A Constructivist Grounded Theory Study: Employers perspective of the factors that contribute towards a decision to refer an early career nurse to the Nursing Midwifery Council's Fitness to Practise Committee.

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Abstract

The Nursing Midwifery Council Fitness to Practise Committee role is to screen allegations of impaired fitness to practise to determine whether there is likely to be a cause for concern, and investigate those where there may be a case to answer. In 2018, the NMC received 5,509 new concerns, an increase of one % from 2016/17 (NMC, 2018). The total number of concerns received represent approximately 0.8 % of registered nurses and midwives; a number of referrals in England were registrants who had been registered for five years or less. This must be a concern to the profession because early career referral rates potentially reflect on standards of pre-registration education, early post registration career progression, and have implications for public protection.

This qualitative research study explained the factors that preceded the referral of an early career nurse to the professional regulator from the perspective of employers. A constructivist grounded theory approach was used. Semi-structured interviews were conducted with 20 healthcare employers in different regions of England across all the fields of nursing practice. The findings highlighted four categories: alarm bells; wanted and unwanted characteristics and values in nurses; a chain of expectations; and situational stressors and health needs. A core category emerged regarding employers' decision to refer early career nurses to the professional regulator based on a combination of factors; i) the employer's responsibility of public safety; ii) the employers perceptions of values and expectations of the nurse; iii) the early career nurse's risk of exposing their professional vulnerability.

It is recommended that the employer and employee learn from errors in partnership, taking into consideration patterns of behaviour, work-life balance, health and well-being. Educational strategies are needed to support early career nurse's resilience and transition into the profession and the workplace. A theoretical model and self-assessment checklist has been recommended for employers and registered professionals which may help to identify practitioners at risk of referral to the professional regulator. This requires piloting and testing in a future study.

Chapter 1 Introduction

1.0 Introduction

The regulation of nurses and midwives is well established in the United Kingdom, to safeguard the health and well-being of the public through maintaining a register of nurses and midwives who are legally recognised to practise in the UK. The Nursing Midwifery Council (NMC) is the UK's regulatory body for the 690,278 nurses and midwives currently qualified to practice in the United Kingdom (NMC, 2018), with 79% of nurses and midwives living in England. It was established by the Nursing Midwifery Order 2001, to safeguard the health and well-being of the public, by:

- maintaining the register of nurses and midwives who have the required skills, knowledge good health and character;
- setting standards for education and training;
- giving advice and guidance to professionals;
- and dealing appropriately with nurses and midwives whose fitness to practise is impaired.

The NMC states that a nurse or midwife (registrant) is "fit to practise if that nurse or midwife has the skills, knowledge, health and character to do their job safely and effectively…Every nurse or midwife is required to regularly declare that they are fit to practise safely and effectively." (NMC, 2017: 6) The Nursing and Midwifery Order (2001) outlines how a registrant's fitness to practise may be impaired by reasons of misconduct, criminal behaviour, and lack of competence, serious ill health, or a determination by another UK body which regulates health or social care. The NMC (NMC, 2017:7) "can stop a nurse or midwife from practising in the UK by removing them from the register or taking action to restrict how they practise or suspend their registration." If a nurse's or midwife's fitness to practise is in question, a referral can be made to the NMC Fitness to Practise Committee.

A referral may be from a number of people: service users; police; employers; a colleague; a member of the public; or other regulators (for example the Care Quality Commission). In 2018 the sources of concerns received by the NMC remain broadly unchanged compared to 2016–2017. Employers made 40% of referrals, the majority of referrals were from England (80%) (NMC, 2018).

The NMC's Fitness to Practise Committee (FtPC) screen all allegations referred to the NMC to determine whether there is likely to be a cause for concern, and to investigate those where

there may be a case to answer. The Committee has the power to issue sanctions; such as interim suspension from the register, interim conditions of practise, cautions and striking off orders. Sanctions against a registrant can be based on one or more grounds; “protection of the public, otherwise in the public interest, or the registrant’s own interests” (NMC, 2017: 12).

During 2012-2013, the NMC received 4,106 referrals (NMC, 2013). The last report that classified the range of referrals was in 2012/2013. This report highlighted the reasons for referrals including criminal convictions (16%), misconduct (63%), lack of competency (17%) and serious ill health (3%), and other regulators (1%) (NMC, 2013). The FtPC annual reports do not clearly define these classifications or what constitutes an allegation of incompetence or an allegation for misconduct. The reason behind this is unknown; the volume and diversity of allegations may be difficult to classify (table 1).

Table 1: Level 1 Screening Assessment Stage Allegation Coding 1 January – 31 March 2017

Level 1 screening assessment stage allegation coding 1 January – 31 March 2017 Allegation	**Number of allegations received**
Behaviour or violence	44
Communication issues	24
Criminal proceedings	56
Dishonesty	40
Employment and contractual issues	27
Information access	5
Investigations by other bodies	12
Management issues	24
Motor vehicle related	26
NMC registration and proceedings	20
Not maintaining professional boundaries	11
Other allegations	9
Other crimes and offences	14
Patient care	136
Prescribing and medicines management	126
Record keeping	53
Registrants health	58
Sexual offences	15
Social Media	6
Total	**706**

Source: NMC (2017) Annual Report 2016/2017

Since then the NMC changed the way it presents the data for referrals to FtP making it difficult to identify the themes and trends of referrals. Table 2 below is an attempt to look at the comparable data, mapped against the NMC’s four categories of criminal conviction, health, misconduct and lack of competency.

Table 2: Level 1 Screening Assessment Stage Allegation Coding Identified into Four Categories

Level 1 screening assessment stage 4 categories	Coding identified against categories from 2016/17 NMC FtP Annual report	Number of allegations from 2016/17 NMC FtP Annual report	Total number of allegations from 2016/17 FtP Annual report	2016/17 NMC FtP Annual report % data	2014/15 NMC FtP Annual report % data	2012/13 NMC FtP Annual report % data
Criminal convictions	criminal proceedings motor vehicle other crimes & offences Sexual offences	56 26 14 15	111	16%	15%	16%
Health	Registrants health	58	58	8%	3%	3%
Misconduct	Behaviour & violence Dishonesty employment and contractual issues Information access Investigations any other bodies management issues NMC registration and proceedings Not maintaining professional boundaries other allegations social media patient care	44 40 27 5 12 24 20 11 9 6 136	334	47%	75%	63%
Lack of competency	Prescribing and medicines management record keeping	126 53	179	25%	6%	17%

Source: NMC (2017) Annual Report 2016/2017

While the incidence of allegations of impaired fitness to practise in developed countries has remained low, there has been an increase in referrals over the past 10 years (Hudspeth, 2016). In the UK, the FtPC has reported an increase in the number of nurses and midwives referred. The Committee received 5,509 new referrals in 2017 -2018, about 1% more than the 5,476 referrals received in 2016–2017, which represented 0.8% of the total number of nurses and midwives on the register (NMC, 2018). The NMC (2017) reported that this is a much lower increase than seen in the previous five years. There appears to be an 85% increase since April 2010 (2009-2010: new referrals 2,986). The NMC received 1,378 referrals in 2005/6 (NMC, 2005/2006), indicating the NMC received 4037 more referrals in 2015/2016. Thus in a decade, the NMC has seen an increase of 300% in referrals (1,378 referrals 2005/6; 5,509 referrals 2017/18; difference = 4,131 referrals).

Nursing regulators are not alone in seeing an increase in referrals. In the UK, there are 288,521 doctors on the List of Registered Medical Practitioners (GMC, 2017). The General Medical Council (GMC) received 68% of complaints from the public and 6% from employers in 2015/16 (Jayaweera et al, 2018). Referrals about fitness to practice increased 52% from 5,773 in 2009 to 8,781 in 2011 (GMC, 2013). In 2017, the GMC received 9,092 enquires about doctors; 91% concerned fitness to practise issues. 28% of the referrals received by the NMC came from the public, while 39% of referrals came from employers. Referrals to the Health and Care Professions Council which regulates 308,203 registered allied health professionals in 16 groups, including physiotherapists and paramedics, also reports an increase from 759 in 2010/11 to 925 in 2011/12 (Sprinks, 2012).

Similar figures were reported in some states of Australia; the Nursing and Midwifery Council in South Wales recorded that 0.6 % (n= 624) of registered nurses and midwives were reported to the New South Wales Health Professional Councils (Nursing and Midwifery Council South Wales, 2017), which is an increase of 2.7 % nurses and midwives since the 2015/16 Nurses and Midwives Council in South Wales Annual report. The Nursing Council of New Zealand (2017) reported that 0.9% of the 55,285 nurses on the register were reported for a competence concern, representing a decrease since the report in 2016 (New Zealand Nursing Council, 2017). In the United States, each US state has its own regulatory board.

The Alabama Board of Nursing had more than 95,000 registrants and of those, 1,505 complaints were received about their fitness to practise, representing 1.6 % of the register (Alabama Board of Nursing, 2016). The information and data in each annual report are collated and presented differently, therefore it is difficult to establish if there is a global increase in fitness to practise concerns.

1.1 Professional Regulation

There are international media reports from Canada of “a serious risk we are proceeding down a slippery slope of further regulatory fragmentation and piecemeal governing practices”, because of the complexity of professional regulations, local politics and workforce issues, rather than good leadership and systematic planning (Garrett and MacPhee, 2014: 64; O’Connor, 2013). In the UK, self-regulation originated from the Medical Act 1858 which established the registration of medical practitioners who forged the way for other occupational groups, including nursing, to gain professional status. Self-regulation has been described as a privilege, in some cases it has been argued to benefit the profession, rather than protect the public (Maurits et al, 2016). This concept of registered nurse’s privileged position in society because of self-regulation will be explored in the chapter 6.

Professional self-regulation has been called into question after the Bristol Infirmary Inquiry (Kennedy, 2001), with further questions asked of the General Medical Council’s regulatory processes following the Shipman Inquiry Fifth report (2004). Since the Mid-Staffordshire NHS Foundation Trust Public Inquiry report in 2013 into how “conditions of appalling care were able to flourish in the main hospital” (Frances, 2013: 7), the Law Commission and the Government agreed that in cases where the public were at risk, regulators need to co-operate with other organisations and act accordingly (Department of Health, 2017). In response, the health care regulators have highlighted “changing the regulatory model from reactive to proactive, improving quality of care and ensuring that safety was an absolute” (NHS Confederation, 2013: 12).

The Professional Standards Agency set out eight elements of “right touch regulation”, defined as “the minimum regulatory force to achieve the desired outcome” (Council for Healthcare Regulatory Excellence, 2015: 4). This model aims to balance over-regulation and under–regulation. The NMC (2017) announced changes to their fitness to practise legislation, which was planned to be effective from the 28 July 2017, to enable the NMC to be a more efficient and proportionate regulator. A new strategy aims to improve the way the NMC investigates concerns raised about nurses and midwives, and to work closely with employers to resolve concerns quickly at a local level (NMC, 2018).

The NMC’s recent report (NMC, 2017) announced the most recent fitness to practise figures, with recommendations for the future. Each case is reviewed following a referral to the NMC Fitness to Practise Triage team. If the case proceeds to consideration for investigation, the NMC Case Examiners issue warnings for registrants who do not pose a current risk to patients and where concerns about their past conduct were not serious enough to require the strongest

sanctions (NMC, 2016). The NMC focuses attention on concerns that are so serious that there is a real prospect of a "striking off order" (NMC, 2017). Less serious cases can be concluded without the need to progress to a full hearing (NMC, 2017: 22). The NMC (2017) reports that Fitness to Practise remains a priority, with a significant increase in case outcomes achieved in 2016–2017, represented by the closure of 1,580 cases (compared to 1,031 cases in 2015–2016). This increase in activity has been a key driver of an increase in expenditure related to Fitness to Practise from £58 million in 2015–2016 to £66.4 million in 2016–2017 (NMC, 2017); the average cost of a hearing was £18,000 in 2016/2017, which currently equates to 77 % of the regulator's income.

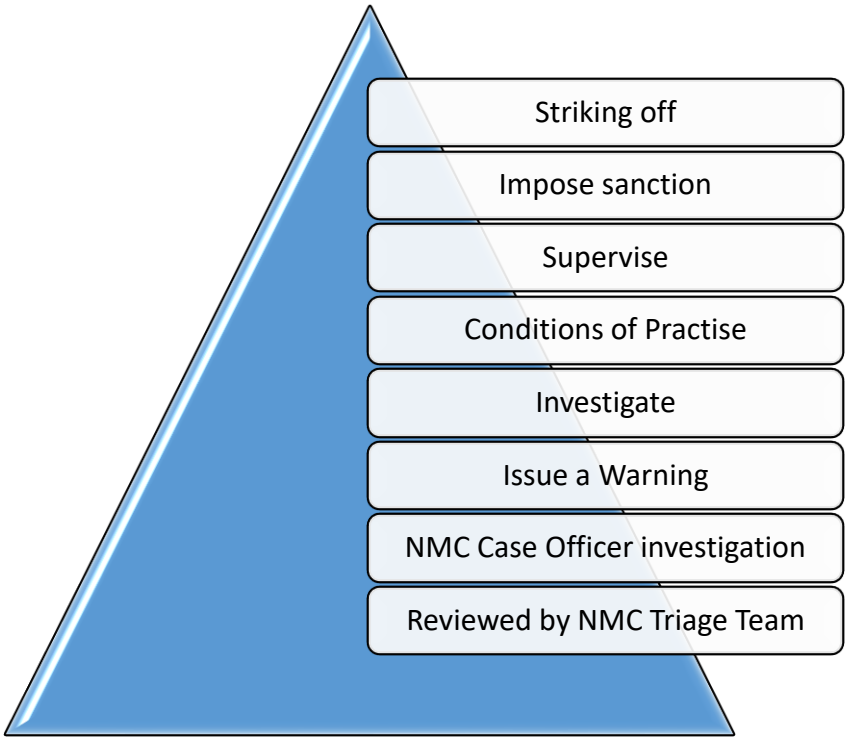
The latest changes implemented by the NMC appear to mirror the "responsive regulation" model, based on studies of regulation in many sectors of the economy (Braithwaite, 2006: 884). In 1992, Ayres and Braithwaite advocated "responsive regulation" which encouraged the government to be responsive to the conduct of regulated professionals in deciding whether a more or less interventionist response was needed (Braithwaite, 2006: 884). Case (2011:614) reports a similar phenomenon with the General Medical Council's Fitness to Practise panel decisions of "the unifying concept of 'impairment", this "style of fitness to practise proceedings characterised by offering doctors opportunities for redemption" Case (2011: 614) further highlights that this was "an example of creative and responsive regulation in using fitness to practise hearings as a means of encouraging compliance for the future and facilitating self-governance within the medical profession," in particular demonstrated by remorse and remediation, acceptance of responsibility, insight and willingness.

The idea of responsive regulation also focuses on the value of self-regulation. The Braithwaite (2006) report recommended the "regulatory pyramid, with an attempt to solve the puzzle of when to punish and when to persuade." The pyramid depicts that professionals whose fitness to practise was in question should start at the base of the pyramid first, with open conversations and dialogue about their deficiencies. However, if a professional moves up the pyramid, more and more intensive interventions are introduced. The escalation of more punitive approaches take place if the professional disengages with open dialogue or other interventions fail. The Braithwaite (2006: 425) report promotes the pyramid as a dynamic model. However, it does not state the types of allegations that should be managed at the different levels of the pyramid.

Responsive regulation requires professionals to engage in reform and work towards addressing their deficiencies. Braithwaite (2006: 425) states that "reform must be rewarded just as recalcitrant refusal to reform will ultimately be punished." The pyramid was designed to strengthen the strategies by putting the less costly, less legitimate, control methods and

more dialogic options lower down to save money (Braithwaite, 2006). “When regulation is seen as more legitimate, and more procedurally fair, compliance with the law is more likely” (Braithwaite, 2002: 33). Healy (2011) argues that responsive regulation should use both support as well as sanctions, praise as well as punishment, build on strength and not to dwell on the weaknesses. Figure 1, below, illustrates an adapted version of Healey’s model of responsive regulation.

Diagram 1: Adapted from Healy’s (2011) Regulatory Pyramids of Sanctions and Support for Registered Nurses in the UK.



1.2 The Challenges of Early Post Registration Career Progression.

The registration, regulation, and monitoring of newly qualified nurses is a challenge because of changes in employment patterns, mobility of the workforce, and the changing role of the registered nurse. The Royal College of Nursing (2009) reported an increase in nurses moving jobs because of stress and workload issues (31% in 2009 compared to 23% in 2007), job dissatisfaction with their previous job (30% in 2009 compared to 26% in 2007). This trend disproportionally affects newly qualified nurses (RCN 2009). The lack of support for newly qualified nurses was linked to the high turnover and job mobility (Park et al, 2011); a newly qualified nurse was more likely to have a change in employer in 2009 than in 2007 (12% in 2007 to 17% in 2009) (RCN, 2009).

Six years later the RCN reported on:

"How reliance on agencies comes as the full impact of cuts to the number of training places is now being felt. A fragmented and primarily local approach to workforce planning has led to substantial gaps in the current workforce compounded by the inability of the various UK workforce bodies to respond to immediate workforce pressures or address any gaps" (RCN, 2015: 3).

This was followed by the NMC reporting that there were 27 % more people leaving the register than joining it (NMC, 2017).

Staffing issues have continued to spiral with little investment, and limited resources. The role of the registered nurse is becoming increasingly demanding and, in some cases, unsustainable. A further report from the RCN (2017) highlighted that nursing staff are overstretched due to insufficient staffing, with 46% of nurses feeling exhausted and negative. Staff reported that "not being able to stay hydrated, eat, or use the toilet impacts on their physical and emotional wellbeing, especially over prolonged periods of time" (RCN, 2017: 8). One of the RCN's (2017) recommendations is for Parliament to find a solution to the longstanding lack of workforce planning which provides an insufficient supply of suitably prepared, educated, skilled and competent nurses to meet the local and national needs. Nevertheless, in 2017, England's Chief Nurse, Jane Cummings, looked to the future at the Chief Nurse Summit, giving the message that the profession was to "focus on doing the right things that deliver safety and the triple aim of good care, improved health, and lower cost" (NHS England, 2017: 9).

Due to the dynamic approach to health-care delivery, nurses are now managing the delivery of care rather than providing it personally, and more care is provided in the community where delivery of care is often more challenging. Registrants now need analytical decision making skills to adapt their approaches to care and to their environment, to be accountable, act autonomously, and be the patients' advocates. In 2016, England's Chief Nurse reported that:

"the challenge for modern nursing and midwifery was to provide patients and the people we support with competent, compassionate care that spans working with those we care for, carers and their families to promote physical and mental health and well-being, assess, diagnose and treat complex needs and have a workforce better able to meet the growing demand on our services and expertise" (NHS Commissioning Board, 2016: 3).

The Chief Nurse continued to comment that "we need new ways to meet the changing needs of the people we care for" (NHS Commissioning Board, 2016: 3). In 2017, in response to the workforce nursing crisis, Health Education England promoted two levels of nursing, with the introduction of the Nursing Associate. This has been criticised by the media as "a cheap

replacement for nurses" (Smikle, 2016: 14). This two-tiered approach to nursing, appears to contradict the research which highlights that "a well-educated nurse workforce leads to better patient outcomes, the more educationally able the workforce is, and the better it is for patients and communities" (Health Education England, 2015: 2; NIHR Clinical Research Network, 2014).

During my professional career, registered nurses have increasingly been expected to perform skills that a junior doctor would have performed twenty years ago. This is aligned with the evolution of the nurse's role moving to a graduate profession in 2010 (NMC, 2010). Furthermore, the advancement of the nurse's role has responded to the increasing complexity of global, national, and local health-care needs. What were previously deemed medical skills are now essential skills for the newly qualified nurse, for example venepuncture, cannulation, the administration of intravenous medicines and prescribing readiness. This is in response to a shortage of doctors, because of changes to their training and working hours, nurses have had to perform advanced roles, with an increasing amount of the fundamental aspects of care delivery being handed over to healthcare assistants (Lewis and Kelly, 2015).

As the nurse's role extends, so too will the preparation and training of pre-registration students. It is likely to increase demand for post-registration and post-graduate level education. In 2018, the NMC published radical changes to pre-registration nurse education to incorporate prescribing readiness of medicines and a wide range of nursing procedures for the four fields of nursing to demonstrate at the point of registration (NMC, 2018a).

The transition from student to registrant is potentially challenging for nurses and has been reported to be a stressful experience (O'Shea and Kelly, 2007) and a "reality shock" (Kramer, 1974: 1). There are a number of stress factors which affect the transition period, including individual responsibility and accountability, the risks and consequences of making errors, management, and prioritising care needs (Park et al, 2011). Newly qualified nurses report that "we only become nurses by practising nursing" (Danbjorg and Birkelund, 2011: 170). However, Draper (2013) reports that newly qualified nurses feel unprepared and lack clinical skills at the point of registration. Thereby, reducing the quality of care and increasing nursing errors, impacting on the patient's confidence in nursing (Peate, 2012).

In 2008, in order to address the transition from student to registrant, the NMC's (2008) consultation on pre-registration nurse education recommended a mandatory period of preceptorship integrated with pre-registration nurse education (NMC, 2009). Yet there remains no legislation to support this recommendation. In 2010, the NMC stated that within nursing and midwifery, a period of preceptorship would support newly qualified nurses by allocating an experienced member of the nursing team, a preceptor, who could act as a role model and

attempt to ease their transition into professional practice and socialisation into the role and nursing community (NMC, 2010). It was argued that this would build confidence and the development of a professional identity (BjorkStrom et al, 2006). Park et al (2011) asserts that the newly qualified nurse experiences a less stressful transition when supported by a preceptor. The early career nurse adapts to their professional responsibilities, increasingly gains confidence in making decisions, and acclimatises to being an accountable practitioner (Park et al, 2011). Bick (2000) reported that newly qualified nurses often feel besieged and vulnerable and that preceptorship offers them support in their own role transition. The partnership between the preceptor and preceptee provides the preceptor with the insight into the strengths and limitations of the preceptee and their individual clinical practice. Gaps in knowledge and skills can be identified, monitored, and development plans implemented., there are challenges of the preceptor's ability to spend time with newly qualified nurses, due to shift patterns and an increasing workload.

These challenges are represented in the number of referrals to the NMC and it would appear that nurses in the United Kingdom are at an increased risk of referral for an allegation of impaired fitness to practise within the first five years of registration. An initial scope of data in 2010 revealed approximately 16% (n=607) of all the 3,929 referrals to the NMC are registrants who have been registered for five years or less. In 2008, there were 25,842 new admissions to the NMC register from the UK, European Union, and other overseas countries (NMC, 2008a). These new admissions represent 3.9% of the register. Of these new admissions 2.3% may be at risk of referral to the NMC FtPC, within the first 5 years of registration, as opposed to the 0.8% of the total number of nurses and midwives who are referred to the NMC every year. These figures represent only a small number of registrants, but it does appear that more early career registrants than expected are being referred. This must be a concern to the profession. Early career referral rates potentially reflect standards of pre-registration education, early post registration career progression and have implications for public protection.

1.3 Myself as a Researcher

It is necessary to situate myself as the researcher in order to embrace the fundamental aspects of constructivist grounded theory that acknowledge the researcher's previous experiences, values and beliefs, illustrated in the ongoing reflexive process in this chapter. Grounded theorists are not passive researchers, who claim neutrality. Researchers, in their "humanness" are part of the research endeavour rather than objective observers, and their values must be acknowledged by themselves and by their readers as an inevitable part of the outcome (Bickman and Rog, 2008). I was engaged in the construction and interpretation of

understanding data. Charmaz (2014) argues that neither researcher nor participant come to the scene untouched by the world. Constructivist grounded theorist's co-construct the project with participants, therefore the research was not discovered but jointly constructed. "Researchers are obligated to be reflexive about what we bring to the scene, what we see, and how we see it" (Charmaz, 2014: 344). Therefore, the decision to write in the first person enabled an exploration of my reflections intertwined with the methodological principles of constructivist grounded theory.

1.4 My Position within the Project

Constructivist grounded theorists locate themselves within the research project, whereas earlier grounded theorists strived to remain neutral observers, outside of the inquiry. However, Charmaz (2003: 13) argues that "it is very difficult, if not impossible, to totally divorce one's self from the accumulations of knowledge and experience which temper understanding, observation, and interpretation." Jones and Alony (2011) advocate that researchers understand two potential biases. Firstly, the double hermeneutic, as defined by Giddens (1984) who recommends that research can be influenced by the researcher. Secondly, the 'Hawthorne effect' (Landsberger, 1958). Landsberger's study discovered that people tend to do things to please researchers resulting in inaccurate findings.

To address any potential bias, I acknowledge that although I share the common experience of working as a Registered Nurse and I am aware of the complex nature of nursing, I cannot enter the research process from a neutral standpoint and dismiss my experiences as a Registered Nurse Teacher and previous Fitness to Practise Panel Member. This information was shared with the participants at the beginning of the interviews.

A grounded theory methodology celebrates inductive analysis of an open approach to developing a new theory that has evolved over time. During the time of research I have professionally matured with a number of changes in employment. I have experienced significant life changing events, from bereavements to health issues. Additionally, my supervisor requested I undertook dyslexia testing and with some reluctance I was initially screened and subsequently assessed by an Educational Psychologist, who diagnosed my dyslexia. This has highlighted my strengths and limitations. From a positive perspective, it has helped identify the level of professional resilience and strategies I have in place to cope with working in an academic environment, because throughout my working life it has never previously been picked up as an issue.

The identification of the researcher's biases and values can assist the reader in determining the reliability of the research and to enhance its replication (Lewis, 2009). My perspectives

have not been ignored but acknowledged throughout the research process and reflected in any findings presented, enhancing the transparency of the study. Glaser (1998) recommends that the researcher engages in the development of reflexive strategies of their preconceived experiences and knowledge about registered nurses referral to the NMC. This will be a vital variable that is weaved into the constant comparative analysis.

1.5 The Organisation of the Thesis

This chapter has provided an introduction to this thesis in terms of placing the study in context. The initial question arose out of my professional curiosity and experience:

Why are nurses being referred to the Nursing Midwifery Council's Fitness to Practise Committee so early in their careers?

After a period of reflection, reviewing the literature and discussing this question with colleagues and presenting to peers (Appendix 1, 2 and 3), it became apparent that little was known about this phenomenon. Therefore the aim of this thesis is to:

- Identify the factors that precede a referral of nurses, by employers in England to the Nursing and Midwifery Council (NMC) Fitness to Practise Committee, within the first five years of registration.

The thesis presents an account of the study throughout the following chapters. Included in each one are visual effects, colourful images and diagrams that reflect my visual learning style, Chapter two provides a discussion of my early pre-understandings found in the literature before the study commenced, over the duration of the study these pre-understanding have been reflected upon and updated. This chapter is divided into two sections to provide a summary of the literature review strategy and the initial literature review, which includes peer-reviewed journals. The review highlights the pre-understanding related to fitness to practise in nursing and other health disciplines. The second section provides a summary of the literature search and a review of the literature, which includes scholarly opinion papers, discussion papers, grey literature and primary research, focusing on criminal convictions, misconduct, and lack of competence and nursing errors.

Chapter three situates my ontological and epistemological stance. This chapter explains the underpinning methodology and methods used to meet the aim and objectives of the research. The chapter focuses on the constructivist grounded theory method adopted for this study, which explains how the 20 semi-structured interviews were transcribed verbatim, data collection and analysis took place concurrently, and the codes and categories developed. Categories designate the grouping together of events, processes and occurrences that share

central characteristics with one another. Field notes were used to record the researcher's perceptions during and after the interviews. The interview schedule changed and questions were modified to reflect the emerging theory. Theoretical sampling was adopted as a process of data collection for generating theory, whereby I jointly collected, coded, and analysed the data. I decided what data to collect next and where to find them in order to develop theory as it emerged (Glaser & Strauss, 1967). For theoretical sampling to be implemented successfully data collection and analysis concurred concurrently, by keeping the codes active using a constant comparative method asking "what is actually happening here?" (Glaser, 1978). Theoretical saturation of concepts occurred, following which the data collection and analysis cycle concluded. "Saturation means no additional data are being found whereby the researcher can develop the properties of the category" (Glaser and Strauss, 1967).

Chapter 3 reveals how memo-writing was the intermediate step between coding and the first draft of the completed study. Memo-writing aided analytical thoughts and provided an audit trial of the developing theory.

Chapters four, five, six and seven illustrate how the integration of categories into a theoretical framework occurs with a core category emerging. Chapter eight explains the core category and how it amounted for most of the variation of data and therefore the major categories relate to it in some way. The core category is the most highly abstracted category, but still remains grounded in the data. The major categories are related to the core category and these categories show how the core category works in the lives of the participants.

Chapter nine presents the seven recommendations; this chapter pulls together the parts of the study and presents the whole experience. Finally chapter ten describes the implications of the study and also offers an insight into the decisions taken throughout the study in order to promote quality of the study findings and how they were interwoven throughout.

Chapter 2 Literature Review

2.1 Conducting an Initial Literature Review for a Constructivist Grounded Theory Study

This initial literature review is underpinned by a Constructivist Grounded Theory paradigm. It is important to acknowledge that Grounded Theory can be divided into three evolving stages of development: traditional; Straussian; and constructivist. The initial literature review for this study deviates from the traditional grounded theory approach which advocates that "there is a need not to review any of the literature in the substantive area under study" (Glaser, 1992: 31). The rationale for this is to avoid constraining, contaminating, or influencing the analysis of codes which emerge from the data (Glaser, 1992). Strauss and Corbin (1998) advocate proactively engaging with the literature from the beginning of the research process. They argue that by "interweaving the literature throughout the grounded theory process it acts as another source of data which contributes towards the researcher's theoretical reconstruction" (Strauss and Corbin, 1998: 45).

Ultimately, a review of the literature can increase theoretical sensitivity, by highlighting examples of similar phenomena that can "stimulate our thinking about properties or dimensions that we can then use to examine the data in front of us" (Strauss and Corbin, 1998: 45). Charmaz (2006) suggests that sensitivity, which includes personal and professional experience, the literature, and the analytic process, is reached through thinking and having time to reflect, by taking into account a wide range of vantage points, following up on fundamental leads, comparing data and generating new ideas.

An integrative, explorative review was adopted for the initial literature review for this study and was conducted prior to data collection and analysis. It gave an understanding of the parameters and general issues related to the research area, (Suddaby, 2006; Lempert, 2007), which are specifically highlighted in the second phase of this initial literature review. The overall literature review provided a frame for the research study. Creswell (2009) advises that a critical analysis of the existing literature enhances the ability to contextualise the prospective findings, to fill existing gaps in knowledge, and to validate existing studies. Subsequent searches of the literature were conducted as the four major categories were finalised.

For ease of reading the initial literature review is presented in sections. The first part presents the search strategy, this is followed by an overview of the literature in relation to registered nurses' impaired fitness to practise and a referral to the nursing regulator. The second section relates to criminal convictions, misconduct, lack of competence and nursing errors. After discussing the research findings in chapters 4, 5 and 6 the advice discuss the literature. The advice from Strauss and Corbin (1998) who recommended engaging with the literature

throughout the phases of the research was sought during chapters 4, 5, 6 and 7. Therefore each of the four findings categories chapters have discussions with the literature.

2.2 Phase One

2.2.1 Search Strategy

Epistemologically, constructivism emphasises the subjective nature of knowledge and interrelationship between the researcher and participant, the co-construction of meaning (Hayes and Oppenheim, 1997; Pidgeon and Henwood, 1997). In this study the researcher was an integral part of the research process rather than an objective observer (Appleton, 1997; de Laine, 1997; Guba and Lincoln, 1989; Stratton, 1997), and so my values, beliefs, personal and professional experience will be acknowledged throughout the study. The concept of constructivist grounded theory provided an epistemological fit with my position.

The search strategy was designed to employ a recognised and replicable procedure to find, evaluate, and draw together the findings of relevant research (Gough et al, 2012) culminating in the integrative, explorative review. The synthesis of the literature began with an overall description of the evidence uncovered through the review (Petticrew and Roberts 2006). This was organised and driven by the study's purpose and aims. The results were drawn together to, describe and summarise the literature. This synthesis identified gaps in the evidence. To compliment the stages the review includes tables to summarise the characteristics, findings, and limitations of each study, as advocated by the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) (Moher et al, 2009).

The search strategy incorporated recommendations from experts but I primarily used the following data - bases and sources: Cochrane; PEDro; PsychINFO; Medline; Clinical Evidence; Bandolier; Professional Websites; Clinical Guidelines; NICE; CINAHL; Embase, illustrated in flowchart 1.

These databases routinely indexed qualitative and/or quantitative research. Synonyms were developed using a combination of truncations and quotations to best capture the search term. Broad search terms were used with the development of a list of alternate terms and synonyms to ensure a breadth of coverage. The Boolean connector 'OR' was used between the term synonyms, and 'AND' was used between search terms to identify literature evidencing fitness to practise, misconduct, and lack of competence, illustrated in the table 3 below.

Table 3: Broad Search Terms for the Initial Literature Review

“Fitness to Practise”
“professional regulation”
“misconduct”
“lack of competence”
“employers”
“nursing”

Exclusion Criteria

The literature review was restricted to those nursing studies that had been conducted following the Nursing and Midwifery Order (2001). International studies were limited to those published in English. The initial review of the literature excluded literature outside the health disciplines.

Inclusion Criteria

The initial review of the literature was conducted across different health disciplines to explore the factors that preceded a referral and possible influencing factors. The objectives of the research focused on the exploration of:

i) employers as the main sources of referrals;
ii) misconduct and/or lack of competence as the most common reasons for referrals;
iii) nurses in all four fields of practice;
iv) events and issues leading up to and the making of referrals for misconduct and/or lack of competence;
v) referral cases made from 2010 onwards and which have been concluded.

Initial parameters were set identifying literature for inclusion between the periods of 2001 to 2013, to align with the Nursing and Midwifery Order (2001) legislation. This initial search was updated in 2018. This time-frame reflected the move within legislation, policy and practice towards inclusive working (Scott, 2010). Only studies published in peer-reviewed journals or published books were included, with the exclusion of conference presentations and graduate theses during the initial literature search. Parry et al (2014) advises that the peer review process can be viewed as a form of quality control upon the publications included in the review.

Screening

The documents were scanned by the title and abstract for relevance according to inclusion and exclusion criteria. The PRISMA checklist (2009) for assessing research evidence was

used as a framework to judge the quality of the references and their inclusion. Flowchart 1 illustrates the four stage approach, firstly, the identification through preparing and doing the database search, manual searches and removing duplicates. Secondly, screening titles and abstracts which helped to determine what was already known about the subject, to identify if there were any gaps in current knowledge, and to get a feel of the field at the time. Thirdly, the number of full texts eligible to be included and those excluded. Finally, the total numbers of articles included.

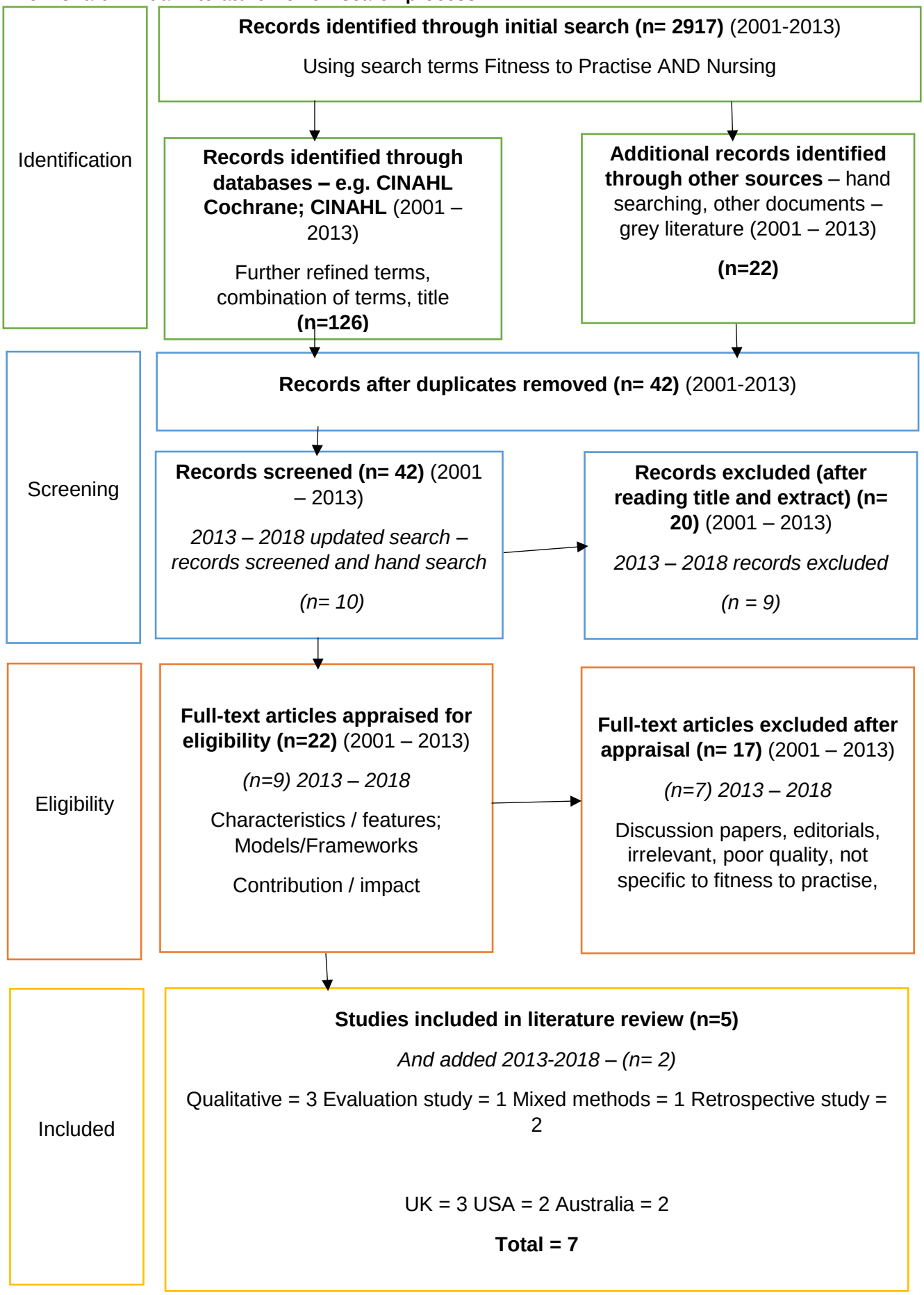
2.2.2 Search Results

This initial review of the literature provided clarity for my own research aim and objectives. It became apparent that there was a gap in qualitative and quantitative research. Therefore, it heightened the necessity to undertake a qualitative, interpretive, constructive grounded theory approach to explore employers experiences of the factors of an early career nurse that precede a referral to Fitness to Practise Committee.

After screening, a surprisingly low number of studies were suitable for inclusion (n=2), which specifically related to fitness to practise. This suggested potential issues within the search strategy. The Faculty Librarian was approached to assist with testing the search strategy and to assess what functions were affecting the search databases. A further three articles were retrieved by scanning reference lists and two articles following an updated search in 2018.

This is illustrated in the section detailing phase two of the initial literature review. Data were extracted from the relevant articles, illustrated in the table 4 Summary of Fitness to Practise Studies. A search of the literature is illustrated in the adapted PRISMA flow chart 1 to demonstrate how the articles were identified and screened for eligibility, the number of articles excluded and why.

Flow Chart 1 Initial Literature Review search process



2.2.3 Phase One - An Initial Literature Review of Fitness to Practise Regulation

Research studies into fitness to practise is slowly increasing in light of the growing importance of professional regulation and public protection, which have slightly different agendas depending on the discipline. It was evident that in some papers there was a lack of methodological discussion and rationale. However, the weaknesses identified in some studies could be primarily associated with the lack of detail reported due to journal article word count restrictions. Three of the studies reviewed adopted qualitative approaches, with limited discussion of their choice of methodology (Pugh, 2009; Pugh, 2011; Crigger and Meek, 2007). Pugh discussed the "methodological rigour" of her qualitative study (Pugh 2009: 2029). Pugh highlighted the importance of "a detailed audit trail of the research process, which included: how the participants were chosen; access to the participants; the development of trust and rapport; data collection and recording processes; and a decision trail" (Pugh, 2009: 2029). Nursing is a practical profession, where the role of the nurse is based on the concept of caring; this is not easy to quantify with statistically significant results, and therefore this professional group tends to use a qualitative research approach to offer a greater understanding of the participant's subjective experience (Benner, 1995). In comparison to the two studies conducted in medicine which adopted quantitative approaches.

Whilst this review of the literature was initially restricted to the factors that preceded a referral to the Fitness to Practise Committee, the search revealed a study carried out by Pugh (2009) in Australia. This study explored nurse's experiences during and after a referral to the professional regulator. She conducted interviews with 21 registered nurses who had been reported to the nursing regulatory body. Pugh (2009) used grounded theory to explore the phenomenon of unprofessional conduct and the transformation of a nurse's experience during and after a referral to the nursing regulator. Pugh (2009: 2035) concluded that a new understanding of unprofessional conduct was needed, aligned with the continued support of a systems approach to "managing nursing errors", in order to strengthen the support for nurses rather than punishing them. Pugh provided verbatim quotes from her participants to represent their lived experience and to justify the themes and conclusions drawn. These powerful quotes added depth and great weight to facilitate the reader's judgement of the findings for themselves. "*I should have telephoned the union and taken a lawyer with me. I didn't have to go and make a statement at all. I should have told them I was not coming in, but I was so vulnerable. [Participant 1]"* (Pugh, 2009: 2032).

Furthermore Pugh (2009) discussed the lack of research that has been conducted into the experiences of nurses reported to a professional regulator, for an allegation of unprofessional

conduct, and the devastating and prolonged psychological and professional consequences. Her substantive theory, the phoenix process, described the "transformation of the personal and professional self which the nurse both "engages in" and "goes through", it was difficult to calculate the transferability of the findings to other countries or other health professionals because of the sample size (Pugh, 2009: 2034). Pugh acknowledges the limitations of the transferability of the findings in a grounded theory study; however a wider sample of nurses was not the aim of the research.

A further research paper written by Pugh (2011) based on 21 participants revealed that nurses reported to the professional regulator experienced personal and professional vulnerability in their practice contexts before they were reported. Pugh's findings help define the nature and construct of personal and professional vulnerability. These vulnerabilities were divided by Pugh (2011) into two trajectories: first, as causal attributes of the inconsistency of decision-making by the nurse which resulted in an allegation of substandard practice; secondly, this appeared to be the trigger to report the nurse to the professional regulator (Pugh, 2011). Pugh (2011: 29) suggests that "professional vulnerability was constant for all nurses in all contexts and not just an issue for the novice nurse." Pugh's (2011) research identified the vulnerability faced by nurses on a daily basis. While this was constant, it could be exacerbated through the behaviours of the individual or an inappropriate response to a situation and the context of practice by the nurse / the employer. Pugh's (2011) conclusion acknowledges that the complexity and human dynamics of the clinical situation and practice context; the challenges of health-care systems and workforce issues; and the fallibility of human thinking can conspire against even the most experienced and conscientious nurse.

In America, Saintsing et al's (2011) evaluation study argues that novice nurses made errors when faced with clinical decision – making in the first years of their nursing career. Saintsing et al (2011: 354) discuss how "novice nurses may be at greater risk of errors than experienced nurses." This was also highlighted by Cloete (2015) who concluded that near error situations and adverse events are disproportionality associated with treatment by novice nurses. Saintsing et al's (2011) paper also states that the National Council of State Boards of Nursing's survey of employers of new nurses found that respondents' perceived newly qualified nurses to be inadequately prepared (Smith and Crawford, 2003). Furthermore, between 49 per-cent and 53 per-cent of novice nurses are involved in errors in nursing care (Smith and Crawford, 2003; Kenwood and Zhong, 2006). Even though Saintsing et al's (2011) paper lacks rigor in relation to the search strategy, with no clear evidence of a systematic review or the quality of the papers reviewed, the author raises a valuable discussion regarding the measurement of errors, determining the type of errors, and the extent of errors rather than exploring the

reasons behind them in the expectations of employers and what they mean by 'inadequately prepared' in a nurse.

Saintsing et al (2011) recommended that research focuses on the transition to practice with a remit of error reduction to assist early career nurses' understanding and mitigating against error rates. They also addressed the challenges faced by novice nurses within the first year of registration, illustrated by Morrow (2009) who identified the fundamental challenges which relate to the support provided by managers and the working environment. Morrow (2009) presents a literature review aimed at exploring the lived experiences of novice nurses in Canada. Morrow (2009) indicates that newly qualified nurses are not receiving adequate preparation for prioritisation of care, time management, and critical thinking skills, including the ability to translate theory into the practice setting. Morrow did not comment on the nurse's reaction and response to a mistake in practice but advocated nurse managers must question why the "disenfranchisement and marginalisation of new graduates continues" (Morrow, 2009: 278).

Crigger and Meek's (2007) grounded theory study of ten registered nurses, who described 17 mistakes explored the response of a registered nurse making mistakes. "The nurse's response to mistakes varied from less healthy responses of blaming and silence to healthier responses, which included disclosure, apologising, and making amends" (Crigger and Meek, 2007: 177). The findings of this study identified four distinct categories: "reality hitting; weighing in; acting; and reconciling" (Crigger and Meek, 2007: 182), with the core category discussing the reconciliation of the personal and professional self.

It could be argued that the data produced provided limited insight into the self-reconciliation following mistakes in nursing practice due to a limited sample size. However, Crigger and Meek (2007) claim this grounded theory study demonstrates new insight into the experiences of nurses who make mistakes in practice. To conclude, they recommended further research is needed to develop the theory and to determine helpful interventions.

A further pertinent study in North America conducted by Maxine Papadakis and colleagues has shown that graduates whose conduct had caused concern at medical school were around twice as likely as their peers to be subsequently disciplined for misconduct as a doctor (Papadakis et al, 2004). The study does not clearly indicate the response of the medical student or registered practitioners when faced with an allegation of impaired fitness to practise. However the researchers reported that "both behavioural and cognitive performance measures during residency training can predict problematic performance in practicing physicians and that there is a continuum of performance" (Papadakis et al, 2008: 875).

Two case-control studies of professionalism (Papadakis et al, 2004; Papadakis et al, 2005) with a sample size of 66,171 physicians over a ten year period, have received extensive attention in the medical education community. The studies showed that documented unprofessional behaviour in medical school records is significantly related to subsequent medical board disciplinary action; that unprofessional behaviour in medical school is a risk factor for board disciplinary action. However, these papers have been criticised, with the recommendations that medical research needs to be more focused, more reflective, and more critical in thinking about and reporting research results in terms of their implications for practice (Colliver et al, 2007). The study indicated the lack of quality control with regard to observations or standardisation for disciplinary actions across different states in America (Papadakis, 2008). This leads to the methodological challenges of determining whether these findings can be generalizable to other professional groups because disciplinary action rates differ (Kohatsu et al, 2004).

