completed, you may have an online copy of this if requested.

If you change your mind about taking part before the meeting and discussion, you can email me your decision. This will enable me to find another participant if needed.

Your discussion should focus upon the time you raised a care concern – if you have a concern regarding care in a placement you should discuss this with your PAT immediately. If, during our discussion, an issue is raised that I feel needs further attention, we will utilise Faculty guidance/ University policy to take appropriate action and offer you support.

Please see the Faculty guidance on raising a care concern via this link. Your participation in the study will be stopped, if this policy is instigated. In order to follow these polices, with your consent your identity will be shared, removing anonymity.

- What are the possible disadvantages and risks of taking part?

There are a few points for you to consider regarding this study. Our discussions will recall situations from your practice placement.

- If as a consequence of recalling you experience, you do feel upset, then you may contact me or your usual academic support i.e. Personal Academic Teacher for further advice.
- If during our discussion, aspects of professional misconduct, student misconduct or a safeguarding issue is identified, the polices identified via the above links will be instigated. Please click on the links above to read the relevant policies.
- Please consider if you are able to meet the time requirement as we will need to meet for approximately one hour for our discussion and approximately half an hour for you to reread the notes relating to the discussion.
- There are no implications for your programme if you are unable to or decide not to participate or if you withdraw from the study at any point.
- What are the possible benefits of taking part?

The main benefit is that you are contributing to the evidence relating to nursing and this would provide you with an opportunity to participate in a 'real' research experience. Participation will contribute to your Curriculum Vitae and would be considered as part of make-up time activity should you need this.

Participation would provide you with an insider knowledge of undertaking research which may be useful for your future career. I would also value your participation, as this research will inform current practices within the Faculty and for our placement mentors. This study cannot take place without people volunteering and taking part. Your participation will be recognised by a letter, on completion of the participation stage which you can put in your professional portfolio, show to future employers and have included in in your end of programme reference by your PAT. If you have any questions before agreeing, please see my contact details at the end of this information letter and do get in touch.

- Will my taking part in the study be kept confidential?

Your participation will be confidential as well as the views and notes relating to the discussion. All this information will be kept on a password locked computer, only shared with the researcher, all information will be anonymised prior to inclusion in the thesis and subsequent publications.

- What will happen to the results of the research study?

The results will be used within my thesis, for completion of my professional doctorate and will be further disseminated by publication and conference presentation. Measures will be taken to ensure the information cannot be traced to yourselves, upholding your anonymity.

- Who may I contact for further information?

If you require further information please contact Liz Cooper: l.cooper@chester.ac.uk or my supervisor: Dr. Sandra.Flynn @chester.ac.uk.

If you have any concerns regarding the research, you can follow the University policy: in the first instance, complaints should be addressed to the Executive Dean of the Faculty of Health & Social Care, Prof Dr. Annette McIntosh-Scott.

Thank you for your interest in this research.

Appendix D: Consent Form

Title of Project: Exploring nursing students' experiences of raising a care concern to a mentor

Name of Researcher: Liz Cooper

By signing this form you are consenting to participating in the above study. As part of this study you will be discussing your experiences in practice, which maybe of a confidential nature. You are agreeing that the researcher may retain this information for the purpose of this study and submission of her doctoral thesis. The findings of this study will be published, however personal data will be held confidentially and destroyed on completion of the thesis.

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason ☐
3. I am aware that if any disclosure which may be considered as professional misconduct or a care concern will be escalated according to Faculty Policy ☐
4. I agree to take part in the above study. ☐
5. I agree that any data arising from this research study can be utlised as stipulated in the pariticpant information sheet, (page 29) ☐

Name of Participant	Date	Signature

Researcher	Date	Signature

(1 for participant; 1 for researcher)

Appendix E: Interview – Topic Guide

Title of Project: Exploring nursing students' experiences of raising a care concern to a mentor

Name of Researcher: Liz Cooper

Interview guide

Welcome; Housekeeping; Introductions; Refreshments;

Consent – Right to withdraw – Any questions.

'Can you tell me about the time your reported care concern to a nurse mentor, include all that you feel is relevant. I may ask you to give me more detail on certain aspects as we go along'.

Prompts:

1. What can you remember about when you reported a care concern to a mentor?

2. Describe how and when you decided to raise the concern with a mentor
   Can you remember what you were thinking /feeling prior to raising the concern with your mentor?