A more recent mixed methods research study in the UK conducted by Jayaweera at al (2018) reviewed 153 cases of doctors referred to the General Medical Council (GMC) with a concern about their fitness to practise. The study concluded that the doctors removed from the GMC register scored poorly in the Test of Competence Assessment compared to those that remained on the register with warnings or sanctions, as well as those who remained in good standing. Interestingly, there was no information relating to the doctors behaviour or conduct, with the competence assessments only related to clinical knowledge and skills. However, the findings highlighted the significant overlap in the doctors categorised by fitness to practise outcomes and case examiner recommendations illustrating and strengthening the consistency between the fitness to practise decision-making stages. The results of the TOC (Test of Competence) assessment contributed to the assessment team's written report, with recommendations for the Case Examiners, who make a decision if a doctor needed to be referred to the Medical Practitioners Tribunal Service for a hearing.

A similar study of 51 cases referred to the General Pharmaceutical Council was conducted by Gallagher et al (2015). The study assessed if mitigating circumstances were considered by the General Pharmaceutical Council when determining an impairment of fitness to practise, aligned with the Council's Indicative Sanctions Guidance as warranting a removal from the register. The study found a statistically significant correlation between the risk of harm and a case of dishonesty as mitigating factors resulting in the sanction to remove the practitioner from the register. Gallagher et al (2015: 209) reported that "risk of harm and dishonesty were considered to be among the most severe aggravating circumstances described in the Indicative Sanctions Guidelines for Fitness to Practise Panel." These were deemed to potentially receive a more serious sanction (General Pharmaceutical Council, 2010; 2011).

Ultimately, Gallagher et al (2015: 209) found that the review of the cases has demonstrated that Committees are adhering to the published guidance. However, the research does not review the extent of how these mitigating factors are considered or if these factors influenced the decision for each individual case (Gallagher et al, 2015).

2.2.4 Rationale for the Primary Research as a Result of the Initial Literature Review of Fitness to Practise

Engaging proactively with the literature at the beginning of the research process yielded little evidence that related to the employers perspective of fitness to practise and professional regulation. Strauss and Corbin (1998) recommended the use of techniques to increase theoretical sensitivity by reviewing literature with examples of similar phenomena which stimulated thoughts from other disciplines. There were a handful of relevant research studies, across the disciplines of heath, including four from a nursing perspective (Pugh, 2009; 2011; Saintsing et al, 2011; Crigger and Meek, 2007), and another two conducted with relation to medicine (Papadakis et al, 2008; Jayaweera et al, 2018), and one from pharmacy (Gallagher et al, 2015). One theme from the nursing literature in Pugh's study (2011) highlighted the nurse's perspective of everyday professional vulnerability experienced by nurses, which could impact on the nurse's response to an error. Whereas medicine and pharmacy focused on the importance of demonstrating the consistency of decision-making by the regulator (Papadakis et al, 2008; Jayaweera et al, 2018; Gallagher et al, 2015).

These four nursing studies represented the lived experience of the professional, exploring their perception of fitness to practise and being involved in an error in workplace. The employer's voice was not heard yet the NMC Fitness to Practise Committee reports that the majority of referrals are made by registrant's employers (40%) (NMC, 2018). Furthermore, there is an increasing emphasis on supporting early career nurses to retain the future workforce, which responds to Morrow's (2009) call for nurse managers to address the culture in the workplace and the support needed following a mistake by an early career nurse.

Early career referral rates potentially reflect standards of pre-registration education, early post-registration career progression, and have implications for public protection, while in the public's interest. Ultimately, the review of the literature revealed the gap in qualitative and quantitative research and the importance of undertaking a qualitative, interpretive, constructive grounded theory approach to explore the employer's experience of the preceding factors of an early career nurse referral to the professional regulator.

Table 4 Phase one - Summary of Fitness to Practise Studies

Author, Year, Study, location, Discipline	Design	sample size	Inclusion criteria	Main findings.	Study limitations.
Pugh, D (2009) Australia Nursing	Grounded theory methods including the constant comparative method were used to analyse data from in-depth interviews.	21 Australian Registered Nurses.	Registered Nurses who were reported to a nurse regulatory authority for an allegation of unprofessional conduct. Data were collected between March 2004 and September 2005.	A substantive theory, the phoenix process, was generated. This described a transformation of the personal and professional self which the nurse both "engages in" and "goes through" (Pugh, 2009).	Transferability of the findings. Limited participant's willingness to participate in the study. Limited pool of participants willing to come forward and share their experiences.
Pugh, D (2011) Australia Nursing	Grounded theory.	21 Australian Registered Nurses.	Nurses reported to a nurse regulatory authority for an allegation of unprofessional conduct.	The study revealed that nurses reported to the professional regulator experienced personal and professional vulnerability in their practice contexts. These vulnerabilities have been divided by Pugh into two trajectories: first, as causal attributes for the inconsistency of decision making of the nurse which resulted in an allegation of substandard practice; secondly, this was the trigger to report the nurse to the professional regulator (Pugh, 2011).	Transferability of the findings. Limited participant's willingness to participate in the study. Limited pool of participants willing to come forward and share their experiences.
Saintsing et al (2011) Nursing America	Evaluation study.	75 articles.	Articles selected included information regarding types of errors, causes of errors and potential interventions.	The primary type of error for a novice nurse was medication errors. The cause of the error appeared to be complex matrix of factors. Critical thinking and experience	Limited information about a rigorous literature search.

				were themes in most of the errors for this review, including time management.	
Crigger and Meek (2007) Nursing	A grounded theory approach was used to explore the process that occurs after nurses perceive that they have made mistakes in practice. Theoretical sampling was used and data were collected until saturation occurred.	10 participants.	Ten participants, who were registered nurses, described 17 personal mistakes. The mistakes they described occurred in hospitals. All participants were practicing nursing either in hospitals or in other work settings.	A process of "Self-Reconciliation After Making Mistakes in Hospital Practice" was identified, with four distinct categories: reality hitting; weighing in; acting; and reconciling. The core category was reconciliation of the self, personally and professionally (Crigger & Meek, 2007). They argue that this research was a first step toward the development of a theory of mistake making in nursing practice. This response to making mistakes was consistent with previous research and was related to cognitive dissonance theory. The responses to mistakes varied from less healthy responses of blaming and silence to healthier responses that included disclosure, apologizing, and making amends (Crigger & Meek, 2007).	Limited insight into the self-reconciliation following mistakes in nursing practice due to the small sample size.
Papadakis et al (2008) North America Physicians	Retrospective cohort study.	66,171 physicians.	Physicians who entered internal medicine residency training in the United States from 1990 to 2000 and became Diplomates.	Poor performance on behavioural and cognitive measures during medical school are associated with a greater risk for state licensing board actions against practicing physicians at every point on a performance continuum. These findings support the Accreditation Council for Graduate Medical Education	The study data was retrospective. Diplomates practicing outside of the United States not included. Non-diplomates were excluded. Difficult to determine if the findings are generalizable to other specialties because disciplinary action rates differ by specialty.

				standards for professionalism and cognitive performance and the development of best practices to remediate these deficiencies.	Individuals that changed specialties because of difficulties during internal medicine training were not included in the data because of incomplete data. Oversees trainees who came to the United States for residency training may have returned to practice in their home country and would therefore not be at risk of disciplinary action in the U.S. medical licensure system.
Jayaweera et al (2018) United Kingdom General Practitioners, Medicine	Mixed methods.	153 General Practitioners.	Data was collated on GPs who were required to undertake a TOC as part of being investigated for fitness to practise issues, from February 2010 – October 2016.	General Practitioners removed from the GMC register scored poorly compared to those that remained on the register with warnings / sanctions, as well as those who remained in good standing. The results of the TOC (Test of Competence) assessment are used alongside the results obtained from a peer review exercise to help the assessment team write a report, which included recommendations about the doctor. There was a significant overlap in the doctors categorised by fitness to practise outcomes and case examiner recommendations highlighting the consistency between the fitness to practise	The TOC assessment are bespoke and tailor made, therefore it is unlikely two doctors will take the same test. Different approaches to the OSCE stations before and after October 2014. As a result statistical analysis was conducted using overall scores. Doctors removed from GMC register and those who voluntary removed themselves were included in the "erased" category. 30 per-cent of GP Assessors declined to participate in the survey with no reasons to explain why, therefore there would be some response

				decision making stages (Jayaweera et al, 2018).	bias in the opinions expressed by GP Assessors who participated. OSCE stations reduced from 12 to 6 to test different skills.
Gallagher et al (2015) United Kingdom Pharmacists	Retrospective study.	51 cases.	Fifty-one cases heard by the GPhC between 1 October 2011 and 30 September 2012.	Pearson's $\chi 2$ test was used to detect a variation from the expected distribution of data. There was a statistically significant correlation between the risk of harm and dishonesty as a mitigating factor and removal form the professional register.	This research does not provide a qualitative analysis of how specific factors influence the decision of the GPhC's Fitness to Practise Committee. This research does not consider the extent to which these mitigating factors are considered, nor does it seek to address how they are affected by the facts of each individual case.

2.3 Phase Two

2.3.1 Search Strategy

The integrative, explorative review revealed a surprisingly low number of research studies which were related to fitness to practice. Consequently, after a meeting with the Faculty Librarian, a second search was conducted. This applied different search terms which represented the three categories identified by the NMC Fitness to Practise Committee (Table 5). This led to the identification of 50 more items that were suitable for inclusion. Following a meeting with the Librarian within the Faculty of Health, Education and Life Sciences, phase 2 search returned an increase in results using different search terms which represent the three categories identified by the NMC Fitness to Practise Committee. The success was driven by spending time reviewing journals, texts, and the dictionary to explore the use of additional search terms, illustrated in the table 5.

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were used again (Moher et al, 2009) to ensure a systematic approach to the literature review was undertaken. This involved recommendations made by experts but primarily used the following data bases: Cochrane; PEDro; PsychINFO; Medline; Clinical Evidence; Bandolier; Professional Websites; Clinical Guidelines; NICE; CIHAHL; Embase.

Table 5 Exploration of Additional Search Terms

Misconduct	Criminal	Incompetence
Antisocial behaviour	Lawless	Inability
Breach	Corrupt	Inadequacy
Criminality	Illicit	Inexperience
Delinquency	Immoral	Unacceptable levels of performance
Illegality	Culpable	
Lawlessness	Illegitimate	Disqualification
Violation	Vicious	Inaptitude
Negligence	Scandalous	Ineffectiveness
Crime	Deplorable	Shortcoming

The databases selected were those that routinely indexed qualitative and/or quantitative data. Synonyms were developed using a combination of truncations and quotations to best capture the search term. Broad search terms were used with the development of a list of alternate terms and synonyms to ensure a breadth of coverage. The Boolean connector ‘OR’ was used between the term synonyms, and ‘AND’ was used between search terms to identify literature.

Table 6: Second Broad Search Terms for the Literature Review

Literature search terms
“Nursing regulation” AND “Fitness to Practise” AND “Preceding factors”
“Referral to Fitness to Practise” AND “employers” AND “misconduct”
“Nurses” AND “Misconduct” AND “Regulatory”
“Professional misconduct” AND “regulatory” AND “employer”
“Health professionals” AND “misconduct” AND “regulatory”
“Professional regulatory” AND “criminal convictions” AND “immoral”
“professional incompetence” AND “regulatory” AND “breach”
“Malpractice” AND “Nursing” AND “negligence” AND “crime”
“Malpractice” AND “Nursing Negligence” AND “employer”
“Malpractice” AND “Nursing regulation” AND “healthcare organisation”

Exclusion Criteria

The literature review was restricted to those nursing studies that had been conducted following the Nursing and Midwifery Order (2001). International studies were limited to those published in English.

Inclusion Criteria

The literature had to closely link with the research aim to explore the factors that precede the referral of nurses to the NMC Fitness to Practise Committee, within their first five years post registration, by NHS and independent health care employers in different regions of England. The objectives of the research focused on the exploration on:

vi) employers as the main sources of referrals;
vii) misconduct and/or lack of competence as the most common reasons for referrals;
viii) nurses in all four fields of practice;
ix) events and issues leading up to and the making of referrals for misconduct and/or lack of competence;
x) referral cases made from 2010 onwards and which have been concluded.

Parameters were set identifying literature for inclusion between the periods of 2001 to 2018. This time-frame reflected the move within policy and practice towards inclusive working (Scott, 2010). Therefore studies prior to 2001 were not considered because of the Nursing Midwifery Order (2001).

Screening

The documents were scanned by the title and abstract for relevance according to inclusion and exclusion criteria. The PRISMA checklist (2009) for assessing research evidence were used as a framework to judge the quality of the references and their inclusion.

2.3.2 Search Results

After screening, there were a number of studies that were suitable for inclusion, which specifically related to criminal convictions, misconduct, and lack of competence and nursing errors, illustrated flowchart 2.

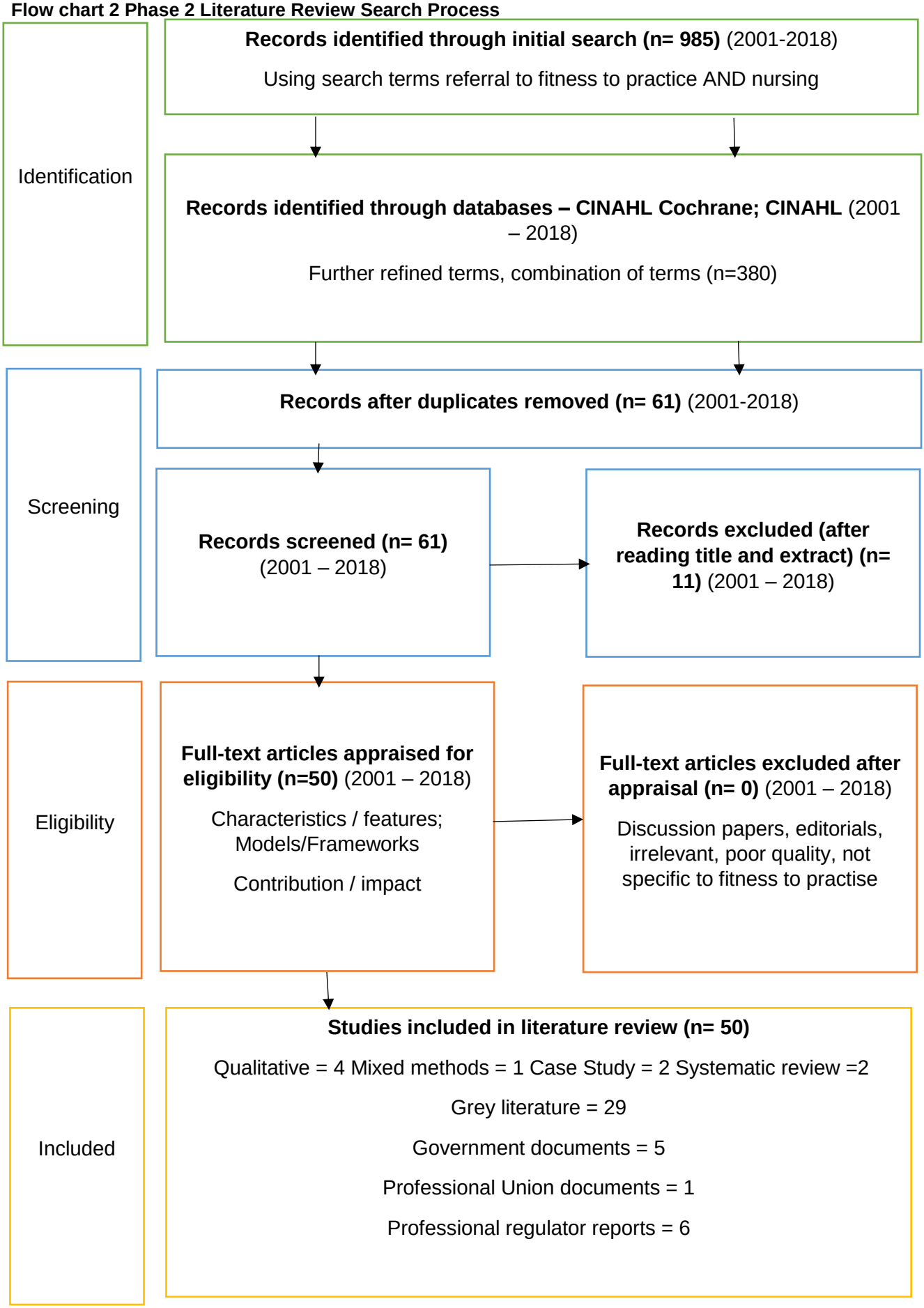
2.3.3 Second Broad Search for the Literature Review

The second broad search for the literature review highlighted patterns that repeated across the data and grey literature aligned with the three categories used by the NMC Fitness to Practise Committee. The following themes related to professional regulation and fitness to practise allegations were identified: criminal convictions; violations; professional misconduct; lack of competence; and nursing errors.

Several articles (Griffith, 2016; Ruthe, 2004) and texts investigated the scope of nursing negligence and impaired fitness to practice that interface with the law (Dyer, 2014; Lomas 2009) and the publication of specific events in the media forum (Rudra, 2013; Lomas, 2009). Previous Nursing Midwifery Council Fitness to Practise Annual Reports identified the types of allegations; many cases involved more than one type of allegation about a particular nurse or midwife. The categories are listed in the table 8 below.

In 2014/15 the NMC reported that 80 per-cent of new referrals were for allegations of misconduct. Since this report the NMC has advised employers to resolve minor misconduct cases. This is represented by the analysis of the data which indicates that more than half of new referrals were closed (Snow, 2012). Previously, in 2002, the RCN and an Independent Barrister highlighted the increasing trend of the NMC hearing “trivial cases of misconduct” (Duffin, 2003: 5), stressing the importance of adopting a responsive regulation. Yet serious professional misconduct in nursing remains difficult to define, often reliant on other health professions, such as medicine, to assist with this clarification through case law. In 2017, the NMC reported the new powers to resolve cases more quickly and proportionally, meaning only the most serious cases progress to a full hearing (NMC, 2017).

Flow chart 2 Phase 2 Literature Review Search Process



Another domain of the literature focused on the multifaceted nature of nursing errors, often revealed through a lack of competence (Anderson et al, 2018). Predominately, the literature focused on patient outcomes (Mitchell, 2008), the type of nursing errors (Benner et al, 2002), the organisation's response to errors in the workplace (Francis, 2013), the factors contributing to errors (Braithwaite, 2017), the impact on the nurse (Haw et al, 2014), the workforce and staff turnover (Takase et al, 2014).

Table 8 Types of Allegations made in new Referrals Received in 2014-2015 Types of Allegations

Types of allegations made in new referrals received in 2014-2015 Types of allegations	Percentage
Misconduct	80%
Lack of competence	5%
Criminal	11%
Health	3%
Fraudulent entry	Less than 1%
Determination by another body (For example, Irish Nursing Board, Health and Care Professions Council)	Less than 1%
Total	**100%**

2.3.4 Criminal Convictions - Serious concerns based on the need to promote public confidence in nurses and midwives

There are consequences for nurses who are involved in a breach of, or failure to meet, a standard by way of impaired fitness to practise. Breaches of the Law are dealt with by the NMC Fitness to Practise Committee, where the Civil Standards of Proof apply. Serious concerns are based on the need to promote public confidence in nurses and midwives. Criminal proceedings can be dealt with by the police and the courts. The last NMC Fitness to Practise report that identified the category of referrals and allegations of criminal convictions was in 2011/12; the report gave examples of violence, fraud and pornography, highlighted in the table 9 below.

The literature tends to focus on clear violations of the law by those nurses who killed patients intentionally (Rudra, 2013; Lomas, 2009; Batty 2007) rather than the other types of allegations listed in the table 9. Over the years it has been debated if charges of manslaughter or murder should be brought against the nurse (Lomas, 2009), in particular reference to the angels of death (Perrini, 2016). Even though these cases are rare, when they emerge they make international headlines.

Table 9 Breakdown of the Types of Allegations Contained in Referrals to NMC for Criminal Offences

Breakdown of the types of allegations contained in referrals to NMC for criminal offences:
Alcohol/drugs misuse
Theft/ dishonesty
Violence
Fraud/forgery
Motor vehicle
Sexual offences
Child protection
Child pornography
Murder/manslaughter
Racism
Source *Nursing Midwifery Council Annual Fitness to Practise report (2011/2012)*

Decades of media coverage have reported allegations of nurses who kill their patients. In the UK, Collin Norris (Lomas, 2009), a Registered Nurse, was imprisoned for 30 years for four murders and one attempted murder of female patients in his care. In 1993, Beverley Allitt was found guilty of murdering four children and injuring another nine (Lunn, 1994). Allitt was found to be suffering from Munchausen by Proxy (Lunn, 1994) which is a psychiatric disorder where an adult individual claims or induces illness in children (Padhye, 2016; Feldman and Ford, 1994). More recently, in 2015 Victorino Chua was found guilty of murdering patients and in his letter, described as "the bitter nurse confession" by Chua, he said he was "an angel turned into an evil person" and "there's a devil in me" (Pidd and Grierson, 2015). Yet, there appears to be little research to explore the reasons behind their actions or to understand their personality, characteristics and values.

More recently, in June 2016, a Danish court sentenced Nurse Christina Hansen to life in prison for the murders of three patients and the attempted murder of a fourth, by using deliberate overdoses of sedatives and morphine (Watkinson, 2016). A psychological evaluation found that the nurse was not mentally ill but that she suffered from a personality disorder characterised by “egocentricity” and a “persistent quest for excitement” (AFP, 2016). Kelleher (1999) suggested that this behaviour was “hero homicide” meaning that some nurses “crave and relish the pinnacles of motion…working in a place where the stakes were so high” states Douglas and Larrabee (2003: 117). It is posited that “such nurses inject themselves into scenarios of ‘high drama’ and engineer clinical situations where they are able to respond to

save the patient's life and become the hero in the situation" (Douglas and Larrabee, 2003: 117).

These are extreme cases which make the international headlines, often with commentary to explain the nurse's behaviour and conduct. In the case of Chua, the Prosecutor, Peter Wright QC, presented a document written by Chua during a therapy session with his counsellor, which explained his frustration and feelings (Pidd and Grierson, 2015). Wright QC told the jury "it is an insight into his thought process during a period of considerable anger and disharmony at home and at work which coincided with these events. The evidence points sadly to a man who, for reasons truly known only by himself, decided to take out his frustrations on his and others patients" (Pidd and Grierson, 2015). These cases are rare, but this behaviour is worthy of further consideration by the profession, because of the devastating impact on patients. The next section will focus on the NMC's category of professional misconduct, the majority of new referrals relate to this category despite its lack of definition.

2.3.5 Professional Misconduct - Serious cases that it may be less easy for the nurse to put right the conduct

An element of the Nursing Midwifery Council definition of registered nurses' fitness to practise referred to their "good character". Any deviation could result in an allegation of misconduct, with 80 per-cent of new referrals to the NMC Fitness to Practise Committee representing these allegations (NMC, 2016). Professional misconduct is difficult to define, it is a dynamic concept with no legal or ethical principles, and often it is dependent on social attitudes (Maurits et al, 2016). This has been reflected over time; in 1934 a matron was removed from the register for having a child out of wedlock with a man employed on her staff (Tingle and Cribb, 2013). In more recent years, the concept of misconduct was represented by cases of child pornography and the down-loading of illegal images from the internet (Tingle and Cribb, 2013). More recently, this is represented on the NMC's Website (2018b) who have broken down the types of allegations for "a small number of concerns which are so serious that it may be less easy for the nurse or midwife to put right the conduct, the problems in their practice, or the aspect of their attitude which led to the incidents happening" (NMC, 2018b), illustrated in table 10. This provides a deeper understanding of the types of allegations referred to the NMC for misconduct or "so serious" cases, in more recent times.

Case Law is available to assist Fitness to Practise Committee panel members when considering an allegation of misconduct cases. The case of *Roylance v General Medical Council* (No 2) (2000) 1 AC, states that "misconduct is a word of general effect, involving some act or omission, which falls short of what would be proper in the circumstances." Previously, in 2003 the NMC defined conduct as falling short of what can be reasonably expected of a

nurse or midwife (NMC, 2003). More recently, the NMC (2018b) consider the “seriousness of each case” is an important concept which informs various stages of our regulatory processes. The NMC (2018b) assess whether a concern is serious, by looking at what risks are likely to arise if the nurse or midwife doesn’t remedy or put this concern right. This could be risks to patients or service users or, in some cases, to the public's confidence in all nurses and midwives.

Table 10 Breakdown of the Types of Allegations contained in Referrals to NMC for Serious cases

Breakdown of the types of allegations contained in referrals to NMC for serious cases that it may be less easy for the nurse or midwife to put right the conduct (NMC, 2018b):
•breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of staff or patient who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care
•sexual assault, relationships with patients in breach of guidance on clear sexual boundaries, and accessing, viewing, or other involvement in child pornography
•deliberately causing harm to patients
•deliberately using false qualifications or giving a false picture of employment history which hides clinical incidents in the past, not telling employers that their right to practise has been restricted or suspended, practising or trying to practise in breach of restrictions or suspension imposed by us
•exploiting patients or abusing the position of a registered nurse or midwife for financial or personal gain
•being directly responsible (such as through management of a service or setting) for exposing patients or service users to harm or neglect, especially where the evidence shows the nurse or midwife putting their own priorities, or those of the organisation they work for, before their professional duty to ensure patient safety and dignity

One type of referral to the NMC is nurses or midwife who have an allegation of being responsible for contributing to a culture which suppresses openness about the safety of care, illustrated in the table above. The nursing profession is underpinned by a Code of Ethics yet, workplace bullying continues to exist despite decades of research (Quine, 2001; Etienne, 2014). Nurse-to-nurse hostility can also be referred to as “lateral or horizontal bullying”, with examples of aggression among peers or colleagues on the same organisational level (Bartholomew, 2016). Researchers have given these behaviours many different names including workplace deviance, counterproductive behaviour, antisocial behaviour (Appelbaum et al, 2007; Rosenstein and Naylorf, 2011), and workplace incivility (Robbins and Judge, 2007; Bartholomew, 2016).

Felblinger (2009) reports that incivility has replaced considerate behaviour in the workplace, with professionals tolerating disruptive behaviour to avoid being the next target. Worryingly, Felblinger explains that a nurse who displays considerate behaviour towards colleagues may

run the risk of being ostracised for not being “tough enough,” resulting in the disappearance of professional behaviour, which is then replaced by a “toxic” environment (Chapovalov & Van Hulle, 2015). Rosenstein and O'Daniel (2005) argue that health-care organisations with “workplace incivility” can influence the interactions with patients, which has been proven to impact on patient safety.

The more extreme ends of behavioural issues is the concept of “toxic employees” a term used by Jonasona et al (2011: 449), who could be employers and managers, as well as stff. However the most typical examples of deviant workplace behaviour include absenteeism, theft, abuse of privileges, and violence (either verbal or physical) (Mathieu and Babiak, 2016). Some characteristics and behaviours are described as unethical, intimidating (Clarke, 2005), repulsively charming (Felblinger, 2008), exaggerated sense of self (Anderson, 2002), and “lacking the ability to demonstrate remorse or guilt when inflicting harm on others” (Murray, 2008). People with these characteristics and behaviours embody many desirable traits like charm, leadership, assertiveness, and impression management skills (Ames, 2009). Recruitment interviews occur over a short period which may not permit sufficient time for the darker sides of these individuals to be revealed (Harms et al, 2011). Smith and Lilienfield (2012) state antisocial behaviour is poorly understood.

Felblinger (2009) discusses the consequences of workplace bullying and incivility. Primarily nurse’s felt shame; anger and a tendency to blame themselves for the behaviour of others, which often results in occupational stress that can adversely affect nurses and negatively affect patient outcomes. Nurses who are stressed or "burned out" are not able to practice competently, increasing the risk of clinical errors (Etienne, 2014). Some nurses experienced symptoms of post-traumatic disorders after being bullied at work (Felblinger, 2009).

2.3.6 Lack of Competence and Nursing Errors - serious concerns which could result in harm to patients if not put right

The NMC (2017) state that nurses and midwives sometimes make mistakes or errors of judgement but unless it was exceptionally serious, a single clinical incident would not indicate a general lack of competence on the part of a nurse or midwife (NMC, 2017). The NMC continue to explain that a lack of competence is judged on a fair sample of the nurse’s or midwife’s work. More recently, the NMC (2018b) refer to serious concerns which could result in harm to patients if not put right, illustrated in table 11. If this demonstrates a lack of knowledge, skill or judgement then the nurse or midwife could be found to be incapable of safe and effective practice which could put patients at risk (NMC, 2017).

Table 11 Breakdown of the types of serious concerns which could result in harm to patients if not put right (NMC, 2018b)

Breakdown of the types of serious concerns which could result in harm to patients if not put right (NMC, 2018b):
Prioritise people
The evidence shows that the nurse or midwife has failed to:
•uphold people's dignity, treat them with kindness, respect and compassion, deliver treatment care or assistance without undue delay, or deliver the fundamentals of care (including hydration, nutrition, bladder and bowel care and ensuring people receiving care are kept in clean and hygienic conditions).
•make sure the physical, social and psychological needs of patients are responded to.
•respect people's right to privacy and confidentiality.
Practise effectively
The evidence shows that the nurse or midwife:
•has not maintained the knowledge and skills for safe and effective practice.
•is unable to communicate clearly, work cooperatively, keep clear and accurate records, without falsification.
•failed to be accountable for decisions to delegate tasks and duties to other people and/or failed to ensure they are adequately supported.
Preserve safety
The evidence shows that the nurse or midwife has failed to:
•recognise and work within the limits of competence, accurately assess signs of normal or worsening physical or mental health, or make timely and appropriate referrals where needed.
•be open and candid with all service users, or act immediately to put right, explain and apologise when any mistakes or harm have taken place.
•offer help if an emergency arises in practice.
•act without delay if they believe there is a risk to patient safety or public protection.
•raise or escalate concerns.
•advise, prescribe or administer medicines in line with training, law and guidance.
•be aware of, or reduce as far as possible, any potential for harm associated with practice, including controlling and preventing infection, taking precautions to avoid potential health risks to colleagues, patients and public.
Promote professionalism and trust
The evidence shows that the nurse or midwife has failed to:
•uphold the reputation of the profession, by not acting with honesty and integrity, treating people fairly, without discrimination, bullying or harassment, in a way that does not take advantage of their vulnerability or cause them upset or distress.
•maintain the level of health needed for safe and effective practice.
•avoid asking for or accepting loans.
•cooperate with investigations and audits, including requests to act as a witness.
•tell us as soon as they could have about cautions or charges, conditional discharges or convictions for criminal offences.

The literature related to nursing errors can be viewed in two broad domains. Firstly, actual errors and patient outcomes (Kohn et al, 2000; Kanda and Takemura, 2003; Mitchell, 2008), and secondly, the understanding and minimisation of errors (Dunn, 2003). Understanding of actual errors and patient safety is paramount (Benner, et al, 2002; Kohn et al, 2000; Laschinger and Leiter, 2009; Pesanka et al, 2009). This may reflect on individual behaviour or failings in an organisations culture and procedures.

Nursing errors occur in a wide range of health-care settings; this can impact on the outcome of the service, contribute to a poor patient experience and in some cases patient fatality, and a rising cost to the health-care provider (Institute of Medicine, 1999). In some cases, nursing errors are preventable. Some can result in serious harm, but the majority are near misses and have no impact on the patient (Stefanacci and Riddle, 2013).

In the United States, the literature states that what constitutes preventable harm remains unclear (Nabhan et al, 2012). Nabhan et al's (2012: 128) systematic review of preventable harm concluded that the most common theme used to define preventability was "a harm with an identifiable and modifiable cause". This definition identified a specific cause, thereby it was preventable because the majority of practitioners would have followed a different and more desirable management plan (Nabhan, 2012). In the UK, it appears this is classified as "Never Events" (NHS Improvement, 2018). This is defined as "serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers" (NHS Improvement, 2018). This is compared to "A Near Miss Incident" which is an incident where an event or an omission does not develop further to cause actual harm - but did have the realistic potential to do so (NHS England, 2018).

Serious patient harm can be classified as a patient safety incident in the NHS; defined as "any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded healthcare" (NHS England, 2018). A retrospective study in Sweden analysed 173 adverse events in nursing homes involving nursing care (Anderson et al, 2018). The study found a total of 693 possible contributing factors, ranging from a lack of competence and poor team working, inadequate documentation and communication (Anderson et al, 2018). The researchers reported that patient safety was dependent on the availability of nurse's competence, which was overestimated by health care providers.

A nursing practice error can include failure to maintain adequate records; neglect of basic care; unsafe clinical practice; failure to collaborate with colleagues; and failure to act in an emergency. Benner et al (2002) reported on the outcome after analysing 21 disciplinary cases

from the nursing professional regulatory body. Benner et al (2002) identified eight categories of nursing error, these included:

1. Lack of attentiveness to the clinical condition of the patient;

2. Lack of ethical agency or fiduciary concern;

3. Inappropriate nursing judgement;

4. Medication errors;

5. Lack of intervention;

6. Lack of prevention;

7. Missed or mistaken orders; and

8. Documentation errors.

In particular, Benner et al (2002) revealed medication errors were further categorised. These ranged from missed medication doses, inaccurate administration time, intravenous infusion rate too fast or too slow, wrong dosage administered, incorrect administration route, misidentification of the patient (Benner et al, 2002). The outcomes of an error to a patient are many and may include delayed discharge from hospital, increased morbidity and mortality leading to litigation (Nute, 2014). In some cases, the patient may require additional treatment and care (Rafter et al, 2016). Kohn et al (2000) argue that, even though some errors are preventable they are often caused by human factors.

It is vital that factors contributing to errors are identified and dealt with systematically in order to provide a deeper understanding of why they occurred and to make effective improvements in patient safety (Braithwaite, 2017). The literature highlighted issues related to nursing errors, including inadequate nurse-patient ratios. Staffing issues have been reported to affect the mortality of inpatients, therefore impacting on adverse patient outcomes (Ludwick, 2009). Meurier (2000) found that nurses reported work overload to be a contributing factor in making errors because they, the nurses could be more easily distracted. Aiken et al (2002) found that deficient staffing levels undoubtedly impacted on patient mortality after examining data related to over 200,000 surgical patients. The study also reported that inadequate staffing levels resulted in nurses reporting emotional fatigue and decreased job satisfaction (Aiken et al, 2002). Rivera and Ben-Tzion's (2010: 304) study reveals that nurses reported a "loss of focus: distraction due to a loss of focus because of, interruptions, problems with technology, nurses working in unfamiliar circumstances or when they are fatigued or have worked too many hours."

The literature continued to report that the culture of the organisation significantly contributes to whether errors are reported (Braithwaite, 2017). Ultimately, errors can have a devastating impact on nurses (Fry and Dacey, 2007; Tang et al, 2007). Nurses emphasised a fear of repercussions as a pivotal obstacle to reporting errors and unsafe practices (Castell et al, 2015: 15). One obstacle is a nurse's fear of disciplinary action by supervisors (e.g., managers or physicians) and feeling that if errors are logged in their files, this will limit career advancement opportunities (Jeffe et al, 2004). Haw et al (2014) report that nurses involved in an error were individually blamed, disciplined and faced dismissal from their employment. Braithwaite (2017: 3) strongly argues that "it was neither necessary nor beneficial to blame individual nurses for errors and reporting should be promoted and embraced by all health professionals."

2.4 Chapter Summary

There were a small percentage of nurses referred to the NMC within the first five years of registration for misconduct and lack of competence, yet there appears to be a gap in the evidence to explain why this was the case so early in their career. The initial literature reviews were planned and conducted systematically and highlighted three areas of concern, firstly, serious concerns which are more difficult to put right. Secondly, nurses have been referred to the NMC because of serious concerns which could result in harm to patients, if not put right. Finally, nurses referred with an allegation of professional misconduct.

Reports in the media have heightened the awareness of the expectations of a nurse by the employer, the public, and the regulator. The literature explains the difficulties of working in health-care environments, yet there are increasing expectations of early career nurse's to function at a high level irrespective of the culture within the organisation, with little acknowledgement of how this impacts on a nurse's performance and ability to practise safely. In light of the literature review, there appears to be little evidence to help explore the objectives of this study in relation to the employers experience of the events and issues leading up to a referral for misconduct and/or lack of competence to the professional regulator.

This literature review helped to identify gaps in current knowledge and thus supported the aim of the study. It has revealed this phenomena is under- researched and could potentially enhance patient care, identify nurses who are at risk of a referral and enhance the understanding of nurse's early career progression, whilst safeguarding the public.

Chapter 3 Methodology Chapter

3.1 Introduction

The aim of this study was to identify the factors that precede a referral of nurses, by employers in England to the Nursing and Midwifery Council (NMC) Fitness to Practise Committee, within the first five years of registration.

This aim was underpinned by a number of objectives:

1. Using a grounded theory approach, to explore the perceptions of health-care employers in England regarding the factors that precede the referral of nurses to the NMC Fitness to Practise Committee, within their first five years post registration.
2. To focus the exploration on

xi) employers as the main sources of referrals;
xii) misconduct and/or lack of competence as the most common reasons for referrals;
xiii) nurses in all four fields of practice;
xiv) events and issues leading up to and the making of referrals for misconduct and/or lack of competence;
xv) referral cases made from 2010 onwards and which have been concluded.

3. To utilise the understanding gained to develop a supportive model that may be used by employers and registered professionals to monitor practitioners at risk of referral.

This chapter presents an account of the conduct of the study by explaining the methodology underpinning the study, and the methods used to achieve the study aim and objectives. The chapter then goes on to present the rationale for using constructivist grounded theory and how this approach was used as a method. It concludes with my position within the study and an explanation of the systematic research process used.

3.2 Choosing Qualitative Research Methodology

In seeking a research methodology that would provide an ontological and epistemological fit with my position a qualitative research study was required because little is known about why a disproportionate number of nurses are being referred to the professional regulator within the first five years of registration. This study required an in-depth understanding of employers'

views and experiences that might not be adequately addressed by quantitative research. Qualitative approaches seek to explore and understand human experience, beliefs, motivations, intentions and behaviour (Parahoo, 2014). The purpose of qualitative and quantitative research is the potential contribution to knowledge, practice and to promote or change behaviour. I took the decision not to use a quantitative methodology even though a questionnaire could have yielded a larger sample population. However, quantitative data does not capture the participants lived experience, compared to qualitative research that seeks to explore the intricate details of the human experience. The five qualitative approaches described by Creswell (2013) were considered. Table 12 attempts to provide a rationale for choosing a grounded theory approach. Table 12 identified five qualitative methodologies which were considered prior to deciding a grounded theory approach was most appropriate. This demonstrates the key aspects of case study, ethnography, phenomenology and narrative. During the analysis of these methodologies it became clear that the breadth of method was unlikely to be available for a case study approach. The diversity of participants demonstrated this was not a cultural group. My research question needed to explore wider professional regulatory issues than the lived experience of phenomenology or stories and narratives. Consequently grounded theory was most appropriate to answer my research question.

3.2.1 The Development of Grounded Theory

Grounded theory originated from two American sociologists Barney Glaser and Anselm Strauss. After completing a study *Awareness of Dying* (1965), Glaser and Strauss published *The Discovery of Grounded Theory* (1967). Whilst working on their study they became frustrated by the traditional research approaches in which researchers began with hypotheses which they then tested to prove/disagree. They, therefore proposed a new approach in which theory arose from the research. At the time this was revolutionary in turning the traditional approach upside down. This new approach added to the mix of ideas from American pragmatism which focused on the practical application of ideas, with all principles regarded as working hypotheses that represent the lived experience. American pragmatism is a philosophical tradition that began in 1870. Thereby, the philosophy of pragmatism "emphasises the practical application of ideas by acting on them to actually test them in human experiences" (Gutek, 2014: 76).

To sum up, grounded theory aims to generate new theory rather than test existing theory. Glaser and Strauss challenged dominant ways of thinking and existing practice. Stern and Porr (2011) argue that these two social scientists challenged the dominant ways of thinking about how to advance sociological knowledge, demonstrating how it could generate outcomes

of equal significance to those produced by quantitative studies. Grounded theory is a qualitative approach and a research method, interpretative in nature and derived from the theoretical framework of symbolic interactionism (Glaser and Strauss, 1967). Symbolic interactionism is both a philosophy of human life and social experience and a distinctive approach to the study of human life (West and Turner, 2018).

Following family bereavements, both Glaser and Strauss embarked on a collaborative research project. While analysing their own social research practices and procedures in hospitals caring for the dying patients, their experiences resulted in the development of a constant comparison method, now known as the grounded theory method. Glaser and Strauss' methods were influenced by a combination of positivism, sociology and symbolic interactionism (Ralph et al, 2015). Glaser's positivist background helped with data analysis by systematically using line by line coding and the development of categories. Whereas, Strauss recognised the richness of qualitative research in relation to the complexity of social life and social processes. Glaser and Strauss aimed to direct qualitative research towards systematic inductive guidelines for collecting vast amounts of analysed and un-analysed data. This positioned them against quantitative research. However, Glaser and Strauss offered research tools for analysing empirical data in a visible, comprehensive and replicable process which assisted the researchers to build theoretical frameworks. These processes explained the collected empirical data. Glaser and Strauss can be described as the first generation of grounded theorists (Glaser, 1978; 1992; Glaser and Strauss, 1967; Strauss, 1987; Strauss and Corbin, 1990; 1998).

The term grounded theory can be understood in two ways. Firstly the development of the research process that results in grounded theory, and secondly, it may refer to the method used in the research process (Charmaz, 2014). Grounded theory is both a theory and a method that seeks to construct theory about issues of importance in peoples' lives (Glaser, 1978; Glaser and Strauss, 1967; Strauss and Corbin, 1998). It does this through a process of data collection that maybe described as inductive in nature (Morse, 2001). This means there is little known about the phenomenon, therefore the researcher has no predetermined hypothesis to justify. Comparatively, the concepts and incidents that emerge are generated from the participants' stories and lived experience explored with the researcher about a shared area of interest. The notion of generating new theory from data, as opposed to testing existing theory, was embraced by social scientists and grounded theory as a research design became increasingly popular (Birks and Mills, 2013).

Table 12: Rationale for Choosing Qualitative Research

Qualitative Approach	What the study aims to investigate	Qualitative research features	Suitability for this study	Decision
Case Study	The development of a detailed, intensive knowledge about a single case, or a small number of related cases (Robson, 2002).	Selection of a single case(s) of a situation, individual or group of interest or concern; study of the case in its context (Robson, 2002).	The data collection in case study research was typically extensive, drawing on multiple sources of information, such as observations, interviews, documents, and audio visual materials (Yin, 2003). In this study, it may be difficult to access the relevant material needed and to design a pre-structure to capture the complex evidence. This approach could have breached anonymity of the nurse.	*Reject*
Ethnography	The researcher involved in participating overtly or covertly in people's daily lives for an extended period of time (Hammersley and Atkinson, 2003)	Researchers observe a cultural or sub – cultural group. They watch what happens, listen to what is said, and/or ask questions through formal or informal interviews, drawing on a range of sources of data (Hammersley and Atkinson, 2003).	This approach tends to be based on extensive participant observation, it can be augmented by interviews and documentary analysis. Nurses who are referred to the NMC cannot be defined as a cohesive cultural group. Participant observation would require consent from all parties, due to the sensitive nature of participants stories this may be declined.	*Reject*
Phenomenology	The aim of phenomenology is analysing daily human behaviour can provide one with a greater understanding of nature (Moustakas, 1994: 26).	Realities are thus treated as pure 'phenomena' and the only absolute data from where to begin. Husserl (1859 – 1938), named his philosophical method 'phenomenology', the science of pure	This approach could enhance the understanding of the employer's lived experience of the preceding factors that lead up to a referral. However this may not provide a deeper understanding of the complex nature of external factors. Patton (2002: 89) highlights the meaning of phenomenology can be diluted through the absence of an in-depth understanding of what is required.	*Reject*

		'phenomena' (Eagleton, 1983: 55).		
Narrative	The experiences as expressed in lived and told stories of individuals. (Pinnegar and Daynes, 2006) A specific contextual focus. (Ollerenshaw and Creswell, 2012).	In a spoken or written text give an account of an event/action or series of events/actions, chronologically connected. (Czarniawska, 2004).	I may be challenged with collecting extensive information about a participant, and having a clear understanding of the context of the individual's life. This approach is a powerful method of data collection for situations which are sensitive in nature (Kumar, 2014) and maybe better suited for post-doctoral work to hear the registrant retelling their experience prior to a referral to the professional regulator.	*Reject*
Grounded Theory	Theory can emerge through memos and qualitative data analysis (Strauss and Corbin, 1990).	In grounded theory the researcher uses multiple stages to collect, refine, and categorize the data (Strauss and Corbin, 1990).	This approach provides explicit procedures for generating theory in research; it presents a strategy for doing the research that is flexible, systematic and co-ordinated; appropriate for areas of research where the subject is under-researched (Charmaz, 2006).	*Accept*

Since the original work scholars have challenged the epistemologies of both Glaser's and Strauss and Corbin's versions and aimed to move grounded theory into the next century, away from its positivist historical stance. Grounded theory has developed into a variety of approaches. This is no longer a single approach; several modifications of grounded theory have evolved over time (MacDonald, 2001; MacDonald and Schreiber, 2001; Wuest and Merritt-Gray, 2001). These adaptations of grounded theory have been developed depending on the researcher's ontological and epistemological beliefs (Strauss and Corbin, 1990; Glaser, 1992; Charmaz, 1995; 2000). However, Glaser and Strauss' original work has been used as a launching pad for their own iterations (Bowers and Schatzman, 2009; Charmaz, 2006; Clarke, 2005).

There are three main approaches to grounded theory, the Glaserian school; the Strauss and Corbin school, and the constructivist (Charmaz, 2006). After the original publication in 1967, Glaser and Strauss struggled to agree on how to apply grounded theory methods. This resulted in a division of Glaserian and Straussian paradigms. Strauss then connected with Juliette Corbin and published *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* in 1990. This was followed by the publication of Glaser's *Basics of Grounded theory* (1992). The key differences of grounded theory according to the Glaserian school were the constant comparative method emphasizing the emergence of theoretical categories from abstracts of time, place and people, as well as data from science, media or fiction. In contrast, Strauss and Corbin focused on codes, coding and categories, validation criteria and a systematic approach. Strauss and Corbin moved the method towards seeing grounded theory as a "method of verification", explained Charmaz (2014: 11).

A later version of grounded theory called constructivist grounded theory is rooted in pragmatism and relativist epistemology. "Viewing the research as constructed rather than discovered fosters researchers' reflexivity about their action and decisions" argues Charmaz (2014: 13). Pragmatism informed symbolic interactionism, a theoretical perspective that assumes society, reality, and self are constructed through interaction and thus rely on language and communication (Charmaz, 2014). Therefore constructivist grounded theory criteria demonstrated credibility and originality. Its connection to the worlds of lived experience, demonstrated its usefulness and its contribution to a better society (Charmaz, 2006).

3.2.2 Constructivist Grounded Theory

Constructivist grounded theory clearly adopts the inductive comparative, emergent and open-ended approach of Glaser and Strauss' (1967) original statement. It shares the set of grounded theory common characteristics (McCann and Clark, 2003), as flexible guidelines

and “not methodological rules” (Charmaz, 2006: 20), with the aim of developing a theory that resonates with participants. Following a period of reflection of Glaser and Strauss original grounded theory, there appears to be four distinct differences promoting the flexibility of the constructivist grounded theory approach that will be explored in this section. These are: researcher reflexivity; multiple realities; the subjective self; and co-construct with participants.

3.2.3 Researcher Reflexivity

Grounded theory is recognised methodology in nurse education (Parahoo, 2014) in order to systematically collect and analyse data to conceptually explain the phenomena of interest. It is important that grounded theory research is credible, whereby the researcher recognises, firstly that data does not stand alone, and secondly, an emergent analysis can take various forms which may or may not be dependent on what the researcher consider as credible data (Engward and Davis, 2015). The understanding of data maybe framed by the researcher’s presumptions which need to be explored through reflexivity. The use of Alvesson and Skolberg (2009) model of reflexivity in research can help to consider levels of reflexivity from a more critical perspective to strengthen the research process, especially to reflect on the findings in chapter 5. This model is based on gaining a critical perspective of the researcher’s position in the research, and the awareness of how their beliefs, values and previous experiences impact on the data, an important factor in qualitative methodologies. During the research project the researcher developed a greater sense of self-awareness and recognised the concepts of power, knowledge and subjectivity of participant’s experiences, which may have been influenced by the culture and constraints of the healthcare organisation.

Diagram 2 Wilkie (2015) Reflexive Thinking

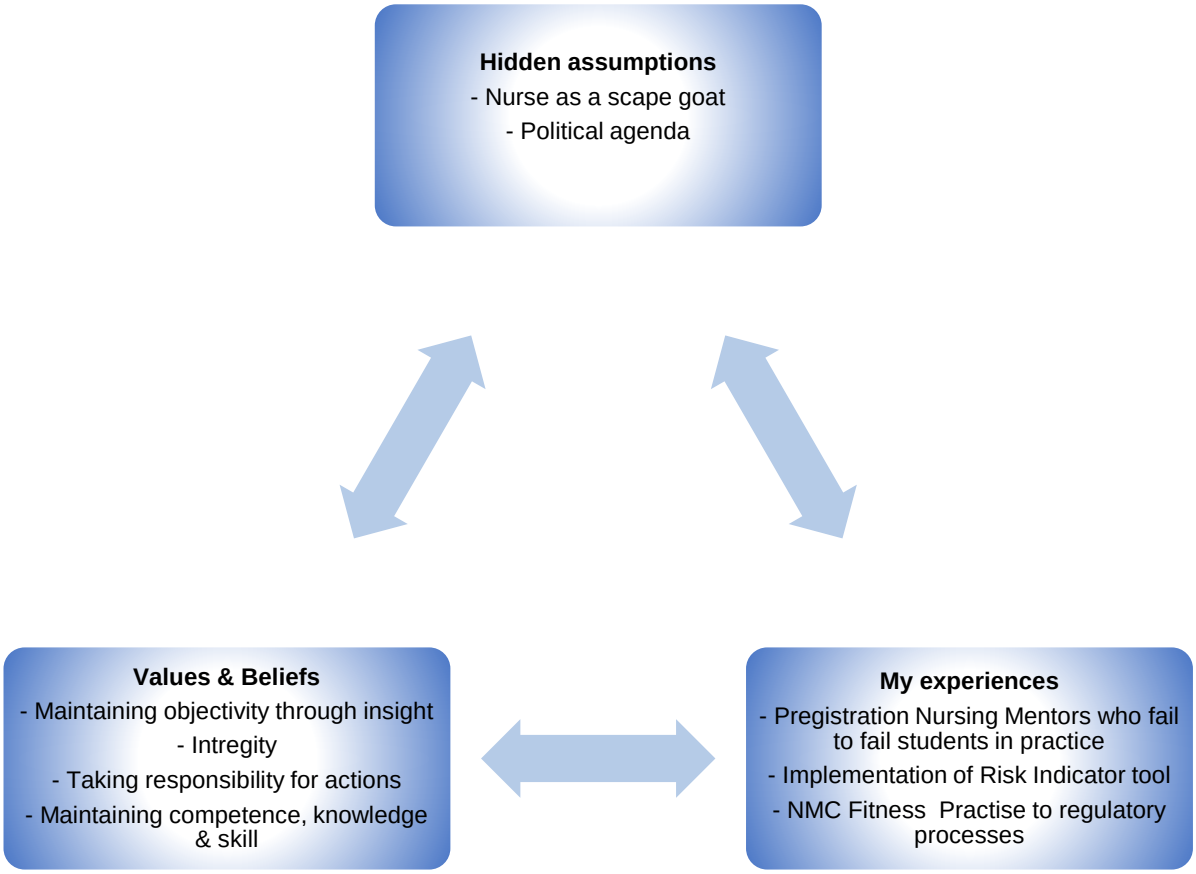
Constructivist grounded theorists locate themselves within the inquiry, whereas earlier grounded theorists ensured they remained “neutral observers” (Feldman, 1989). Diagram 3 highlights the interpretation of the participant’s response that may in fact be influenced by my experience, values and hidden assumptions. These can be teased out during the study’s ongoing reflexive process. Three key themes were addressed; firstly, my hidden assumptions about the employer, using the early career nurse as a ‘scape goat’ assuming they had been involved in an incident, rather than exploring the possibility of human factors playing a role in the event. Secondly, my experience of working in pre-registration nurse education with exposure to mentors in practice who “fail to fail” student nurses (Duffy and Hardicre, 2007). Thereby questioning if they are fit for practise post qualification. In response to pre-registration progression and early indicators of the struggling student I was involved in the development and implementation of a risk indicator checklist. This experience heightened my awareness of early career nurses referred to the Fitness to Practise Committee, whilst working as a registrant panel member. Finally, my own values and beliefs of sustaining longevity in a professional career as a registered nurse by acting with integrity and taking responsibility for my actions at all times.

To address these potential biases, Berger (2013) recommended three strategies to maintain the balance between my experience and that of the participant. Firstly, document any interpretations of what was said during the interviews, considering what this may mean and any thoughts about this, by using a reflexive diary. Berger (2013: 12) advocates reviewing the interview transcript a few weeks later after the original analysis, providing the opportunity to view the data through a “new lens”. Finally, Berger (2013: 12) discusses the importance of “peer consultation”, when supervisors or colleagues can offer advice or feedback on the interview transcript and data analysis.

3.2.4 Multiple Realities

Constructivism is a research paradigm that rejects the notion of an objective reality, “asserting instead that realities are social constructions of the mind” (Guba and Lincoln, 1989: 43). Constructivist grounded theory adopts the methodological strategies of pragmatism and relativist epistemology, but takes a reflexive approach and views research as occurring within specific social conditions, and thus attempts to learn how these conditions influence their study (Silverman, 2011). This study was based on the subjective, looking at human realities instead of concrete realities of objects. I acted as the research instrument embracing the ontological assumption of multiple truths that each participant understands reality in different ways, reflecting on individual perspectives.

Diagram 3 Key Themes from Ongoing Reflexive Process



3.2.5 Subjective-self

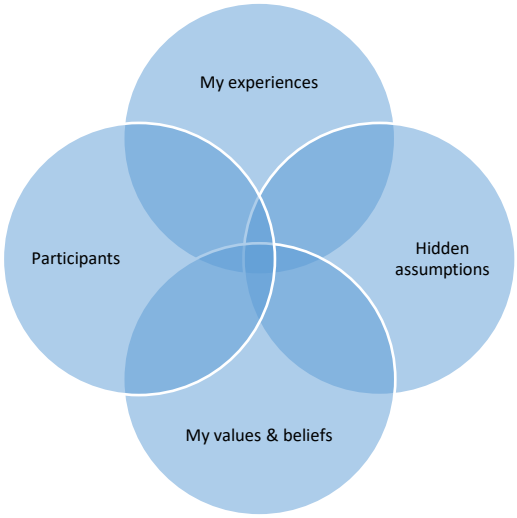
Qualitative researchers started to question their place in research texts (Denzin and Lincoln, 2005). Thus Strauss and Corbin, (1998: 97) argued that "we emphasize that it was not possible to be completely free of bias." It would appear Strauss and Corbin's work expressed a balance between post-positivism and constructivism, advocating terms such as recognizing bias and maintaining objectivity, in relation to the participants and the data, when describing the position of the researcher. Charmaz (2014: 13) argues that "researchers can use grounded theory strategies without endorsing mid–century assumptions of an objective external reality, a passive, neutral observer, or a detached, narrow empiricism."

Constructivism celebrates the researcher's multiple perspectives from their own personal subjective professional life, including the interactions with participants which are an integral part of the research process. Constructivist theory was influenced by the researcher's perspective, values, positions, interactions, and geographical location (Denzin and Lincoln, 2005). The research worked closely with the data and embraced data collection and analysis, drawing on my own professional experience and analytical ideas.

3.2.6 Co-construct with Participants

The constructivist grounded theory approach assumes that data and theories are neither emergent nor discovered but rather are 'constructed' by both the researcher and the research participants (Allen, 2010; Charmaz, 2006). As an epistemological stance, constructivism asserts that reality is constructed by individuals as they assign meaning to the world around them (Appleton and King, 2002). Diagram 4 represents my role in the construction and interpretation of the data, with the acknowledgement of my potential subjectivity. The interaction between the researcher and the participants is necessary in order to understand the meaning of the experiences shared during the research process (Charmaz, 2000; Lincoln and Guba, 1985). This is achieved from a constructivist perspective framing how the interviews are directed to aid theoretical usefulness and gathering data for theory construction.

Diagram 4 The Researcher's Role in the Construction and Interpretation of Data and Potential Subjectivity



Overall, these reflexivity strategies were apparent in my reflexive diary and aided the development of on-going mutual shaping between myself, as the researcher and the research. This involved my increasing awareness of the interactions between the participants and reflected my experiences of the researcher in the field.

3.2.7 Rationale for Choosing Constructivist Grounded Theory

Constructivist grounded theory was advocated by Charmaz (2003; 2006; 2014) as an alternative to Glaser's classical grounded theory (Glaser, 1978; 1992; 1998; 2004; 2013) and Straussian grounded theory (Strauss and Corbin, 1990, 1998). Charmaz (2003: 250) has

indicated that her constructivist version of grounded theory “takes a middle ground between postmodernism and positivism, and offers accessible methods for taking qualitative research into the 21st century”.

Constructivist grounded theory is distinctly different to the classic methodology (Breckenridge et al, 2012). Charmaz and Bryant (2007: 9) argue that “constructivist grounded theory offers researchers a sound epistemology and makes using grounded theory strategies accessible.” Charmaz (2006: 10) advocated grounded theory methods “as a set of principles and practices, not as prescriptions or packages.” I was drawn by Charmaz’s social constructivist perspective, which emphasises an interpretative, constructivist, qualitative methodological approach, to explore the complexity of referrals to the NMC from the perspective of the participant themselves.

The appeal of constructivist grounded theory research was that it facilitated an exploration of multiple meanings in situations, events and experiences. To use constructivist grounded theory methodology could aid the advancement of knowledge by using data that were created through an interactive process whereby the researcher and participant construct a shared reality (Mills et al, 2006). Breckenridge et al (2016) argue that constructivist grounded theory attempts to interpret how participants construct their realities and present multiple perspectives.

In my view, this was a flexible qualitative research approach, which facilitates the researcher and participant constructing a shared reality. Rather than look for one main concern, grounded theorists should seek to construct a “picture that draws from, reassembles, and renders subjects’ lives” (Charmaz, 2003: 270). This was best suited to my research question and the meaning participants assigned to the preceding factors which are framed within the context of their working lives.

Constructivist grounded theory was ultimately selected because it had the potential to produce a theory about the practical actions needed to identify issues and support nurses who are underperforming in order to reduce the chance of a referral to the NMC within the first five years of registration. The flexibility of the grounded theory method allowed the data to lead the way, through the theoretical sampling process. This resulted in gathering data from participants with experience of making a referral to the NMC from a particular field setting or in conjunction with data analysis.

The constant comparative methods approach chosen for data analysis was seen as the most appropriate method as it provided a structured framework and fitted well with the study aims

and objectives. Constructivist grounded theory emphasises keeping the researcher close to the study and grounded in the data. This is through using the participant's language or "vivo coding" in the process of data analysis (Chesney, 2001: 79), to ensure the findings are closely grounded in the data. This can be achieved by using the participants' own words to help formulate the title of the codes or categories. A constructivist grounded theory approach enhanced the possibilities to transform knowledge beyond the academic requirements and professional credits, to influence and change practice; a constructivist grounded theory in practice.

3.3 Research Methods in Grounded Theory

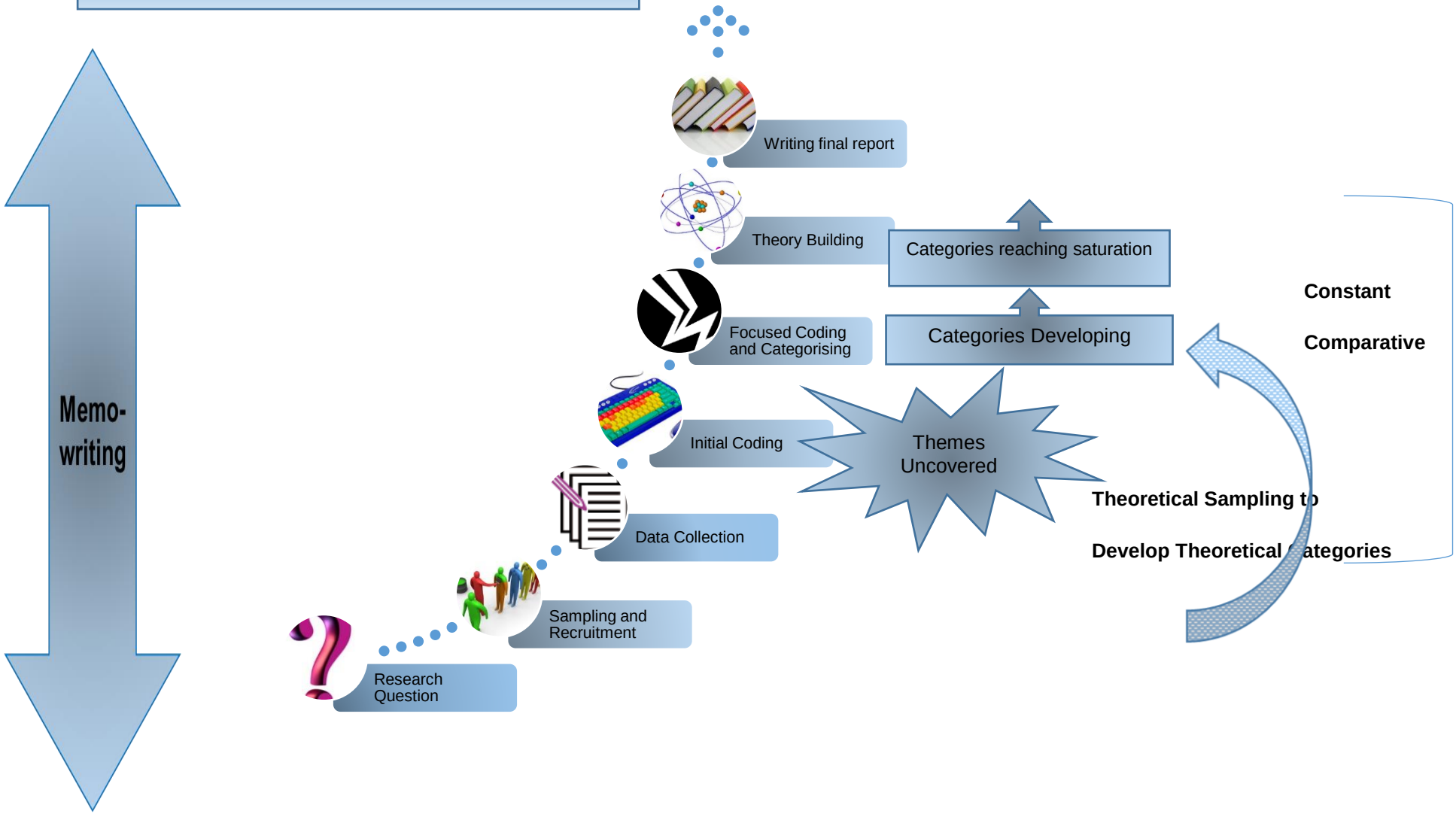
Glaser and Strauss offered research tools for analysing empirical data using a visible, comprehensive and replicable process which assisted the researchers to build theoretical frameworks that explained the collected empirical data (Glaser, 1978; 1992; Glaser and Strauss, 1967; Strauss, 1987; Strauss and Corbin, 1990; 1998)

3.3.1 An Introduction to Constructivist Grounded Methods

A constructivist grounded theory approach has provided an in-depth exposure to the field and the opportunity to explore employers' experience of a referral to the NMC, with developed theoretical ideas about this. During the research study, the rich data reflected the subtle interplay between data, concepts and theory development. The interactive method of constructivist grounded theory required me, as the researcher, to follow a set of salient characteristics of grounded theory research design, which involved a systematic process of data collection and analysis (Bryant and Charmaz, 2007), and it drew on my own experiences and ideas towards theory development.

Constructivist grounded theorists use a strategic yet flexible method as a process and the theory as a product of the process to answer their research question. The hallmarks of grounded theory method will now be discussed. These are sampling and recruitment strategy, conducting data collection and analysis, coding practice and initial coding, focused coding and categorising, memo-writing, theoretical sampling, theoretical saturation, constant comparative analysis, theoretical sorting, and theory building. This is represented in Diagram 5.

Diagram 5 A Visual Representation of Grounded Theory. This has been Adapted from Charmaz (2014: 18).



3.3.2 Sampling and Recruitment Strategy

The sampling strategy in qualitative studies is not directed by an attempt to produce generalised findings (Thompson, 1999). Palinkas et al (2015: 533) argue that “it’s depth not breadth” that matters. The sampling strategy must be driven by providing ‘information rich’ data to enhance the level understanding. Therefore exposure to individuals who have experience of the phenomenon was crucial (Patton, 2002). Palinkas et al (2015) advises that the recruitment of participants with the lived experience of the phenomenon can provide valuable information to address the study aims. Kemper et al (2003) recommends that the sampling strategy should provide the opportunity of depicting clear interpretations and conclusive meanings from the data.

A number of texts offer valuable discussions on sampling in qualitative research (Miles and Huberman, 1994; Wengraf, 2001; Mason, 2002; Silverman, 2005). However, in grounded theory research, a variation of sampling and recruitment strategies were highlighted prior to theoretical sampling (Sbaraini et al, 2011). Grounded theory projects are fundamentally characterised by theoretical sampling. The starting point for this project required purposive sampling, followed by theoretical sampling and snowballing as the project got underway. This section will focus on the sampling and recruitment strategies adopted for a sample population of potentially hard to reach elite professional participants. The methodological challenges will also be discussed.

3.3.3 Sampling Strategy

This project recruited an initial, small purposive sample and then sought further participants, in line with Creswell’s (2009) recommendations, that the sample size guidelines range from 15-20 participants for grounded theory research. The inclusion criteria for this study was NHS and independent health-care employers from the different regions in England, who employ registered nurses and have been involved in making an early career (within the first five years of registration) referral to the NMC Fitness to Practise Committee that was concluded between 2010 - 2013. The rationale to recruit employers from England was to represent the fact that the majority of referrals to the NMC come from the nurses’ in England. Therefore employers include, but were not limited to:

- Human Resources Department Managers;
- Directors of Nursing;
- Senior Nurses (Matron);
- Ward/Unit Managers;

- Education leads for the organisation;
- Key Stakeholders.

3.3.4 Sampling Process

Information about nurses referred to the NMC for an allegation of impaired fitness to practise, who are subject to an interim conditions of practice order or received an outcome from the Conduct and Competence Committee information is in the public domain. This information includes: the nurse; referrer; allegations; and the outcome of the case. The first step of the sampling process required examining the NMC Fitness to Practise website page. On the website there is a list of the cases heard at the NMC during each calendar month. This list displays the nurse's PIN number; the first digits refer to the date the nurse entered onto the NMC register, the letter at the end of the PIN refers to where the nurse completed their pre-registration nursing programme. For example E = England, S = Scotland, O = Overseas.

After establishing the nurses who had qualified within the first five years of registration, over the time scale of 3 months I looked at the hearing transcript. These explained who referred the nurse to the NMC, this was more likely to be their employer. All this information is available on the NMC Fitness to Practise website.

A preliminary search identified approximately 28 potential employers from the cases on the NMC website, who met the inclusion criteria. During the search on the NMC Fitness to Practise website the cases that were excluded, these included participants who had referred overseas nurses and nurses outside England. Table 13 illustrates the inclusion and exclusion criteria approved by the Ethics Committee (Appendix 2, 3 and 4).

After identifying who had referred the nurse, the next step was to retrieve the employer's contact details from the organisation's website. The most appropriate and relevant person was the Director of Nursing / Chief Nurse, because they will be directly involved or aware of fitness to practise referrals within their organisation and more likely to be in correspondence with the NMC.

Table 13 Inclusion and Exclusion Criteria

Inclusion	Exclusion
NHS and independent health-care employers who employ registered nurses and have been involved in making an early career referral to the NMC Fitness to Practise Committee.	The exclusion criterion includes employers who have not been involved in a referral to the NMC.
Four fields of nursing practice	Midwifery registrant referrals.
NHS and independent health care employers from the different regions in England.	Participants outside of England.
UK trained registrants.	International / overseas registrants.

3.3.5 Methodological Sampling and Recruitment Challenges

One segment of the sample population that met the inclusion criteria were the employers, who were the Chief Nurses / Directors of Nursing. Wejnert and Heckathorn (2008) discussed the existence of a “hard to reach” population as having no sampling frame, so the size and boundaries are unknown. Directors of Nursing by the nature of their elite status are fewer in number yet are frequently in positions of power, knowledge and influence, with considerable authority. Learmonth (2009) concluded that strategic and operational developments and changes that are features of everyday practice, are guided by elites.

It became apparent that this group of elite professional participants were willing to engage in this research project, however due to a wide range of job titles across England this group was hard to identify and therefore difficult to contact. The job titles ranged from Chief Nurse, Director of Nursing or Patient Safety and Quality Nurse.

Atkinson and Flint (2001) advised that hard to reach populations may not wish to be found or contacted. In this study the information required to aid recruitment was not freely available in the public domain via the health-care organisations’ website, even though the individuals were in an elite position of power and authority. Shaghaghi et al (2011) highlights in table 14 below people who are categorised as hard to reach, especially the first category of those who are under social pressure from the wider community.

Table 14 People who are Sometimes Categorized as being Hard-to-reach

People who are sometimes categorized as being hard-to-reach or hidden (Shaghaghi et al, 2011):
Those being under social pressure of the broader community
Those living in faith based communities
Those who fear confrontation with legal authorities
Illiterates
Those who have no interest to be found or contacted
Migrants
Newly arrived residents
Over-researched people
Those living in remote physical and geographical locations
Those living in vulnerable social and economic situations

There are a range of methodological challenges when developing a recruitment strategy. One of the challenges considered was the lack of information available from existing studies about their methodological dilemmas and how to overcome these challenges. Textbooks that concentrate solely on qualitative research devote little attention to the procedures or problems entailed. Sampling techniques and the actual practice of recruitment are not often discussed together in many discussions of qualitative research (Kelly, 2010). These considerations remain vital for those studying hard to reach populations and makes the issue of sampling critical.

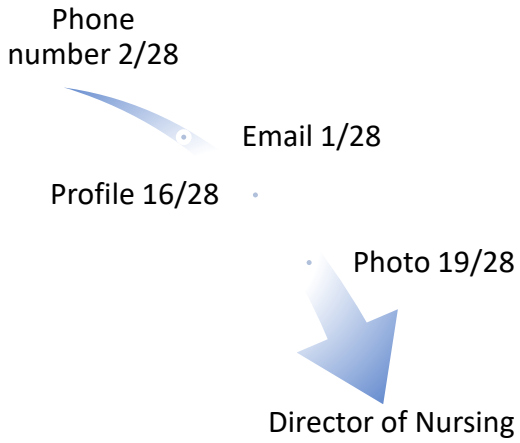
To narrow the search, it was identified that the Director of Nursing tended to be a member of the healthcare organisation's Executive Board. However, even with this degree of seniority within the organisation, it remained a significant challenge to retrieve their contact details. The main barrier was that the majority of the organisations' websites were multi-layered. It proved difficult because the search engine required the correct role title to narrow the search on the organisation's website. This required several entry attempts to identify the correct job title for that organisation.

When the person's name of the Director of Nursing was retrieved from the website, their contact details proved to be difficult to obtain. The information about the Director of Nursing was varied, ranging from an extensive profile, photo, email and telephone number, to a brief

profile and photo only. Diagram 6 illustrates how inaccessible the Director of Nursing were to the general public, only one of the 28 Director of Nursing email was available on the website.

Note: The initial search on the NMC website found 28 health care organisations who employed registered nurses and had referred an early career nurse to the NMC Fitness to Practise Committee.

Diagram 6: Accessibility of Director of Nursing Contact Detail via Organisations Website



3.3.6 Recruitment Strategy

Following the identification of employers on the website, a range of recruitment methods was used to select the sample population. These included:

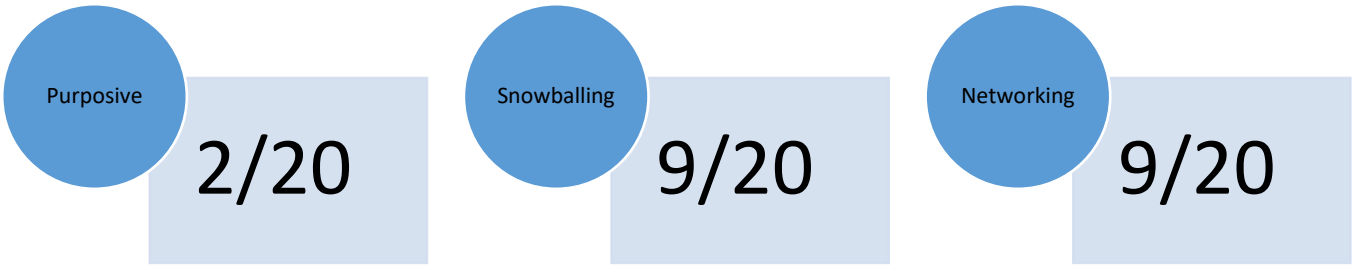
- A letter to the Director of Nursing (the employer) who had referred a registered nurse to the NMC identified from the initial search of the NMC website;
- Contacting colleagues in various regions in England, who might help facilitate the recruitment process;
- A snowball technique. A recruiting technique that was used in this study, where an employer meets the criteria for inclusion in this study and was contacted by another person or participant who was aware of the study and has made a referral to the NMC. Colleagues were contacted in various regions who supported the recruitment process.

3.3.7 Recruitment Process

In total, 20 participants were recruited to this study and theoretical sampling continued throughout data collection. Initially 7 letters were sent to potential participants who met the inclusion criteria whose information was retrieved from the NMC website search. This yielded two responses.

Networking and snowballing strategies were used to recruit further participants to the research study following the successful recruitment of the initial purposive sampling of two participants. Diagram 7 below illustrates how the participants were recruited.

Diagram 7: Recruitment strategy



The essential feature of theoretical sampling is that the researcher does not know, in advance, who to interview (Parahoo, 2014). As the data were analysed, the emerging themes guided the recruitment of participants with experience of making a referral to the NMC. It was important to obtain a sample of participants that reflected the different fields of practice experiences and organisational perspectives of making a referral to the NMC, to prevent the study being represented by only one organisation. Parahoo (2014) argues that the researcher chooses those who have different characteristics and different contributions. Diagram 8 demonstrates the breadth of the participants' fields of practice who were recruited to the study.

One of the emerging themes from the data collected at the beginning of the study was the context of staffing and the lack of remorse following an incident or error in practice. It became important to follow up these concepts by recruiting staff from Human Resource Departments, who play an integral role is dealing with the issues of managing people in the organisation prior to a referral to the NMC. Theoretical sampling and subsequent recruitment strategy lead to the representation of a breadth of professional experience ranging from Director of Nursing to Ward Manager to key stakeholders. Diagram 9 illustrates the participants who were recruited and their role within their organisation.

Diagram 8 Summary of Participant Field of Practice

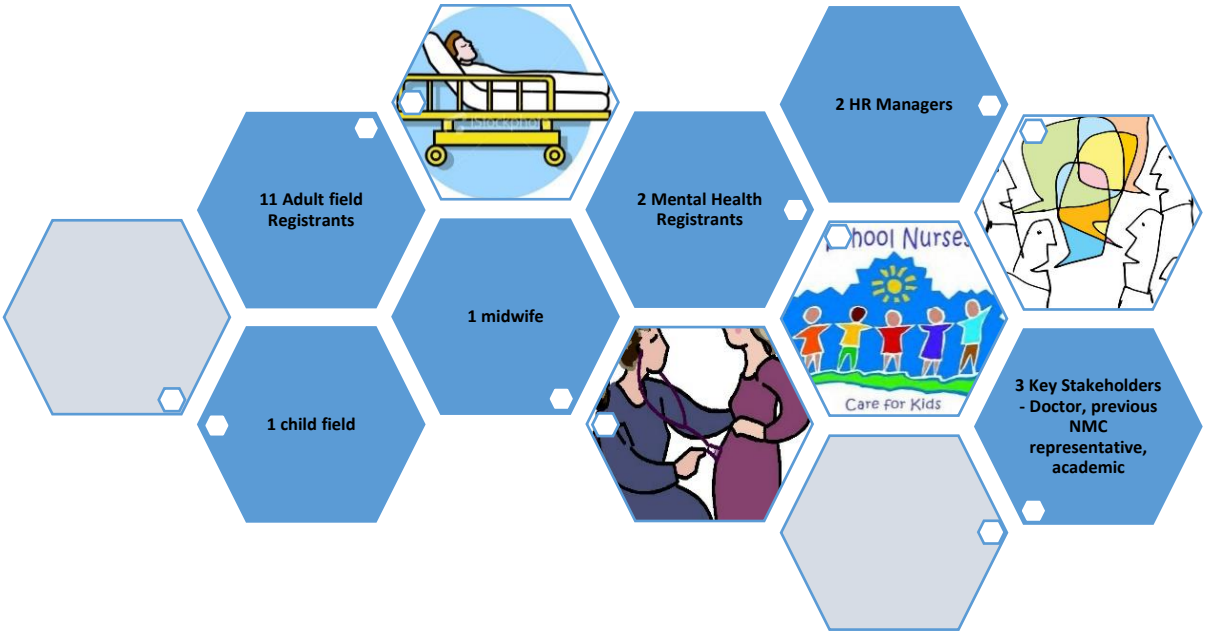


Diagram 9 Participants' Job Role within the Healthcare Organisation

Participants were recruited from 17 different healthcare organisations in both inner city and rural locations in England, from a range of the fields of practice. The majority of participants (n=17) were employed by the NHS and three worked in education or the private sector. This provided the opportunity to explore individual experiences of making a referral to the NMC. The sample population was recruited from four regions across England and is represented in table 15 below.

Table 15: Participants Recruited from Different Regions in England

Region	Numbers of Participants
London	5
West Midlands	13
South East	1
North West	1

3.3.8 Implementing the Snowball and Networking Techniques

Though the challenges are not often discussed extensively, sampling and recruitment considerations remain important for those doing qualitative research. Shedlin et al (2009) recommends sensitive, flexible and innovative recruitment methods that build on the genuine nature of the research to develop a trusting relationship, which assured contact with the researcher will be confidential and safe for potential participants.

This study used a variety of recruitment approaches to access elite professional participants that were hard to reach. The strategies for sampling hard to reach populations which appeared frequently in the literature, include network sampling or snowball sampling. This was achieved by the researcher actively asking participants if colleagues who met the inclusion criteria would be interested in taking part in the study. This study relied on a successful snowballing technique of Senior Nursing colleagues who reassured their colleagues in the nursing community of the genuine and confidential nature of this study. This approach made theoretical sampling difficult, yet there were opportunities to recruit participants to help focus on a specific theme generated by the data. For example, the recruitment of the Preceptorship Lead explored experiences of supporting a newly qualified nurse with perceived wanted and unwanted characteristics. Strauss (1987: 276) advocated that examination of concepts from various angles can take place in order to question their meaning, for the developing theory to emerge.

Faugier and Sargaent (1997) state that snowball sampling has the potential of producing a rapidly growing data-base for the researcher. Snow-balling techniques are frequently used to

conduct qualitative research, mainly through interviews (Atkinson and Flint, 2001; Daniulaityte, 2012), and is often also known as “chain-referrals” (Bonevski, 2014). This sampling method falls into the category of “a wider set of link tracing methods that exploit the social networks of identified respondents to give the researcher an expanding list of potential contacts” illustrated by Atkinson and Flint (2001: 33). Ashing-Giwa et al (2012) and Martin et al (2011) suggest that the confidence that develops between the researcher and the participant is the best guarantee of sincerity and should enhance the validity of the data. These snowballing and networking strategies were adopted following ethical approval during the interviews and when attending nursing conferences.

3.4 Conducting Data Collection and Analysis

Interviews are effective in obtaining narrative data that allows researchers to explore participant's experiences in greater depth (Kvale, 2007). Cohen et al (2007: 29) highlight the benefits of interviewing as “a valuable method for exploring the construction and negotiation of meanings in a natural setting”. Interviewing has been advocated as a fundamental element in qualitative research design (Weiss, 1994). Alshenqeeti (2014) explores the advantages of interactive interviews, with the ability to probe for clear answers and investigate into emerging themes. Ultimately, interviewing can broaden the scope of understanding into the lived experience of the participants through an “extendable conversation” (Schostak, 2006: 54).

In this study the first purposively selected interview was initially coded and themes uncovered, before more data were collected. Theoretical sampling informed further data collection and an on-going analysis process, where more data were yielded, codes were formed and categories developed, until no new categories emerged. It was this process that differentiated grounded theory from other types of research design (Birks and Mills, 2013). Constructivist grounded theory research is a dynamic and systematic process. While comparing the data I was constantly modifying and sharpening the developing theory (Glaser, 2004).

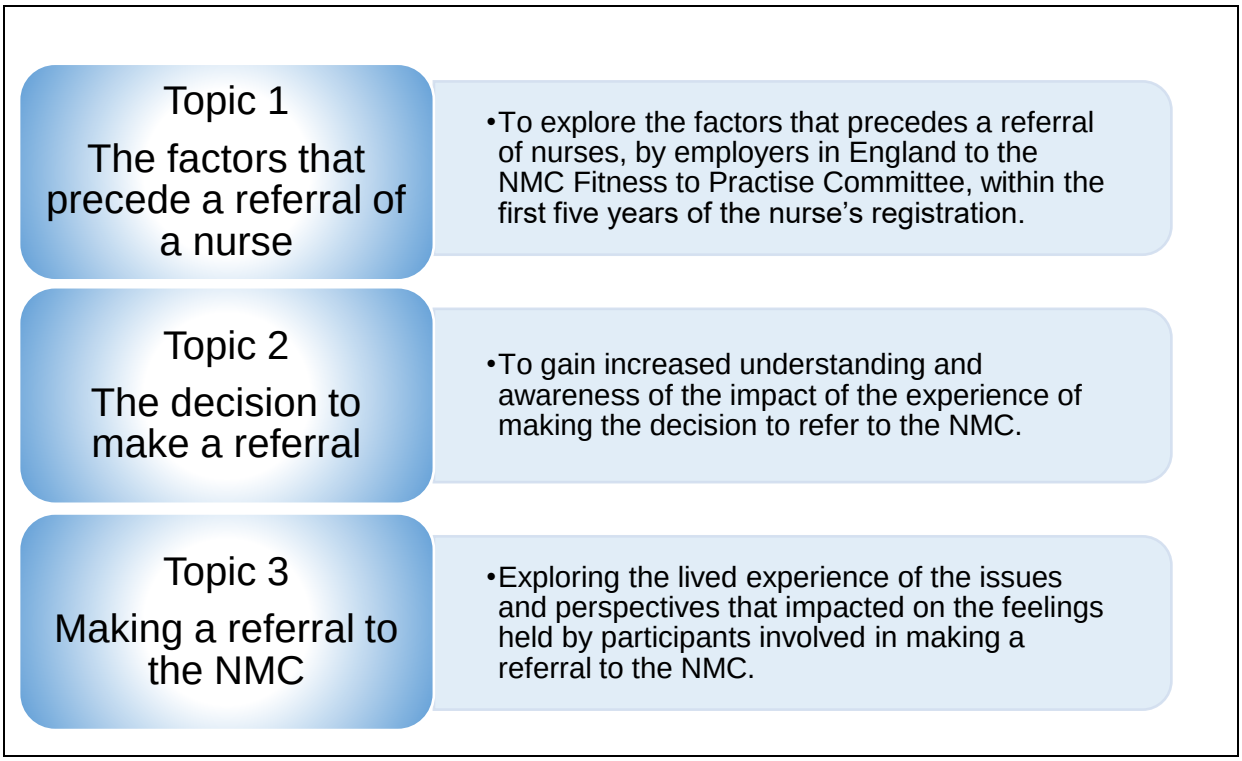
3.4.1 Interviews

Grounded theorists have the opportunity to gather data from participants to help illuminate and explore specific topics. Interviewing is a commonly used method to gain an in-depth account of the participants’ lived experience used in social research (Bell, 1987; Kvale, 2007, 1996; Berg, 2007). The interview is a flexible and adaptable way of finding things out (Robson, 2002). “During the interview, the participant talks; the interviewer encourages, listens and learns”

(Charmaz, 2006: 57). Gadamer (1989) upholds the superiority of the spoken word over the written, asserting that language is the channel through which significant understanding and agreement occurs between two people. Therefore, understanding happens through a process of a conversation. Notwithstanding, Parahoo (2014) states that the purpose is collecting valid and reliable data to answer particular research questions. This is highlighted in diagram 10 below which explains the rationale for the interview topics.

Semi-structured interviewing can provide a more flexible focus as "it allows depth to be achieved by providing the opportunity on the part of the interviewer to probe and expand the interviewee's responses" (Rubin and Rubin, 2005: 88). Flick (2011) states that there is room for deviation from the interview schedule to allow for the exploration of particular topics. Therefore, the researcher can "follow up interesting developments and to let the interviewee elaborate on various issues" (Dörnyei, 2007: 136). In this study, the researcher aimed to encourage participants to expose their personal experience of early careers nurse's performance and conduct whose fitness to practise had been questioned. At times this revealed the organisation's policies and practices, by using direct, probing and sometimes challenging questions.

Diagram 10 Rationale for Interview Topics



3.4.2 Interview Schedule

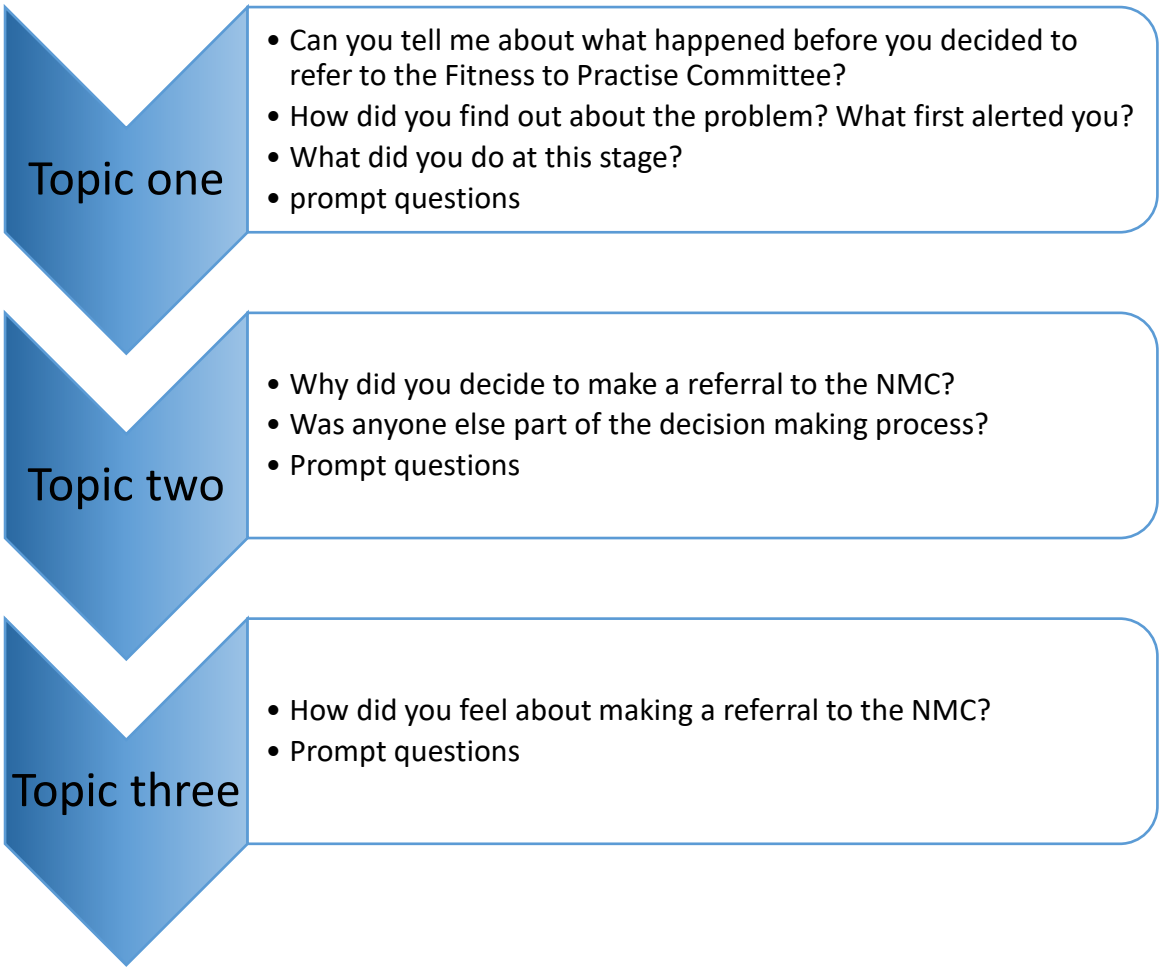
An interview schedule guide was used to address issues and develop theoretical questions. This helped to explore the emerging categories and concepts identified from the constant comparison process. The interview guide outlined the key principles of an introduction and the aim of the interview, including ethical approval, confidentiality, signing the consent form and sharing the participant's information sheet.

The interview was divided into three topics to follow a logical sequence – firstly, the factors that precede a referral of a nurse, secondly, the decision to make a referral and finally, making a referral to the NMC. The rationale to use a structure embracing the three themes is illustrated in diagram 10. A series of clear and easy to understand questions were asked. The participants were encouraged to reply freely, with no set answers, leading to the dynamics of an interview situation as unique and creating an open environment to discuss their experiences. Therefore, their understanding and stake in the interview all figure in the quality and usefulness of its content (Charmaz, 2006). Each topic had a series of prompt questions to help illustrate or clarify certain points, especially if the participant was reflecting on a specific fitness to practise case they had been previously involved with. Cresswell (2007) highlights that the researcher must be prepared with follow-up questions or prompts in order to ensure that they obtain optimal responses from participants.

3.4.3 Interview Questions

A great deal of consideration was placed on the types of questions asked during the interviews. The final decisions were teased out during the pilot interview. The majority of participants had a senior role in the organisation and therefore the time allocated for the interview was valuable. It was important to generate relevant and useful data to help formulate themes and concepts through the constant comparison method. Diagram 11 highlights the structure of the interview with three sections and the questions under each topic.

Diagram 11: Three Topics and the Interview Questions



3.4.4 Pilot Interview

The pilot test assists the researcher in determining if there are flaws, limitations, or other weaknesses within the interview design and allows them to make necessary revisions prior to the implementation of the study (Kvale, 2007). A pilot interview was conducted with a participant with a similar interest of pre-registration fitness to practise. The pilot interview lasted 48 minutes and assisted in refining the interview guide, alongside confirming its feasibility and usefulness as a research instrument (Creswell, 2009). Following the pilot interview it was identified that the interview would be split into three sections, this decision helped enhance the momentum and logical' flow of the interview. Following the pilot interview, the initial questions remained unchanged, only the structure changed. The eight principles highlighted by McNamara (2009) were applied during the pilot interview and subsequent interviews, illustrated in table 16.

Table 16 McNamara (2009) Eight Principles for Interview Preparation

McNamara (2009) Eight principles for interview preparation	Implementation strategy
Choose a setting with little distraction.	The majority of interviews were conducted in the participant's office or a quiet area.
Explain the purpose of the interview.	Interview schedule and participant's information sheet.
Address terms of confidentiality.	Interview schedule and participant's information sheet. All transcripts were securely stored and password protected.
Explain the format of the interview.	Interview schedule and participant's information sheet.
Indicate how long the interview usually takes.	Interview schedule and participant's information sheet.
Tell the participant how to get in touch with you later if they want to.	Interview schedule and participant's information sheet.
Ask the participant if they have any questions before you both get started with the interview.	Interview schedule and participant's information sheet. Field notes recorded any questions and answers.
Don't count on your memory to recall their answers.	All interviews were recorded.

3.4.5 Interviewing

Dörnyei (2007: 140) recommended two key features when undertaking qualitative interviews, firstly that the interview flows naturally, and secondly that it is rich in detail. Richards' (2003) advises that the researcher establishes an appropriate atmosphere to ensure the participants feel at ease and thus talk freely. In this study, the majority of interviews the participants actively engaged and shared their experiences. One of the participants appeared reluctant to disclose information at first but half-way through the interview they appeared more relaxed and openly expressed their opinion. Interestingly, the topic they spoke freely about was the characteristics and values wanted and unwanted in nurses. This suggests people can be reluctant to share and disclose their experiences, due to the fear of repercussions, of what may be perceived as a biased opinion.