3. Describe the interaction between you and the mentor when raising your concern.
   What were your feelings/ thoughts during the interaction?

4. Describe what happened after you raised a concern
   What were your thoughts /feeling about this situation?

Probes: 'can you expand on that, why did you think that'

Further questions/inquiry/ exploration may occur whilst completing data analysis.

Appendix F: Email for Participant Review

Dear Student.

Many thanks for contributing to my research relating to your experiences within placements. Your involvement has meant that the study is progressing well.

You have received a word processed copy of your interview attached to this email. Please can you return this to me by _____, stating your agreement that the content is a true account of your interview. If there are sections which you do not feel are representative and/ or you wish to add further clarification, please make additional comments in your return email and this will be included in the analysis stages of the study.

I thank you once again for your participation,

Regards

Liz Cooper,

Doctoral Student

Faculty of Health and Social Care,

University of Chester.

Appendix G: Full Transcript of Interview with Abi

Interviewer: OK, as we've described we're just going to erm…listen to what you want to tell me about your experience of raising concern in practice. So I'm just going to let you talk.

Participant 1: OK.

Interviewer: And introduce as you want to.

Participant 1: OK erm…so in my…the end of my second year of my nurse training erm…I was in a situation where I felt like a child was being neglected erm…the…the whole kind of set up of the day was I was in charge of this one particular child.

Interviewer: Yeah.

Participant 1: Erm…and he had autism and moderate learning disabilities erm…and I was also assigned a health care worker.

Interviewer: Yeah.

Participant 1: And my mentor wasn't on shift that day until the night time.

Interviewer: Hmm.

Participant 1: And throughout the day I was…in the morning I was starting to feel like I was becoming slightly abandoned by my health care staff.

Interviewer: Right.

Participant 1: Erm…and I started to get a bit worried because I just kept reading the care plan over and over again to make sure that there was nothing that I had missed out.

Interviewer: Yes.

Participant 1: Erm…because obviously I then felt like all the onus was on me because I had been put in charge of this child and that if anything went wrong then it would come back on me.

Interviewer: Yeah.

Participant 1: Erm…and…so…when was that…let me have a look…so…so in the morning erm…he was due to have his nebulizer which one of the nurses came and put on er…one nurse was off sick that day so there was only two nurses when there should have been…there should have been four. One was in training and two were on the floor erm…and so he had his nebulizer on and to my common knowledge a nebulizer should have only lasted until either the liquid's gone out or around about ten, twenty minutes erm…and it was on for about forty minutes erm…and this child was getting very distressed and obviously I was alone in the room and I didn't know what to do. So I just…obviously couldn't leave him, so I just kept popping my head

out in to the corridor and obviously everyone was running around quite stressed cause there was only two nurses erm…but luckily enough a nurse from upstairs, cause upstairs is like an outreach in to peoples' homes in…

Interviewer: Yeah.

Participant 1: So she came passed and I managed to grab her and I said look, I'm only a student and I don't really…I'm not too sure whether he's having more or…but he's getting quite distressed and she said oh yes, it's finished, will you take it off and put it away erm…but I can't help you because I've got to go now. And I was like that's fine erm…and then it got to about…so at this point I was a bit worried but I thought, do you know what, he's OK, he's alright. And then I got told that he was gonna go swimming. So I prepared him for swimming erm…however, that day, by this point it was a bout eleven, he hadn't had a bowel movement erm…so…and there was smearing in his pad.

Interviewer: Mm.

Participant 1: Erm…and the physio came and saw him. By this point my health care woman still hadn't come back erm…and the physio said I'm really sorry he can't come in the pool because he needs to have a bowel movement and we can't risk it with all the other children erm…and I thought right, OK, I'll do something else but there was no-one around to help me hoist him erm…and he had activities planned that he couldn't do cause no-one was around to help me and it was at that point that I thought to myself he hasn't had his pad changed and I checked and it was completely saturated and (sounds exasperated) and luckily enough my health care walked passed so I…I grabbed her and I said ah, you know, his pad needs to be changed, it's really not good and we need to get him up and out and she felt his pad, she said ooh yeah, but we don't wanna waste pads cause he hasn't had a bowel movement yet erm…and his skin was quite sore and it wasn't nice and she…so she p…just put the pad back up and I said but that's, you know, I said it's…it's…his skin's sore, he's got a special cream and things but she…she didn't want to change it because she didn't wanna waste his pads erm…so she left. So that kind of left me with a very distressed erm…young boy who had a…he had autism, he had a routine to stick to…

Interviewer: Hmm.