The majority of the interviews (17 out of 20) were conducted face to face with the advantage of observing human behaviour and non-verbal cues. Non-verbal communication cues assisted in understanding the verbal response. In particular, one participant explained her extremely stressful week of external inspection visits resulting in allegations of misconduct against her staff. To gain this level of insight into the participant's world demands alternative social interactions to take place in comparison to every day conversations.

Each interview lasted approximately one hour (from 37 minutes to 1 hour 12 minutes). Robson (2002) argues that anything under half an hour was not valuable; anything going much over an hour may be making unreasonable demands on busy interviewee's. The breadth of understanding explored during the interviews transformed the research study and clearly focused on constructivist grounded theory criteria. This demonstrated the study's connection to the worlds of lived experience of the participants. The interview questions were slightly amended to accommodate theoretical sampling to explore ideas from the initial data analysis process. The interview process worked in collaboration with the characteristics of the constructivist grounded theory method illustrated in diagram 12. The interview techniques intertwined with constructivist grounded theory methods: initial coding; theoretical sampling, leading to theoretical focused coding and categorising; memoing and constant comparative methods; then towards the final destination of theoretical saturation and the move to theory building.

3.4.6 Field notes

Field notes were taken during the interviews, this often captured the participant's reluctance to explore their experiences, the use of probing and asking direct questions prompted their thoughts and yielded valuable data. Yanos and Hopper (2008) acknowledge that researchers and participants can both default to pre-emptive disclosure, one that sidesteps uncomfortable issues. Semi-structured interviews are useful in asking the question – what is happening in the interview? Charmaz (2014: 80) points out that "such interviews offer important leads about silences, forbidden topics and vulnerabilities". The field notes reflected during one of the interviews the participant's vulnerability was evident by the burden of responsibility to protect the public. This was displayed throughout the conversation and nonverbal cues. Barbour and Schostak (2005: 42-43) identify two key concepts of value and trust, this refers to the value of the interview itself, and the value of the participants' words. Ultimately, this level of trust during the interview can help with the research guarantees of objectivity, accuracy, and honesty.

3.5 Coding Practice

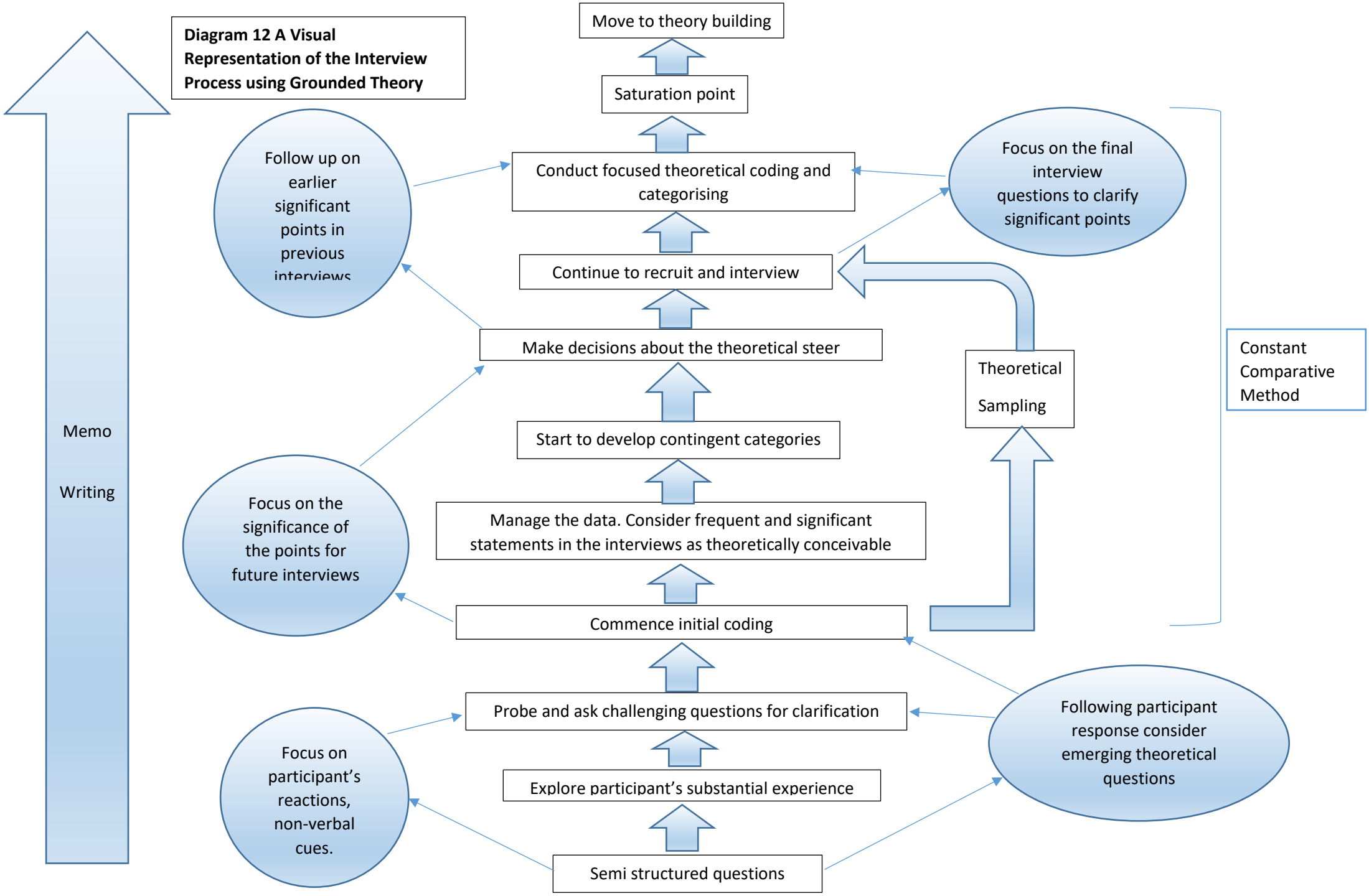
3.5.1 Initial Line by Line Coding

Strauss and Corbin (2008) refer to the process of analysing data as coding. The first fundamental analytic phase of the research project consisted of initial coding. This involved the analysis of data starting with the first interviews and the beginning of identification of the fundamental concepts. Originally, Glaser and Strauss (1967) refer to this phase as “open coding”. In this study, a comparison of the first two interviews yielded basic codes and some initial categories in their infancy. This initial coding process was used to fracture the data (Glaser and Strauss, 1967), coding the data line by line, word by word (Glaser, 1978), illustrated in extract from interview with participant 1. However, line by line coding can be a discretionary process and can produce a “helter skelter” (Glaser, 1992: 40) approach of over-conceptualised incidents that generates too many codes. Yet “line-by-line” coding helps you to see the familiar in new light” (Charmaz, 2014: 38). Incident by incident coding assisted with the discovery of patterns and themes in the data. This was the starting point of the constant comparison method of looking back and forward at the two transcripts to identify emerging codes and themes. Charmaz (2014) recommends that careful initial coding prevents the researcher from inputting their own motives, fears, and assumptions.

This initial coding phase yielded extensive codes yet a pause in data collection assisted with a period of reflection, as illustrated in the image 1. This process assisted with the decisions of what kinds of data were needed next. Theoretical sampling commenced after reviewing the two interviews a few weeks later and a discussion with the supervisory team.

Image 1 to Represent a Period of Reflection

Diagram 12 A Visual Representation of the Interview Process using Grounded Theory



Extract from Interview with Participant 1

So her insight was completely non-existent. As a result of that she was only going to be unsafe doing a drug round but unsafe because she wasn't able to recognise the conditions of a deteriorating patient and all the other things that go on. With that she argued and they argued it was unfair.

And so in order to make it, and my responsibility as much as to get her to acknowledge her lack of competence to herself, so rather that dismiss her there and then I actually stopped the hearing.

And I spoke very frankly to her about her of understanding was a concern to me and that I wanted her to do one last drug round and she can choice the assessor, she chose the ward she chose everything. On the understanding that if she failed that would need to acknowledge she was lacking competence to complete a drug round. This was quite effective because she failed. And she was very clear at that point that if she failed again then the next step would be for me to refer her to the NMC. So for me the major impact for me was the lack of insight to the code so I think the issues for me was it not just being that she couldn't do a drug round and by omitting something that was also part of the code that her actions could have put someone in danger. To be honest, for the people I refer the people that I see as part of the disciplinary process a lack of general understanding of the code and the implications of the code, so when I chair a disciplinary I have the code in front of me. And I have the various sections highlighted, and my questioning is in relation to the code and the incident.

Initial coding

- Lack of insight
- Inability to practise safely
- Medication error
- RN lack of knowledge, competence and skill
- RN lack of responsibility
- Compromised patient safety
- Internal processes and support mechanisms
- Fair employer
- Managing risk of repetition
- Breach of the Code, UK standards, law
- Lack of understanding of the code
- RN Lack of awareness - Employers responsibility to ensure RN recognises their inability to practice safely
- Lack of competence
- Internal processes and support mechanisms
- RN engagement with support
- Lack of insight
- Medication error
- Breach of code
- Compromised patient safety
- Public protection
- Lack of understanding of the code
- Internal processes
- Employer responsibility to protect the public
- The Code
- The situation

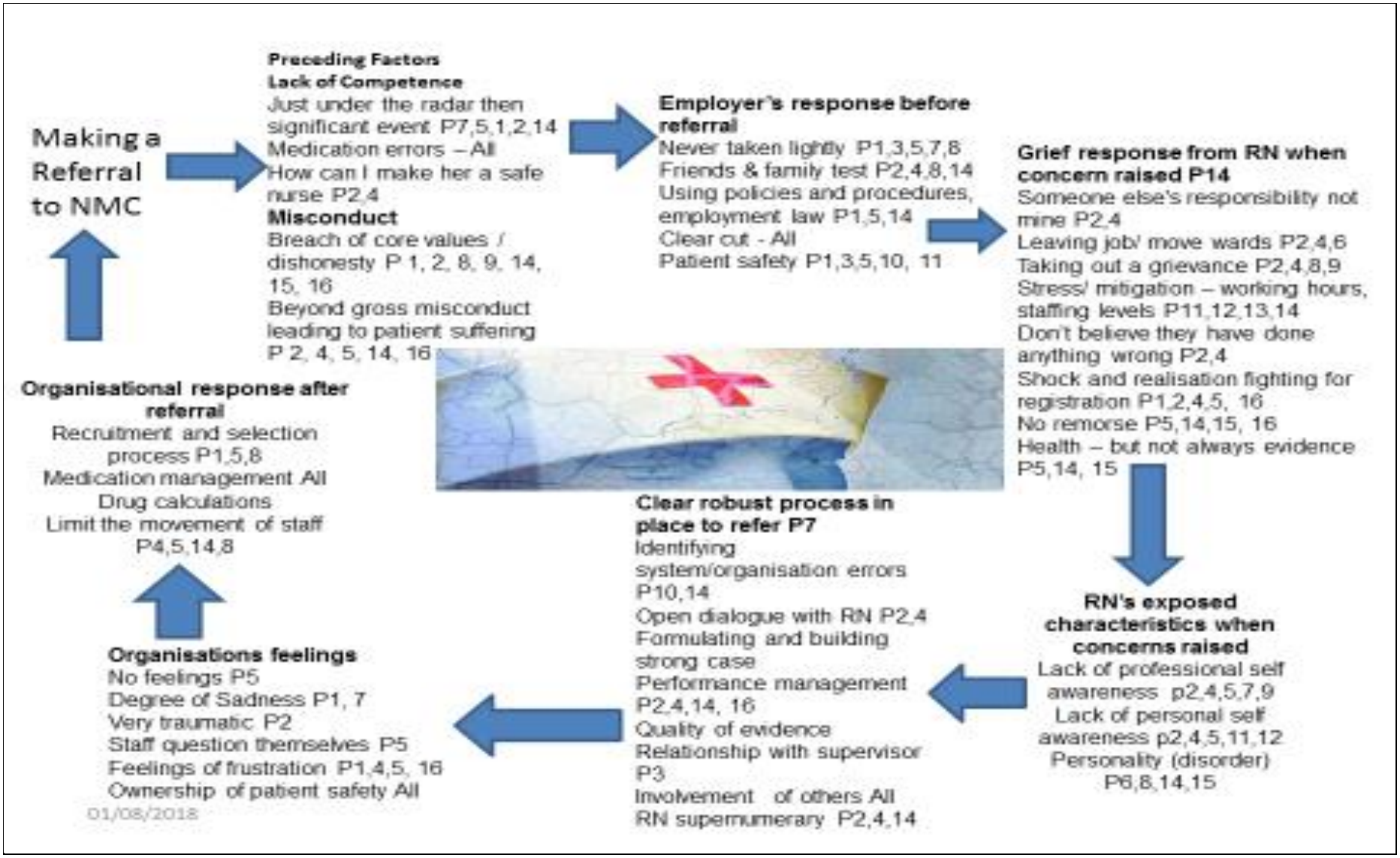
The interviews were read and re-read, the recordings listened to, and this helped gain insight and understanding into the participants' experiences. Initially, NVIVO 10 was used but due to the lack of skills of the researcher, NVIVO was not useful and thereby abandoned. The volume of data generated by the transcripts meant that some NVIVO functions were not intuitive and therefore took considerable time to learn by reading the manual or by viewing the online tutorials. Thus, a decision to use traditional analytical techniques was adopted, using colour codes on a word document, illustrated by an extract one from an interview with participant one. This also involved manually cutting out key sentences and placing them into labelled envelopes.

The key concepts were put into themes and documented onto large sheets of paper, to gain a fuller picture of the participants lived experience. This was an overwhelming, time-consuming process, but it focused my thoughts and provoked ideas about the types of cases and the participant's experiences of referring to the NMC for misconduct and lack of competence, that could have been missed when reading the data for a general thematic analysis. It also facilitated discussion with the supervisory team constituting to form 'peer review' (Lincoln and Guba, 1989). Diagram 13 represents the initial coding and fracturing of the data to explore the concept of why employers refer within the first five years of registration. This process helped with theoretical sampling.

3.5.2 Constant Comparative Analysis

Kolb (2012) explained the four stages of the constant comparative method. Firstly the researcher continually collects rich data until the point of saturation. Secondly the data are analysed, and thirdly codes are generated from the data by comparing incidents, followed by the emerging categories. The fourth stage was reinforcing theory generation through the process of theoretical sampling. Glaser and Strauss (1967) state the benefits of using this method are that research begins with raw data, then through constant comparisons, a substantive theory will emerge.

Diagram 13 Representing the Initial Codes Generated from Fracturing the Data



Kolb (2012: 83) acknowledges that “Grounded Theory is a labour-intensive task that requires the researcher to invest time in the processes of analysis and data collection”. Strauss and Corbin (1998) discuss that the art of comparison has to do with creative processes and with the interplay between data and researcher when gathering and analysing data. Ultimately the researcher develops concepts from the data by coding and analysing at the same time (Taylor and Bogdan, 1998). I made decisions on what data to gather from the participants’ based on the interpretation of phenomena and theoretical questions being asked of the previous data collected.

The interviews became richer with information as analysis occurred concurrently with data gathering (Chenitz and Swanson, 1986), and theoretical sampling. Morse and Field (1998) state that each piece of data must be compared with every other piece of relevant data. This enabled the discovery and assignment of segments of data to form categories, in a way that assisted me to efficiently and effectively answer the questions, helping the comparative process to progress. Boeije (2002) advocates the cycle of comparison and reflection on ‘old’ and ‘new’ material can be repeated several times. The data were then compared again as more data is yielded, until the categories analysed become saturated. It is only when there are no new themes emerging from the data that the category is described as saturated. The constant comparative of the data sharpens the developing theory.

3.5.3 Memo-Writing

Memo-writing was the intermediate and strategic step between coding and the first draft of the completed study. Memoing was the accumulation of memos that served to assist in making “conceptual leaps from raw data to those abstractions that explained research phenomena in the context in which it is examined” (Birks and Mills, 2013: 40). Glaser (2013) states that memos are the media which tie together the concepts for a grounded theory study. Therefore, memos consolidated thinking as the research advanced and formed into the developing categories. Segments of memos were represented in the categories to reflect my analytical thoughts and enhance the findings, illustrated below.

Glaser (2013) recalls that memoing is just one of many procedures discovered but deemed as the least pronounced grounded theory procedure. Memo writing is adaptable, yet a vital research component that enables analytical thoughts, conception development, and provides an audit trail of the developing theory, by tracking the natural progression of the study. Fundamentally, memos contribute substantially to the grounded theory process (Groenewald, 2008).

3.5.4 The Focus on Significant Points and Theoretical Sampling

Line-by-line coding has its advantages in helping to recall the stories being told by participants during the interview. This helped to gain a close insight into their implicit concerns as well as explicit statements about an early career nurse who had been referred to the NMC. One of the initial line-by-line codes revealed the lack of insight and 'disconnection' by a nurse following an error or incident in practice.

Studying the data through line-by-line coding did lead to new ideas being explored. My existing understanding guided the theoretical decision-making process regarding these new concepts, which especially aided theoretical sampling. After four interviews I decided to focus on recruiting a participant from Human Resources and a Ward Manager. Furthermore, the revision of my interview guide focused on insight, characteristics, remorse and team working. I was mindful of my thoughts remaining open to the opportunity of a different theoretical steer, which was pointed out by Charmaz (2014; 15), who advised researchers "to remain open to the possible theoretical directions".

3.5.5 Move to Focused Coding

The move to comparing data with data became more evident, this helped to focus on analytical questions being asked of the data, as well as identifying gaps in the data alongside what subsequent data is required next (Charmaz, 2014). The initial coding phase is the beginning of the fundamental concepts, writing memos and field notes. This phase assisted in helping to explore ideas about the codes and tentative emerging sub-categories and categories. After the interviews further data was gathered that would benefit the formation of the developing categories. From the initial fracturing of the data, 35 initial codes were highlighted. The process of moving to focused coding resulted in the development of 19 theoretical codes.

The emerging category *'alarm bells'* needed further exploration, initially nine sub-categories emerged but with further focused coding the 9 sub-categories merged into five sub categories of an early career nurse's referral to the NMC being *'breach of the Code,*' *'clear cut*,*'* '*just under the radar,'* '*patient complaints'* and a genuine '*terrible mistake'*. This is illustrated in diagrams 14 and 15 below. This informed the development and formation of the emerging category of the *'alarm Bells'.*

Diagram 14 – Alarm Bells Category – Initial Focused Theoretical Coding

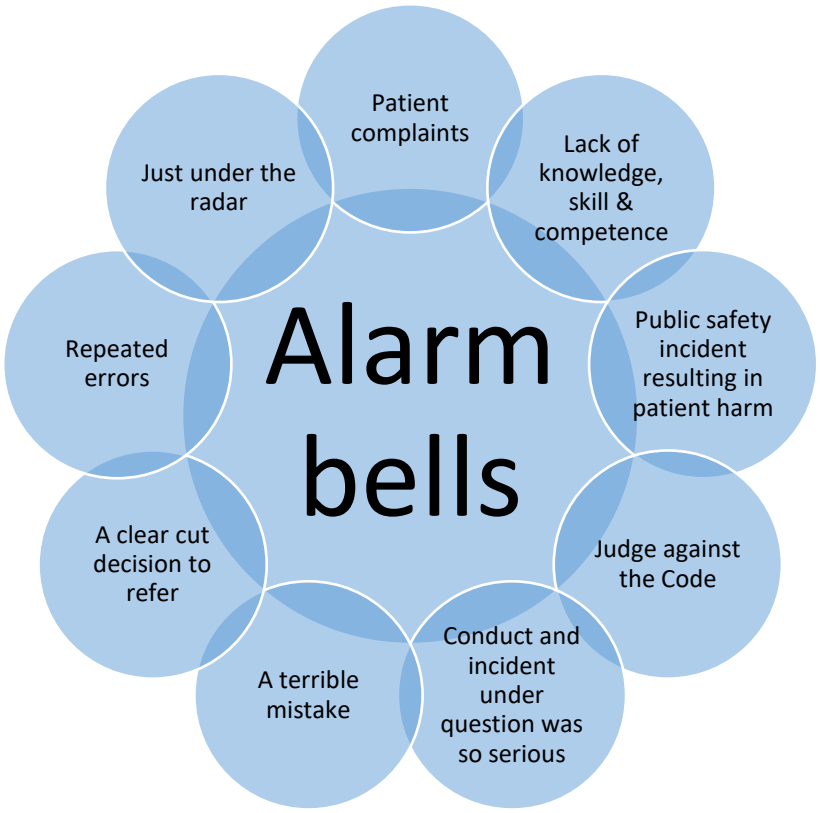
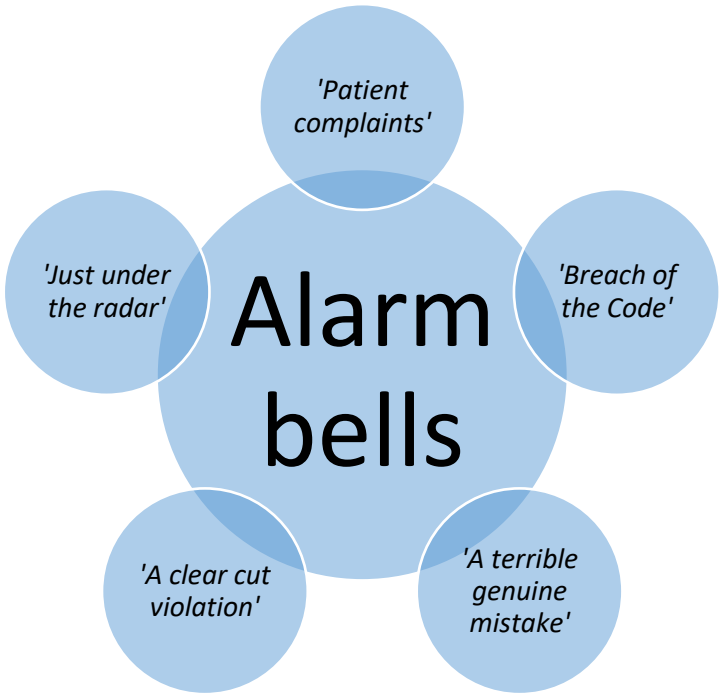


Diagram 15 - Alarm Bells Category, Focused Theoretical Coding Leading to Five Sub Categories



3.5.6 Theoretical Coding and Categorising

The development of theoretical coding and categorising consolidated the theory by intertwining the fragmented initial codes into hypotheses that work together in a theory. This illustrated the key experiences of the participants. Focused theoretical coding is the process of constantly comparing the data, field notes and memos. This informed the development and formation of the emerging four categories, illustrated in table 17 which provides evidence of a high percentage of participants linked to the same conceptual category. The next section will focus on how the rigour of the research process was managed using the next three steps of the grounded theory process: managing the data; decision making and the move to theory building.

3.5.7 Managing the Data

Following the initial coding process, the significant and frequent initial codes become clear and were arranged, combined, integrated and organised (Chesney, 2001). This led to the next step of a theoretical focused coding process. This helped the researcher to examine a large batch of data (Charmaz, 2014). The theoretical focused coding involved analysing the focused codes and specifying the relationship between the categories and concepts (Chesney, 2001). From the theoretical focused coding, the focused codes merged to form a discrete category, illustrated in the diagram below which shows the number of initial codes, focused theoretical codes, sub-categories and the core category.

The core category takes time, extensive coding, and data analysis. There is a clear pathway from the initial fracturing of the data to the core category via the major categories and sub-categories and back again. This is illustrated in diagram 16 and flow chart 2 - Alarm bells Category - A clear pathway developed from the initial codes to this core category via the major categories and subcategories and back again.

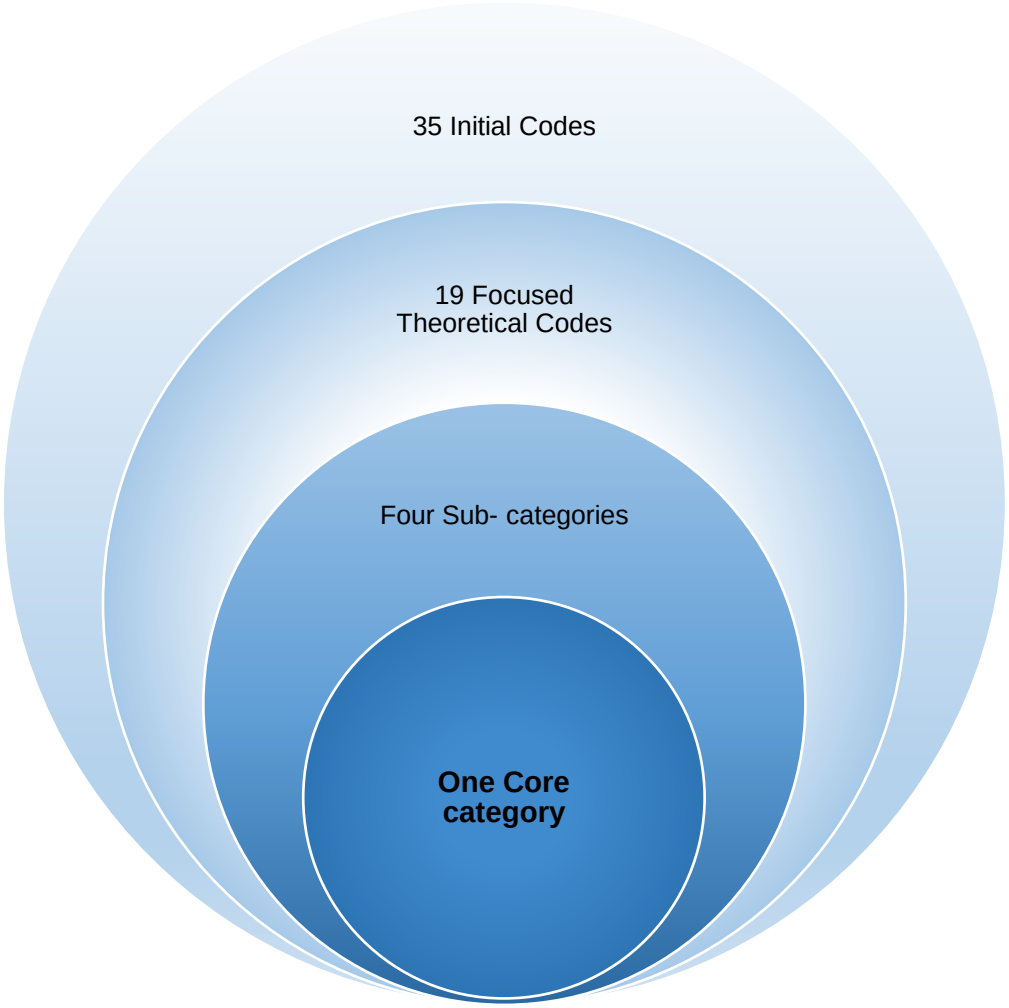
Table 17 The Numbers of Participants, with Verbatim Quotes Linked to the Same Concept

Category - Alarm bells		**Category - Characteristics and values wanted and unwanted in nurses**	
Sub-Category **Number of participants**	**Verbatim quote**	**Sub-category** **Number of participants**	**Verbatim quote**
A genuine "*terrible mistake"* **16, 1, 4, 9, 15, 11, 5, 8, 2, 14, 20**	*"'I think it is sad when you've got some high performing individual who has made **a terrible mistake** and somebody has died or is harmed as a result of it. That's very sad because it could happen to anybody, but that's minority of cases…it is public safety" Participant 9.*	***"Dishonest"* nurse** **1, 13, 16, 4, 17, 9. 11, 6, 10**	*"The other bit of **dishonest**y is where it is the trust and the relationship with the hospital has been broken down. Because how could you trust them to do anything else. It is a fundamental part of what we do here. And it is massive, and there is a zero tolerance of dishonesty" Participant 1.*
"Just under the radar" **7, 8, 9, 4, 18, 11, 5, 17, 3, 20**	*"The registrant was **just under the radar**, there were always some underlying concerns that never rose to the surface. She never did anything that put her in the spotlight but there was always an issue around sickness absence, around attendance, around time keeping, there was nothing from a practice point of view that was highlighted particularly" Participant 7.*	***"Scary"* Nurse** **4, 2, 9, 8, 5, 6, 16, 13, 10**	*"I don't see any common pattern, and I've come across individuals who **scare** the bejesus out of me" Participant 4.*
"Complaints from patients"	*"Rarely have **complaints from patients** about individual nurses" Participant 8.*	***"Friendly"* Nurse** **17, 4, 2, 9, 6)**	*"In terms of their behaviour and the way they work and how they (the registrants) are **friendly"** Participant 17.*

8, 2, 10, 6, 5, 9, 10, 14			
"A clear cut violation" **4, 8, 9, 16, 18, 7, 20**	*"The majority of cases are fairly **clear cut** so I will often have a review of the documentation, I will read the reports, I'll read and generate the referral and it will be quite clear to me. That the referral is entirely appropriate and I have no feelings about it" Participant 4.*	***"Difficult"*** **Nurse** 4, 8, 9, 14, 16	*"They may be an excellent nurse but have some sort of a personality trait i.e. they might be abrupt or **difficult** or a bit too over-familiar, a bit loud" Participant 4.*
"The Code" 17, 4, 14, 16, 18, 15, 1	*"I also do use the Code, the principles within the Code, but then apply it to employment law. And I think again a lot of people don't realise that they are different" Participant 15.*	***"Odd"*** **Nurse 2, 19, 4, 5, 15**	*"There are people that display **odd** behaviours" Participant 15.*
Category – Chain of expectations		**Category - Situational stressors and health**	
"Admission of…I'm human" **1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 18**	*"I made a mistake. I'm really sorry. I'll do anything, any retraining. And that is all it needs sometimes. Is that **admission of, you know, I'm human**. It wasn't deliberate"* Participant 10.	***"Systemic failure"*** **10, 11, 14, 18, 9, 17, 4**	*"They've illustrated the scene… We are trying to ensure that our investigating team do the fact finding and then establish the need for a disciplinary…If it is a **systemic failure** than that needs to be exposed rather than a protracted suspension and then formal process" Participant 11.*

"Remorseful" **14, 13, 1, 9, 20, 5, 19, 8, 10**	*"Absence of remorse … and absence of acknowledgement that what you've done …and saying, that you regret it and you are sorry is part of it, it's actually very worrying" Participant 13.*	***"Mental health"*** **needs 1, 17, 8, 9, 18, 1, 15**	*"That's in a both* ***physical health and mental health*** *because there will be people that have got issues with alcohol and drug dependency, etc, etc, There will be because that's the nature of life. But we just need to make sure that we have sorted it as much as possible" Participant 17.*
Take responsibility "***Look at other options"*** 4, 17, 15, 3, 9, 5, 20	*"Before you actually refer somebody. First of all its identifying what the issue is, trying to identify some support for that individual, we can try and support them so that they can rectify the issue" Participant 15.*	***"Lack of emotional resilience"*** **1, 4, 10, 14, 15, 17 and 18**	*"Nursing can be extremely stressful and emotional …and if you* ***don't have the resilience,*** *if you are not taught how to manage stress, how to develop more resilience is part of your fundamental education training" Participant 15.*
"Challenge it" **but don't '*deny it'*** 2, 4, 5, 8, 16, 9, 10, 2, 7, 13, 14, 15	*"And some registrants, do have that insight but because they go through a capability or disciplinary process will often challenge it and, and deny it" Participant 4.*	***"Extreme Personal stress"*** **2, 7, 3, 4, 1, 6, 8, 9, 11**	*"I have been involved in a case where an individual was under* ***extreme personal stress*** *and problems related to a potential situation of domestic violence" Participant 4.*
"Possess insight" **2, 9, 1, 4, 11, 12, 13, 15, 17, 18, 20**	*"I find it bizarre sometimes, the lack of insight into people's actions" Participant 9.*		

Diagram 16 – Number of Initial Codes, Focused Theoretical Codes, Sub-Categories and the Core Category



The core category is the most highly abstracted category but is still grounded in the data. The major four categories and sub-categories are related to the core category and these categories show how the core category works in the lives of the participants. Holton (2010) identifies the criteria for establishing the core category: it is central; it relates to as many other categories and their properties as possible; and it accounts for a large portion of the variation in a pattern of behaviour.

Flow chart 3 – Alarm Bells Category - A Clear Pathway from the Focused Theoretical Codes to the Core Category via the Major Categories and Sub-categories and back again

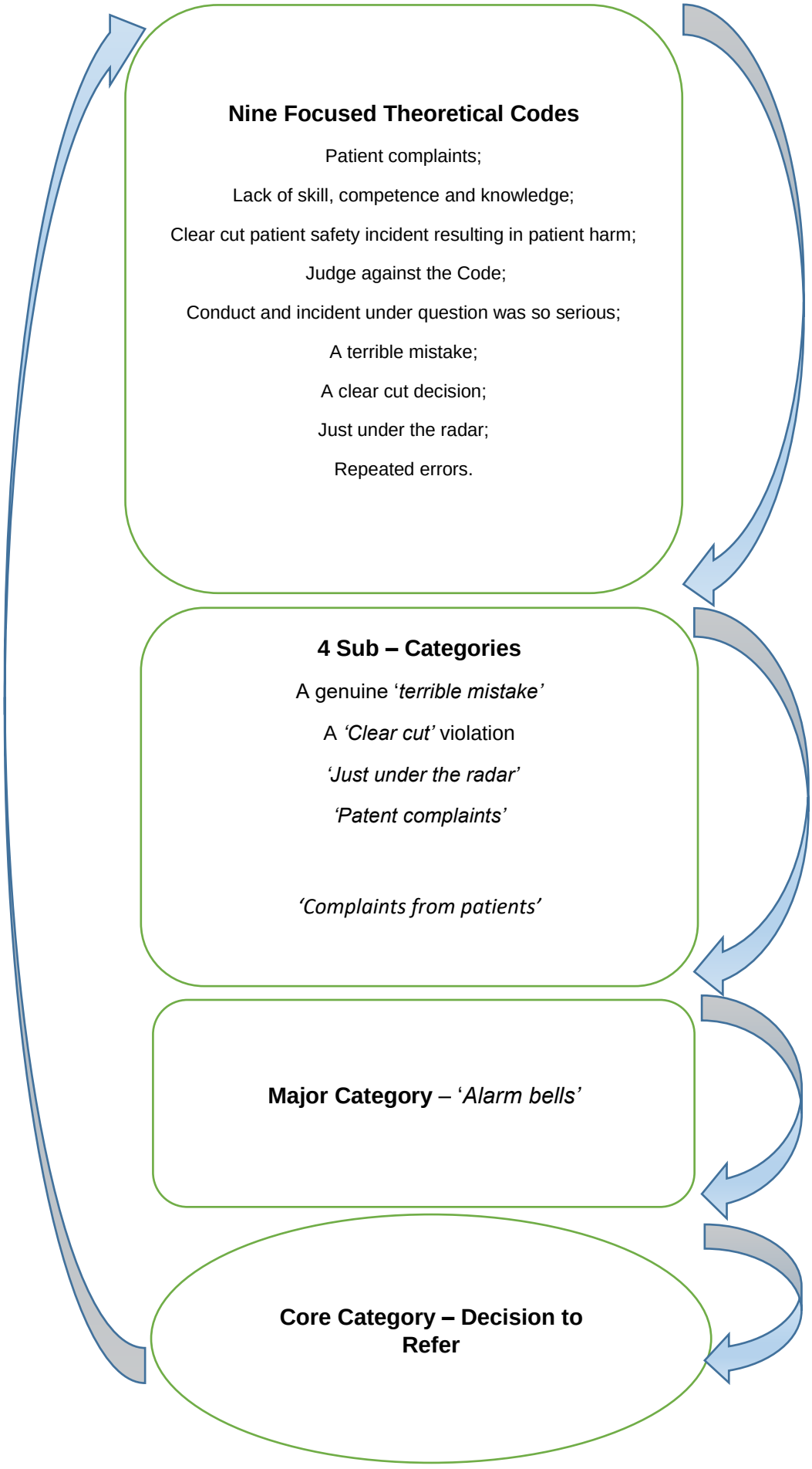
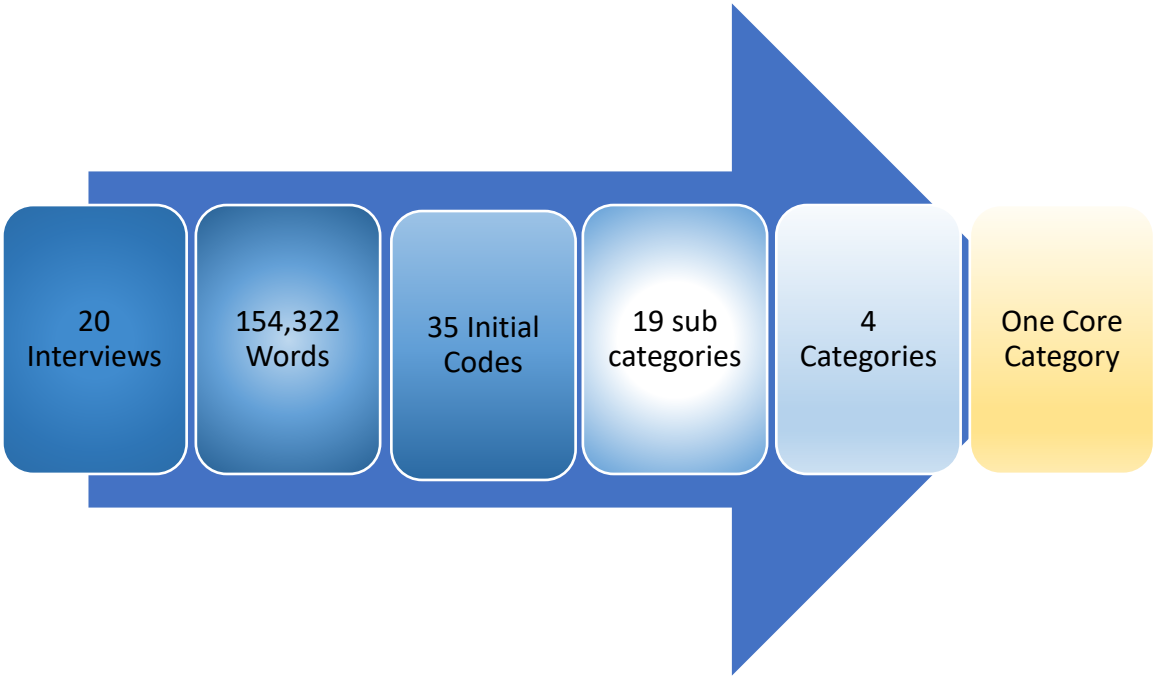


Diagram 17 illustrates the volume of data involved with 20 interviews, these initially generated 154,322 words, the line-by-line coding yielded 35 initial codes. The focused theoretical coding generated 19 sub-categories, leading to the formation of four categories and one core category. The organisation and integration of the initial and theoretical focused codes resulted into a coherent and logical emerging theory.

Diagram 17 – The Volume of Data involved with 20 Interviews



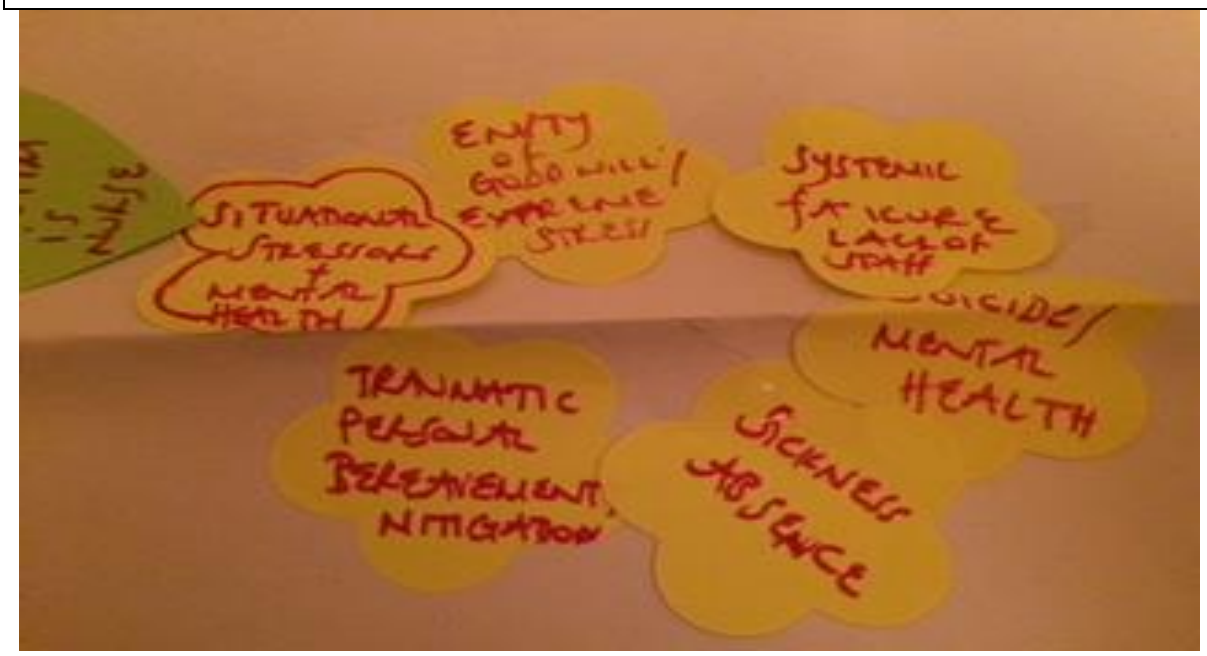
The organisation of the codes related to the newly formed category was enhanced through memoing. “When critical ideas were sparked, the coding process was interrupted to write memos about the emerging codes” illustrates (Martin and Gynnild, 2011: 125). During the interactive coding process there was a continual review of the codes and allocation to larger categories. Finally, a resolution of the research question came to light, it became apparent how the categories were directed to form a core category – a decision to refer, which was at the centre of my research question.

3.5.8 Decision-Making

Decisions are made about the degree of importance of each of the 35 initial codes, to justify the merging of the theoretical focused codes to form a category. This makes deep analytical sense to categorise the data incisively and completely. Focused theoretical coding condenses and sharpens what the researcher finds important in their emerging analysis (Charmaz, 2014). Reflective practice during this phase strengthened my deep appreciation of the lived

experience. At this point it was important to consider my position in the study, to reflect on my previous experiences that influenced this stage of data analysis and not hinder theory development. It was vital to recognise the alternative theoretical directions the study might take, but to also appreciate my own feelings of mixed emotions. The image 2 represents the formation of one of the theoretical categories – Situational Stressors and Health.

Image 2 - Representing the Formation of the Theoretical Category – Situational Stressors and Health



3.5.9 The Move to Theory Building – Core Category

Diagram 18 illustrates how the focused theoretical coding process led to the formation of four categories which assisted in the advancement of the emerging theory. This insight into studied life was a growing body of knowledge. This led to categories integrating to form an abstract grounded theory (Charmaz, 2014). The relevant current literature was woven in to put the theory in a scholarly context, illustrated in chapters 4, 5, 6, and 7. Glaser and Strauss (1967: 40) state that “During the research the emergent categories will begin to form patterns and interrelations which will ultimately form the core of the emerging theory”. Glaser (1978) reinforces the importance of a core category and that the requirement for the generation of theory occurs around a core category. He believed that “without a core category an effort of grounded theory will drift in relevancy and workability” (Glaser 1978: 93).

However, Charmaz, (1994: 1164) view challenged Glaser's statement that 'Weaknesses in using the method have become equated with weaknesses inherent in the method' and Charmaz (1994: 132) outlines the constructivist's position:

"A constructivist approach does not adhere to positivist notions of variable analysis or of finding a single basic process or core category in the studied phenomenon. The constructivist view assumes an obdurate, yet ever-changing world but recognizes diverse local worlds and multiple realities, and addresses how people's actions affect their local and larger worlds. Thus, those who take a constructivist approach aim to show the complexities of particular worlds, views, and action".

Yet in this study a core category was essential because of the inter-relationship of the 4 categories around public safety, values and expectations and vulnerability when considering a decision to refer an early career nurse to the professional regulator.

My reflection on these iterations was that my analysis lead to the development of a core category and sub categories that answered my research question. Diagramming helped to integrate ideas and establish the logic of ordering (Charmaz, 2006), this is illustrated by the diagram 18: the move to theory building. This diagram highlights how the categories interlink with each other. The dark blue circles represent one of the scenarios described by the participants of a newly qualified nurse who significantly lacked competence, skills and knowledge to safely function as a qualified nurse. These concerns questioned the nurse's current fitness to practise. Firstly, the *'alarm bell'* was raised by a relative and *'patient complaint'* after the newly qualified nurse failed to deliver care following the instruction of medical staff. It became apparent that the newly qualified nurse had low level concerns about their practice and performance of medication errors and near misses, "*there were always some underlying concerns that never rose to the surface"* (P4), resulting in performance management.

The diagram continues to highlight how colleagues referred to the nurse's unwanted characteristics and values, describing the nurse as *'scary'* to work with because of their lack of knowledge, skill and competence. The nurse displayed *'odd'* characteristics, lacked empathy and compassion towards patients and *'was quite difficult to like and quite cold in some ways'* (P2). The participants explained the chain of expectations of a nurse when a concern had been raised. Yet the newly qualified nurse denied the complaints made against them and blamed other members of the team. It was evident that the participants were concerned when the nurse demonstrated a *'lack of remorse'* for the distressed caused to the

relatives and patient. The nurse did not *'possess insight'* into their deficiencies or understand the serious nature of the concerns raised, aligned with a lack of awareness of their responsibilities to deliver care under the direct instructions of medical staff.

The majority of participants referred to the situational stressors and health. In this situation the Trust acknowledge that the '*systemic failures'* could have contributed towards a newly qualified nurse receiving a complaint from a family relative, mainly due to time constraints and a lack of supervision at the time of the incident. Yet there was no evidence of mitigation or extreme personal stress raised by the nurse. Diagram 18 visually played an important part of the development of the core category by illustrating how the four categories intertwine, ultimately dovetailing into the core category and the theoretical model – a decision to refer.

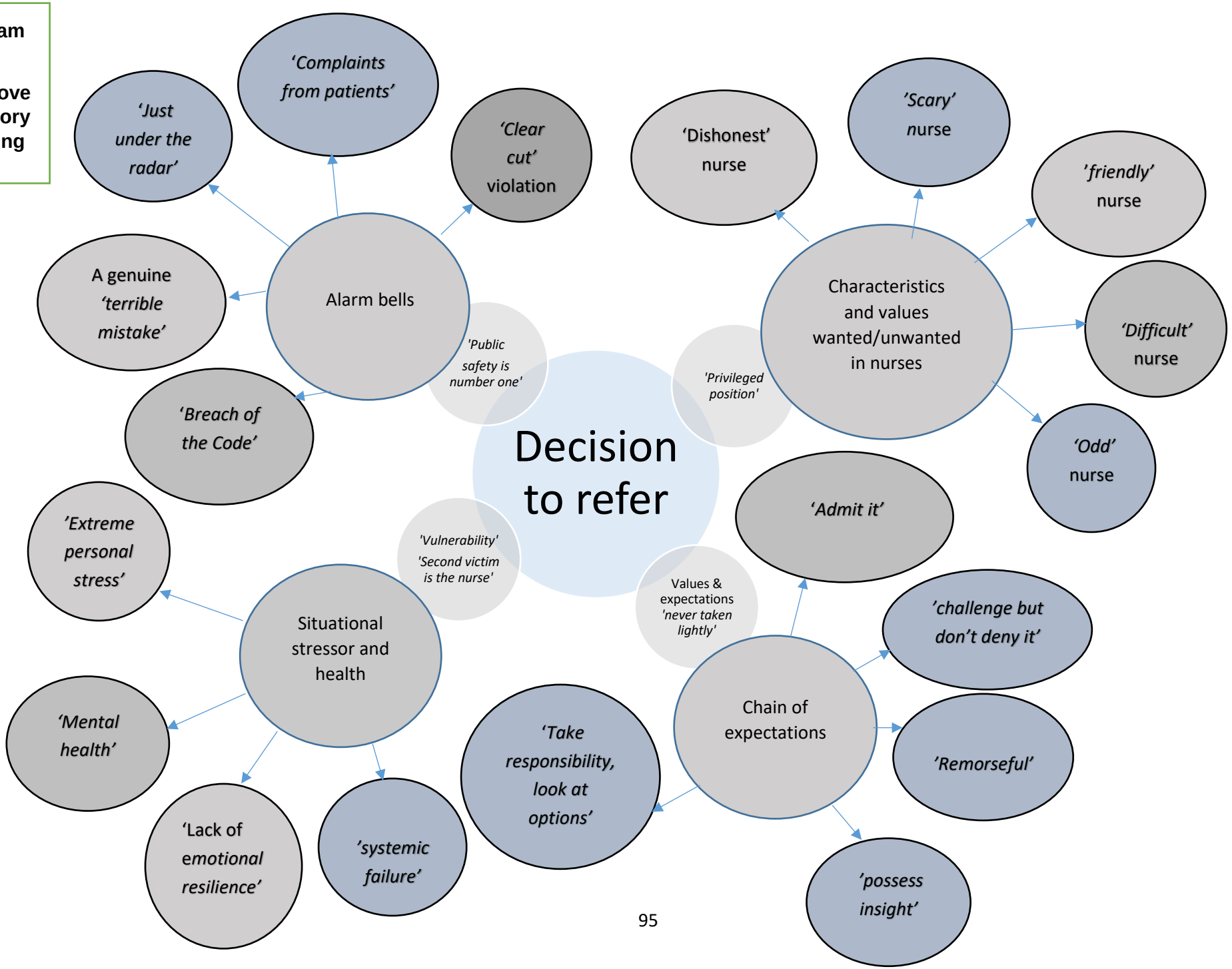
3.5.10 Theoretical Sampling

Theoretical sampling is an integral part of grounded theory after the initial process of data collection using a small purposive sample. Theoretical sampling was fostered to seek more data. The development of the theory involved data collection, coding and analysing the data, while making theoretical decisions about what data to collect next, where to find it and recruit participants.

Charmaz (2014) argues that theoretical sampling is a process of identifying and pursuing clues that arise during analysis in a grounded theory study. Birks and Mills (2013) agree that looking for clues is an active process of following new leads that arise from data collection. New lines of inquiry were sought in subsequent interviews, this was reflected in the developing analysis. This approach shaped the formation of the emerging four categories by asking the participants with a strategic or operational role to explore sensitive questions about the participant's experience of the nurses' wanted and unwanted characteristics and values, situational stressors and health. Glaser and Strauss (1967) describe this process as an iterative sampling process that is based on emerging theoretical concepts.

Diagram 18

The Move to Theory Building



3.5.11Theoretical Saturation

Theoretical saturation of concepts is the point at which the data collection and analysis cycle can conclude. Glaser and Strauss (1967) advocate that this leads the researcher to finalising the properties of the category. Bloor and Wood (2006) agreed it is the continuation of sampling and data collection until no new conceptual insights are generated. Whereas, Dey (1999) stated that saturation is not exhaustion of data sources, but the full development of a category. Therefore saturation can be a professional judgement to cease data collection, when the categories are theoretically saturated yet substantively grounded, thus linking the data with a comprehensive and credible theory. However, Dey and Wasoff (2007) highlights this should not be at the expense of the refinement of categories. Being mindful that data analysis in grounded theory does not conclude until the final formulation of the theory, theoretical saturation will not be achieved until the study is completed. Even then it may never be truly possible to achieve theoretical saturation as described by Glaser and Strauss (1967) and Bloor and Wood (2006).

Evidence of how theoretical saturation has been reached was required, to explain the decision making process as a mechanism of ensuring accountability and quality. Saturation in this time limited study was achieved by using effective and active theoretical sampling principles to ensure that a diverse range of data was collected. Charmaz (2014) discusses a study based upon rich, substantial and relevant data which stands out, and emphasises the depth and scope of the data, making a difference to the overall study. Table 18 provides evidence of a high percentage of participants linked to the same conceptual category. Morse (2001) agrees that counting the frequency of a code was an indicator of theoretical saturation.

Table 18 - The Number of Participants Linked to the Four Conceptual Categories.

Category	Participants	Overall number of participants
Alarm bells	**1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 20**	17/20
Chain of expectations	**1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20**	19/20
Situational Stressors and Health	**1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 17, 18, 20**	17/20
Characteristics and values wanted and unwanted in nurses	**1, 2, 4, 5, 6, 8, 9, 10, 11, 13, 14, 15, 16, 17, 19, 20**	16/20

3.5.12 Theoretical Sorting

The constant comparative process was reflected in the written memos of how the emergent substantive and theoretical categories developed. The advancement of theoretical sorting integrated these memos into the related core category, once the category reached theoretical saturation. Theoretical sorting generated new ideas, these were captured in new memos and resulted in the concept of memos on memos. Theoretical sorting of memos assisted in the formation of the emerging theory and the strong links between concepts that explained the key factors that precede a referral to the NMC within the first five years of registration.

Theoretical decision making and the openness to creative thought processes, embraced unexpected discoveries in the data. Holton (2010: 260) argues that “the researcher requires the confidence in following what emerges regardless of how counter-rational it may seem to extant theoretical perspectives”. Glaser (2004) describes theoretical sorting forces, the "nitty gritty" of making theoretically discrete discriminations, as to where each memo fits in the emerging theory.

Theoretical sorting of the memos is the key to formulating the theory for presentation or writing (Holton, 2010). It helps put the fractured data back together (Glaser, 2004). Holton (2010) advocates theoretical sorting of the memos into the core categories, as this will generate a theoretical outline, or conceptual framework, for the full articulation of the grounded theory through an integrated set of hypotheses. From which emerged a theoretical model – A decision to refer.

3.5.13 Theory Building and Development of a Theoretical Model

The development of theoretical codes consolidated the theory by intertwining the fragmented concepts into hypotheses that work together in a theory. By illustrating the key experiences of the participants who have made a referral to the NMC within the first five years of registration, the theoretical codes emerged from the process of constantly comparing the data in transcripts, field notes and memos. During this final stage, a grounded theory theoretical model was close to being finalised and the relevant current literature was woven into the theory in a scholarly context. This process has been reflected in each of the four categories with discussion with the literature after the findings section. Chamaz (2006) promotes the use of diagrams to help integrate ideas and establish the logic of ordering.

3.6 Constructivist Grounded Theory – Quality Issues

It was my decision to take the constructivist grounded theory journey because this research methodology embraced my ontological and epistemological position. This approach has explored the complex and unexplained decision to refer a registrant to the NMC within the first five years of registration. This provided the opportunity to understand the participant's subjective experience (Benner, 1995), underpinned by an interactive process whereby the researcher and participant construct a shared reality (Mills et al, 2006), with the constructivist grounded theorists locating themselves within the study (Charmaz, 2014). Following a period of reflection, Guba and Lincoln (1998) and Crotty (1998) provided further guidance on the importance of identifying epistemology and theoretical perspectives underpinning a study. It became clear that a positivist (or objectivist) paradigm (Crotty, 1998; Guba and Lincoln, 1998) was not congruent with my thoughts. A positivist approach was unlikely to extract the information necessary to truly understand the experiences in question.

There is a long standing discussion that these traditional terms continue to provide support for the view that qualitative research studies are unreliable and invalid (Kvale, 2007). However, forceful debate has counteracted this argument by suggesting this term of unreliability and invalidity is not relevant to qualitative research (Morse, 1999). In this approach, Charmaz (2006: 10) explicitly assumes that any theoretical renderings offer an "interpretive portrayal of the studied world, not an exact picture of it". Therefore the decision to adopt an interpretive qualitative approach has to take into consideration the particular threats to the study's validity of interpretation. Mason (1996: 150) explains that "validity in any form of qualitative research is contingent upon the 'end' product, including a demonstration of how that interpretation was reached". Maxwell (1992: 490) clarifies the term 'interpretation,' explaining it is an understanding of the meaning and perception of the participants' lived experience and stories told during the interview process. The necessity for an auditable trail is an essential component to justify the interpretations made throughout the research process (Lincoln and Guba, 1989).

This research has strong credibility and trustworthiness due to the wealth of rich quotes include in the findings chapters and the augmentation of peer review with supervisory team. The reflexivity demonstrates dependability and this is supported by the interrelation audit trail. Conference presentations and delegate responses have suggested transferability to other professional groups.

The nature of constructivist grounded theory can be portrayed as problematic. Robson (2002) argues that there is typically a close relationship between the researcher and the setting, and

between the researcher and the participants. It is the identification of bias and acknowledgement of the researcher's personal value systems and areas of subjectivity that can assist the reader in determining the reliability of the research and to enhance replication (Lewis, 2009). A description of my role conflicts and possible influence of who the researcher approached to engage in the research study are discussed earlier in this chapter. It is my engagement in the development and implementation of reflexive strategies that can relieve concerns of bias.

Reliability in qualitative research is the use of standardisation of research instruments. The concern is whether the tool can provide consistent results (Robson, 2002). The lack of standardisation could question the reliability of the study, with bias difficult to eliminate. The term reliability "refers to the degree of consistency with which the instrument produces the same results administrated in the same circumstances" (Parahoo, 2014: 316). However, Robson (2002: 176) argues that the "researcher using qualitative researcher designs do not need to concern themselves seriously with the reliability of their methods and research practices".

Strategies have been implemented to deal with the issue of reliability, which include a degree of professionalism, reflexive practices and rigour. In practice, the interviewer- interviewee interaction in semi – structured interviews differs from situation to situation, so researchers have to be flexible in their approaches (Parahoo, 2014). Moreover, the interviewer can introduce a number of biases because of personal characteristics, such as gender, age, clothing, accent, which can interfere with the collection of valid and reliable data (Davis et al, 2010). Reliability in a qualitative study is questionable. The semi-structured interviews conducted consisted of a list of topic areas to discuss, however each interview had a unique interaction and is not replicable. The notion of reliability is problematic in qualitative research and instead the terms "accuracy", "credibility" and "truth" are used (Parahoo, 2014: 316).

3.7 Ethical Considerations

Appropriate ethical approval and permission was sought using the procedures currently in place in the Faculty of Health. These included project registration in the Faculty followed, once the University documentation was accepted, by an application to the Research Indemnity and Insurance Committee (RIIC) which was required prior to ethical review. Advice was sought from the NHS about whether or not this project required review by an NHS Research Ethics Committee. This review was not required. An ethical o

inion was obtained from the Research Ethics Committee in the Faculty of Health, Education and Life Sciences at Birmingham City University. Approval was obtained.

The following ethical issues were identified and the steps taken to address them are discussed below.

Respect for autonomy: Potential participants were given written information about the project and informed written consent was obtained. Included in this process was an explanation of the purpose of the study, duration and procedure of the study, the ways of maintaining confidentiality, anonymity and privacy of the participants, the role of the participants, their freedom to withdraw their consent, the future use of the data as well as how the findings will be published (Silverman, 2013). In this study, no participants withdrew from the study at any stage.

Non-maleficence: Measures have been taken to minimise the risk to the participants and the organisations concerned. Protection of the identity of nurses discussed during the interviews, the participants and organisations has been maintained through the allocation of codes/numbers. Data has been managed in accordance with the Data Protection Act 2018, General Data Protection Regulations (2018), Safeguarding policy and procedures.

Integrity: The researcher has dual roles – Researcher and previously NMC Fitness to Practise Committee Registrant Panel Member on the Investigating Committee. I have not received funding or financial costs from the NMC towards this study. I avoided any cases in which I was a member of the NMC fitness to practise investigation team. I maintained a reflexive diary to explore my experience of and place in the research, decisions made and interpretations in ways that bring me into the process and allow the reader to assess how and to what extent my interest, position and assumptions influenced the inquiry. A reflexive stance informs how the researcher conducts the research, relates to the research participants and represents them in written reports (Charmaz, 2006).

Fidelity: I was aware when I recruited participants to the study I had to build a trusting relationships by being open and honest about the risks, to ensure I fulfilled my obligation to protect each participant, as far as possible, from any harm as a result of participating in their research. For example, I was aware and discussed with the participants before the interview the potential unintentional disclosure of names during the interview process and the measures taken to ensure confidentiality and anonymity within the transcripts. Thereby, protecting the individual nurse, the participant and the organisation.

I had been a Fitness to Practise Registrant Panel Member for eight years, due to the longevity of the role I have heard some extremely sad and tragic stories of life events which have impacted on the nurse's ability to function as a safe practitioner. During the interviews, some of the participants did disclose the challenges of managing nurses whose fitness to practise has been questioned, often referring to cases being *"tragic. I was very sad" (P1).*

Trustworthiness: The participants also discussed cases when the nurse had mental health issues, one example the nurse *"pulled a bow and arrow at his partner and then self-referred to an outpatient psychiatric unit and then wondered by we found that quite disturbing"* (P1). These disclosures required a degree of empathy, listening skills and ability to effectively deal with the situation, embracing the level of trust and rapport between myself and the participant.

3.8 Chapter summary

Constructivism celebrates the researcher's multiple perspectives from their own personal and professional life, including the interactions with participants which are an integral part of the research process. Constructivist grounded theory was influenced by the researcher's perspectives, values, privileges, positions, interactions, and geographical locations (Denzin and Lincoln, 2005). The researcher worked closely with the data and embraces data collection and analysis, drawing on their own professional experiences and analytical ideas. Charmaz (2014: 13) continues to assert that the constructivist approach perspective "shreds notions of a neutral observer and value free expert".

This chapter illustrated the use of a strategic yet flexible constructivist process and theory to answer the research question, whilst taking into ethical considerations. The hallmarks of the constructivist grounded theory method of sampling and recruitment strategy, conducting data collection and analysis, coding practice and initial coding, focused coding and categorising, memo-writing, theoretical sampling, theoretical saturation, constant comparative analysis, theoretical sorting, and theory building.

Chapter 4 Research Findings – Theoretical Category One: The Alarm Bells

4.1 Introduction

The aim of the study is to explore the factors that preceded a referral of impaired fitness to practise. As data collection and analysis progressed, four theoretical categories emerged from the constant comparative method, these are: the alarm bells, wanted and unwanted characteristics and values in nurses, a chain of expectations and situational stressors and health. The participants explained, it is specific **alarm bells** which can trigger a concern about an early career nurses fitness to practise, displayed in diagrams 19 and 20, and often exposed the **wanted and unwanted characteristics and values in nurses**. Diagram 19 is a visual representation of how the categories and subcategories build up over the four chapters. Diagram 20 clearly displays the five sub categories of the Alarm Bells chapter.

This research describes an allegation of impaired fitness to practise can reveal a **chain of expectations** that the nurse concerned will demonstrate insight, admit to the error and take responsibility, show remorse and say sorry. The participants reveal their experience of one of the preceding factors to a referral to the NMC relates to the **situational stressors and health** of the nurse.

This chapter will explore the participant's perception of the **alarm bells** which trigger a concern about an early career nurse's fitness to practise and contributes towards a referral to the professional regulator.

This chapter explores the *'alarm bells'* that trigger a concern about an early career nurse that is summarised in diagram 20. The participants discussed a diverse range of cases they had experienced that have evolved into the five sub-categories that emerged from the interviews. This chapter will firstly explore the nurse who had been involved in a genuine mistake, moving onto the participants who discussed the nurse whose conduct and performance had led to a '*clear cut'* violation and a *'breach of the Code'* (NMC, 2018). Thirdly, it will discuss the nurse who was known to the organisation for low level concerns, whose performance and conduct did not warrant any formal action, yet tended to sit '*just under the radar'* until he/she made a significant mistake. Finally, this chapter will explore the nature of patient complaints.

Diagram 19 A Representation of Theoretical Category: Alarm Bells

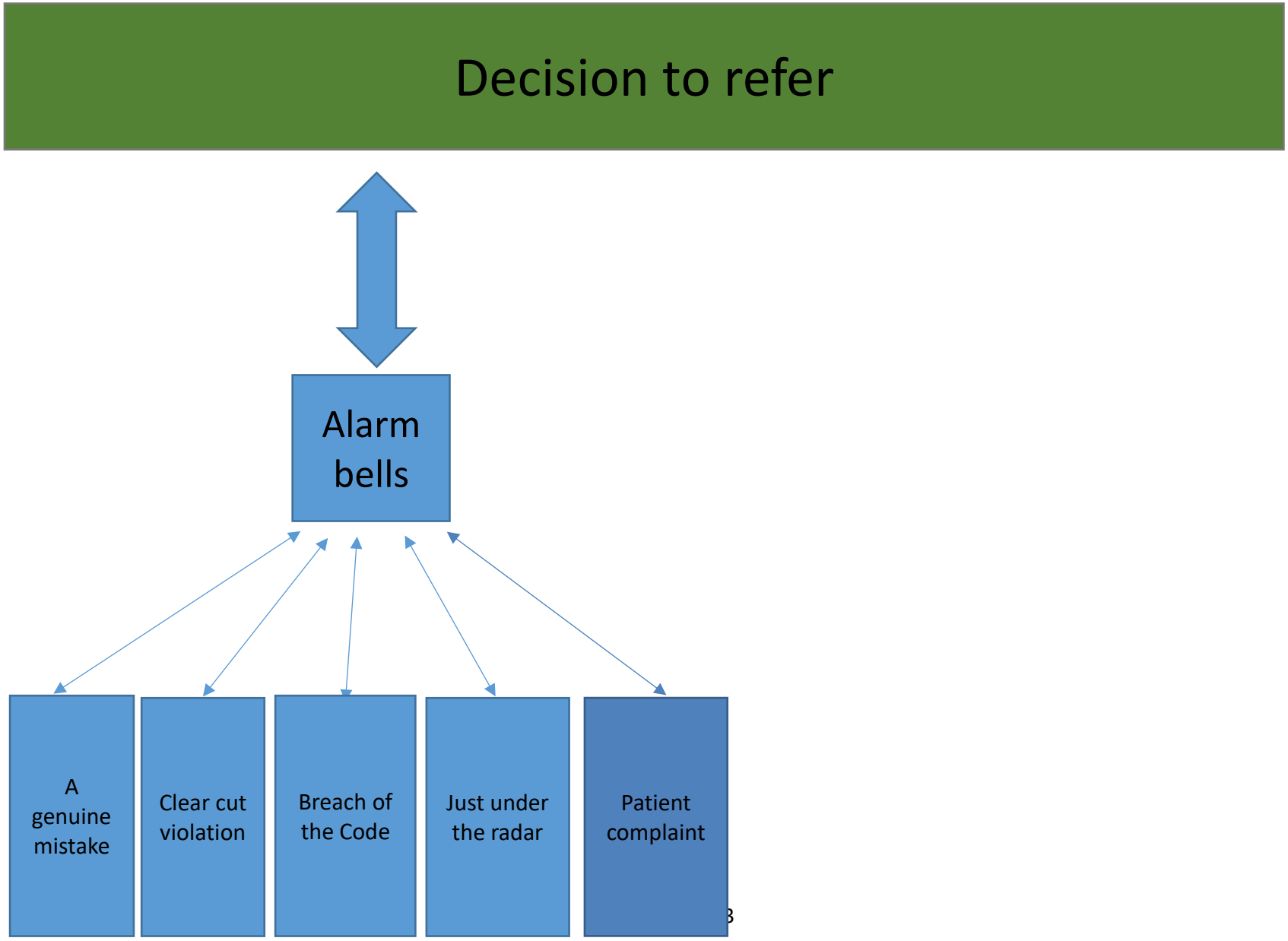
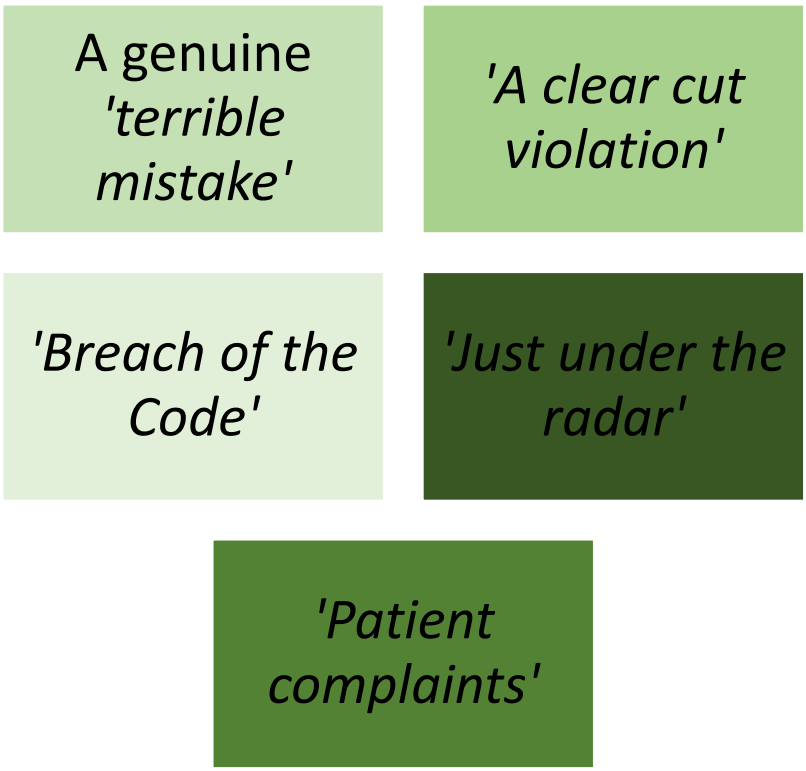


Diagram 20 A Representation of the Alarm Bells

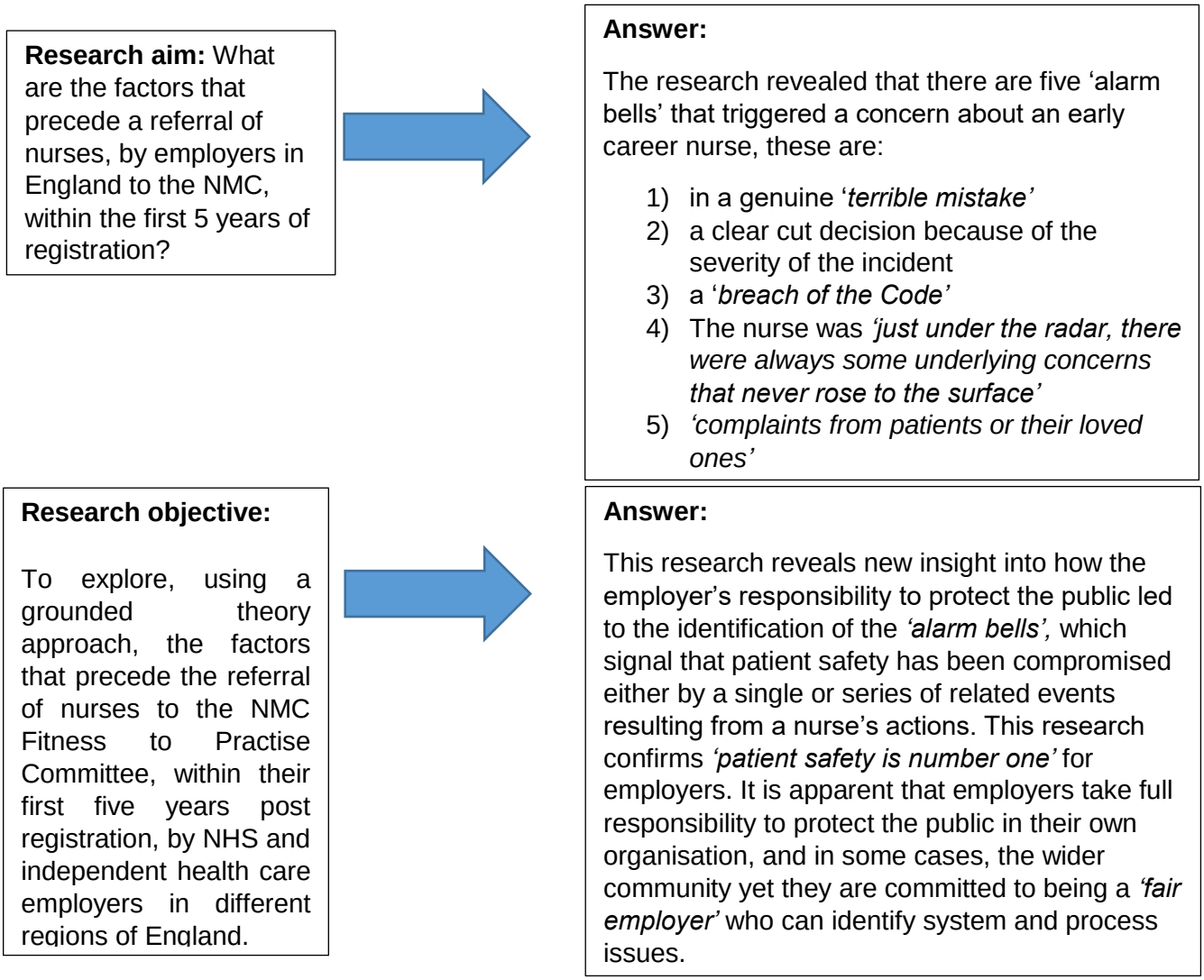


Participant 9 captured the importance of patient safety when identifying the '*alarm bells'*:

"The number one is public safety. Would be the first one. The attitude and insight of the registrant as well. If there is a recurrent theme of that individual's actions or omissions. But really the overall theme is about public safety. They would be the things that would probably be the ***alarm bells*** *for me"* - Participant 9.

Each of the sub categories is presented from the participants' perspective and is underpinned by individual quotes and memos from the interviews. This chapter will provide an insight into the experiences of 17 participants. Diagram 21 summarises how the research aim and objectives have been answered in this section.

Diagram 21: Summary of the Questions Answered for the Alarm Bells Category



4.2 A genuine *'terrible mistake' (Participants 16, 1, 4, 9, 15, 11, 5, 8, 2, 14, 20)*

The nature of nursing involves nurse's making complex decisions in challenging environments. Sometimes mistakes can be made that have a detrimental effect on the patient's experience. However, a genuine mistake can be made by highly performing and competent nurses, who had no previous clinical or conduct concerns. Participant 9 describes a case of a nurse who made a genuine yet significant mistake that led to a patient fatality, a one off incident that resulted in a referral to the NMC:

*"I think it is sad when you've got some high performing individual who has made **a terrible mistake** and somebody has died or is harmed as a result of it. That's very sad because it could happen to anybody, but that's minority of cases…it is public safety" - Participant 9.*

The participants reflected on the severity of patient harm and breach of safety. A decision to refer a newly qualified nurse was not taken lightly. Participant 9 referred to the nature of the mistake that left the nurse unable to continue to practise without restrictions. However, it was only the regulator who can place formal restrictions on a nurse's practice:

"Public safety is number one, absolutely paramount and we will go directly to refer if needs be. I can think of one case where there was just one incident and went direct to NMC referral" - Participant 9.

Errors in practice involve nurses who are deemed competent and have no previous record of concerns regarding their fitness to practise. Participant 9 and ten other participants described hard-working nurses working in challenging high risk environments, who dealt with complex situations. Memo 2 explores this in more detail outlining the participant's experience of caring

MEMO 2
After the second interview the participant said that compared to years ago patients are sicker, with greater technology to care for these patients, which require nurses to perform at a different level.

for sicker patients using advanced technology.

In one case, a nurse's genuine error of judgement resulted in serious consequences for the patient. The organisation had no choice but to make the difficult decision to refer the nurse to the NMC:

"So they're kind of heart-breaking ones where you've got individuals who are hardworking, highly thought of, by their team members, and they just make a terrible mistake in a high risk environment and actually, we have no choice but to refer them. But actually you have no choice because of the level of harm or death. So that's kind of, that's sad in a way. But they are very few and far between" - Participant 9.

There appears to be a number of compounding factors underpinning a one-off error in practice and a genuine "*terrible mistake"*. Participant 16 and ten other participants clearly recognised the human factors that adversely influenced the nurse's performance on the day. The participants described errors in practice as being part of being human, with 15 participants referring to medication errors. *'I think …errors can be human'* (Participant 16).This is discussed in the category 'situational stressors and mental health needs'.

During this section the participants describe the one off genuine "*terrible mistakes,"* by nurses who had no previous concerns raised about their fitness to practise. It is apparent these are difficult and challenging referrals compared to nurses whose performance and conduct was a "*clear cut violation".*

4.3 "*Clear cut violation"* (Participants 1, 4, 8, 9, 18, 7, 14, 15, 16, 17, 20)

Participant 4 and ten other participants explored their experience of '*clear cut'* cases, due to a violation of professional standards, UK law and - /- or local policies. The participants describe serious cases of patient harm that led to a straightforward decision to refer the nurse to the NMC, illustrated by participant 4:

"The majority of cases are fairly ***clear cut*** *so I will often have a review of the documentation, I will read the reports, I'll read and generate the referral and it will be quite clear to me. That the referral is entirely appropriate and I have no feelings about it" - Participant 4*

In some cases, participant 4 continued to explain he would write directly to the NMC, alongside the referral, to stress his concerns about the level of risk the nurse posed to the public. Often with the recommendation the nurse should not practise while under investigation by the NMC:

'In fact there are certain cases where I will write directly to the NMC, subsequent to the referral indicating I am deeply concerned about them being able to practice even though they've been dismissed from our organisation. Their behaviour and the incident under question was so serious that for me, I don't think they should be practicing and even whilst they're under investigation by the NMC' - Participant 4.

It is evident that the scope of responsibility to protect the public and the ownership of patient safety was wider than their own organisation. Yet participant 18 and ten other participants acknowledged that their decision to refer an early career nurse to the NMC could consequently result in the nurse losing their job and future ability to work as a registered nurse:

'For gross professional misconduct … then I've done that thinking. The difficulty is ensuring that my decision is the correct decision and that's the right sanction... sounds a very powerful person doesn't it? I suppose it is in a way because you could be that person losing their livelihood is a very serious matter. But then once that's done then it's clear cut' - Participant 18.

Participant 8 described a gross misconduct case referred to the organisations disciplinary panel. It was evident that participant 8 had little sympathy for the nurse involved. The severity of the case was "*never taken lightly"* with a chain of expectations from the employer. This concept is explored further in the chapter a chain of expectations:

'I do feel very sad for people, but not as sad as if they'd killed a patient. Or hurt a patient, damaged a patient' - Participant 8.

Participant 4 described an example of a '*clear cut'* violation which involved a nurse whose alleged impaired fitness to practise was initially escalated by a student, who was directly involved in the incident. The nurse was investigated and referred to the organisation's disciplinary panel, who made the decision to dismiss the nurse for gross misconduct. The nurse could not understand the severity of the situation and appealed against the decision. At the appeal the decision was upheld:

"The registrant allegedly, although proved during our disciplinary process, allowed a patient to deteriorate to a significant degree as an opportunity to teach somebody (Pause in dialogue) but allowed the student to flounder whilst this emergency situation was unfolding in front of them before stepping in to deal with the situation" - Participant 4.

Participant 16 described another example of a nurse qualified for five years or less. The nurse was caring for a patient with challenging behaviour, which was a manifestation of the patient's illness. The nurse's conduct was reported by a Health Care Assistant. Following an investigation, the disciplinary hearing decided to dismiss the nurse for gross misconduct and referred her to the NMC. The nurse continued to deny the allegations and appealed against the decision, but at the Appeal hearing the decision was upheld. The outcome of the case resulted in an irretrievable *'breakdown of relationships'* between the employer and the nurse:

"She (the registrant) physically assaulted the patient by pouring water on to her and inappropriately restraining her causing an injury to the patient's face. (The registrant) was verbally abusive towards the patient during the incident" - Participant 16.

Participant 16 described a '*clear cut'* violation of patient safety. They described a case of an early career nurse whose conduct and performance was referred to the organisation's disciplinary panel, the nurse was subsequently dismissed for gross misconduct. Part of the reasons for dismissing the nurse was a violation of safety and dignity of the patient in their care:

'(A registrant) engaged in an inappropriate behaviour, compromising the safety and dignity of the patient, by leaving the doors wide open while she used the toilet' - Participant 16

During this section the participants described the '*clear cut*' cases that without doubt proceeded to a referral to the NMC because of significant patient harm or death. It is evident that this is one of the *'alarm bells'*.

4.4 "*Breach of the Code"* (Participants 17, 4, 14, 16, 18, 15, 1)

Health-care organisations disciplinary panel's decisions are informed by UK law, local policies and procedures, alongside the professional standards published by the NMC. The Code (NMC, 2018) outlines the professional standards that nurses must uphold at all times. The standards set out the public's expectation of how a nurse should perform and conduct themselves. Seven of the participants stated that a "*breach of their Code"* formed part of the decision to refer to the NMC. Yet they raised concerns early career nurses do not understand this is their "license to practise". Participant 17 and six other participants described the Code as the underpinning standard for practice, which protects the public and upholds the reputation of the profession.

'The principle if somebody's lied, stolen, whatever, then I think it should be very simplistic way, it should be fairly straightforward. Because if you look at the Code and you look at the professionalism, and the trust that patients and the public put in us. And we have got a duty to spend NHS money in the best possible way. Anybody that commits fraud, steals, lies, goes against the code' Participant 17.

Participant 1 discussed a case of a nurse whose conduct linked to a fundamental breach of the Code, exposing their professional vulnerability to being referred to the NMC. The participant had to guide the nurse to the relevant sections in the Code:

"I mean he pulled a bow and arrow at his partner and then self-referred to an outpatient psychiatric unit and then wondered why we found that quite disturbing, and he kept writing really obnoxious letters to me and HR person that gave the sanction. In the end I wrote back to him and I said can I refer to section ….in the code, I am adhering to my Code by expressing my concerns to the NMC about how I do not have assurance that you are" - Participant 1.

Participant 4 explained the nurse "*breached their Code,"* but argued that it was the regulator's responsibility to make the decision whether the nurse has the license to continue to practise, with or without restrictions:

"My view is always that I am referring a registrant clearly to have my allegation of failure to deliver against the Code of Conduct be tested out in a formal setting with the appropriate panel within the NMC. So that individual, in my view, was clearly in breach of their Code in relation to safety" - Participant 4.

Participant 15 and 6 others applied UK law and local policies, together with the NMC Code (2018) when considering an allegation against a registrant during a disciplinary hearing:

"I also do use the Code, the principles within the Code, but then apply it to employment law. And I think again a lot of people don't realise that they are different" - Participant 15.

This section demonstrates how it is the employer's responsibility to protect the public in their own organisation and the wider community. The decision is "*never taken lightly",* it is informed by UK law, local polices and professional standards.

4.5 "*Just under the radar"* (Participants 7, 8, 9, 4, 18, 11, 5, 17, 3, 20)

Ten of the participants discussed nurses whose underlying low level performance or conduct issues lay "*just under the radar"*. The participants gave examples of a number of concerns previously known to the organisation about a nurse's performance or conduct. These ranged from mitigating factors such as sickness and absence; relationship problems with colleagues; lower end performance management programmes, often underpinned by a lack of competence, knowledge and skills. However, it is evident that some nurses continue to function in their role until they are involved in a significant error. The nurse is then under the spotlight. Participant 7 described a nurse who was under investigation for an allegation of gross misconduct. The investigation revealed previous concerns about the nurse's conduct:

*"The registrant was **just under the radar**, there were always some underlying concerns that never rose to the surface. She never did anything that put her in the spotlight but there was always an issue around sickness absence, around attendance, around time keeping, there was nothing from a practice point of view that was highlighted particularly" - Participant 7.*

Participant 20 reflected on her experience of supporting a newly qualified nurse's first position as a staff nurse. The participant gave examples of a number of low level minor mistakes and medication errors. The organisation could not sustain the level of risk to patient safety. The accumulation of errors escalated into more serious concerns, which ultimately resulted in a referral to the NMC. Fifteen participants referred to early career nurses being involved in medication errors:

"There were incidents of errors…drug errors, there was discharge errors, and there was lots of … nothing catastrophic" - Participant 20.

Participant 9 recalled a case of an early career nurse whose performance was borderline, with little or no formal intervention because of the lack of evidence. Questions were asked when the nurse was involved in a significant mistake. Could these low level performance issues have been identified sooner - preventing the significant mistake?

"Some of these individuals their performance isn't great and they are on some form of performance management or some form of disciplinary pathway in the lower ends. Then

there is an incident, so I suppose could we have detected it earlier and seen these minor issues as near misses? I don't know, actually it's difficult, possibly" - Participant 9.

MEMO 7
After the interview the participant disclosed that the organisation had referred a registrant to the NMC for an act of dishonesty for coercive behaviour of a junior member of staff completing their online mandatory training. The registrant had a history of patient complaints, bullying and intimidating junior staff. The registrant lacked the ability to deal with challenging or stressful situations. Due to the registrant's employment history, the relationship between the employee and employer had irretrievably broken down.

It was evident that a number of participants considered whether any actions could have prevented the error. They questioned if the evidence could be interrogated to reveal if it is systemic failure or human error. Participant 18 questioned if the information about the nurse could have been used to predict future concerns.

"I can think of cases where we haven't known or haven't thought that there is anything untoward and then, there is a serious breach now, you may say well but when you look back and you recall, couldn't there have been enough data to, or enough information to challenge that? Yes, in some cases when you then sit down and think, ah but with the benefit of hindsight, or, I can think of situations because I've been doing this job a long time, where it is not a single abhorrent practitioner" - Participant 18.

A number of participants disclosed the complexity of managing and supporting large teams due to the volume of workload and time constraints. Participant 9 reflected on the complexity of managing staff in big departments, predicting future practice and the management of risk. The participant gave examples of a nurse who had been through the investigation process. The outcome was to reinstate the nurse with conditions of practice. However, it is evident that managers found it challenging to manage the level of risk. Is it possible to predict if a nurse could improve with relevant support or irrespective of the level of input their practice would never improve? This is discussed in the category a "chain of expectations":

"Are you picking up on the smaller things those kind of smoke alarms...maybe. But it is very difficult. Really difficult in a big department to of think actually, this person's going to kill somebody or harm somebody, but there is cases where we will suspend people, I guess quite a few times where there is serious issues that have occurred. We've suspended people pending investigation. But then we have reinstated them again and there hasn't been further

…yet touch wood kind of thing, incident or errors or admissions, so yeah it is a difficult one actually" - Participant 9.

Overall the participants described the nurses who fall "*just under the radar"* whose low level concerns have never been addressed until the nurse is involved in a significant mistake. It is apparent at this point the participants questioned if anything could have been done to address the low level concerns to prevent future patient harm and to protect the public.

4.6 "*Complaints from patients"* (Participants 8, 2, 10, 6, 5, 9, 10, 14)

This section will explore the participant's experience of managing a patient complaint. Eight of the participants described three types of complaints from patients. Firstly, the participants referred to direct written patient complaints, secondly, informal patient feedback to staff and finally, a formal complaint. Participant 8 described that a formal written patient complaint was rare but could be one of contributing factors that led to the decision to refer a nurse to the NMC:

*"Rarely have **complaints from patients** about individual nurses" - Participant 8.*

It appears that these complaints are unusual yet had a profound impact on the participants who had to manage patient and relatives' negative experience, as a consequence of the actions of their staff. Participant 2 was made aware of a newly qualified nurse's lack of competence and subsequent performance management review. A formal patient complaint was one of the factors that formulated part of the case against the nurse and ultimately the decision to refer the nurse to the NMC. The nurse had been caring for a patient with profound disabilities. Following the doctor's round, the nurse neglected to redress the patient's wound, leaving the patient in extreme pain and distress. During a meeting to discuss the incident, the nurse denied the allegations, blamed others, and demonstrated a lack of responsibility and ability to understand the seriousness of the incident.

"There was a big complaint that had gone in. A (patient) who was quite severely disabled from a condition that she had from a young (age) and she had a large nasty pressure sore on her sacrum. (The registrant) was looking after this patient, and she was told the doctors had taken the dressings off and she was told a dry dressing was on, but she needs to pack it and sort it out. Well she left it, and she left it and she left it, until the patient was screaming in pain. The dressing had dried inside and was just sticking to her skin, and then she (the registrant) denied she had been asked to do it and then she said someone else had been asked to do it" - Participant 2.

Patient complaints help to triangulate evidence when considering a nurse's level of performance, competence, and conduct. Participant 10 described a patient complaint that

identified a wide range of issues about a newly qualified nurse. The participant felt the nurse had the opportunity to remediate her practice through the preceptorship programme. However, it became clear that the nurse had a distinct lack of insight into her limitations. This is discussed in the category a "chain of expectations":

"I think there was an acceptance that she didn't quite get it, I mean a lot of the issues and how it came all surfaced was through patient complaints. I think, the individual had lots of chances to address, but the insight wasn't always there" - Participant 10.

This research reveals how patients use a number of mechanisms to raise a concern about a nurse. The patients are receivers of care, observing the activities taking place on the ward. The participants described experiences of managing informal patient feedback about a nurse's conduct and performance to members of staff. Participant 5 explained how a newly qualified nurse working on the ward had been struggling to perform safely. The participant recalled some of the difficult conversations she had had with her patients about the nurse's character and performance, which ultimately contributed towards her decision to refer to the NMC. This is explored further in the category characteristics and values that were wanted and unwanted in nurses:

"(The registrant would) just do the obs (observations) and walk off. And some patients would say, they don't want her, don't let her near me. Very quiet, she didn't engage really" - Participant 5.

Participant 2 recalled the patients' comments over a number of shifts about a newly qualified nurse's conduct. The comments referred to the nurse's attitude, communication and personality, rather than her performance, skills and knowledge:

"They (patients) found her, she wasn't bright and bubbly, and there was little things that came out like 'she didn't really talk to us.' She didn't do that and she said she would do things and then didn't" - Participant 2.

Participant 20 reflected on a similar situation whilst supporting a newly qualified nurse on the preceptorship programme. The nurse received positive patient feedback because the nurse was a kind and caring person. However her competence, skill and knowledge was suboptimal with numerous reports of errors, incidents, and near misses. The nurse was perceived as a "*friendly"* nurse yet "s*cary"* to work with because of her lack of skills, knowledge and competence to underpin her practice. These characteristics are illustrated in the chapter wanted and unwanted characteristics and values in nurses':

"I think that it was because the errors that occurred were more about some professional issues, like the discharge planning, the admission of the drugs the patient didn't realise it

was a harm to them, at that point. They (registrant) were never rude. They were never uncaring…so what the patient saw was a good caring nurse" - Participant 20.

Over recent years the public have become more aware of the different avenues to raise a concern about a nurse's fitness to practise, by making a direct referral to the NMC. Participant 10 described a number of queries from the NMC questioning a nurse's fitness to practise:

"We have had individuals referred by the public or by other members of staff. And the NMC write to us to check out whether there's any investigations. Often it would be a vexatious complainant or a member of staff that's aggrieved. Lots of complainants go straight to the NMC. (Be)cause they will clock your badge" - Participant 10.

Interestingly, participant 9 described how direct NMC referrals are for a variety of reasons, ranging from vexatious complaints to estranged partners or non – practice related concerns:

"It would only be a handful two or three but are largely these have been domestic issues. Estranged husbands, estranged wives, neighbours, all that sort of stuff. Really bizarre. Non-professional kind of issues. Related to relationships outside of work" - Participant 9.

In this situation, the NMC will ask the organisation to comment on the nurse's performance and conduct in the workplace.

'What we see, a lot more now is the NMC contacting us to say we've had a Fitness to Practice referral and say this nurse has been referred. These are the allegations and you now, are they on some disciplinary or performance pathway? And all the ones I've dealt with recently haven't been on a performance pathway.' Participant 9.

Overall, this chapter explains the "*alarm bells"* which trigger a concern about an early career nurse, co-constructed by the participant's experience. The chapter has so far explored the five sub categories of a genuine "*terrible mistake"* and a "clear cut" violation which questions an early careers nurses fitness to practise, the nurse whose low level performance and conduct tended to sit *'just under the radar'* and the nature of patient complaints.

4.7 Discussion of Research Findings with the Literature

4.7.1 A genuine "*terrible mistake"*

This research has highlighted the importance of how a nurse responds to a genuine "*terrible mistake"* who often hold up their hands and adopt the principles of professional duty of the candor with their employer. It was important to embrace the disclosure of errors requires a culture that promotes professional courage, while recognising the potential for multiple actions at multiple levels across the organisations. Non-punitive or open culture policies recognised

that multiple reasons may cause an error (Tocco and Blum, 2013; Institute of Medicine, 1999), including human factors. Ullstrom et al (2014) reports that their research highlighted a lack of organisational support or unstructured and unsystematic support. Without support or sufficient feedback, the health-care professional will find it difficult to emotionally process the situation and reach the opportunity of disclosure and closure (Ullstrom et al, 2014). This was reflected by participant 6:

"I think that's a big step for people, a learning curve to realise when you went wrong, look at making improvements, think right, I can see now. Maybe they didn't at the time, their judgements were clouded…you investigate that. Actually saying sorry, it's such a big thing for us, as an employer. Acknowledge it, learn from it, move forward" - Participant 6.

NHS England have committed to the principles and practices of Human Factors to optimise human performance. It has been recognised that a deeper understanding of the behaviour and conduct of people, and their interactions with others in complex healthcare environments, is needed (NHS England, 2013). It is more commonly recognised that delivering current healthcare can result in people, teams and the organisation being under great pressure (HEE England, 2015). Nurses work in unpredictable and dynamic situations with an expectation of making difficult decisions. At times, decision making can be compromised which impacts on the patient experience and quality of care, performance of the nurse and others.