Participant 1: Erm…no-one was around to help me and it's at this point I felt like…I felt a bit trapped cause I fel…I felt the onus of anything that…I felt accountable. I felt like anything that was gonna happen from that…from that morning was gonna come back on me.

Interviewer: Yeah.

Participant 1: Because obviously I was getting to the end of my placement and it was time to, you know, it was time to take charge of a child.

Interviewer: Yeah.

Participant 1: And, you know, throw yourself in to it erm…so then I thought, do you know what, I'm not happy about this. So I went on a bit of a walk up and down the corridor and I found another health care, this was about half an hour later and I said…I found myself almost begging her, I was like will you please just come and change the pad with me, I really need it changed and if I don't meet any of the needs I just want to change it and she came and she was like ah this is disgraceful, let's get him changed. So that was done and that was happy and I said while you're here can we hoist him out of bed and we managed to do that, so that was great, and then I read the care plan and it said he…erm…he needed chest physio every morning cause he had repeat episodes of pneumonia erm…and that hadn't been completed because I was with him all morning and then I read in the notes that were completed by her that afternoon that she'd done it, she'd done the chest physio.

Interviewer: Right, the physio had written that?

Participant 1: Erm…no sorry the...

Interviewer: The…

Participant 1: …healthcare…

Interviewer: Right. OK.

Participant 1: …had written it who I was supposed to be with…

Interviewer: Yeah.

Participant 1: …and I saw it all unfolding and I hadn't seen a nurse yet and I couldn't leave him because I felt like if I left him that was it. So I felt like I had to stay with him and then round about lunch time erm…the lead nurse for the…for the teenagers came and she sat down and I found…I found myself (sounds flustered) I…it was almost like I was about to cry. I was like I've got so much to tell you.

Interviewer: So where were you at that point?

Participant 1: In…

Interviewer: Where were you sat down with her?

Participant 1: In…oh I was in…the lounge n…which was for the teenagers.

Interviewer: Right, OK.

Participant 1: So it was in a lounge and it was just me, her, the healthcare who helped me change the pad.

Interviewer: Yeah.

Participant 1: And the…the young child in…on a bean bag.

Interviewer: OK.

Participant 1: And I just said I've had a really horrible morning and I've got so much to tell you and…and she was like oh it's fine, you know, just…just say it, you know, what's happened? And she kept putting the emphas…emphasis on you're doing a great job, don't worry, you're doing a great job, don't worry and I was like but I'm not because obviously my…my health care hasn't stayed with me. I haven't been able to do anything with him and she just kept saying it's fine, don't worry we're short staffed, so it's fine, you know. What you've done is al…is good enough. And then I was like OK, that's fine I've…I almost felt like ooh, you know, I've done…I've told her, that's all I can do now and I kind of…left her to it. Erm…and then we got to the middle…oh, sorry, let me just go back to lunch time erm…my health care, my boy, my young child had a liquidised diet and she said she was going to go and sort out his lunch and about an hour later it hadn't happened. So we're still there about one o'clock and I thought why hasn't she brought his lunch? Because of his autism he had to stay in quite a quiet area and I was on my own with him and I thought do you know what, I'm not having this, so (laughs) I got him in…he was in his chair by this point, he was in his chair, and I thought I'm gonna wheel him down to the canteen where everybody else was sitting and I'm gonna ask because I can't leave him, so he's gonna come with me. Erm…and he came with me and this health care was having her lunch with all the other people and…and she…she got a bit…she got a bit angry erm…and she just kept saying, you know, take him back, the noise, the noise is too much and I thought…I kind of thought in my head, do you know what, everything you've done today has not been helpful.

Interviewer: Mm.

Participant 1: So I'm just gonna take it (laughs) on board myself and we sat in a corner and it turned out she hadn't done his lunch. So he hadn't had a meal. The cooks had gone wherever they'd gone.

Interviewer: Mm.