There is a responsibility for the nurse when caring for their patients, to tell the truth about an error, even when they may run the risk of professional vulnerability. There may be a fear of the repercussions, disciplinary action, and an emotional reaction to the error by the employer (Pereira, 2009). Even though some nurses are relieved when they do report an error to their employer (Christensen, 1992). Peyrovi et al's cohort study reveals that nurses prefer not to report their errors because of the stigma and damage to the professional reputation (Peyrovi et al, 2015). However, many nurses accept responsibility and blame themselves for serious-outcome errors (Meurier, 1998). It is essential to act after errors are reported, with interventions aimed at protecting the welfare of patients (Robinson Wolf and Hughes, 2008). However, the "*second victim" (P9)* may be the nurse who can experience emotional distress following a genuine mistake (Ullstrom et al, 2014). Ullstrom et al (2014: 325) state that this "distress has been shown to be similar to that of the patient, the 'first victim"'. Ullstrom et al (2014) report that the impact on the healthcare professional is dependent on the healthcare organisation's response to the mistake.

4.7.2 "*Breach of the Code"*

Nurses and Midwives have a professional responsibility to adhere to the Code (NMC, 2018). This research has revealed employers will refer to the Code if a nurse fitness to practise is in

question. Aligned with the publication of the Duty of Professional Candor (GMC and NMC, 2015) explaining that every healthcare professional must be open and honest with patients, colleagues, employers and relevant organisations when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. The Duty of Professional Candor highlights that healthcare professionals must: tell the patient when something goes wrong, apologise, offer an appropriate remedy or support, and explain the short and long term effects of what has happened.

There has been national, political, and legislation drivers to ensure health-care organizations and their employees to embrace an open reporting culture (Berwick, 2013; NHS England, 2015). *Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* has been published with specific requirements for health-care organisations to follow if there is a concern about a patient's care and treatment. The Care Quality Commission can prosecute for a breach of parts 20(2)a and 20(3) of this regulation by embedding Human Factors principles within its assessment of how safe, effective, caring, responsive and well-led organisations are; with a particular focus on developing just and open cultures (NHS England, 2015).

4.7.3 "Just under the radar"

The Department of Health (2006: 82) report that healthcare professionals may find their practice called into question yet for "an overwhelming majority, an episode of sub-standard performance will not spell the end of their career," illustrated in table 19. However, this is not reflected by participant 4's experience who explains multiple events leads to a possible dismissal:

"There was a clear issue about capability and also performance in there. So you might have multiple events that lead to … the sort of accumulative effect of potential, level of dismissal" - Participant 4.

It is important to reflect on other disciplines who manage the risk of underperforming people. For example, in Australia, the National Offshore Petroleum Safety and Environmental Management Authority (NOPSEMA) (2016) state that identification and management of human factors is critical for the effective and reliable minimisation of risk. NOPSEMA (2016) state that by understanding those human factors which influence employees, responsible parties are able to implement targeted solutions to improve human reliability and reduce error.

In healthcare, a number of factors can induce an error in the workplace; this can be at individual and organisational levels but with the appropriate intervention the majority of nurses will continue in their roles. However, if these factors are poorly managed and the environment

was fraught with obstacles, there is a likelihood for things to continue to go wrong or a pattern of repeated errors. Participants described concerns which mirrored the guidance document published by Department of Health (2006) and National Patient Safety Agency of low level concerns, illustrated in the table below.

Table 19 Handling Concerns about the Performance of Healthcare Professionals: Principles of Good Practice

Handling Concerns about the Performance of Healthcare Professionals: Principles of good practice
Concerns about performance may relate to:
Low standard of work, for example, frequent mistakes, not following a task through, inability to cope with instructions given
An inability to handle a reasonable volume of work to a required standard
Unacceptable attitudes to patients
Unacceptable attitudes to work or colleagues, for example, un-co-operative behaviour, poor communication, inability to acknowledge the contribution of others, poor teamwork, lack of commitment and drive
Poor punctuality and unexplained absences
Lack of skills in tasks/methods of work required
Lack of awareness of required standards
Consistently failing to achieve agreed objectives
Acting outside limits of competence
Poor supervision of the work of others when this is a requirement of the post
A health problem

It is evident it is everyone's responsibility to ensure patient safety and the protection of the public. The Department of Health (2006) states that effective and efficient performance procedures should aim to maintain the quality of the service and ultimately protect the welfare of the nurse. Yet Manojlovich's (2005) study found that nursing leadership helped to explain 46% of the variance in nursing practice behaviours overall. This was identified by participants who highlighted the significant role of a Nurse Leader.

"There are others (registrants) who have been poorly performance managed and with a lack of courage perhaps or a lack of robustness …because it does happen if you've got weak ward managers or weak team managers, and then that pattern of behaviour which is allowed to fester, leads to a further transgression which is a more serious nature" - Participant 18.

"So I think there's something about people not being confident about dealing with poor performance" - Participant 17.

Performance management triggers the factors that may place a nurse at further risk of repeated unwanted behaviour. This performance management involves establishing the personal mitigating factors, education and training needs, alongside environmental and systemic issues. On occasion, the nurse's characteristics are factored into the performance management review of the evidence following repeated incidents, such as identifying "*she was a bit odd and she is a bit strange and do you remember that incident and that incident"* (P4). A number of participants commented on the strength of the leader to follow up on concerns if a nurse was performing "*just under the radar".* It is apparent employers adopted Braithwaite and Ayres' (1992) model of "responsive regulation", frequently referring to the strategies of open dialogue to support an early career nurse but recognised that the managers need support too, discussed in the Chain of Expectations chapter. Best practice advocated the "person taking action should be of appropriate seniority and experience with access to appropriate clinical and human resources advice" (DOH, 2006: 13).

"It's about talking about the competence of the individual to be able to do whichever job it is they are employed to do" - Participant 17.

However, Maxfield et al (2008: 149) explain that health-care professionals "frequently recognize error, poor judgment, or incompetence in colleagues, yet it is extremely rare that they confront the person involved in the error, or report it to supervisory personnel." Instead, a nurse whose performance or conduct is "*just under the radar"* may be highlighted by a "*patient complaint".*

4.7.4 "Patient complaints"

By reflecting on the history of nursing in Florence Nightingale's view, good nurses were good people who cultivate certain virtues or qualities in their character (Bradshaw, 2011). As Nightingale reiterated in letters to probationer nurses, it is what the nurse is inside that counts, "the rest is only the outward shell or envelope" (Nightingale, 1859 a; 1859b). Therefore, good interpersonal skills, the ability to communicate and interact with people from a variety of backgrounds are an important part of nursing. They form the foundation of the nurse-patient relationship. Peplau (1999: 13) considers nursing to be a "significant, therapeutic, interpersonal process, defining it as a human relationship between an individual who is sick, or in need of health services, and a nurse specially educated to recognize and to respond to the need for help".

In this study, the participants explained how the ability to form human relationships influenced the patient's feelings towards the nurse influenced by the nurse's character traits, for example lack of social and communication skills. It is apparent this increased the patient's nervousness and enhanced their perception of the nurse's lack of competence, knowledge and skill,

compared to the "*friendly"* nurse described by participant 6. This is discussed in the "characteristics and values wanted and unwanted in nurses" chapter.

"(She would) just do the obs(ervations) and walk off. And some patients would say, they don't want her, don't let her near me…So they obviously picked up that she didn't have the skills, they didn't feel safe with her. She didn't talk to them" - Participant 5.

Reinertsen and Clancy (2006) argue that when patients entrust themselves to nursing care, the nurse makes two implicit, but important, professional promises: nurses promise to do everything possible to help them; and while they are going about that task, they promise not to hurt them.

4.8 Conclusion

To conclude the findings for the *"alarm bells"* chapter, there is now a greater understanding of the meaning of the experience as a whole. The "*alarm bells"* category has clarified the pre-understandings identified at the out-set of this study in relation to criminal convictions, professional misconduct and lack of competence and nursing error in the Initial Literature Review chapter.

This chapter has challenged the pre-understandings in a different way. Throughout the study, the process of theoretical sampling pursued clues that arose when exploring the factors that contribute towards an employer referring an early career nurse to the professional regulator. The participants confirmed employers have a duty of care and a responsibility to protect the public, thereby a genuine "*terrible mistake,"* a "*clear cut"* violation, a "*breach of the Code",* managing a nurse whose performance is "*just under the radar"* and - / - or a "*patient complaint"* contribute towards a referral to the NMC.

4.9 Key Findings for the Alarms Bells Category

- The research confirms that healthcare employers ensure that "*patient safety is number one"* with a commitment to being a "*fair employer".*
- This research confirms the "*alarm bells"* that identify a nurse at risk of referral, which contribute towards the decision to refer a nurse to the NMC.
- The research confirms "*terrible mistakes"* take place in the work place, sometimes with a detrimental effect on the patient's experience. These genuine mistakes can be made by highly performing and competent nurses, who had no previous clinical or conduct concerns but because of the severity of the mistake, even though a one-off incident, resulted in a referral to the NMC. Thereby, the "*second victim"* is the nurse.

- The decision to refer is "*never taken lightly". O*ften employers found the genuine "*terrible mistake"* cases difficult and challenging decisions.
- The research reveals some nurses fall "*just under the radar".* It is evident that some nurses continue to function in their role even though there are low level concerns that have never been addressed. This is sometimes due to lack of evidence, until the nurse is involved in a significant error.
- The research demonstrates that early career nurses can be involved in a "*clear cut violation" that* without doubt proceeds to a referral to the NMC.
- It is evident that the participants felt early career nurses do not always understand the serious consequences of "*breaching the Code*." The participants perceive the Code as their "*licence to practise*."
- The research confirms there appear to be three main avenues patients' use to raise a concern about an early carer nurse's fitness to practise, which can contribute towards a referral to the NMC.

Chapter 5 Research Findings – Theoretical Category Two: Characteristics and Values Wanted and Unwanted in a Nurse

5.1 Introduction

This chapter presents the participants' views and opinions about the wanted and unwanted characteristics and values of nurses who have been referred to the NMC. Diagram 23 summarises the content of this chapter in relation to answering the research questions. The first section of this chapter explores the breach of the fundamental value of honesty. Nine of the participants described early career nurses who had received an allegation of dishonesty. The second section of this chapter explores the four characteristics displayed as: the "*friendly"* nurse; the "*odd"* nurse; the "*difficult"* nurse and the "*scary"* nurse, illustrated in the chart 23. Each of the sub-categories is presented from the participants' perspective and is underpinned by individual quotes from the interviews. Diagram 23 is a visual representation of how the categories and subcategories build up over the four chapters, clearly displaying the five sub categories of the characteristics and values wanted and unwanted in a Nurse.

This chapter will provide an insight into the experiences of 15 participants, with a summary of how the research questions have been answered for the characteristics and values wanted and unwanted in nurse's, addressing the research aim and objectives, as illustrated in the diagram 24.

Diagram 22 The Characteristics and Values Wanted and Unwanted in Nurses

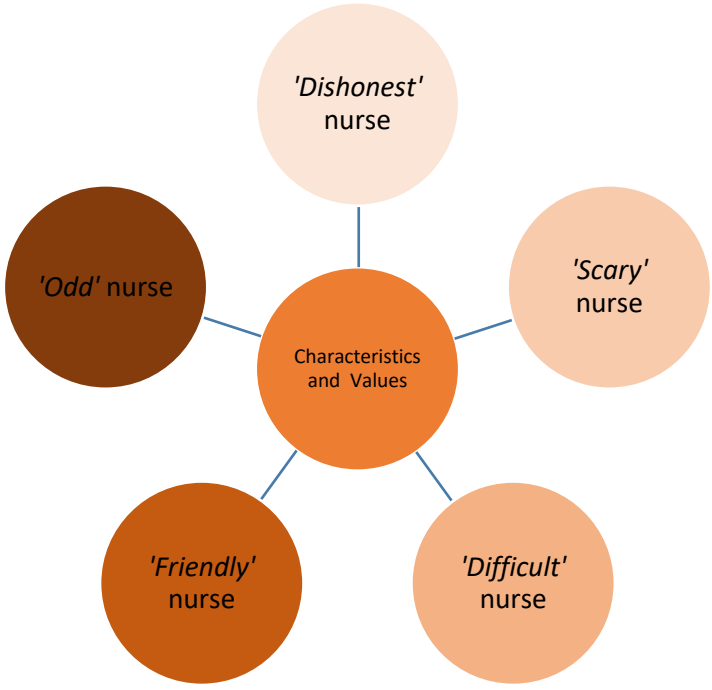


Diagram 23 A Representation of the Theoretical Category Characteristics and Values Wanted and Unwanted in Nurses

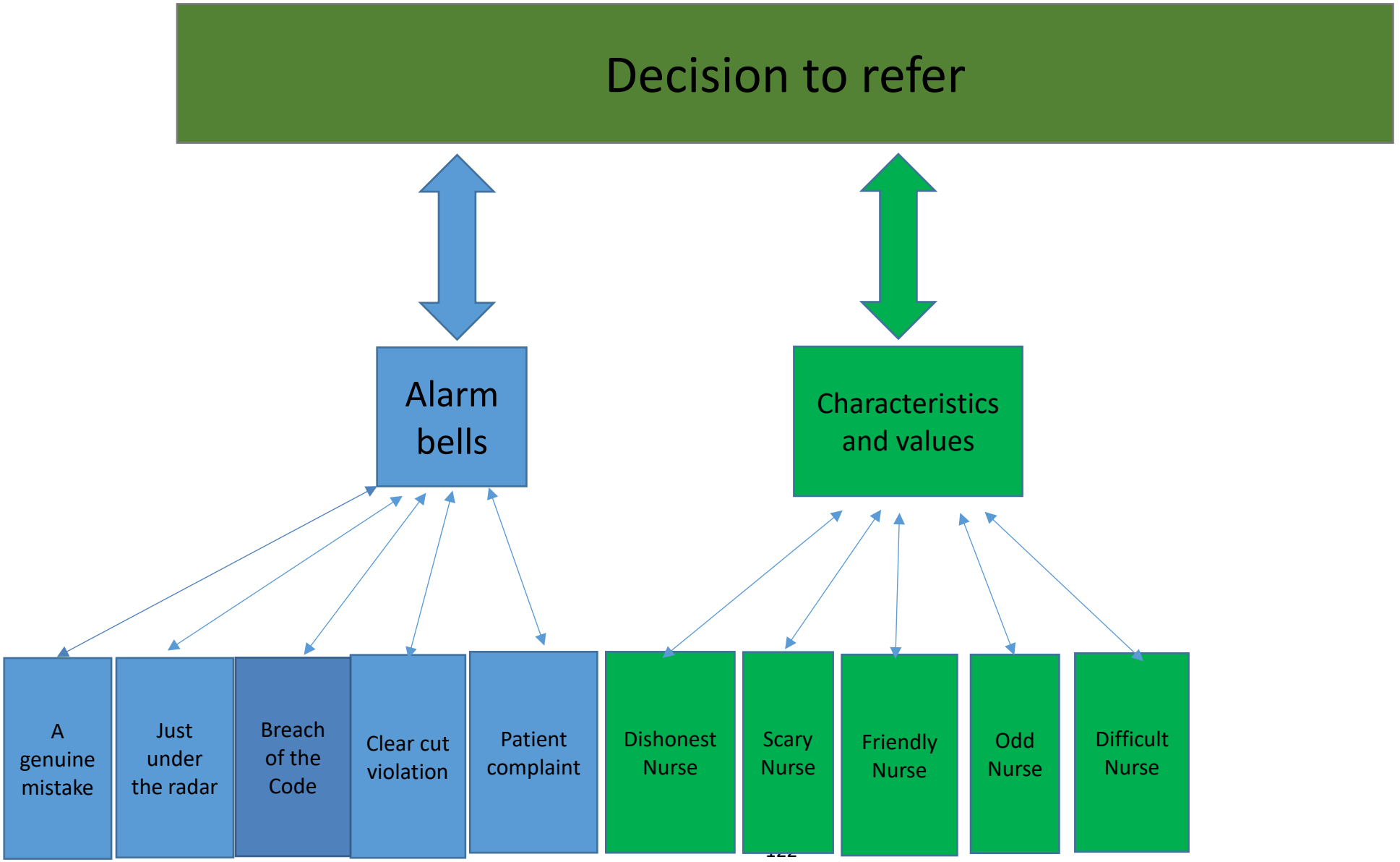
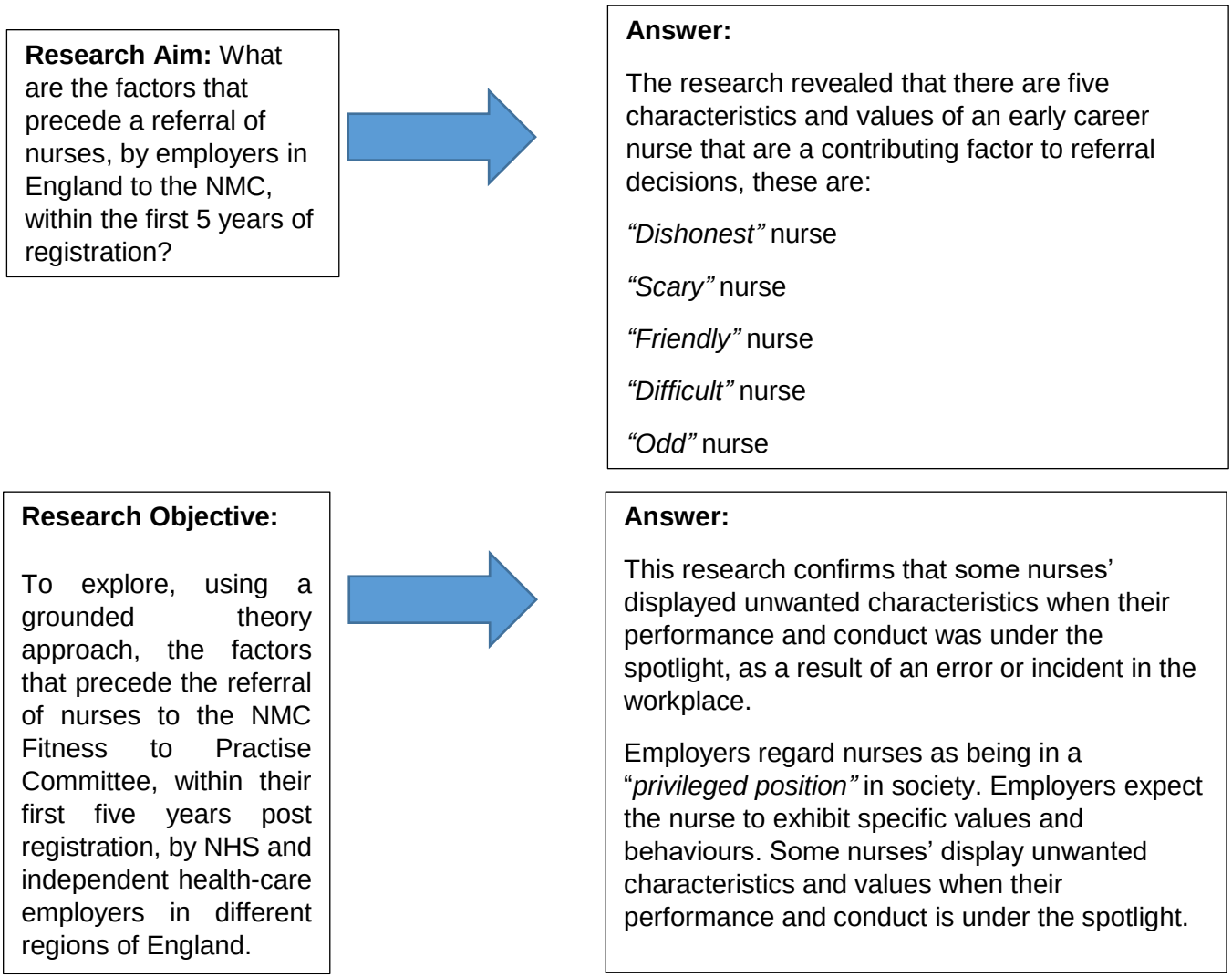


Diagram 24: Summary of Dialogue and Questions Answered for the Characterisitics and Values Wanted and Unwanted in Nurses Category



5.2 "*Dishonest"* Nurse (Participants 1, 13, 16, 4, 17, 9, 11, 6, 10)

The participant's expressed how honesty is an important value in nursing. The participants gave examples that an act of dishonesty can have irretrievable ramifications for the patient, the nurse, the nursing team and the wider organisation. In this study the dishonest nurse often results in the breakdown of trust between the nurse, the patients and the employer. Participant 1 described a "*zero tolerance"* of dishonesty because it destroyed relationships and had an impact on the organisation. Furber (2012) argues that the breakdown in trust must be substantial and employers need to ask the reason for the cause of the loss of confidence:

"The other bit of dishonesty is where it is the trust and the relationship with the hospital has been broken down. Because how could you trust them to do anything else. It is a fundamental part of what we do here. And it is massive, and there is a zero tolerance of that (dishonesty)" - Participant 1.

This concept is acknowledged by participant 17 who discusses the level of trust as essential to maintaining an effective working relationship on different levels between employee and employer, the nurse and patient:

*"If somebody's **dishonest** then, you can't, I mean it just, ruins all the trust" - Participant 17.*

A case of dishonesty has future repercussions for the nurse's reputation to safely care for patients. The nurse/patient therapeutic relationship is the basis of professional practice, bears wide ranging responsibilities, risks and pressures. The duty of care to the patient is paramount and the nurse's prime consideration should be the patient's best interest. Participant 16 questioned whether, if a nurse's integrity and values had been questioned, they could be trusted to look after patients? The participant expressed that it is the organisations responsibility and ownership of patient safety that patients were cared for by honest staff:

"We simply didn't feel that somebody who's honesty and integrity was that impaired could really go on to look after our vulnerable patients and for us to feel comfortable with that"

- Participant 16.

An act of dishonesty can manifest itself in varying degrees with subsequent consequences for patients and ultimately, in extreme cases lead to the death of a patient. Participant 13 illustrated the severity of dishonesty by describing a clinical scenario:

"It is really important, I mean honesty is sort of fundamental, and my illustration of it is that I think lying kills people. You know you've got somebody who makes a mistake… what was the blood pressure and you forgot to measure it and then instead of saying oopps, I haven't done that I'll just go and check. You lie and say it was normal and then actually the patient's got very high blood pressure and dies. So being honest about things particularly about mistakes, because we all make mistakes" - Participant 13.

The participants describe the nurses "*privileged position"* in society in relation to patients and their families. They have considerable social responsibilities that need to be upheld at all times, reinforced by the professional standards set out by the NMC. Participant 13 conveyed the view that whilst errors and incidents do take place in practice, it is how the nurse manages and recognises their mistakes that incurs confidence in their employer about their future practice. Participant 1 describes examples of dishonesty when a nurse stole medication for

personal use. The case was twofold: stealing medication from the organisation; and falsifying documents to reflect that the patient had received the medication, when they had not:

"It is the lowest to steal, it is from the public purse, we don't know whether she was saying she was giving patients tablets and not giving them, so potentially not giving patient's treatment for her own benefit. It covers every level of depravity that you can do and then the breakdown of that relationship with that individual has gone" - Participant 1

Trust is about belief, confidence, or faith in someone's reliability and ability. A patient's trust in a nurse provides the confidence that the nurse will act safely and in the patient's best interest. The organisation's disciplinary hearing committee have to consider the risk of repetition of the nurse's future conduct in a dishonesty case. The risk assessment weighs up if there are any strategies that can be implemented to manage and support the nurses conduct if they return to practice. No-one can say with certainty that a dishonest act will not be repeated or if the nurse can remediate against their conduct. Participant 4 discusses the operational complications of dealing with dishonesty cases:

"Just come and check your handbag every day. I mean we, we can't do that and I don't think it's appropriate to put a system around an individual registrant just too sort of prove that they don't steal. It should be implicit within our contract with that individual that they uphold the standard and dishonesty is clearly a breach of the code. So in my view that in itself, I can't see how that can be remedied" - Participant 4.

MEMO 4

The participant reflected on the challenges of this case. The nurse had been a long serving staff member as a Health Care Assistant, Student Nurse and Staff Nurse. After a tragic family bereavement the nurse's behaviour and conduct significantly changed, with an inability to recognise the serious nature of stealing medication and the consequences to the patients, the team and the wider organisation.

Overall, it is evident that the participant's experience of an early career nurse's dishonest conduct is not tolerated because of the "*privileged position"* nurses hold in society to uphold the reputation of the profession. The outcome of dishonest conduct can result in an irretrievable "*breakdown of relationships" (P1)* between the employer and the nurse. This is irrespective of the personal mitigation surrounding the case. In the next section, the participants explain how some nurses' performance, behaviour, and conduct had caused exceptional concern, referring to them as a "*scary"* nurse to work with.

5.3 The "*Scary"* Nurse (Participants 4, 2, 9, 8, 5, 6, 16, 13 and 10)

Nine of the participants reflected on working with nurses who have displayed elements of misconduct and behavioural issues, a lack of knowledge, skill, and competence, which caused them deep concerns, to the extent they found the nurse to be "*scary"* to work with when on duty.

Participant (4) discussed the wide range of nurses in their organisation ranging from the "*friendly"* nurse, "*odd"* nurse, and the "*difficult"* nurse, to the other end of the scale; the "*scary"* nurse:

"I don't see any common pattern, and I've come across individuals who ***scare*** *the bejesus out of me" - Participant 4.*

In some cases, the participants experienced an early career nurse whose fitness to practise was proved to be unsafe, with a real risk of repetition. This resulted in dismissal for gross misconduct, lack of competence, leading to a referral to the NMC. Participant 2 discussed a case of a newly qualified nurse who significantly lacked competence, skills and knowledge, demonstrated no insight into the responsibilities of the role of the nurse and an inability to function safely as a staff nurse. The participant expressed concerns about the nurse's lack of care and compassion for her patients, a number of patient complaints and medication errors and near misses. Due to the severity of concerns the participant felt strongly about her responsibility to protect the public and a duty of care to patient safety:

"This sounds very OTT but I don't ever want her looking after my patients ever again and ***it scares me*** *the thought of her looking after patients" - Participant 2.*

Participant 13 was clear that insight is a vital component of everyday practice to function safely as a professional. The participant's explanation was that a nurse who lacked insight does not understand that there was a problem with their practice. Therefore, how can the nurse remediate against their actions and improve, preventing a reoccurrence? Thus, it is difficult to offer support and manage a nurse who does not recognise their own deficiencies. This is explored in more detail in the chapter A Chain of Expectations.

"I think insight is recognised as being the most important quality and I think if you possess insight, then you don't have run-ins with your regulator because you recognise you've done something wrong or somebody says to you that wasn't very clever, and you think it through and take steps to stop it happening again. So insight is life and death" - Participant 13.

Participant 2 labelled a nurse who lacked insight as a "*scary"* characteristic. The participant described a newly qualified nurse involved in repeated drug errors and omissions, and a

subsequent formal complaint from a patient. The participant was the Investigating Officer who found the lack of insight displayed by the nurse about a potentially serious incident very concerning:

"Because what I see here and particular what I am hearing from you scares me, and it worries me and about your knowledge and your lack of insight, it's really very ***scary****. And she said I don't understand that. And I said if I said to you what you said to me it wasn't a drug error because you were stopped" - Participant 2.*

The participant described some newly qualified nurse's displaying attitudinal and behavioural traits aligned to bullying. One example provided by participant 9 referred to the "*scary"* nurse whose character traits are displayed by destructive and manipulative behaviour. The participants explained the "*scary"* nurse's characteristics resulted in staff feeling unable to report concerns about a nurse's performance or conduct. This reinforces Lathrop's (2007) study which refers to the difficulties of confronting a bully or saboteur, mainly because of the risk of the personal consequences when confronting a tormentor. In some cases, nurses were stuck in a conspiracy of silence. A nurse with these "*scary"* character traits can influence the confidence of a member of the nursing team to report concerns:

"You know because this person has either scared them for so long, or they've been so disruptive or manipulative" - Participant 9.

Participant 4 described a case of a nurse with a manipulative attitude, which was not reported or brought to the attention of senior managers by the nursing team. The nurse was eventually investigated, dismissed for gross misconduct, and referred to the NMC. The original complaint was reported by a student nurse, after the nurse left a patient to significantly deteriorate, with the aim of creating a good learning environment for the student nurse to manage the emergency situation:

"In terms of their attitude and their behaviour, the investigation proved the allegations because there were clearly three witnesses to that, to the events that went on that night. But actually once we were doing the investigation we started to then draw in other evidence of people going, oh well actually I've seen that before and that's a common pattern of behaviour. So, you do see some individuals who do genuinely have poor practice but actually some people don't raise it" - Participant 4.

Participant 8 recalled a similar scenario of staff not feeling able to report significant conduct, attitude, and performance that breached the professional codes of practice:

'People are frightened, you know? There are some people and I hope we haven't got any here but I couldn't hand-on-heart say we haven't, who actually are a bit intimidating for some

staff to work with and it takes a lot of guts to stand up and report somebody that you're working with.' Participant 8.

It is evident that there are certain characteristics that resulted in the nursing team lacking the confidence in a newly qualified nurse's ability to function safely. Participant 5 reflected on the appointment of a newly qualified nurse where the nursing team almost immediately raised concerns for the safety of the patients. They reported the nurse displaying characteristics of being "*robotic"* and lacking an emotional response to situations:

"The way I can describe her, she just glided round really but almost left not quite a disaster behind her….the emotion isn't there if something happens" - Participant 5.

The participant stated that the nurse did not display unpleasant characteristics or was not a "*difficult"* nurse. The nurse was quiet and calm but lacked the required social and human skills to help connect with her patients and the nursing team:

"She wasn't rude, unkind, and detrimental, I don't think she'd ever say a nasty word" -

Participant 5.

The research highlighted a number of cases of nurses whose characteristics and behaviour contributed towards a referral to the NMC. It is evident that there was a triangulation of evidence about the incident, the nurse's insight and characteristics of an early career nurse - within the first five years of registration.

5.4 The "*friendly"* Nurse (Participants 17, 4, 2, 9, 6)

Five of the participants disclosed one of the favourable characteristics of a nurse being someone who was talkative with a "*friendly"* personality. The nurse with these characteristics can be funny, energetic, seen as 'the life and soul of a party'. These nurses like the centre stage, make friends easily, they can be charming company. Participant 17 reflected on the character and behaviour of nurses:

"In terms of their behaviour and the way they work and how they (the registrants) are ***friendly" -*** *Participant 17.*

Participant 4 recalls the nurses whose staff, patients and relatives saw as "*a really good nurse"* because of their personality and character traits. Perkins (2016) argues that 'the best nurses combine superb organizational skills, with a hefty dose of compassion'. However it is apparent the "*friendly"* and "*really good nurse"* can make mistakes and be involved in errors and incidents in practice, which was often a shock and surprise to the nursing team.

"(Nurses) who are … the life and soul, the best nurse and that can often be noticing, well I am really surprised 'x' did that because they're a really good nurse and their patients say so and often that's the case" - Participant 4.

Participant 9 described a nurse who was hardworking and well respected who was involved in a one off incident that resulted in a patient fatality. There was a degree of sadness with the outcome of this case but because of the severity of the incident but the organisation felt they had no choice but to refer to the NMC:

"They're kind of heart-breaking ones where you've got individuals who are hardworking, highly thought of, by their team members and senior clinicians, and they just make a terrible mistake in a high risk environment and actually, we have no choice but to refer them. But actually you have no choice because of the level of harm or death. So that's kind of sad in a way" - Participant 9.

On the other hand, participant 6 describes the bubby, "*friendly"* nurse who was loved by the residents for their characteristic traits and personality. Yet, they were difficult to manage from an employment perspective. The nurse would try and please the patient and their relatives, irrespective of whether the promises were achievable or possible. The participant regarded this as misleading and dishonest. Cherry and Jacob (2013) argue that inherent in the concept of promise keeping are the qualities of honesty and integrity, once a commitment has been made every effort should be made to fulfil that promise. Yet, Perkins (2016) argues that caring too much destroys objectivity and decreases effectiveness.

"I always find the ones that we have trouble managing from an employer point of view, residents and relatives love. But then the residents would love her if she's there promising yeah we'll do this, we'll do that" - Participant 6.

Finkelman (2006) acknowledges that nurses may feel that they are responsible for tasks and yet have no control or power to affect change with these tasks. It is evident from the employer's perspective that the early career nurse who is caring and chatty, with an empathetic character trait provides patients with a reassuring and supportive aspect to their care by promising too much, which is seen as working beyond their level of responsibility.

"Because you know there are some people (registrants) who are very sort of tactile and chatty and I'm not saying offer a lip service but tell people what they want to hear and give them the reassurances" - Participant 6.

Participant 6 highlighted how newly qualified nurses sometimes had a limited understanding of the level of responsibility of the registered nurse in the care setting:

"I think we've some nurses and especially the newly qualified, if they're in an environment like this there is a level of responsibility that they are now given and I think they sometimes over step that mark. Not always intentionally, just take it a bit too far…Then it goes a bit pear-shaped and that's when me and the manager come in and try and resolve it. So I think … it's not a power thing that goes to their head, it's just the boundaries, one-step at a time" - Participant 6.

This research has revealed the employer felt that the nursing team is often shocked and surprised when a highly regarded "*friendly"* nurse has been involved in an error or incident in practice. However, one of the participants reflected on the level of responsibility by setting out the boundaries to prevent the newly qualified nurse from working outside their scope of practice. The next section explores how the level of scrutiny during the investigation and internal formal processes can expose the character traits of the "*difficult"* nurse.

5.5 The "*difficult"* Nurse (Participants 4, 8, 9, 14, 16)

This research has revealed that a range of characteristic traits that can be displayed in the workplace, such as awkward behaviour, being abrupt with staff, demonstrating challenging and disruptive conduct. Five of the participants discussed nurses that exhibited abrasive behaviour and a lack of regard towards their team members. Rosenstein and O'Daniel's (2008) survey of staff, nurses, and physicians found that disruptive behaviour; including using disrespectful language or berating staff, was common among nurses and physicians. Participants 4 and four others highlighted that, in some cases, the nurse's performance and practice was safe and competent yet the conduct and attitude portrayed by the nurse was "*difficult":*

"They may be an excellent nurse but have some sort of a personality trait i.e. they might be abrupt or ***difficult*** *or a bit too over-familiar, a bit loud" - Participant 4.*

"Certainly some of her colleagues found her quite ***difficult"*** *- Participant 14*

There appears to be no standard definition of disruptive behaviour or the "*difficult"* characteristics towards patients. Participant 8 describes the "*difficult"* nurse as direct and "*abrupt"* with patients in their care. This conduct is deemed to impact on the patient's experience, especially when meeting the nurse for the first time. Unprofessional behaviour by health-care professionals has been linked to adverse events and affects the quality of care (Rosenstein and O'Daniel, 2008).

"There is something about the way people talk to each other, and I think that people are a bit abrupt, aren't they? And actually that is okay if you know them, but if it is the first time you're meeting them and you're vulnerable you're in a bed, then that's a bit difficult isn't it?" - Participant 8.

Participant 4 has experience of working with a newly qualified "*difficult"* nurse and explains the level of monitoring that is needed from the start of their employment. Leape and Fromson (2006) illustrates a systems-level approach is needed to identify, monitor, and remediate poorly performing heath care professionals, including those who regularly engage in unprofessional behaviour. It is apparent that some early career nurses require consistent support and ongoing dialogue to effectively manage their performance and conduct in the work place.

"Other people who are you know, a pain in the backside from day one. And are constantly in matron's office for a variety of issues and misdemeanours" - Participant 4.

Participant 14 referred to a case involving two employees who could be considered as "*difficult".* They worked on the same ward but due to similar character traits they tended to clash, make demands, issue complaints and forced their opinion onto others. This caused significant problems for the wider nursing team. Eventually following an unsuccessful mediation period the one nurse left the organisation.

"I think there was a claim and a counter claim with this other member of staff. We tried to handle that through mediation. And ultimately the other member of staff left. And I have to say, the other member of staff was equally ***difficult****. So you'd got two very strong personalities in close proximity and they just never rubbed well together at all" - Participant 14.*

A number of participants described examples of the "*difficult"* nurse where characteristic traits led to them manipulating situations to their advantage. The participants discussed how the "*difficult"* nurse would mask their own limitations in practice to distract the situation away from the truth. Participant 9 described the nurse who blamed the patient for their own benefit:

"They've (the registrant) been very manipulative case that we referred, part of the referral was about kind of abuse of power and manipulation of a bereaved relative, and that formed part of the dismissal. ..Some of the cases they've (the registrant) manipulated patients to make themselves look good" - Participant 9.

Participant 9 recalled another "*difficult nurse"* who took revenge on the organisation through social media following their dismissal for gross misconduct and subsequent referral to the NMC:

"The people without insight would probably be angry and will go to Twitter and go to … their blogs or … set up websites, you know and all that sort of stuff. And then you can feel their anger in social media campaigns, that they might have against … you as an individual or against the organisation" - Participant 9.

It is evident that following an error or incident in practice the investigation and the organisations disciplinary proceedings exposed the characteristics described as "*difficult".* Interestingly, Papadakis et al's studies (2005) report that unprofessional behaviour during medical school was linked to subsequent disciplinary action by licensing boards. The recommendation of the study suggested that an early emphasis on teaching professionalism and addressing disruptive and difficult behaviour during training may prevent subsequent incidents (Papadakis et al, 2005). The next section discusses the level of scrutiny during the investigation and organisation disciplinary processes of early career nurse with "*odd"* characteristics.

5.6 The "*odd"* Nurse (Participants 2, 19, 4, 5, 15)

This section explores the sub category generated from the data of the participant's experience of working with a nurse who displayed "*odd"* characteristics. This concept is different from the "*difficult"* nurse whose attitude and behaviour was disruptive, obstructive and argumentative. The participants refer to the "*odd"* nurse as someone who appears to lack social and human skills, in some cases, they have a lack of compassion and communication skills, with a lack of caring instinct towards their patients and colleagues.

*"There are people that display **odd** behaviours" - Participant 15*

Participant 2 was the first person to describe the "*odd"* characteristics which appeared to be one of the contributing factor that led to the decision to refer a newly qualified nurse to the NMC. The participant explained that it was the nurse's second substantive post as a staff nurse within the first year of registration. The participant outlined a wide range of concerns, from an inability to deliver safe care, for example follow instructions, frequent mistakes and no insight into the role of a nurse or taking responsibility for her actions, numerous patient complaints and consistency failing to meet objectives. The participant described the nurse's lack of human and social skills, care and compassion. The participant gave examples of how the nurse did not integrate with the nursing team or connect with patients or their relatives, or display care and compassion towards her patients. Eley et al (2012) reports that a caring nature is a principal quality of the nursing personality. This research highlighted employers are looking beyond the incident or error towards the nurse's personality:

"When I say an odd person, she was quite difficult to like and quite cold in some ways" - Participant 2.

The participant continued to describe the nurse's character as strange yet noted that she was highly intelligent, and excelled at interview. The participant recalled reviewing the interview records, to examine the nurse's background and appropriateness of the appointment. These actions were taken because the nurse significantly struggled within the first few months of employment and shortly left the organsition. The newly qualified nurse lacked the ability to put theory into practice and to independently function as a caring and safe staff nurse:

"(the registrant) would come across as a bit of an odd girl, but very clever and very intelligent and would say all the right things but just can't then put it into the practical sense and appear to understand what she is doing when she is actually carrying out the roles but no insight what so ever" - Participant 2.

At times, the participant appeared to struggle to describe the nurse's characteristics so referred to the term "*autistic".* There was no apparent formal diagnosis yet the participant needed to understand the reason for the nurse's behaviour and conduct:

"She lacked social skills, she definitely lacked social skills there is a part of me that whether she has some sort of personality disorder she was almost a bit, autistic if I am honest. She showed that kind of strange, very clever and high functioning in some ways because you can't, there are not many people that get maximum score for the interview. You know all the right things to do but you can't put it into practice. And that is the disconnection, you can say it but my hands can't do it" - Participant 2.

These traits were described by participant 19 who had been supporting a newly qualified nurse who displayed similar characteristics of lacking appropriate social skills and the inability to concentrate. Again, the participant tried to diagnosis the problem by using terms such as "*autism".*

'I would say she had some kind of autism or something. You know? … She was in my space and loud and can't focus … yeah.' Participant 19.

A further participant described a newly qualified nurse, who had been appointed following a successful interview. The participant reflected that from day one the nurse struggled to integrate into the team in a busy acute surgical environment or grasp the role of the nurse, or function as a safe clinical staff nurse. The participant explained she had looked at the interview records to establish the nurse's background and experience. It was questioned if the nurse's characteristics and behaviours could have been picked up earlier during her pre-registration nursing programme:

"Well actually she was a bit odd and she is a bit strange and do you remember that and that incident, and other people are saying, all of these minor issues were they a fundamental character flaw that we should've picked up" - Participant 4.

Participant 5 enhanced the picture of the character traits of the "*odd"* nurse. They described a newly qualified registrant who also lacked social and human skills. It is evident that the nurse also had limited personal self-awareness and a lack of responsibility. The participant described the nurse as immature, not obstructive or rude compared to the "*difficult"* nurse but lacking the ability to manage her own welfare:

"She was quite a classic, I'm not quite sure what she was, but no sense of responsibility for herself" - Participant 5.

The participant reflected on an example that caused her concern. The nurse was disorganised and unable to plan for her own welfare. This was amongst a variety of practice related issues, limited progression, inability to work independently and the nurse's lack of connection with the nursing team and patients, specifically in relation to care and compassion.

"She wasn't living here and she hadn't sorted out any local accommodation. And the first of shift she worked I believe, you know you discover later, I think she'd probably done the early. She was on the next day and she just was wandering around trying to find somewhere to live. What am I gonna do with her? Shall have to take her home? I didn't know, but you think because when people have come before, they've had enough notice from interview and now, been successful, to find somewhere to stay. But she was wandering around looking, so these aren't normal behaviours are they?" - Participant 5.

MEMO 5

On reflection my thoughts highlighted that the themes generated during the interview were similar to the second interview. Interestingly the participant could have been talking about the same nurse. This is virtually impossible because they live in different parts to the country. Both participants described similar characteristics and personality traits: lack of communication skills; distant with colleagues and patients; unable to relate to patient safety concerns raised by their manager; very articulate but unable to apply knowledge to practice; poor social skills; lack of care and compassion excelled at interview (recruitment process).

Yet, participant 15 portrayed a different perspective of the nurse who displayed "*odd"* characteristics. The participant acknowledged the very small percentage of nurses who struggle to fit into the profession often excel with the qualities of being highly intelligent who

could be the potential leaders of the future, because they are different with an ability to see things from another perception:

"Because I think you know, there are people that display odd behaviours. Very clearly. But there are also people that are a bit different, that perhaps are going to be the leaders in the future …because they are a bit different" - Participant 15.

It is apparent that a very small percentage of nurses struggle to fit into the profession. The participants referred to the "*odd"* nurse as someone who appeared to lack social and human skills, a lack of compassion, communication skills, and a caring instinct towards their patients and colleagues. It is evident that employers take into consideration a nurses characteristics and values as part of the decision making process to refer an early career nurse to the NMC.

5.7 Discussion of Research Findings for Characteristics and Values Wanted and Unwanted in Nurses with the Literature

This chapter is grounded in the data and represents the voice of the participants, with verbatim quotes and memos, but it is important to reflect on the perceived unconscious biases disclosed by the participants when describing the characteristics and values wanted and unwanted in nurses (Persaud, 2019). It could be argued we all have unconscious biases, which are learned stereotypes that are automatic, unintentional, deeply engrained within our beliefs, universal, and have the ability to affect our behaviour. The researcher acknowledges it has exposed the participant's views of nurse leaders who could be considered to be ethically responsible for creating diverse and inclusive spaces for early career nurses. It is crucial leaders openly acknowledge and address the negative influence of bias and prejudice when managing an early career nurse whose fitness to practise is in question, which may stem from the culture within the organisation. This process begins with an in-depth examination of one's own biases and continues through actions at the individual and organisational levels (Persaud, 2019), which is aligned to one of the recommendations of this study.

Persaud (2019) promotes that nurse leaders are well positioned to address and mitigate the negative influence of bias within organisations. This is reflected by one of the participant who strongly advocated "there are people that are a bit different, that perhaps are going to be the leaders in the future …because they are a bit different" (Participant 15). Other participants described certain early career nurse's behaviour and characteristics as "odd" and "difficult", "scary" and a "personality disorder". From a critical perspective the participants who appear to hold unconscious beliefs and biases are displayed by categorising the nurse's behaviour and conduct as an unwanted characteristic or value. In this case this could be perceived as constraining the early career nurse's opportunity to be innovative and creative, which could

be an essential quality for leaders of the future who 'think outside the box' to react to the rapidly changing healthcare needs and policy.

This constructivist grounded research is not about power, status, prestige, manipulation, the rule of experts, fear, insecurity, but is based on a strong, well-founded argument. It is up to the reader to decide if the participants provide a reasonable and authentic argument which can be perceived as appropriate for this research. Alvesson and Skoldberg (2018; 189) describe the importance of considering if participants views carry "equal weight". This can be dependent on a number of factors, including knowledge and experience, wisdom and the basis of their authority, their closeness to clinical practice and understanding of the reality and challenges faced by early career nurses. In this study the participant's inclusion criteria required experience of making a referral to the NMC, therefore ascertaining the scope, relevance and reliability of statements made by experts in the field and it could be argued reasonable weight can be ascribed to them.

5.7.1 "*Dishonest"* Nurse

Honesty underpins a nurse's integrity and professionalism when caring for people and their loved ones when they are vulnerable (Banks and Gallagher, 2008). The Nursing and Midwifery Council Code (2018) states that a nurse must uphold the reputation of the profession and act with honesty and integrity at all times. However, the complex role of the nurse involves delivering safe, effective clinical care for the health, welfare, maintenance, and protection of their patients, within an inter-professional health-care environment. The context of this work tends to be in an ever-changing set of social, cultural, ethical and political boundaries. Dishonesty in nurses may be both a state of mind and a course of action. The NMC (2018) state, when making a decision on a dishonesty charge, panel members of the Fitness to Practise Committee must decide whether or not the conduct took place, and if so, what was the nurse or midwife's state of mind at the time, aligned with case law, such as Uddin v General Medical Council [2012] EWHC 2669 (Admin). British law assumes that people from all walks of life can easily recognise dishonesty when they see it, illustrated in the case of Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67 para 53; further Ivey (para 48) restates that judges do not and must not attempt to define dishonesty, citing R v Feely [1973] QB 530. A course of action might be theft or it may be a state of mind, in which a nurse deliberately lies or cheats for their own personal reasons. A deliberate act of dishonesty may be influenced by a drug dependency, this may be fundamentally linked to their personality traits. However, the NMC (2018) advocate Panel Members consider if there is an innocent explanation for the registrant's conduct, for example was it an innocent or carless mistake?