Participant 1: So one of the nurses improvised with some mashed food and that was fine and he sat in the corner, had a great time erm…and that was great and then…I'm just gonna see…what else have you got? Oh no, that's the one. Erm…he needed a water bolus after his lunch and it wasn't stated in his care plan erm…and the health care said just give him 200mls and I thought to myself you're estimating, how is that…how is that, you know, how is that right and I refused to do it (laughs) and so she did it and then I…while she was doing that I went to one of the nurses and said it doesn't say in his care plan, there's nowhere anywhere about how much water to give him erm…and she eventually found out it was on the system so nobody…all we knew is that mum said give him water boluses after his dinner.

Interviewer: Mm.

Participant 1: Erm…and it turned out he needed 500mls after every meal and he'd only been getting 200 three times a day. Erm…so I told that to the nurse and she just wrote…wrote it in the care plan.

Interviewer: Mm.

Participant 1: And then I think that was it. Erm…so by this point we had quite a nice teatime, I think the teatime was OK.

Interviewer: Hmm.

Participant 1: And then…at…oh this is the bit…at teatime I said again, to the nurse in charge, this was the nurse in charge of the…of the baby…section…

Interviewer: Right.

Participant 1: …of where I was. I said it all again and she repeated, you know, tell your mentor, cause she's coming in on the nights, and all I can remember thinking is I cannot wait for my mentor to come in.

Interviewer: Come in.

Participant 1: Cause I just need to cry (laughs).

Interviewer: (Laughs).

Participant 1: And I need to…I just need to…and I felt myself getting really hectic when everyone else around me was being so calm and I felt like I was overreacting but I felt like this was such a big deal, you know, my…from not having his chest physio to having it written down, an incorrect water bolus, his pad was left on for so long erm…his neb was left on erm…and then his mum phoned in the night and said he needed erm…PRN Senokot before he went to bed because he hadn't had a bowel movement.

Interviewer: Mm.

Participant 1: Erm…and I passed that on to the night staff and she was obviously running around and I was like please just the one thing before I go, he needs his Senokot and then…and then that was that for then and she said that was fine and then my mentor come in of a night, she was a learning disability nurse, the two nurses on shift were child.

Interviewer: OK.

Participant 1: Erm…and she was mortified erm…she…she…I think at the start she was a bit angry at me because she thought why haven't, you know, if…she kept saying if you feel like a nurse isn't listening to you, you need to take it further. Why didn't…you know, the manager was in, (Name) erm…but she was in meetings and I thought…well, to be honest I thought ah, do you know I'm not, she was quite scary. I thought I don't wanna (laughs)…

Interviewer: Absolutely.

Participant 1: I thought…she was really…she was really scary and I thought the last thing I wanna do is go in and talk to her.

Interviewer: Yeah.

Participant 1: So I thought, do you know what, I've done my bit, I've told the nurses, both nurses and then (Name) got me to write a report (whispers) I said her name.

Interviewer: It doesn't matter.

Participant 1: My mentor told me to write a report and I wrote it and she said that's brilliant but the problem is one of the nurses who you reported to, she's actually leaving today. So they said they're not going to be able to do anything with her but the…

Interviewer: You were reporting…was she who you'd said something to?

Participant 1: Yes.

Interviewer: Right, well…OK.

Participant 1: Yeah. Yeah. Erm…so erm…she said we're not gonna be able to do anything about that erm…but you know, we can do some other things and then before I…I came out of the room then and I felt a bit better and I then came back the next morning to find out he hadn't had his Senokot, so he hadn't had his tablet, and his…

Interviewer: Was that your mentor or someone else?

Participant 1: No, that…I told, the nurse.

Interviewer: Yeah, OK.

Participant 1: Who was on…so he hadn't had his Senokot and then that came back on me. The nurse manager pulled me in and said you took the phone call, you should have told the nurse and I said I did tell the nurse but obviously this nurse had (laughs) then left and they didn't…they didn't even know how to go about it because this nurse had now left and erm…it also just turned out like little things with his autism he had his bath time round about 8 to help his sleep pattern and because parents were staying…it's a…it's a hospice so some parents were staying with their children, the teenagers that were next door, they took priority. So obviously they're in…I don't want to say their routines are perfect but I could definitely see that they were getting better care compared to my child whose parents weren't staying. So he never got his bath and that was really important for his routine and then I read that his sleep pattern in the night was horrendous and I thought well, he's probably, you know, constipated cause he's not having his water boluses and he didn't have his Senokot and he didn't sleep properly because of his bath and he's probably upset because now his bum's sore because of his pad and…yeah, so it was just a really awful day.

Interviewer: Yeah.

Participant 1: Erm…and about…about a week later (Name)…ooh, my mentor came up to me and said right, we need to go and speak to the clinical director of the hospice and oh, I've never felt so sick. I honestly…I felt like I was gonna get told off.

Interviewer: Yeah.

Participant 1: I felt like it ru…it had ruined (laughs) my whole experience. I'd absolutely loved it and I felt like this was now, you know, just ruining my lovely…my lovely little placement because I'd raised so many, well, raised a concern and…but I went in and she was very nice, she was lovely erm…she wasn't (laughs) horrible at all and…yeah, that's…that's all I can…think about really. I didn't…I didn't really hear anything. She emphasised that I needed to write it all down.

Interviewer: Yeah.

Participant 1: And then a week later I emailed it to them and that's all I've heard. And then I had a PAT meeting with Uni, with my PAT obviously.

Interviewer: Yeah.

Participant 1: And it all came out and things.

Interviewer: Yeah.

Participant 1: Because obviously it was a horrible day erm…and obviously my PAT was mortified and she said, you know, she'll be in contact with my mentor, you know, just to make sure everything's going alright and apart from that I haven't heard anything…since.

Interviewer: OK.

Participant 1: Yeah.

Interviewer: Yeah. How long ago was it?

Participant 1: It was erm…ooh, the start…sorry the end of my second year, that'll be this year won't it?

Interviewer: Yeah (laughs).

Participant 1: (Laughs) Yeah.

Interviewer: About June, July (laughs).

Participant 1: Yes er…yeah (laughing) it in…June. June, July…yeah.

Interviewer: Yeah. It does take a long time.

Participant 1: It does (laughs). Yeah.

Interviewer: So I don't think that's necessarily a thing, but yeah. OK. Erm…I was just interested that you actually waited to tell your mentor.

Participant 1: Until the night time?

Interviewer: Yeah.

Participant 1: Yeah.

Interviewer: So I just was…I just wondered if you could…

Participant 1: I dunno…

Interviewer: …talk about that a bit. I just found that…

Participant 1: I don't know. She was on nights so…I…yeah, she was on nights and that's…that's it really. So I thought…I felt like I'll wait and tell her. And obviously I told the nurses but then…

Interviewer: Yeah, yeah, you had.

Participant 1: …but then…I don't know. I felt like the real…the real action will start when I tell my mentor.

Interviewer: Right.

Participant 1: Cause I thought, you know, she's got to do something then and…yeah. And obviously your mentor is, you know, she's there…well, I say she's there to look after you but you always…I don't know. Maybe it's cause you've built up a bond with your mentor and you know her and you know how you can talk to…them and…yeah, so if she was on shift I definitely would have gone to her first. And I was definitely reluctant about going to the other nurses because I didn't really know them but yeah, I did, and…yeah.

Interviewer: Yeah, no, I was just interested cause…

Participant 1: Yeah.

Interviewer: You know what I mean? Cause it…

Participant 1: Yeah.

Interviewer: To me that was…that came out quite strongly really.

Participant 1: Yeah.

Interviewer: Erm…I think you've covered…some of my other questions were just really about what you were thinking and feeling as you were going through that day. I think you've covered most of that.

Participant 1: (Laughs) Yeah.

Interviewer: Yeah, but that's good.

Participant 1: It was horrible. Yeah.

Interviewer: But that's good isn't it because that's what we're trying to get to the bottom of really.

Participant 1: Yeah.

Interviewer: Erm…and I think you've also…you've actually covered most of what I wanted to know.

Participant 1: (Laughs) Good. I'm glad, yeah.

Interviewer: So it was worth having your little prompt sheet (laughs).

Participant 1: Yes, my little prompt sheet. It was…yeah. A l…a lot…a lot happened and…I don't know, I feel…I don't know whether that can be raised as one concern itself or whether that's…that's…that could have been ten different concerns in one day or…

Interviewer: No, I think that's quite interesting.