Dishonesty, cheating and lying, are seen as a lack of integrity (Caruana et al, 2000). In English law there are two definitions of dishonesty. The Theft Act of 1968 defines dishonesty as a course of action. The second view is that dishonesty is a state of mind. This emerged from R v Ghosh (1982) 75 CR App. R. 154 in which the Court of Appeal held that dishonesty is an element of means, clearly referring to a state of mind. The Court of Appeal decided a test must be applied which "looks into the mind" of the person concerned and establishes what he was thinking (Allen 2005). The test asks the question: "Were the person's actions honest according to the standards of reasonable and honest people?" The decision of whether a particular action or set of actions were dishonest remained separate from the issue of moral justification.

Trust has been indicated as a nursing ethical value and is defined by traits of honesty in words and practice (Shahraira, 2013). Nurses should gain patients', their families', and society's trust through understanding patients' situation and status (Rassin, 2008; Pang et al, 2009; Rchaidia, 2009). To act honestly is a moral value. A person's personality may influence how they react to certain situations. The Temperament and Character Inventory (TCI) is an inventory for personality traits devised by Cloninger et al (1994). TCI operates with seven dimensions of personality traits: four temperaments: these are Novelty Seeking; Harm Avoidance; Reward Dependence; Persistence, plus three characters: Self-Directedness; Cooperativeness; and Self-Transcendence. Cloninger et al (1993) argue that autonomy, moral values, and aspects of maturity and self-actualization are captured by self-directedness, cooperativeness, and self-transcendence respectively.

It appears that the "*dishonest"* nurse's characteristics and values match the temperament traits of Novelty Seeking descriptors. Cloninger and his colleague Dragan Svrakic (2004) found that temperament alone did not capture the full range of personality. Cloninger (1994) identifies a second domain of personality variables, using character traits to measure a person's humanistic and transpersonal style. Participant 1 described, following an internal investigation the "*dishonest"* nurse's conduct was orderly and detached. This appears to link with people who have low scores for the Novelty Seeking temperament, who have defined personality traits of indifferent, reflective, frugal and detached, orderly and regimented (Cloninger et al, 2012). Participant 1 recalled a case of an early career nurse who systematically stole medication for her personal use while being filmed by CCTV:

"We caught her on CCTV, and it was clinical, to see her take the tablets, she went into the clinical room, she took them out of the TTO packet she disposed of the packet and put them in her pocket" - Participant 1.

Cloninger's TCI model (2012) is unique in assessing components of personality related to the body, thoughts, and psyche. The emotional drives of the body are assessed as Temperament.

The self-regulatory functions of thought are assessed by the character traits of Self-Directedness and Cooperativeness. The spiritual aspects of character are assessed by the dimension of Self-Transcendence. The TCI model is particularly effective in order to understand the development of a person's capacity to work, love, and understand the meaning of life, as well as to understand the basic emotions they feel that may complicate mature development (Cloninger, 2012).

Case (2011) reports that a doctor in the early stages of their career who has an allegation of dishonesty, their actions can be mitigated against if they have several glowing testimonials. Participant 1 reflected on a case of dishonesty involving a newly qualified nurse who had worked for the healthcare organisation as a healthcare assistant, a student nurse, and a staff nurse. The registered nurse was caught stealing medication for her own use, following a significant family bereavement. During the disciplinary hearing the nurse showed no remorse, insight or acknowledgement that her conduct was in breach of professional standards and legislation. This conduct and behaviour could be perceived to mirror the Novelty Seeking temperament (impulsive, quick-tempered vs. rigid, slow-tempered), in particular, the low score descriptor of frugal and detached behaviour. The nurse's misconduct could have been triggered by a life changing event. Interestingly, Zald et al (2008: 14372) highlights that "novelty seeking personality traits are a major risk factor for the development of drug abuse and other unsafe behaviours." Studying personality may help researchers better understand and treat these problems (Rettner, 2014).

"There was no acknowledgement that actually what she was doing was dishonest" - Participant 1.

It is apparent the conduct and behaviour of the "*dishonest"* nurse could map against the character traits of a low score in Cooperativeness. Conrad et al (2014) describes that individuals who are low in cooperativeness are critical, unhelpful, and opportunistic with the tendency to be inconsiderate of other people's rights or feelings. Interestingly, participant 14 reflected on a serious case of a nurse who stole from a relative. The nurse eventually admitted the theft after the money was found in her possession. This is a dishonest act and a significant breach of professional standards. The participant who worked in the Human Resources Department clearly felt the nurse saw an *"opportunistic moment*" to steal the money. The participant described this person as "*dishonest"* and a "*difficult nurse"* with a history of inconsiderate and unhelpful behaviour and conduct towards colleagues in the workplace, often displaying a lack of regard for others. Eley et al (2015: 569) states that a nurse with "low CO is indicative of someone who tends to be self-absorbed, less tolerant, and more opportunistic, looks out for themselves."

"I just think she saw an opportunity. There was absolutely no reason for her to steal. She lived at home with parents, she there was absolutely no … justification for what she did. As I say if she was destitute, she was a single parent on a … on a restricted income… But there wasn't anything that she offered that was reasonable mitigation for what she did at all" - Participant 14.

Paal and Bereczkei (2007) found a strong negative correlation between low cooperativeness and a person's tendency to deceive and manipulate other people for their personal gain. Participant 16 recalled a case of a nurse who presented fraudulent documentation to deceive and manipulate the organisation to gain employment, the newly qualified registrant was referred to the NHS counter fraud services:

"It wasn't a spur-of-the-moment, there wasn't anything like that to mitigate it. It was deliberately planned in full knowledge that it was actually a criminal act" - Participant 16.

It is apparent that the participants have described significant cases which have questioned the nurse's rationale for their conduct with a reaction of "*I can't believe she did that"* (participant 4). Ultimately, the participants explained their experiences but often reflected on a *"zero tolerance"* to dishonesty.

5.7.2 *"Scary"* Nurse

The participants have described cases of the early career nurse who are *"scary"* to work with because they tend to significantly lack insight into their knowledge, skills and competence deficiencies, *"whose fitness to practise was perceived and proved to be unsafe."* These characteristics appear to map against the qualities of inert and ineffective identified in Cloninger et al's (1994) model, illustrated in table 20.

"So insight is life and death" - Participant 13.

"Your lack of insight, is really very scary" - Participant 2.

It is apparent that the participants have experienced the "*scary"* nurse demonstrating the characteristics of self-striving and not recognising their behaviour or conduct had an effect on patients or others. In this case, employers often perceived the nurse to be at a real risk of repeating this behaviour of conduct, resulting in dismissal for gross misconduct and lack of competence and a referral to the NMC.

"The difficulty being, you're dealing with somebody who doesn't recognise they've got a problem" - Participant 13.

The participants described nurses whose qualities reflected traits of blaming others and who completely denied the allegations. Participant 16 discussed the case of an early career nurse who had been caught sleeping on night duty by two senior nurses. This is discussed in the chapter A Chain of Expectations. This conduct and behaviour could be linked to Eley et al's study (2015: 569), who describes nurses with "Low Self-Directness shows someone who tends to be blaming and is less reliable people and less able to define, set and pursue internal goals."

"There were witnesses but she just totally denied it" - Participant 16.

The participants explained that some nurse's natural response is to deny the allegations when they are fighting for their registration, ultimately reflecting on their values and beliefs and revealing their true character traits.

"I think people accused of something and they know they're going to lose their career. And their livelihood if they're found to have committed those acts so therefore, they almost are compelled to deny"- Participant 16.

Notwithstanding the case of an early career nurse who refused to admit the error and in fact blamed the patient described by participant 10:

"It is when somebody says, nothing to do with me that was the patient's fault" - Participant 10.

Overall, it is apparent that if a nurse with a low scorer for the Self-Directness dimension and character profile could impact on their reaction when a question is raised about their fitness to practise. The participants felt their inability to demonstrate insight into their deficiencies and take responsibilities for their actions was a risk. Further research is needed to explore how this behaviour and attitude can be tackled to give the nursing team the confidence to manage and report this type of behaviour and conduct.

5.7.3 *"Friendly"* Nurse

It is apparent that the participants who described the "friendly" nurse match the higher scorer for Self-Directness, whose qualities reflect traits such as socially tolerant, empathic, helpful, compassionate, constructive, ethical and principled. This has been illustrated in the table 20 Character traits (adapted from Cloninger et al, 1994). The participants describe cases of the early career nurse being involved in a one off incident that resulted in patient harm yet due to severity of the error, the organisation had no choice but to refer the nurse to the NMC. This is discussed in the chapter Alarm Bells. The participants explored the characteristics of the friendly nurse as hard-working and respected.

"Individuals who are hardworking, highly thought of, by their team members and senior clinicians, and they just make a terrible mistake" - Participant 9.

"An excellent nurse and they've just had a one off problem" - Participant 4.

The participants referred to the "friendly" nurse as ethical, applying principles and upholding standards to provide good care for their patients.

"Great person, great registrant, gave good care, was well-liked, well-respected, always turned up on work on time" - Participant 4.

"A lot of integrity and they've got a lot of, really bright and you know really ambitious and they are really patient focused" - Participant 9.

Overall, it is apparent that the compassionate and empathic, highly ethical nurse can be involved in a one off incident that has serious consequences for their patients and their professional registration. A nurse with the characteristic of self-directness may react positively to this situation when involved in a one off incident, thereby assuring the employer the risk of repetition is lower.

5.7.4 *"Difficult"* Nurse

Eley's (2012) research concluded that nurses in their study strongly represented the character trait of a high score of Cooperativeness. A character trait reflects personal goals and values, which are subject to socio-cultural learning; therefore, each trait quantifies the extent to which an individual displays certain related qualities (Eley et al, 2012). Previous studies have revealed the stability of personality factors across time and the factors which may influence the character traits of students in the caring profession, such as relationships, work satisfaction, role strain and coping (Bradham et al, 1990; Deary et al, 2003; Baldacchino and Galea 2012). It is apparent that the participants who described the "difficult nurse" match the low score for Cooperativeness, whose qualities reflect traits such as socially intolerant, critical, unhelpful, revengeful and destructive, opportunistic. This has been illustrated in the Table 20 Character traits (adapted from Cloninger et al, 1994). Participants recalled the experience of managing an early career nurse whose personality was "difficult" and closely linked to the critical and unhelpful descriptors of Cloninger's model.

"They might be abrupt or difficult" - Participant 4.

"I think, certainly some of her colleagues found her quite difficult" - Participant 14.

Participants described problematic nurse's attitude and behaviour as "confrontational", "hostile" and "abrupt" which influenced their interpersonal relationship with patients or their colleagues:

"She could be a little bit confrontational" - Participant 14.

"She was a bit hostile" - Participant 10.

"But there is something about the way people talk to each other, and I think that people are well some people are a bit abrupt" - Participant 8.

It would appear that participants have experience of the early career "*difficult nurse"* whose characteristics are associated with the low scorers of Cooperativeness, illustrated by Cloninger's model (1993). These match the descriptors of destructive behaviour and attitude.

"Some people I think are, are actually disruptive so they're unpleasant and a bit bullying really" - Participant 8.

"You know because this person has either scared them for so long, or they've been so disruptive or manipulative" - Participant 9.

In some cases, when a nurse is faced with adversity and the threat of losing their livelihood this exposed the rawness of their characteristics. Participant 15 recalled a case of a nurse whose behaviour and conduct was destructive following repeated errors and incidents in practice that resulted in performance management process. The nurse's behaviour caused significant distress to the nursing team.

"I had one instance but it was, it was around the grievance line where there was an individual who was going through the performance management process, who got really angry with the people involved in that performance management and referred them to the NMC, and obviously the anxiety and stress that that caused to the team and those individuals in particular was really horrible" - Participant 15.

Participant 16 described an early career nurse who was found asleep on night duty by senior nurses. The nurse was dismissed for gross misconduct and referred to the NMC. The participant recalled the registrant's destructive and unhelpful attitude. The senior nurses who reported the nurse found the situation challenging and stressful due to the revengeful manner in the nurse's response to the allegations. The allegations were proven with a subsequent referral to the NMC:

"She said there's a history of people making up allegations against staff. Which was not found to be the case" - Participant 16.

Interestingly, Pugh (2011: 25) grounded theory study interviewed a registered nurse who had been referred to the professional regulator in Australia, who described their situation as:

"It has been made clear to [me] that I have an attitude—that is, I say what I think, too often. This obviously upsets my managers, and while I certainly try not to do it in a confronting way, but I don't put up with people being rude to me. If people are rude to me, I can [be] ruder. I can be louder."

Overall, the participants experience of early career nurses whose fitness to practise has been questioned following an error have displayed competitiveness, hostility, emotional detachment, and a lower level of cooperativeness. Thereby contributing towards the employer's decision to refer the NMC.

5.7.5 *"Odd"* Nurse

Participants reported the "*odd"* nurse as socially insensitive, cold and detached, traits that are similar to the low scores for the Reward Dependence dimension. Cloninger (1993) explains that Reward Dependence is viewed as heritable bias in associative learning in response to reward, namely, upholding of ongoing behaviours related to social attachment and dependence on approval of others. As a result, Reward Dependent individuals have a heritable tendency to respond intensely to reward and learn to maintain rewarded behaviour (Conrad, 2014). Cloninger (1993) predicted from his biosocial theory that individuals most at risk of aggressive, antisocial behaviour, will be those with lower Reward Dependent scores and these individuals are equated with the primary psychopaths who show aloofness and social detachment. Participant 2 reflected on a newly qualified nurse's cold and detached character:

"When I say an odd person, she was quite difficult to like and quite cold in some ways" - Participant 2.

Studies on Cloninger's (1993) definition of temperament and character in adult populations have repeatedly shown that Autism spectrum disorder is associated with low Reward Dependence (Soderstrom et al, 2002; Sizoo et al, 2009*).* Interestingly, participant 2 reflected on the social skills of a newly qualified nurse, who had been involved in repeated errors and incidents in practice, which resulted in patient complaints. This is discussed in the chapter Alarm Bells:

"she lacked social skills she definitely lacked social skills there is a part of me that whether she has some sort of personality disorder she was almost a bit, autistic if I am honest" - Participant 2.

Participant 20 recalled supporting a newly qualified nurse who presented with "odd" characteristics. The nurse's character appeared to be socially insensitive. The participant reflected on many occasions when she had the "*personality that she didn't know when to be quiet."* The participant described how the newly qualified nurse's characteristics and social skills do not match with the expectations and standards of a registered nurse:

"Her social skills were not of a level that was required in the profession... she'd just blurt out anything" - Participant 20.

Participant 19 recalled supporting a newly qualified nurse who lacked the skills, knowledge and competence of a safe nurse to the extent that her social skills and characteristics interfered with her ability to focus and concentrate on the art and science of nursing:

"She'd forget to sign for stuff. She'd be busy talking, not concentrating" Participant 19.

The participant gave examples of her significant lack of social skills. The nurse was extremely friendly yet never displayed unpleasant or rude conduct but she was unable to distinguish between personal, professional, and therapeutic relationships in the workplace.

"*Social skills … inappropriate … saying inappropriate things…just being so familiar with everybody and just …saying things that perhaps she shouldn't say to people... not being rude and not saying rude things but just things that … Which you probably shouldn't say in the workplace" - Participant 19.*

This was at the detriment of her relationship with colleagues, to the extent that the nursing team were reluctant to work with her. The participant stated that "*she drove them (colleagues) mad. They used to say oh no, she's not on again is she? ...Don't put her with* me" *Participant 19.*

It was clear that the participant was trying to rationalise the nurse's conduct and performance by explaining how the nurse was a mother of three children with a husband who supported her, she was the main breadwinner in the household. The participant was the Ward Manager who eventually reflected on how the nurse's behaviour mirrored her own autistic son:

"That's what she was like. She was almost, I would say she had some kind of autism or something…That's what it was like…You know? … She was in my space and loud and can't focus … yeah. Either that or I don't know" Participant 19.

These temperament traits are heritable not influenced by socio-cultural learning and therefore there is potential for this to be identified during the pre-registration programme selection and recruitment process. However, research on the assessment of personality traits of nursing/midwifery students is scarce (Baldacchino and Galea, 2012). In recent years, there

has been a professional drive for Universities providing pre-registration nursing programmes to work towards values based recruitment. This concept was acknowledged by participant 4:

"They a fundamental character flaw that we should've picked up" - Participant 4.

Ultimately nurse education aims to prepare students to become competent nurses at the point of registration, by assessing their knowledge and skills, attitude and conduct to deliver therapeutic nursing care (Jackson et al, 2008). Interestingly, the characteristics and attributes that form an integral part of an individual's personality are not taken into consideration. This could provide valuable insight into an individual's ability to develop 'positive relations' (van Dierendonck, 2005; Herzberg and Brahler, 2006), empathy and orderliness (DeYoung et al, 2007; Mlacic and Goldberg, 2007), helpfulness and honesty (Pauronen, 2003; Schmukle at al, 2008).

Overall, this section the participants used diagnostic terms for mental health conditions, in particular autism, to 'explain' or label behaviour that was experienced as difficult. It is evident that the identification of specific characteristics was taken into consideration by employers when there was a question about an early career nurse's fitness to practise. It is apparent that the formal processes led by the employer following an error in the workplace can exacerbate the rawness of an individual's characteristics and values. The participants acknowledged this maybe because the nurse was "*fighting for their livelihood"* (P1). The investigation and disciplinary hearing are aimed to tease out the underpinning factors of the misconduct, the level of knowledge, skills and competence, but tended to reveal the nature of the nurse's characteristics and values. In some cases the investigation uncovered the nurse's inability to recognise their deficiencies, displaying a lack of insight.

Table 20 Temperament and Character Descriptors Mapped against the Sub-categories (adapted from Cloninger et al 1994)

Cloninger's et al (1994) The four dimensions of Temperament	**Research findings**	**Representative participants quotes**	**sub category**
Novelty Seeking – observed as exploratory activity in response to novelty, impulsiveness and extravagance	Eley (2012) Zald et al (2008) Howard et al (1997)	*"It was clinical, to see her take the tablets" Participant 1.* *"Falsified a prescription to get a type of medication. Couldn't afford the payments but needed to go through IVF" Participant 4.*	*"Dishonest"* nurse
Reward Dependence indicates cues of social reward and is observed as sentimentality, social sensitivity, attachment, and dependence on approval of others	Eley (2012) Eley (2015) *Anckarsater et al (2006)* *Soderstrom et al (2002)* *Sizoo et al (2009)*	*"She was quite difficult to like and quite cold in some ways" Participant 2.* *"She didn't know when to be quiet" Participant 20.* *"She was in my space and loud and can't focus" Participant 19.* *"She's lost… Lost in space" Participant 5.*	*"Odd" nurse*
	Eley (2012)	*"There is nothing" Participant 1.* *"She was a bit robotic" Participant 5.* *"Very hard-faced" Participant 14.*	*"Odd" nurse* *"Scary" nurse*
Self-Directness – quantifies the extent to which an individual is responsible, reliable, resourceful, goal orientated and self-confident	Eley et al (2012) Eley et al (2015)	*"The difficulty being, you're dealing with somebody who doesn't recognise "they've got a problem" Participant 13.* *"Your lack of insight, is really very scary" Participant 2.* *"She just totally denied it" Participant 16.* *"That was the patient's fault" Participant 10.*	*"Scary"* nurse
Cooperativeness – quantifies the extent to which individuals are cooperative, tolerant, empathic and principled.	Eley et al (2012) Eley et al (2015) Conrad (2014)	*"I just think she saw an opportunity" Participant 14.* *"You can feel their anger in social media campaigns" Participant 9.* *"They might be abrupt or difficult" Participant 4.* *"It wasn't a spur-of-the-moment" Participant 16.*	*"Difficult"* nurse *"Dishonest"* nurse
	Eley et al (2012) Eley et al (2015)	*"Great person, great registrant, gave good care" Participant 4.* *"A lot of integrity" Participant 9.*	*"Friendly"* nurse

5.8 Conclusion

To conclude, this research has provided a greater understanding of the unwanted and wanted characteristics and values in nurses. It has also clarified the pre-understandings identified at the out-set of this study in relation to the profiling of a nurse explored in the Literature Review Chapter. The characteristics and values wanted and unwanted in nurses has, however, challenged pre-understandings in a different way, illustrated in table 20 - Temperament and character descriptors mapped against the subcategories (adapted from Cloninger et al 1994). Throughout, theoretical sampling pursued themes that arose when exploring the factors that contribute to an employer referring a newly qualified nurse to the NMC. This research reveals one of the contributing factors is when an early career nurse displays unwanted characteristics and values when their performance and conduct is under the spotlight, as a result of an error or incident in the workplace. It is evident that employers hold nurses in a "*privileged position"* in society because the employer has a responsibility to uphold the reputation of the profession.

5.9 Key Findings for Characteristics and Values Wanted and Unwanted in Nurses Category

- It is evident that participants referred to nurses holding a "*privileged position"* in society.
- The research demonstrates that dishonest conduct often results in an irretrievable "*breakdown of relationships"* between the employer and the nurse. Yet it is important to demonstrate being "*a fair employer"* by investigating system issues.
- The research reveals some nurses are "*scary"* to work with when on duty because of their significant lack of competence, skills and knowledge, often demonstrating no insight into the responsibilities of a registered nurse, hindering their ability to function safely as an independent qualified nurse.
- The research demonstrates that the "*friendly"* early carer nurse make mistakes. However, this is often a shock and surprise to the nursing team. The nurse can be highly regarded yet involved in a "*genuine mistake"* in practice.
- It is evident that newly qualified nurses whose fitness to practise has been questioned can expose the "*difficult"* characteristics of an individual.
- The research highlighted how some nurses struggle to fit into the profession. It is evident that some nurses lack the character traits of the "friendly" nurse and they are perceived by colleagues as displaying "*odd"* characteristics.
- The participants disclosed that some nurses are "*vulnerable to disciplinary action".*

Chapter 6 Research Findings – Theoretical Category Three: A Chain of Expectations

6.1 Introduction

This chapter explores the participant's experience that errors in the workplace is part of a longer chain of expectations. Figure 27 summarises how the research questions are answered in this section. This chapter will focus on presenting the interpretation of the findings resulting from the researcher being grounded in the data, engaging in a dialogue with the text and developing an understanding of the lived experience. This category has been divided into five sub categories represented in diagram 25 and 26. These sub-categories will take the reader through an understanding of the participants' expectations of employees following an error or incident in the workplace: (a) "*an admission of...I'm human"* by the nurse; (b) *"challenge it"* but *"don't deny it*"; (c) possess insight; (d) expression of remorse by a nurse following an error; (e) take responsibility and look at other options.

Each of the sub-categories is presented from the participants' perspective and is underpinned by individual quotes from the interviews. This chapter will provide an insight into the experiences of 18 participants. The analysis of the 18 transcripts indicated employers expect the nurse to:

a) admit the mistake;
b) Challenge but don't deny it;
c) demonstrate a level of insight;
d) Say sorry;
e) Be willing to look at other options

These sub categories explain the organisations expectations of an employee when a question had been raised about their fitness to practise, illustrated in Figure 27 below. It is necessary to present the sub-categories in this way to organise the rich data that was collected, as suggested by Charmaz (2014).

Diagram 25 A Representation of the Chain of Expectations Category

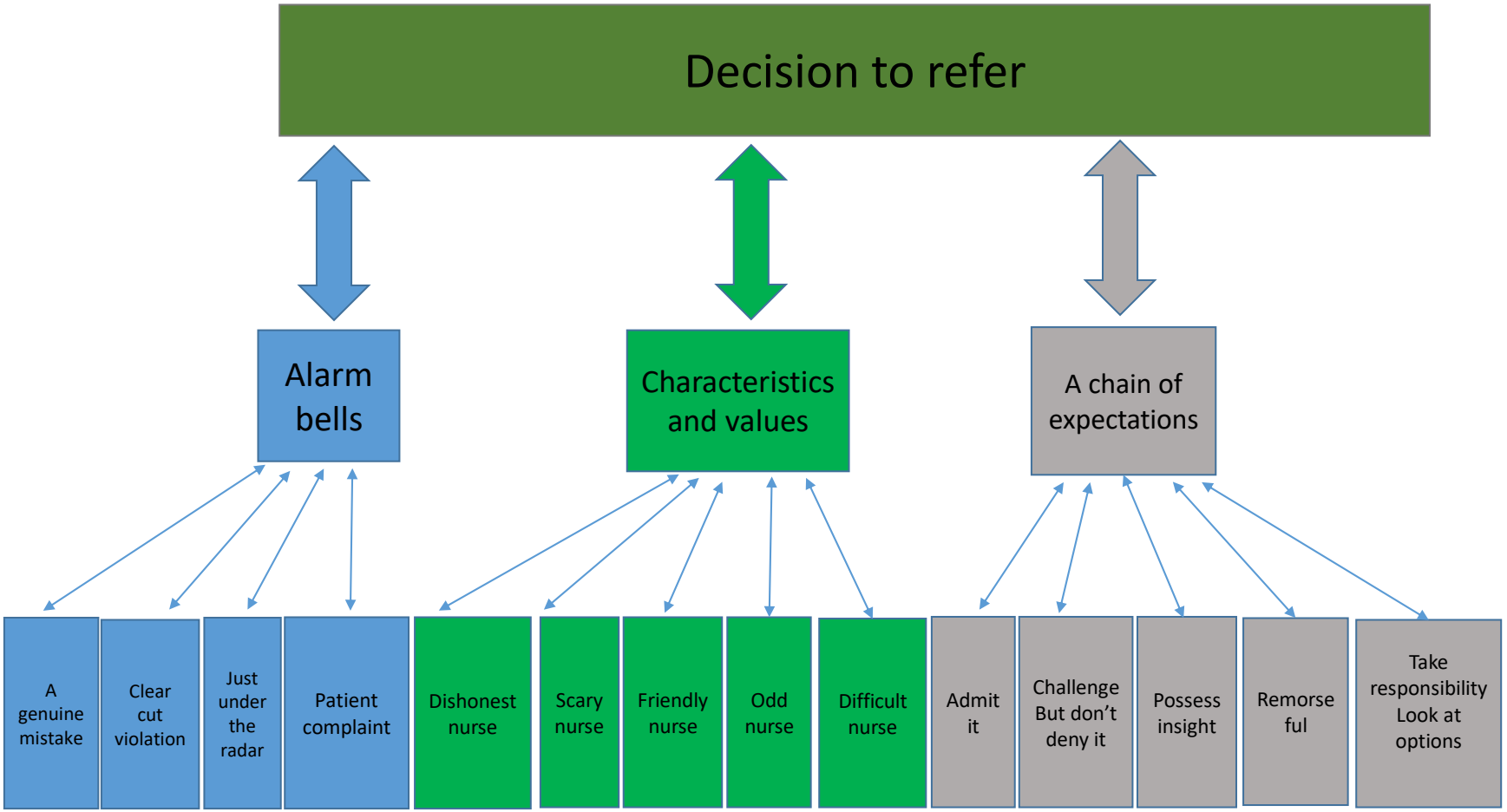


Diagram 26 The sub-categories A Chain of Expectations

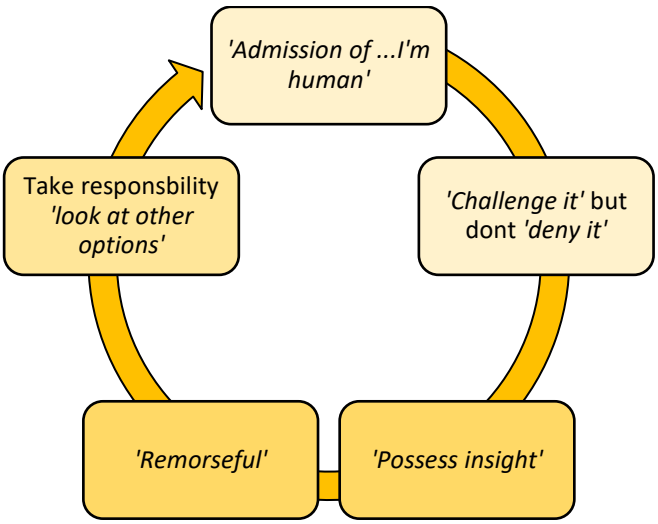


Diagram 27: Summary of Dialogue and Questions Answered for a Chain of Expectations Category

Research Aim: What are the factors that precede a referral of nurses, by employers in England to the NMC, within the first 5 years of registration?

Answer:

The research revealed that there are five expectations that contribute towards a decision to refer an early career nurse, these are:

Admit it

Challenge but don't deny it

Possess insight

Demonstrate remorse

Take responsibility and look at other options

Research Objective:

To explore, using a grounded theory approach, the factors that precede the referral of nurses to the NMC Fitness to Practise Committee, within their first five years post registration, by NHS and independent health care employers in different regions of England.

Answer:

This research reveals a new understanding of how a nurse's reaction to an allegation that questions their fitness to practise is taken very seriously. This research confirms that a decision to refer an early career nurse is "*never taken lightly".*

The employer expects the nurse to show "*professional responsibility and insight"* into their actions, admit to the error, say sorry and demonstrate remorse. A mismatch between the employer's expectations and the nurse's response to the error or incident can cause an "*irretrievable breakdown of relationships"* between the nurse and their employer.

6.2 "*Admission of…I'm human"* (Participants 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 18)

Fifteen of the participants recognised that during a disciplinary hearing nurses have held up their hands and disclosed that they had "*made a mistake".* They may have acknowledged they required additional training and support to address their deficiencies. Participant 10 describes nurses who admit they have made a mistake and what they plan to do to rectify this:

"I made a mistake. I'm really sorry. I'll do anything, any retraining. And that is all it needs sometimes. Is that ***admission of, you know, I'm human****. It wasn't deliberate"* - Participant 10.

Self-reporting of an error is important to establish the system-based issues alongside exposing the nurse's level of knowledge, skill and competence. This takes moral and practical courage so a nurse's reaction to an error is crucial yet should be nurtured by managers.

"If the nurse would just say…oh god I cocked up or, do you know what I was so overwhelmed I didn't know what to do, I get it, I totally get it. It is when somebody says, nothing to do with me that was the patient's fault" - Participant 10.

In recognising and taking responsibility of the error, the nurse can demonstrate to their employer that they have learnt from the incident. Participant 7 explains how the risk is reduced because the likelihood of the error being repeated is minimal due to the nurse's understanding of the incident:

"The big thing for me is that if they, I, if they recognise that they've learnt a lesson and oh my goodness, you know I would never make that decision again. That that's half the battle to getting there" - Participant 7.

When a nurse has reflected on their limitations, they can demonstrate a level of understanding of how they can improve their practice. Participant 6 discusses the nurse's response during a disciplinary hearing. These factors were taken seriously when deliberating over a case:

"And I think that's a big step for people a learning curve to realise when you went wrong, look at making improvements, think right I can see now. Maybe they didn't at the time, their judgements were clouded, you know, you investigate that. Actually saying sorry, it's such a big thing for us, as an employer. Acknowledge it, learn from it, move forward" - Participant 6.

Whilst the disclosure of individual errors and deficiencies should be encouraged, more robust methods are needed to assess the full scale of the organisational issues. The self-disclosure of an error unravels an individual's performance and conduct, which is teased out during the full fact-finding investigation and disciplinary hearing. This establishes the nurse's professional

insight, knowledge, skill and capability. Participant 4 describes his experience of managing nurses who have insight into their knowledge, conduct and performance:

"Registrants, come in many shapes and forms and, and one of the issues we understand in capability is, is whether there is what I determine as being professional insight into limitation to practice. So that would be, for me, that would be a view that they understand that they either lack knowledge, capability or skill to be able to deliver a certain task or type of care" - Participant 4

Errors in practice can lead to potential harm yet can be difficult to identify, especially by those who are not health-care educated and trained. The patient is often vulnerable and unwell when being treated and cared for by a nurse. The first people to know that an error has occurred is the nurse or the team. Participant 4 gave an example of a nurse who had good professional insight into the serious nature of the incident. She recognised her limitations, sought advice and guidance, developed an action plan and was genuinely sorry for her actions:

"I've got a good example where I had somebody through, a nurse went through a capability process and clearly had insight and so expressed remorse for the incident itself. It did result in patient harm. Clearly understood that they had made an error of judgement, had implemented their own rectification plan …had sought, support and advice. Had received that support. and had clearly understood what her professional role was in that situation, what her role should have been in terms of rectifying it, and also accepted her accountability. So stepped into that meeting with a clear view that … I'm essentially putting my hand up to this, completely understand its wrong, and this is what I have done about it. now that's not to say that that individual didn't get a sanction because of the nature of the incident required that as part of the process, however that, clearly for me, was a level of insight that warrant, that I believe was in tune with what is in the NMC scope of Code of Conduct" - Participant 4.

The core component of a high quality respectful organisation is promoting the self-disclosure of errors by staff. This research reveals the challenging and emotional conversations during this time between the nurse and their employer. Participant 14 reflects on his experience of a nurse who was open and honest but because of the severity of the incident the relationship between the trust and employer had irretrievably broken down:

"People will be completely honest with us and very remorseful but, sometimes it is still a situation whereby the trust is broken so much you can't, you end up having to dismiss anyway" - Participant 14.

Overall, fifteen of the participants described the importance of self–disclosure and admitting to an error, recognising their limitations and saying sorry. The participants described examples

of nurses' appropriate responses during a disciplinary hearing, however, due to the serious nature of the incidents, sanctions were needed to protect the public. This research identifies that a nurse's reaction is taken very seriously when making a decision about the nurse's current fitness to practise. This section has illustrated the participant's experience of managing early career nurses who admit they have made a mistake. In the next section, a number of participants describe the importance of an early career nurse to "*challenge it"* but don't *"deny it".*

6.3 "*Challenge it"* but don't "*deny it"* (Participants 2, 4, 5, 8, 16, 9, 10, 2, 7, 13, 14, 15,)

Twelve participants described their experiences of early career nurses denying they made a mistake or involved in an error or incident in the workplace. The participants explained the challenges of managing an underperforming nurse, who demonstrates a lack of competence, skill and knowledge in practice. The participants described the process of the manager's responsibility to protect the public, by ensuring the internal processes are followed by engaging in an open dialogue with the nurse. At this point the participants acknowledged the early career nurse should challenge their employer and accept responsibility for their actions:

"She had clearly understood what her professional role was in that situation, what her role should have been in terms of rectifying it, and also accepted her accountability" - Participant 4.

This research additionally uncovered how during the internal disciplinary process, some nurses completely deny the allegations and do not take responsibility for their actions:

"And some registrants, do have that insight but because they go through a capability or disciplinary process will often challenge it and, and deny it" - Participant 4.

Participant 7 expressed concerns for an early career nurse who denied the allegations and continued to shift the responsibility onto their colleagues, the team and wider organisation.

'The (registrant) persistently said, I didn't do anything wrong, it's not my fault I'll blame everybody else. It's the staffing establishment, it's the line manager, and it's my colleagues, that's when it worries me.' Participant 7.

It is evident, in some cases, if a nurse has an allegation of impaired fitness to practise this can expose a nurse distancing themselves from the professional responsibilities, aligned with professional practice:

"I think ability to recognise that you, that you're wrong is important. (Be)cause one of the characteristics that worries me … is the person who distance themselves from responsibility. So it was her fault and it was his fault and actually it wasn't my fault" - Participant 13.

In some cases, the participants described cases of the nurse taking out a grievance against the manager:

"I think it goes back to what I was saying, possibly about lack of insight. And the ability to understand the other person's point of view and the fact that perhaps they are not doing as well as they could do. But yes I have had people take grievances out" - Participant 15.

A number of participants discuss cases where they have managed a grievance. Participant 2 has been involved with a newly qualified nurse who was on performance management review. The nurse had requested to move to another ward. However the organisation policy restricted movement of staff who were in this situation. In response to the request being rejected the nurse threatened to file a grievance against the ward manager:

"(The registrant) was told she couldn't move, she then put a grievance in against her manager. Because and basically this grievance, the bottom line was if you move me, I will take away this grievance" - Participant 2.

Following an investigation and gathering the facts, the participant made the decision that the nurse was being managed and not bullied.

"I was made aware of this case at this point and I went through all the paper work. And I talked to the people involved and I was really clear she wasn't being bullied she was being managed... She just didn't like the fact that she was being managed and could not understand why she was being managed" - Participant 2.

Participant 15 reflected on a case of a nurse who was so grieved by the performance management process she referred the managers directly to the NMC:

"I had one instance but it was around the grievance line where there was an individual who was going through the performance management process …who got really angry with the people involved in that performance management and referred them to the NMC" - Participant 15.

This research has revealed the importance of following a rigorous process when investigating allegations of bullying. Participant 4 discussed how an allegation of bullying was raised during a disciplinary hearing. The nurse explained she was being bullied and this had impacted on her performance and conduct at the time. A decision during the disciplinary hearing was made

to investigate the allegation, to explore the context and nature of the bullying allegations. During this time the nurse was reinstated pending the outcome of the investigation:

"She had made an allegation of bullying and that had largely been ignored through the disciplinary process and what I said we need to go back and investigate that cause I think that's a causal event in relation to her behaviour" - Participant 4.

Participant 4 reflected on the necessity to satisfy the panel that an allegation of bullying was fully investigated to gather the facts, so an objective and fair decision can be made. In this case, the outcome of the investigation proved there was not a case of bullying.

"You need to have satisfied yourself that didn't prompt her to do what she did. It transpires that it was complete nonsense, she hadn't been bullied at all. The investigation didn't uphold it, she was brought back in and she was dismissed again. You can use the process to make sure that it is judged fairly" - Participant 4.

Participant 5 reflected on the complexity of managing conversations and the appropriate use of language during sensitive encounters with an underperforming nurse:

"(The participant) you're very obsessed…about making sure you say the right thing, you do the right way, (be)cause people do pull that card. It was never about that" - Participant 5.

This research demonstrates that accusations of bullying and harassment are reported at any stage of the organisations disciplinary processes, even at the end of the disciplinary stage. Participant 8 describes a case where the panel had announced the decision to dismiss, in response the nurse made an allegation of racism and ageism. The employer referred the case to the NMC and within two weeks she received an interim suspension order:

"The most hideous one, was when somebody just told me I was a racist. I was a racist and ageist, that's why I dismissed them. The fact that they'd practically killed a patient seemed to have completely bypassed them, which made it even worse, for me" - Participant 8.

This section has illustrated the participant's experience of managing early career nurses who deny the allegations made against them. In the next section, a number of participants described the importance of an early career nurse to "*possess insight".*

6.4 "*Possess insight"* (Participants 2, 9, 1, 4, 11, 12, 13, 15, 17, 18, 20)

An allegation of impaired fitness to practise can personally and professionally impact on the nurse. Notwithstanding the importance of a nurse's ability to have a deep understanding and recognise the consequences of their actions. This includes the capability to see intuitively and to understand the cause and effect of their conduct or behaviour on others. Insight is the

intuitive understanding of the truth about people or a situation and is often defined as a 'eureka moment' (Friedlander et al, 2016). Eleven of the participants described the importance of a nurse's level of insight. This research describes the lack of insight displayed by some early career nurses following an error in practice. Participant 9 reflected on his astonishment at a nurse's lack of insight into their performance or conduct:

"I find it bizarre sometimes, the lack of insight into people's actions" - Participant 9.

Participant 12 acknowledged that over two decades they have noticed a number of nurses who have been referred to performance management review who demonstrated a lack of insight:

"Most people who I've dealt with either, you know, in any capacity really in the last twenty years, who are in trouble have got a lack of self-awareness" - Participant 12.

Participant 15 acknowledged that a lack of insight can result in a nurse's inability to acknowledge feedback from colleagues. The role of a Line Manager is to provide constructive feedback about a person's conduct, attitude or performance. The performance management process can be perceived as punitive or "*unfair"*. This research reveals how, in response, some nurses make complaints or take out a grievance.

"I think it goes back to what I was saying, possibly about lack of insight. And the ability to understand the other person's point of view and the fact that perhaps they are not doing as well as they could do. I have had people take grievances out. Sometimes. Or it's about anger. And it's about head in the sand and not wanting to believe that, that they've done something wrong" - Participant 15.

Participant 1 recalled a case of a newly qualified nurse who had been involved in repeated medication errors. One of the underlying factors was a lack of knowledge, skill and competence, in recognising the conditions of a deteriorating patient. However, her lack of insight prevented the nurse from understanding the serious consequences of her deficiencies. During her disciplinary hearing she argued the case was "unfair".

"So her insight was completely non-existent. As a result of that she was only going to be unsafe doing a drug round but unsafe because she wasn't able to recognise the conditions of a deteriorating patient and all the other things that go on. With that she argued and they argued it was unfair" - Participant 1.

Participant 20 provided significant support to a newly qualified nurse following repeated errors, incidents and omissions in practice. The participant recalled the nurse's lack of insight into her appearance, attitude and level of professionalism. These preceding factors contributed

towards the decision to terminate her employment and a subsequent referral to the NMC for lack of competence, skill and knowledge and misconduct:

"Lack of insight and awareness …I think she (exhales breath) this is gonna sound … awful and I don't mean it in a bad way. (Her) hair was always all over the place, she was very disorganised when she come in. Everything was flowing around the place so she was, personality was quite disorganised. Quite chaotic type person. So her personality was very like that and she lived in like organised chaos2 - Participant 20.

Overall, the participants discussed their concerns about a nurse who had demonstrated a lack of insight following an incident, error or omission in practice. The research has demonstrated a nurse's lack of insight is a significant barrier to remediate and rectify their deficiencies in practice because of their inability to see or understand their limitations. In the next section, it becomes evident that the employer expects the nurses to be "*remorseful"* following an incident in the workplace.

6.5 "*Remorseful"* (Participant's 14, 13, 1, 9, 20, 5, 19, 8, 10)

Saying sorry plus demonstrating remorse could be interpreted as a joint response to display an admission of fault and an empathetic acknowledgement of the consequences for the patient. This is tied to an attempt to rebuild an interpersonal relationship with the nurse's employer. Nine of the participants described their reaction to early career nurses who do not display remorse following an incident or error in practice. Participant 14 outlines it is the expectation of the Director of Nursing for a nurse to say sorry and demonstrate remorse:

"The Director of Nursing wants to see that the member of staff has understood and is ***remorseful*** *for what they've done if that's, that's a relevant response to the action" - Participant 14*

Early career nurses who do not express remorse can cause uneasiness because of the lack of acknowledgement of being at fault or understanding the potential or actual harm to patients. Participant 13 explains if the nurse does not say sorry this is a notable concern:

"Absence of remorse … and absence of acknowledgement that what you've done …and saying, that you regret it and you are sorry is part of it, it's actually very worrying" - Participant 13.

A lack of remorse was initially discussed by participant 1 who reflected on the duty to protect the public and her responsibility to safeguard patients in the wider community:

"'The registrants where there is no remorse and no mitigation, and there is nothing, then you feel differently about that. I feel it my duty, so I obviously don't do it unless I think it is the

right thing to do…but it is about patient safety, so first and foremost it is what I need to do, how would I feel if this nurse went and applied for a job in another trust on the basis of what I know" - Participant 1.

Ultimately, the actions of not saying sorry plus a lack of remorse are considered a deep concern for participants. This was clearly explained by Participant 9 who gave the nurse the benefit of the doubt by considering other human response that may inhibit their ability to demonstrate remorse:

"If I think about the cases really recently, very little or no remorse. Again that's a big alarm bell for me. You know I think when there's a little or no remorse again that just scares the hell out of me. I just think oh my God! You know what, again you try and try and tease out if this is nerves?" - Participant 9.

After considering the contributing factors that may prevent the nurse from displaying remorse, participant 9 comes to the conclusion that these are extreme cases. Even after considering all the facts and providing opportunity to fully understand the nurse's perspective, it triggers "*alarm bells".*

"You try and give people, you bend over backwards to give them an opportunity to explain themselves, you re-read the statements, you know you go through it again. You know mentor them and all this sort of stuff and these people are at the extremes and generally largely there is little or no remorse which again is just another … warning bell for me" -' Participant 9.

On the other hand, to say sorry and to express remorse could be perceived by the nurse as an attempt to defuse a confrontational situation, in the context of a marked disparity of power relations. Participant 14 reflected on a disciplinary hearing of gross misconduct and dishonesty. In this case, the nurse did say sorry and demonstrated remorse, but the relationship between the nurse and employer had irretrievably broken down, due to the serious nature of the allegations. Thus, this research reveals how the severity of the allegations outweigh any attempts to say sorry or demonstrate remorse.

"People will be completely honest with us and very remorseful but, sometimes it is still a situation whereby the trust is broken so much you can't, you end up having to dismiss anyway" - Participant 14.

At any stage, the nurse will have opportunity to say sorry for their actions. This is acknowledged by participant 8 who took this into consideration when deliberating over a case when deciding on a subsequent referral to the NMC:

"There's always a bit at the end (of the disciplinary hearing) where people say you know, they're terribly sorry and they're never going to do it again. And all that sort of thing. And of course, I absolutely will take that into consideration" - Participant 8.

This section has illustrated the early career nurse's lack of remorse following an incident or error in practice. The action of not saying sorry plus a lack of remorse is considered a deep concern for participants.

6.6 Take responsibility "*Look at other options"* (Participants 4, 17, 15, 3, 9, 5, 20)

Seven participants described the opportunity to support early career nurses through the organisations performance management process, if a concern had been raised about their fitness to practise. This may provide the nurse with the opportunity to remedy any deficiencies in their performance or conduct. The participants described how the outcome of multiple incidents and errors in practice required the employer to identify the support needed and for the nurse to undertake a performance management process. The participants also reflected on the different levels of performance management prior to a referral to the NMC.

"Before you actually refer somebody. First of all it's identifying what the issue is, trying to identify some support for that individual, we can try and support them so that they can rectify the issue. But if it's clearly there is an issue that can't be resolved through support then actually if they are still not competent to practice then you have to go through the capabilities process, and through to disciplinary and then ultimately to referral" - Participant 15.

However, the participants highlight the difficulties of this process, especially when managing a nurse following an initial concern about their performance in practice. It is apparent that the manager has to manage the risk to establish if the nurse is likely to repeat the error or if this was a one-off incident. Therefore, there is a question of when a nurse needs to start a formal performance management process. The participants explained that there is a number of support strategies to help the nurse rectify deficiencies in their practice, these can include open and transparent dialogue between the manager and nurse, to explore other options.

"There is a capability issue, and there is an expectation for a registered nurse that they do not meet, so managing that is quite difficult. I think other key things is giving people other options, so are there other things you could be doing? You are a registered nurse, but actually if you are not meeting your competences then is there something we have to follow up on? And are there other options we can look at?" - Participant 3.

This requires a degree of skill from the management team to enable open and honest dialogue and feedback about the nurse's performance and conduct, to ensure the individual had the opportunity to function at their full potential:

"We will find that it might be capability issue, but we redeploy them or performance manage them out or support them into a different role that suits their skills" - Participant 9.