Participant 1: Yeah. Yeah.

Interviewer: Cause you've actually erm…told me a journey.

Participant 1: It was a journey, yeah (laughs).

Interviewer: But that's what I'm saying is…and I think that to me is what's quite interesting actually…

Participant 1: Yeah. Yeah. Mm.

Interviewer: …is, you know, sort of almost where we get to the point.

Participant 1: Yeah (laughs).

Interviewer: You know what I mean?

Participant 1: Yeah.

Interviewer: And you also made the statement at one point that you said I'm not having this and you…you just…I'm not having this…

Participant 1: Yeah.

Interviewer: …so…and I just wondered what was erm…what was sort of going through your mind when you'd got to that point?

Participant 1: Yeah.

Interviewer: Cause I…that seemed to be quite…

Participant 1: Is this when he was left in his pad?

Interviewer: Well you made a point that…you…it was about his lunchtime…

Participant 1: Oh, OK.

Interviewer: And you…you just said I'm not having it and I thought mm…that's quite an emphatic…

Participant 1: Yes. That was it. Yeah, that was…that was breaking point I think. That was…it was breaking point…that was the point where I thought right, nothing is gonna change unless I change. So instead of me just sitting there thinking I have to

wait for a superior person to come and deal with the situation I thought right, that's it, I'm gonna have to do it because someone has to and…yeah, so I thought I'm gonna…yeah, it was, got up and…(laughs) off we went, yeah, down to the lunch hall and I just kind of took it upon myself then because…I don't know. I don't know whether I should of…whether I should of done that anyway because I was his…his…almost his one to one but then I thought, you know, the clear guidelines say he should not be in the dining room because there's been issues in the past with boys and things but I think I just over…I just felt overrode or that (laughs) and just…yeah, just took him down myself, yeah.

Interviewer: No, I just thought that was really interesting cause you were quite strong at that point when you were saying that.

Participant 1: Yeah.

Interviewer: Yeah and I thought that…that's…

Participant 1: (Laughs) Yeah.

Interviewer: …there was obviously…at a point…

Participant 1: That was the point, yeah.

Interviewer: …it was obviously an interesting point in the whole day?

Participant 1: Yeah, yeah, yeah.

Interviewer: That I just thought you know...

Participant 1: Yeah. That was it, yeah.

Interviewer: …for you to just sort of expand on that if you had the chance to just…

Participant 1: Yeah.

Interviewer: …you know, think about what that was really.

Participant 1: Yeah.

Interviewer: And then you talked a little bit, at the end, you just summed it, you sort of said I feel like crying.

Participant 1: Yeah.

Interviewer: I just wondered whether you'd be able to…I don't want to upset you obviously if it's…

Participant 1: Yeah.

Interviewer: But…just trying to…unpick that emotion.

Participant 1: OK. Yeah.

Interviewer: That you're sort of expressing like that really.

Participant 1: Yeah.

Interviewer: If you're able to?

Participant 1: Unpick it.

Interviewer: To put words to…what was leading up to that feeling.

Participant 1: I think it was almost like an incompetence, almost like a…I can't take all this on myself. I can…I cannot change his pad on my own, I cannot give him a Senokot because I am a student nurse, you know? I…I can…I think it was just the…I cannot…I cannot do this by myself as a student. I need someone else, you know, I…I rely on someone else…

Interviewer: Yeah.

Participant 1: And all my student practice I've had someone else and finally I got to this point where I didn't have anyone else.

Interviewer: Yeah.

Participant 1: And that was like taken aw…taken away (laughs) so then it was all on me and I can remember saying, I said to my mentor I said, I feel like this is what it's like to be a qualified nurse and I've lost that side and everything, yeah everything just piled on each other and…and then I did feel like crying, yeah, because it was just horrible, yeah.

Interviewer: Yeah. No, I thought that was really interesting. It was quite powerful. So even though you've recounted things to me…

Participant 1: Yeah.

Interviewer: …there's been some quite powerful statements as you've gone along, isn't it?

Participant 1: Oh it is! It is! It's very…it is, it was horrible!

Interviewer: Yeah.

Participant 1: I felt like…I feel like I'm there every time I talk about it.

Interviewer: I could tell.

Participant 1: Yeah (laughs). Did you? Yeah?

Interviewer: Yeah, yeah.

Participant 1: Yeah.

Interviewer: Yeah, you were sort of…you were getting…

Participant 1: I do, I get quite irate, yeah. Yeah. Mm.

Interviewer: So that's…yeah, that…I could tell that idea of…

Participant 1: (Laughing) Yeah.

Interviewer: …re…you were almost reliving all of that…

Participant 1: Yeah, yeah. I was…I was, yeah, yeah (laughing).

Interviewer: …as you were going through, so.

Participant 1: Yeah.

Interviewer: You know, I appreciate the fact that you've stood here…

Participant 1: Yeah.

Interviewer: You've sat here telling me about it really.

Participant 1: (Laughs) Yeah, yeah.

Interviewer: You know, with all of that going on. Was there anything else that you'd like to just add in to that really? Anything else that's sort of floating in to your mind, that obviously links to that day and those events…

Participant 1: Yeah.

Interviewer: …that you think actually, that was important to me, or is important to me?

Participant 1: Erm…

Interviewer: But if you're happy you've covered it then…

Participant 1: No, I think the only thing is I would have liked to have known what happened.

Interviewer: Yeah.

Participant 1: And definitely another thing that I was talking…well to my mum about the other day erm…it was the fact that I really enjoyed it there but now I don't think I'd apply for a job there.

Interviewer: Right.

Participant 1: For…for the fear of seeing that woman again.

Interviewer: Yeah.

Participant 1: And because…

Interviewer: Even though she was ok?

Participant 1: Yeah, no. For the clinical director? No…the…

Interviewer: Oh, the H…?

Participant 1: Yeah.

Interviewer: Right, I get you.

Participant 1: Yeah. Because…I feel like even people talk about it now about going on their MPE and I'm like ooh, like…the idea of seeing her again…

Interviewer: Mm.

Participant 1: …it's horrible and I loved it there. I really loved it there.

Interviewer: Yeah.

Participant 1: And my mentor, you know, kept saying oh, she's…I've got emails off her saying when are you coming back to work for us and in my head I'm just…I just…I…I don't' know, I don't feel like I could…work there…which isn't like me, it's like the more I think about it that's not like me.

Interviewer: In what way is it not like you?

Participant 1: (Laughs) It's not like me because I don't let, you know, things like…I'm quite…oh I don't know, I don't know how to say this now. You know, I've worked in some really bad places and I've stayed pure…but I think this is because I…I think it's because I have raised a concern and it's the first time I'd ever had to do it.

Interviewer: Hmm.

Participant 1: And I amost felt like a…quite cliquey, so I feel like a bad person, yeah. Even though I know that I'm not.

Interviewer: Yes.

Participant 1: But to them or the staff members, well to her, I would be.

Interviewer: Mm.

Participant 1: And…yeah, I'd feel like that'd be a barrier to me working there.

Interviewer: Right, OK.

Participant 1: Yeah.

Interviewer: That's interesting isn't it?

Participant 1: Yeah. Which I hate to admit because I feel…I feel weak.

Interviewer: Oh don't now.

Participant 1: I feel like (laughs) I feel like that's a weakness.

Interviewer: You're just a person.

Participant 1: Yeah.

Interviewer: You're only being a person (laughs) ??24:57

Participant 1: Yeah, yeah. I know ??24:59 yeah.

Interviewer: Don't because you know, a lot…this is almost what it's…this is trying to pull out.

Participant 1: Yeah.

Interviewer: That we're actually human.

Participant 1: Yeah.

Interviewer: So we might have these titles and we might have these things…

Participant 1: Yeah.

Interviewer: But actually there's very real…other things going on in there…

Participant 1: Emotions, yeah.

Interviewer: …isn't there you know and that's what we're trying to unpick really.

Participant 1: Yeah, yeah, yeah.

Interviewer: Yeah, that's interesting though isn't it?

Participant 1: Yeah, it's horrible. It's horrible. I wish that one day hadn't happened because then I probably would have worked there and I'd be on the bank now and…I'd be, you know, really enjoying it but…yeah.

Interviewer: No, that's really interesting.

Participant 1: Oh good (laughs).

Interviewer: Are you happy that we've finished?

Participant 1: Yeah.

Interviewer: Or is there anything else that you wanted to say?

Participant 1: Er…no, that's fine. Yeah.