MEMO 5
After the interview the participant stated she had found the whole experience of managing and supporting an 'unsafe' and 'scary' newly qualified nurse to the NMC very stressful and negative. This was exacerbated by the significant lack of support from the senior management team. The participant acknowledged she was an experienced Ward Manager who 'mothered' her team. This case caused her undue concern and personal distress.

Participant 17 clearly described the difficulty in defining borderline practice and referred to a similar scenario of failing a student in practice. Interestingly, the participant reflected on the decision to start the formal performance management process for an early career nurse whose competence, knowledge and skills "*isn't actually that bad".*

"I mean it is a really difficult scenario because most people tend to want to believe the best of others and until something which they perceive to be significant happens, it is quite difficult to flag, particularly (if the registrants) performance is not as good as it should be but isn't actually really bad. And I think there is a lot of people that will just assume that until something significant happens, they may be a bit uncertain but they just don't want to go that step. It's a bit like when you get people that will not fail a student during a clinical placement. Because they don't want to be the person that fails them. They just sort of let somebody else deal with it" - Participant 17.

Performance management is clearly described by a number of participants as an opportunity to support staff whilst protecting the patients. This process can be an interim period to provide the nurse with the opportunity to remedy their deficiencies in practice, however the participants were clear that if the performance management process is unsuccessful it may result in a referral to the NMC Fitness to Practise team.

"My experience of referring people is that you go through that whole performance management process, you try and give them a chance, and you try and support them. But if at the end of the day they are not safe to continue to deliver patient care in your eyes, then you need to refer them" - Participant 15.

A number of participants referred to significant situations that may be the nurse's last chance to remediate their performance. If this is unachievable, results in the implementation of a number of strategies prior to a referral to the NMC.

"If we've been doing eight to nine weeks supernumerary, and a decision had to be made...I guess we'd be moving down that where a very serious conversation would be taking place with people above me. But they're always very reluctant and we've had it before where you shouldn't have to performance manage a newly qualified nurse because we should be developing them and nurturing them" - Participant 5.

Participant 20 reflected on two newly qualified graduates who were referred to the NMC following an extensive support strategy implemented by the organisation in her role as Preceptorship Lead. The participant recalled that the level of support and supervision did improve their ability to be a safe and competent registrant. However, this practice could not be sustained and when this level of support or supervision is removed the incidents and errors reoccur:

"Unfortunately these two graduates that we referred. They went down this process and no matter how much elements of support and guidance that we put in they just didn't develop. We tended to find that they were great under supervision … great under minimal supervision, but the minute we moved any supervised practice and … they became independent practitioners, incidents of errors occurred" - Participant 20.

A number of participants discussed the nurse's opportunity to engage in the organisation's informal phase following an incident or error in practice; the investigation stage; the formal performance management process; and at the disciplinary hearing. However, a number of participants described situations when early career nurses decided to withdraw and/or "*failed to engage with the process"* (P4).

Participant 5 gave an example of supporting a newly qualified nurse during her first post as a staff nurse, yet the nurse did not engage in the support strategies provided for her. The participant explained that the nurse failed to attend training sessions or take advice, alongside this she distanced herself from patients and her colleagues:

"(The registrant) was very quiet, she didn't engage really, you know what patients are like especially here, don't let her near me duck. That's what they were like. Really and obviously and I'm going she's new and, no duck, and they were just picking up" - Participant 5.

This research demonstrates that in some cases a nurse can disengage with the internal support processes at any stage. Participant 4 discussed an example of an early career nurse who disengaged with the investigation team. The nurse was alleged to be stealing the

substance from partially used medication vials for personal use and not following trust policy when disposing medicines:

"(The registrant) failed to work with us through the investigatory process, so failed to attend any investigatory meetings. Basically disappeared off the face of the planet and tried to run away and hide from the problem" - Participant 4.

The participant continued to explain that the nurse had a degree of insight because he deliberately withdrew himself from the process. This may be because the nurse could not face the reality of their mitigating circumstances:

"(The registrant) has got such a level of insight! It's the other way! He realises he was clearly bang to rights and had a problem and its' just a way of avoiding it. That individual won't have to face the emotional difficulties of going through that process (be)cause they've not sat in front of a panel, they've not sat in front of it, so it's a classic running away from the problem. But the problem carries on and continues. So I don't know what happens to that individual. But in the end they didn't engage" - Participant 4.

A number of participants discussed the nurse's lack of engagement with the disciplinary proceedings. However, this does not delay the organisation's procedure because the panel can be held in absentia. Once the organisation has investigated and gathered the facts of the case the hearing can proceed with or without the nurse being present.

"This individual failed to engage with the process, was dismissed in absentia, and I got a report to say this was the allegation. It was obviously serious enough for me to think there was a breach of trust in relation to this registrant and so a referral was made including the outcome of the disciplinary process and report" - Participant 4.

Participant 3 reflected on the organisation's formal process and questioned its rigid structure. The participant empathised with nurses who are reluctant to engage, in what may appear to be an inflexible process. The participant gave examples of how nurses took periods of sickness and absence because of a fear of failure and recognition they could not meet the targets or performance indicators:

"I think it was a quite prescriptive process, isn't it? in terms of regular meetings, reviews etc, etc there is a lot of scrutiny and I think particularly one individual felt that's was too robust a process for them, and I think that is why they disengaged with it, and had long period of time off sick because they didn't feel as if they could meet the performance, so therefore they dropped out of the process" - Participant 3.

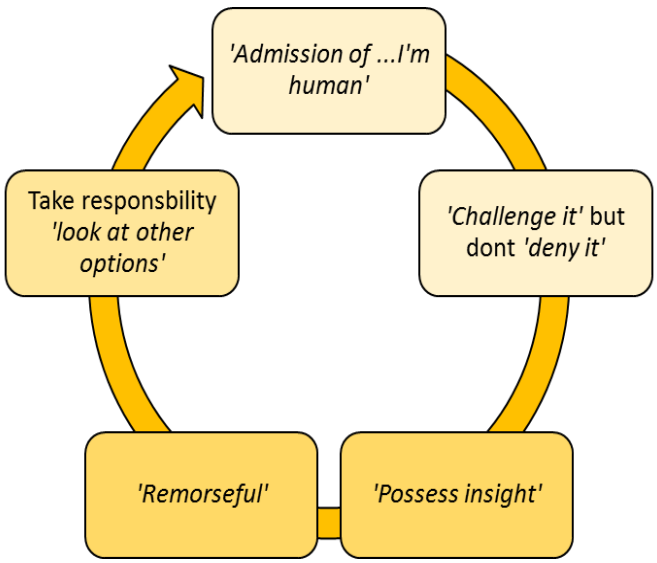
The participants described a range of support strategies for early career nurses following a number of errors and incidents in practice that have an adverse impact on the patient's experience, in order to protect the public and deter future errors. However, for some nurses, the implementation of a rigorous support package does not guarantee improvement or the prevention of mistakes being made. On the other hand, a robust action plan can aid performance but once support is removed, the nurse can continue to make mistakes. These are often complex cases that require the early career nurse to acknowledge their deficiencies in order to remediate and improve their practice, knowledge, and skills. Moreover, if the nurse denies the allegations, it is increasingly difficult for the nurse to rectify the concerns raised.

6.7 Discussion of Research Findings for a Chain of Expectations Category with the Literature

6.7.1 Introduction

This first part of this section will explore how an incident can result in a longer chain of expectations by the employer, illustrated in diagram 28. It will take the reader through a deeper understanding of responsive regulation, with additional examples in Appendix 5. The emergence of the chain of expectations category has been interwoven with the literature, exploring two participant's expectations of an early carer nurse following an incident in the workplace: "*an admission of...I'm human"* by the nurse; challenge but don't "*deny it"*; possess "*insight"*; expression of remorse by a nurse following an incident; take responsibility. Appendix 5 also discusses the case law that refers to the case of dishonesty. Key case law can help with the panel's decision regarding a nurse's fitness to practise.

Diagram 28 A Chain of Expectations



6.7.2 "*Admission of ...I'm human"*

Openly acknowledging that errors in the workplace take place is the first step to developing safe systems and improving practice that will minimise them. Woods (2005) advocates that "those who first put their heads above the parapet often need praise and support". A move away from an individual blame culture following a clinical error would assist with gathering reliable system-focused data, to help assess the scale of the problem. A commitment to individuals raising and documenting practice errors is vital but the specific details of the error needs to be fully investigated to assess the true nature of the issues.

This research has revealed that in the event of a nurse making a genuine mistake in the workplace the employer felt that they need to admit to the error. Errors that are perceived by the nurse to be "serious", that have had an adverse outcome for the patient tend to be reported more frequently, compared to errors that are perceived to be "not serious" or unintentional with no adverse outcomes for patients (Lawton and Parker, 2002; King, 2001; King and Hermodson, 2000). Reason (2000) highlights "a longstanding and widespread tradition of naming, blaming and shaming individual people who have been involved in unsafe acts". Reasons highlights the level of confidence and self-awareness needed to disclose an error. Participants confirmed self-awareness was a core personality strength that can help people manage their careers and lives:

"We heard a case, if the nurse would just say I cocked up or, do you know what I was so overwhelmed I didn't know what to do… I get it, I totally get it" - Participant 10.

An admission of error should be celebrated. However, the figures show that reporting of medication errors by nurses occurred in only 37.4%–67% of cases, therefore underreporting of errors in the workplace can make it very challenging to analyse the reasons behind the error or near misses (Haw et al, 2014; Mayo and Duncan, 2004; Mrayyan and Al-Atiyyat, 2011). Over the past few decades there appears to have been a change of culture to address the barriers of reporting errors in practice. The International Council of Nurses (ICN, 2002: 1) strongly advocate "a system-wide approach, based on a philosophy of transparency and reporting, not on blaming and shaming the individual care provider and incorporating measures that address human and system factors in adverse events".

6.7.3 "Challenge it" but don't "*deny it"*

The participants discussed the individual nurses' actions or omissions whereas the literature says that upstream /structural factors are important to understand in relation to error. Some of the participants described the systemic failures (addressed in chapter 7) within the workplace described by Reason (2000) who states there is "an emerging international consensus that

most human errors are largely the products or consequences of a series of events or 'upstream' system processes, rather than of individuals 'at the sharp end' (the practice edge) doing the wrong things." This required a significant change in the culture of blaming individuals who have made an error in the workplace. Yet participants discussed their grave concerns of nurses who deny an error in practice during the fact-finding investigation or disciplinary hearing. The participants explained that nurses are fighting for their registration so their natural response is to deny the allegations, ultimately reflecting on their morality.

This has been highlighted in the case of Pillai v GMC [2009] EWHC 1048 (Admin). The doctor performed surgery on a young child and the parents were dissatisfied with the operation. The procedure had to be repeated by another practitioner. The family wrote several letters through their solicitor requesting the medical notes. The request was not dealt with until the GMC became involved. At the GMC Fitness to Practise Committee panel hearing the doctor did not plead guilty, in this case this was regarded as relevant to the doctor's attitude and therefore of relevance when assessing whether fitness was impaired. However, Reason (2000) highlights two key factors that need consideration by employers. Firstly, "the best people make the worst mistakes – error is not the monopoly of an unfortunate few". Secondly, "far from being random, mishaps tend to fall into recurrent patterns. The same set of circumstances can provide similar errors, regardless of the people involved" (Reason, 2000: 769). This suggests system factors occur outside the individual's control.

6.7.4 *"Possess insight"*

There is little written in the literature to define insight, yet eleven of the participants referred to this concept. This research has identified through the eyes of the participant's the level of insight required following an error in practice. The literature helps define self-awareness (Merriam-Webster, 2016). In psychology Rochat (2003) states that self-awareness has been called "arguably the most fundamental issue in psychology, from both a developmental and an evolutionary perspective". More recently, Merriam-Webster (2016) defined "self-awareness is the capacity for introspection and the ability to recognize oneself as an individual separate from the environment and other individuals".

This research has revealed that to "*possess insight"* the nurse must be aware of their past and future thoughts and actions, in the same way they are aware of their present thoughts and actions. In order to do this the nurse had to demonstrate their ability to:

- Acknowledge the impact of the error on the patient, colleagues and the wider team;
- Understand and recognise their skills, knowledge and competency deficiencies;

- Remediate against their actions;
- Evaluate and compare the current standards and values expected of a Registered Nurse.

Rasheed (2015: 730) refers to “self-awareness as getting to know about one-self as a person and the important things in life which influences us in different ways, it also includes the reflection on how our attitude and belief can influence others”. Winson (2007: 59) described self-awareness as an “unconscious body language, with uncontrolled emotions and a lack of insight is potentially harmful.”

6.7.5 *“Remorseful”*

Saying sorry and demonstrating remorse is deeply rooted in historical religious practices. This has influenced the criminal justice system and employers who manage employee’s behaviour, conduct, and competence. This is manifested if an employee displays a lack of remorse or emotional response during a disciplinary hearing following an allegation of misconduct. There appears to be an expectation for a nurse to express emotion and remorsefulness following an error in the workplace and during the disciplinary hearing. Remorse displays empathy, care, and compassion, whereas a lack of remorse can be determined as the nurse being socially insensitive, cold, withdrawn and detached from the situation. Participant 1 agreed that a nurse’s reaction during a disciplinary hearing has an influence on the panel member’s decision about the actions needed to reduce the risk of reoccurrence and to protect the public. It could be argued that a lack of emotional reaction links to one of the four dimensions of Temperament.

“No remorse and no mitigation, and there is nothing, then you feel differently about that”
Participant 1.

The literature is sparse on the influencing factors beyond the evidence during a disciplinary hearing, and if the absence of remorse impacts on the decision making process. Leape (2012) notes that patients who have been directly involved in an incident resulting in harm, may expect an apology. The Full Disclosure Working Group (2006) explains that firstly, patients expect an acknowledgement that something has gone wrong, and an explanation of what happened. More recently, in 2014, there are several clear strategies that the NHS could learn from to implement and sustain a policy of openness (Birks et al, 2014). It has been recognised future work could usefully evaluate the impact of disclosure on legal challenges within the NHS, best practice in models of support and training for open disclosure, embedding disclosure conversations in critical incident analysis and disclosure of less serious events (Birks et al, 2014). Secondly, the nurse needs to take responsibility for the incident. Finally,

patients expect the hospital (healthcare organisation) to make a serious effort to find out why the incident happened and make changes if possible to ensure that it does not happen to another patient. It is apparent that participants expect registrants to say sorry and demonstrate remorse following an incident that questioned their fitness to practise.

‘Sorry is the hardest word' has been debated in criminal law for centuries, dating back to the Puritan Colonies of the 18th century America. Prior to a public hanging there would be an execution sermon from the minister who would request the offender to repent. This repentance would not influence the individual’s fate. However, there were religious expectations and a deterrent message to the public. Wilson (2008) illustrates the Judeo-Christian tradition of confession: including disclosure and apology; repentance, which involved the actions to compensate for the error; and forgiveness; the person who has been harmed is adequately compensated.

These principles have been adopted by health organisations and ethicists who encourage the disclosure of health care errors to patients. However the concept of offering an apology is of more recent origin, argues Wilson (2008). Interestingly, Neidermeier et al (2001: 605) conclude following a diverse literature review on remorse that “there is an existing cultural assumption that remorse is the appropriate reaction when a transgression has occurred”.

Leape (2012) explained that a “meaningful apology” requires the doctor and institution both to take responsibility, show remorse and make amends. Neidermeier et al (2010) found jurors were less likely to convict a remorseful defendant than a defendant showing no remorse. Participant 4 discussed a newly qualified registrant characteristics and lack of remorse:

“I’ve been involved in one case where a nurse was sort of hesitant and slightly reluctant to admit it but got themselves into a bit of a pickle …and in my view would have been, sorry” – Participant 4.

“Saying sorry” is not demonstrating remorse argues Leape (2012). Saying sorry is an expression of regret, of empathy (Leape, 2012). Feeling sorry is an emotional response and this may be an appropriate response directly after the incident to express prompt and sincere genuine feelings. Whereas Ward (2003: 913) defines “remorse as a feeling of compunction of deep regret and repentance for a sin or a wrong committed”. In the context of demonstrating remorse following an error in practice leading to disciplinary action, a deeper acknowledgement and understanding of what actions are needed have to be displayed by the nurse.

Staff react in different ways when there is a question about their fitness to practise following an error in the workplace. Participant 11 acknowledged that prior to a referral to the NMC, the

formal nature of a fact-finding investigation and preceding disciplinary hearing may result in a misleading response from the registrant. Participant 11 felt this may be due to the lack of understanding of the internal process, nerves, and inexperience:

"It doesn't feel like it warrants dishonesty, but I think that along the way sometimes during the fact finding investigation individuals sometimes tie themselves in a bit of a knot, and instead of just realising that it was probably just time to stop and say look, I've made a mistake, I'm remorseful, I need some retraining and sometimes, and I do appreciate it because being on the end of a disciplinary and fact finding are very formal" - Participant 11.

Hooper (2009) makes the relevant point that remorse is "a slippery concept to pin down". She raises the question of genuine feelings of regret, being a subjective response. This requires certain skills in articulating emotions. Hooper (2009) argues that "the most remorseful defendant may not have the skills to demonstrate such remorse". Moreover, the defendant may feel remorse but find it undignified to talk about the situation. Furthermore, cultural barriers and misunderstandings may inhibit their response. This is reinforced by participant 10 who reflected on junior staff being exposed to new and challenging situations with little preparation, inexperience, and sometimes poor or a lack of advice during a disciplinary hearing:

"I think some of our junior staff and existing staff groups, actually, are unprepared for what happens within a disciplinary and the consequences, consequences of it until they are stood there …" - Participant 10.

Ethnically, culture, age, and background can have an impact on self-presentation, argues Hooper (2009). A US Appeals Judge speculates that "often young black men are sullen and arrogant." On reflection the judge comments "the person is trying desperately to maintain their own dignity, his personhood". On reflection, the judge comments that "the person is trying desperately to maintain their own dignity, his personhood". This is mirrored by the former Chief Probation Officer in Inner London Probation Service. A demonstration of remorse at trial can often depend on the defendant's mental state (Hooper, 2009). In the UK, Harding (2010) demonstrates this by reflecting on youths aged under 21 who have committed murder and how their remorseful emotions have not evolved.

6.7.6 Take responsibility *"look at other options"*

This research has revealed that some early career nurses with skills, knowledge and competency issues require bespoke support and training:

"We're trying to provide support and further education for her. But we still have to investigate what she has done …because there might be other learning outcomes" - Participant 14.

The literature highlights that leaders should teach and support staff to investigate and debrief early career nurses after an error, to prevent blame and to promote a positive association with the incident (Davidson et al, 2015; Serembus and Youngblood, 2001).

However, performance management is fraught with problems. Cascio (2010: 334) defines performance management is "an exercise in observation and judgement, it is a feedback process: it is an organizational intervention; it is a measurement process; as well as an intensely emotional process; above all, it is an inexact, human process". Hence, "ill-chosen, badly designed or poorly implemented performance management schemes can communicate entirely the wrong messages as to what the organization expects from its employees" (Sheilds, 2010). Brown (2010) highlights that the issues with performance management are "not of ambition or intent, but rather practice and delivery". The inadequacy of the process results from the frequency of limited conversations, with a lack of feedback and follow up about the employee's progression, uncommitted senior staff members and poorly equipped line managers. This was underpinned by complex and bureaucratic human resource processes.

There are key factors that can enhance an individual's potential to personally and professionally develop, fostered by workplace collegiality. Armstrong (2000) highlights three factors that influence behaviour and therefore performance: motivation; commitment; and engagement. Armstrong (2000) argues motivation is encouraged to enhance a person's performance, and can include incentive and reward. Engagement and commitment can be affected by leadership and managerial actions. Engagement of employees occurs when staff are committed to their work alongside the organisation's motivation to accomplish high levels of performance. According to the Chartered Institute of Personnel and Development (2012: 13) "engagement has become for practitioners an umbrella concept for capturing the various means by which employers can elicit additional or discretionary effort from employees – a willingness on the part of staff to work beyond contract. It has become a new management mantra." This approach of engaging staff could enhance early career nurses to take responsibility and work in partnership with their employer to work towards a higher standard of performance.

6.8 Conclusion

To conclude the chain of expectations category there is now a greater understanding of the meaning of the experience as a whole. The chain of expectations category demonstrates new knowledge that challenges the limited pre-understandings identified at the out-set of this study

in relation to the professional regulation of early career nurses, described in the initial Literature Review chapter.

The chain of expectations category emerged during theoretical sampling and constant comparison of the data. This research reveals employers have a chain of expectations of their employees if there is a question raised about their early carer fitness to practise. The findings confirm that employers expect the nurse to: admit the mistake; say sorry; demonstrate a level of insight; accept responsibility for their actions; recognise their deficiencies, and engage in the organisations processes. This research confirms that a decision to refer an early career nurse is "*never taken lightly"* when making a decision about a nurse's current fitness to practise. This information is a contributing factor towards a decision to refer an early career nurse to the NMC.

6.9 Key Findings for a Chain of Expectations Category

- This research reveals a nurse's reaction to an error or incident in the workplace is taken very seriously, especially when making a decision about the nurse's current fitness to practise.
- Employers expect an early career nurse to demonstrate remorse following an error in practice.
- The participants experience early career nurse who deny the error or incident. It is evident that this is taken into consideration when making a decision to refer a nurse to the NMC due to the risk of repetition.
- This research reveals that employers expect an early career nurse to demonstrate a level of insight and to understand their limitations.
- The participant's experiences highlight that it is difficult for the nurse to remediate and rectify their deficiencies in practice if they do not understand their clinical limitations.
- The participants explain the importance of being a "*fair employer"* who offers a number of bespoke support strategies to help the nurse rectify clinical deficiencies in their practice.
- It is evident that managers need the skills and competency to have open and transparent dialogue with early career nurses to explore other options if needed.

Chapter 7 Research Findings – Theoretical Category Four: Situational Stressors and Health

7.1 Introduction

This chapter will explore the participants' experiences of the situational stressors and mental health of nurses prior to a referral to the NMC. Figure 31 summarises the dialogue with the text in relation to the research questions that were answered in this section. This chapter is divided into four sections represented in diagram 29; the first part of the chapter explores the participants' experience of working and managing nurses with "*extreme personal stress",* "'*mental health"* needs and a lack of emotional "*resilience".* Finally, the "*systemic failures"* that impact on a nurse's performance and conduct in the workplace will be discussed.

Each of the sub-categories is presented from the participants' perspective and is underpinned by individual quotes from the interviews, illustrated in the figure 30. This chapter will provide an insight into the experiences of 18 participants.

Diagram 29 - Situational Stressors and Health

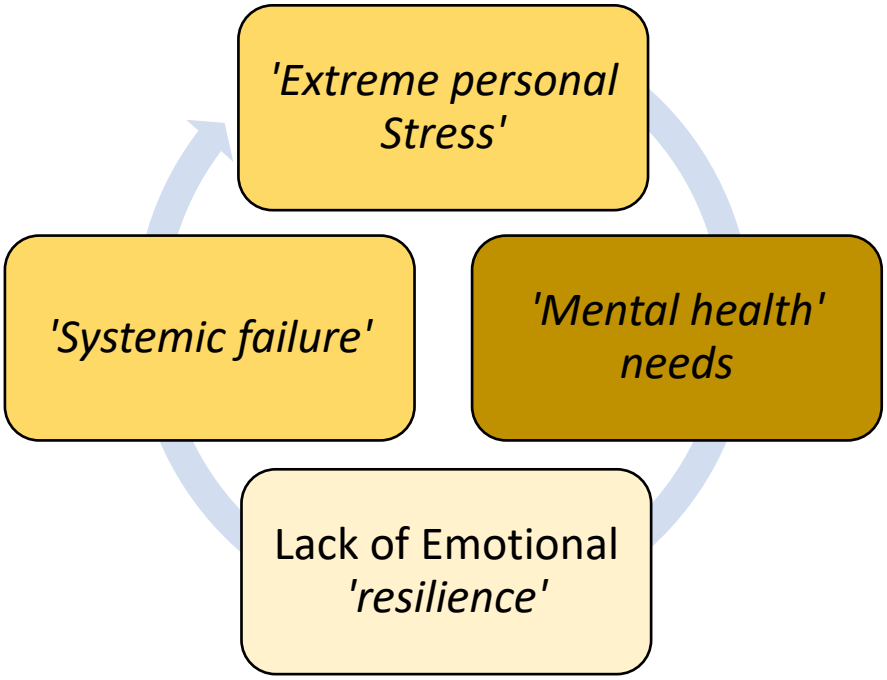


Diagram 30 Theoretical Category Situational Stressor and Health

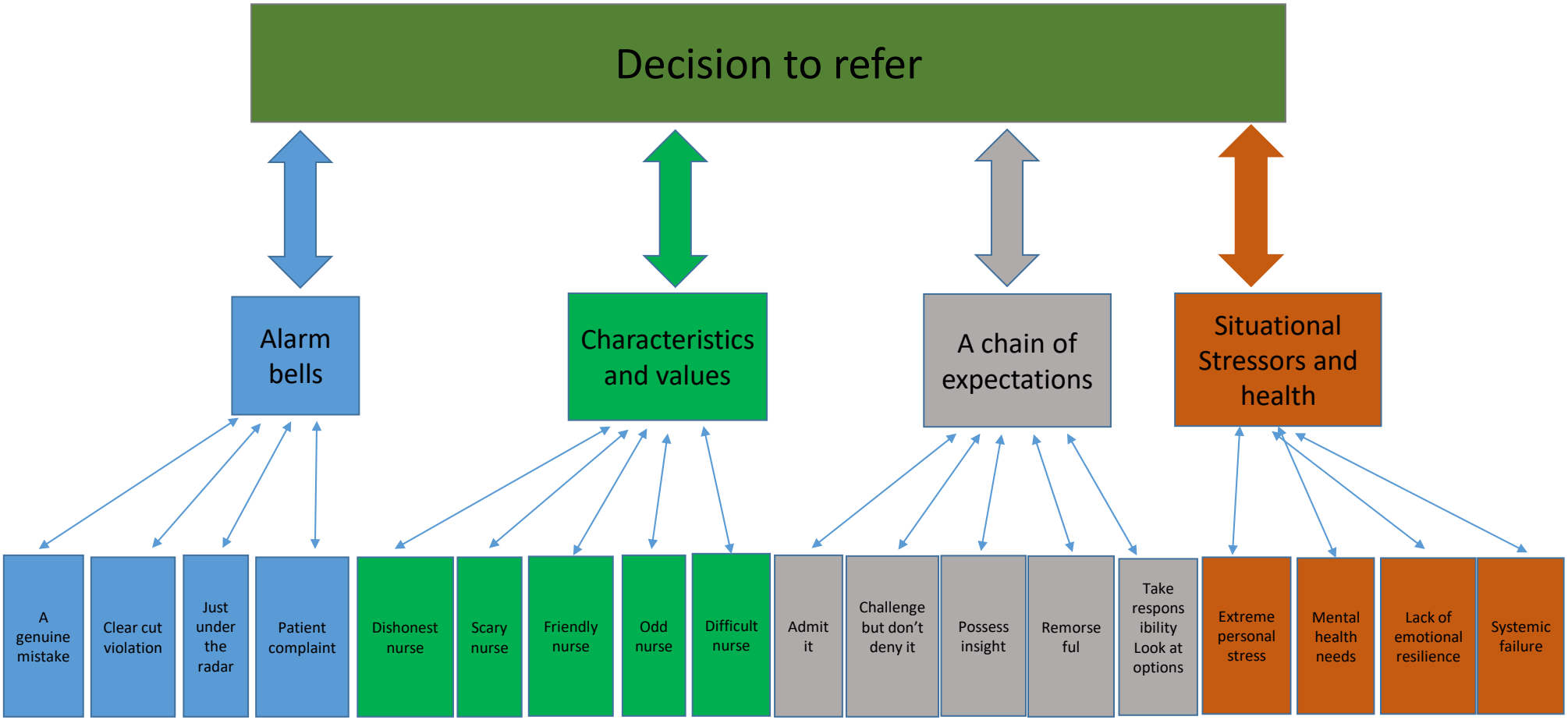
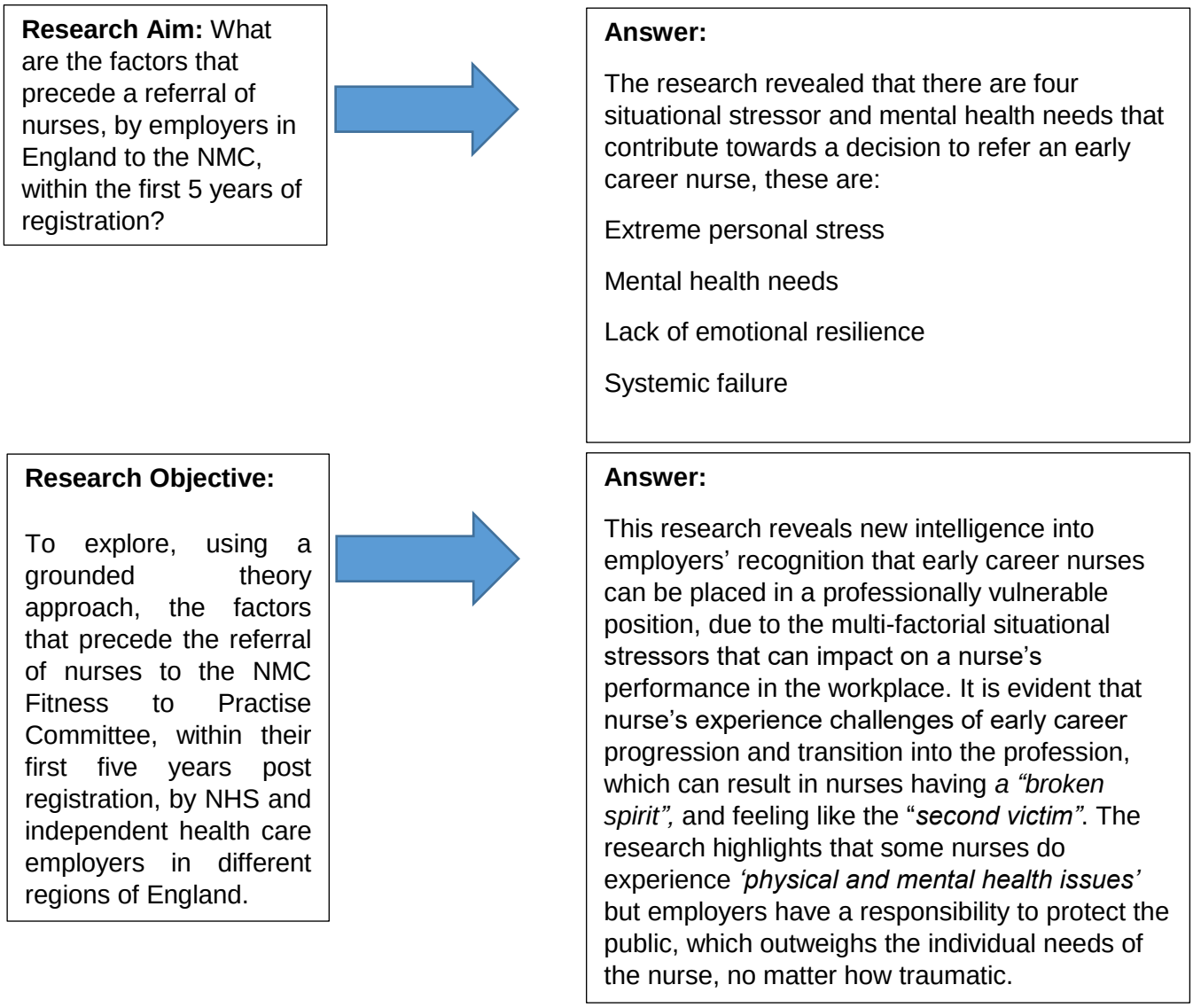


Diagram 31: Summary of Dialogue and Questions Answered for the Situational Stressors and Health Category



7.2 "*Extreme Personal Stress"* (Participants 2, 7, 3, 4, 1, 6, 8, 9, 11)

Nine of the participants discussed a range of mitigating circumstances that had been disclosed after an error or incident in practice as part of the investigation or disciplinary process. This section will explore the personal mitigating factors that are exposed during the investigation and considered during a disciplinary hearing.

The participants have experience of nurses who had internal influences such as a stressful home life or the breakdown of a relationship that had impacted on their performance and conduct. Participant 4 reflected on cases within his organisation ranging from personal stress to domestic violence:

"There will be a lot of internalised references, so they will be issues around I am going through y or x difficult time, or I am struggling here or I'm struggling there with a variety of different situations. I have been involved in a case where an individual was under ***extreme personal stress*** *and problems related to a potential situation of domestic violence" - Participant 4.*

Participant 6 reflected on a nurse who was grieving over the anniversary of her daughter's death. The nurse's natural instinct was to continue with the normal routine of working life. However this significant mitigating circumstance impacted on her ability to function safely in the workplace. The manager was concerned that her emotional distress was affecting her rationale thinking and ability to make reasonable decisions, especially if unduly challenged by workload pressures:

"I mean it was quite sad that the situation it was the anniversary of her daughter's death, she said she felt tearful, but felt better coming to work. You think okay, I understand you want to be around, your decision wanted to be around people on that day, you know that obviously made you feel better. But it didn't help the home or the residents, you being there" - Participant 6.

Participant 4 recalled how some nurses disclosed their entire life events to their colleagues whereas others are very private:

"So people are sometimes are known to have been going through difficult times and just lead up to having some sort of catastrophic problem. Whereas others, we don't know. And they keep themselves quite private. You get them into a room, you ask them about why on earth this happened and then it all suddenly comes out and you then have to start doing, sort of an explanation underneath" - Participant 4.

Participant 11 explained that the nature of the investigation process was to establish the mitigating circumstances surrounding the error or incident in practice. This formulated an objective decision taking into consideration a number of factors. These range from the adherence to local policies, appropriate training and personal mitigation.

"With safety incidents, and that's the stages that we tend to test at disciplinary as well. Whether there were policies, you know whether the individual was healthy for a start, whether they were fit to practice health wise then if there was a policy whether it was in good use. Whether they were trained to do that if there was any mitigation and frequently they fall down on failure to follow policy and …or they'll often try and bring in some sort of personal circumstance, which later often … appears to be less-weighted but we are trying to ensure

that our investigating team do that. That they do the fact finding and then establish the need for a disciplinary" - Participant 11.

A number of participants reflected on nurses' sickness, absence and lateness records alongside their lack of performance and misconduct. This may be due to genuine mitigating circumstances that need to be managed as part of the performance management process.

"They had managed the process of sickness and absence and lateness in an appropriate manner, the line manager hadn't ignored it she had dealt with it. But sometimes she felt they gave her a little bit of leeway because they knew her history" - Participant 7.

The research confirms that, in some cases, early career nurses had multiple episodes of sickness, absence, and lateness. This behaviour was a lower level performance indicator but may be a trigger that forms a larger picture of the nurses overall performance and conduct in the workplace.

"It will describe the types of misdemeanour or issue that person may get a disciplinary for. So you know mine are through from sort of absenteeism, multiple sickness episodes to being difficult or failing to follow management's instructions, such as a senior nurse. Right through to patient safety incident resulting in harm, so it covers the whole remit really" - Participant 4.

The participants explained the difficulties of supporting and managing a nurse who took long periods of sickness and absence.

"I think engagement has been quite an issue. People have had longer periods of sickness and then come back and then not really engaged in the processes, and performance is difficult. I think it is just difficult, and I think it is difficult to manage" - Participant 3.

Participant 6 reflected on a situation involving a nurse whose conduct and performance was under investigation by the organisation. The nurse immediately went off sick and subsequently handed in her notice and left the organisation. This left the organisation in a difficult situation. On this occasion, even though the organisation could not complete a thorough investigation, the organisation was sufficiently concerned about the nurse's future performance that they referred the case to the NMC:

"The difficulty with that particular case, is as soon as we start investigating, the nurse goes off sick. And puts her notice in. And we didn't actually get very far, with our investigation but everything seems to indicate we were at fault and now I've got a family suing us. Because of the knock-on effect of this lady's health of having an operation at the age of eighty and never being the same again. That nurse doesn't realise that because she's left now. But we did

refer her to the NMC …because you know, all indications were that she was at fault" - Participant 6.

This section has captured the participant's experience of the "*internalised references"* described by participant 4 and *"personal stress".* The participants explained the importance of investigating and learning from incidents and errors in practice to ensure a rigorous and fair process was followed. The next section explores the participants' experiences of early career nurses who have '*mental health'* needs.

7.3 "*Mental health"* needs (Participants 1, 17, 8, 9, 18, 1, 15)

Seven participants discussed a range of mitigating circumstances related to the health needs of the nurse that had been disclosed following an error or incident, as part of the investigation or disciplinary process. However, the participants explained that a number of questions need to be considered when assessing a nurse's fitness to practise following an allegation: is the conduct or performance likely to be repeated? Can the nurse demonstrate remediation against their actions? Are there significant mitigating factors? Are there any systemic failures or external factors impacting the nurse's ability to perform safely in the workplace?

Participant 17 explained the level of risk was measured by reflecting on a number of high profile cases in the media. The participant continued to weigh up the correlation between behaviour and conduct, physical and mental health, insight and mitigation. This research has demonstrated that these contributing factors can affect a nurse's ability to function as a safe nurse. The employer had a responsibility to protect the public, uphold the reputation of the profession, and, at times, act in the nurse's best interest.

"Just think about all the ones that have been arrested from you know, Beverley Allits' of this world. And the nurse that the A&E nurse from Oxford Radcliffe that's just admitted rape and sexual assault while on duty in an A&E department. Just you know, how on earth did that happen?! So there will be people amongst us that are … not well. That's in a both physical health and ***mental health*** *because there will be people that have got issues with alcohol and drug dependency, etc, etc, There will be because that's the nature of life. But we just need to make sure that we have sorted it as much as possible" Participant 17.*

Participant 17 continued to discuss the number of nurses on the NMC register and the national average of people in society with a mental health illness:

"We've got whatever it is four hundred and seventy thousand registrants in England. So if you think about that number of people there's got to be some …that will have a mental illness. Well basically one in four people are supposed to have a mental illness at some part and at some point in their lives2 - Participant 17.

Participant 8 reflected on the complexities of encouraging a culture of disclosure and recognition of an individual mental health needs. The participant explained that if a nurse lacked the ability to recognise their own health needs, this tended to significantly impact on their conduct and behaviour in the workplace. During the interview participant 8 claimed this was deeply worrying:

"The other one that I've struggled with recently and been a real problem for me, is a nurse where I think she's actually has a real psychiatric problem…Her behaviour was really bizarre, throughout the whole of the disciplinary hearing, so I've suspended her from practice …I insisted that she had a full independent psychiatric review, which I had to see, before we made the decision for her to come back or not. But it was really difficult. She couldn't understand what my problem was" - Participant 8.

Participant 9 described a case where a nurse had displayed a lack of insight into their performance and attitude during the organisation's formal disciplinary hearing. The participant appeared to question if this obstructive conduct and disruptive behaviour was a result of a "*personality disorder"* (P9).

"It's just the pure lack of insight. And you know to me does that fall under the spectrum of personality disorders, I don't know, I'm not the same as a psychologist but things like that worry me greatly. In people who've got positions of trust with vulnerable patients, kind of denial means no insight…they are right and that everybody else is wrong" - Participant 9.

However, participant 1 provided an example of a self-referral by a nurse who had been admitted to the mental health services. This was a result of a significant deterioration in their mental health following an incident with his partner. The participant recalled the internal processes in place to protect the public and the nurse:

"(The registrant) had mental health problems, and after the disciplinary, even though he had left, and he wouldn't give me access to his health records, and we are talking some serious stuff. I mean he pulled a bow and arrow at his partner and then self-referred to an outpatient psychiatric" - Participant 1.

Participant 15 provided an example of a nurse who lacked insight into their attitude and performance because of an underlying mental health issue. The participant explained that the nurse displayed odd and challenging behaviour in the workplace. It appears this behaviour and conduct was negatively perceived by others and the employer, rather than understanding or accepting the individual mental health needs of the nurse:

"*But then … again if you have an issue, particularly if it is a mental health issue … you may not be aware of the way that you are coming across and that plays a part of the health problem" - Participant 15.*

The research therefore reveals the different perceptions of the participants when managing a nurse with "*a physical and mental health"* needs. Seven of the participants discussed nurses who displayed characteristic traits that may be a result of a "*mental health illness"* or an inherent type of "*personality disorder"*. Participant 9 clearly acknowledged they were:

"Not a psychologist or an expert in this field but their experience of managing nurses lead them to believe some registrants 'fall under a spectrum of personality disorders" - Participant 9.

Participant 15 reflected on their experience of working with nurses who present a diverse range of characteristics and behaviours by explaining the possibility of the nursing profession attracting certain types of personalities:

"I'm not saying that is the same as mental health issue but then if you get that in the extreme…Munchausen by proxy, Beverley Allitt. You know? Then perhaps it attracts some people that do have personality disorders, I don't know. I think it is both. Because I think you know, there are people that display odd behaviours"- Participant 15.

Participant 9 was trying to articulate the distinction between a mental health illness and a personality disorder. He emphasised that it was not his role to diagnose, however there are internal policies to manage employees with health issues and guidance to refer to experts who can make a diagnosis.

'It means that certainly some of them (registrants) clearly … possibly some personality disorders of sorts. … not necessarily mental health issues, because we do refer people as well to occupational health for a view to see if there's anything organic.' Participant 9

Another interpretation could be that wider contexts can adversely influence a nurse's personality traits, this could range from the environment, cultural, social or professional, and personal life described by participant 15:

"I think it is not just about personality disorder. It's about the context within that person is working as well" - Participant 15.

During this section the participants have described some of the "*mental health needs"* of nurses. It is apparent that a nurse's health needs can change during the course of their career. This was dependent on their ability to recognise their own health needs and the mitigating

circumstances that may affect a nurse's performance and conduct. The next section explores the participants' experiences of early career nurses who lack emotional "*resilience".'*

7.4 Lack of Emotional *"resilience"* (Participants 1, 4, 10, 14, 15, 17, 18)

The research confirms the need to identify early signs of a nurse's conduct and performance that may be an underlying health need exacerbated by the working environment, system failures, and/or significant mitigation. Participant 18 felt from her experience the term professional "*burn out"* was used too freely, whereas an underlying mental health diagnosis could be a more likely contributing factor:

"People use the phrase 'burn-out'. They use it too liberally. … That can often mean depression too. I don't believe any of these practitioners came into our profession thinking who can I be cruel to today?" - Participant 18.

It appears that the demands of nursing practice are significantly under-estimated. These new challenges to an inexperienced nurse can actually unknowingly expose certain character traits. These behaviours may never have emerged before but may be exaggerated when dealing with the emotional, physical, and spiritual adversity of nursing.

"Because often there is something that triggers a certain type of behaviour …and you know, nursing can be extremely stressful and emotional …and if you ***don't have the resilience,*** *if you are not taught how to manage stress, how to develop more resilience is part of your fundamental education training" - Participant 15.*

The research reveals the importance of appropriately supporting nurses with or without known mental health needs. To ensure the nurse can continue to work to their full potential and capacity. Participant 1 described a tragic case of a newly qualified nurse, who had a young family. The challenges of family life, work commitments, and previous experiences of working in the forces overseas caused a relapse in the nurse's mental health. The nurse ended up as a patient in A&E being cared for by his peers. The early career nurse understood the future consequences of his actions. Participant 1 recalled the nurse saying in the disciplinary hearing "*I lay in A&E when they were trying to sort me out… 'my life is over, my wife isn't going to accept this, my job is over, will I ever get to see my daughter?".*

The participant described this traumatic and emotional case. She acknowledged that the level of ownership to protect the public outweighed her own feelings of empathy towards the nurse:

"(The nurse's) wife didn't know, he was young, married with a young baby, they were living opposite lives trying to juggle child care, they never saw each other, probably, it was all this, he wasn't get the right support and you could see when you were talking to him he was just

getting more and more in on himself. I still had to dismiss him. And I still had to refer him to the NMC" - Participant 1.

The participant openly disclosed to the nurse the actions taken to refer to the NMC by his employer. She stressed that under the circumstances a supporting letter be sent to the NMC which outlined the level of insight, mitigation and support provided to help the nurse. This case highlighted the employer's role, in some cases, acting in the best interests of the nurse, to maintain the protection of the public.

"I sat and spoke to him and I said he is getting the right help, and I said I will write you, the kindest letter I can write to the NMC, to tell them about the outcome of this, he came to the disciplinary, I said to him he deserved a medal just for the bravery of turning up. He was just distraught. It was probably the saddest thing I will ever .ever do but would it stop me from referring to the NMC, it couldn't stop me from referring him to the NMC" -Participant 1.

A number of participants referred to cases that involved personal internal and external mitigation. Participant 4 explained the external influences that impacted on an individual's practice; these can range from the workplace culture, breakdown of professional relationships, environmental work force factors, such as working hours:

"There will often be an externalisation both in terms of environmental as well as also often other people behavioural stuff" - Participant 4.

One of the situational stressors addressed by participants was stress. The research shows that participants have experience of managing staff who have expressed feeling stressed because of work and/or family issues. The research reveals how a culture of sharing experiences and reasonable adjustments can be made to accommodate an individual's circumstances in order to relieve stress. Participant 10 acknowledged that work-related stress can be managed by sharing experiences with colleagues. The participant believed this strategy can reduce incidents and errors in practice because it fostered a caring culture in the workplace:

"What I'm saying is where there's a facility to off-load, share experiences, share the stress, the tension, problems. I think there's less likelihood of any mistakes or lack of compliance around policy to take place" - Participant 10.

Participant 17 reflected on a scenario described in the social media of a nurse supporting a colleague during a stressful shift at work, while caring for challenging and demanding patients. The actions of the nurse significantly helped a colleague by recognising the stress levels and offering support of a coffee break and some "*time out".* The consequences of these actions resulted in the best outcome for the patients:

"There's a great blog that a healthcare assistant wrote, about how he was really stressed and really found it really difficult to provide good care on a demanding ward, with lots of people with dementia. Because there was some quite challenging behaviour, he was finding it really, really difficult and he said that one of the staff nurses actually spotted that he was really struggling, and just said okay I'll look after this particular patient. You go and have a cup of tea, go and sit down, take twenty minutes time out. Let me go, I'll look after your patient for you. The blog was basically around six Cs, but the point he was making was that there was somebody there who looked after me, who recognised and stopped me from not providing good care" - Participant 17.

During this section the participants have described the level of "*resilience"* needed in contemporary nursing. This section has captured the participants' experience of the relationship between emotions, behaviour and conduct, mental health, and insight. The research has demonstrated how these contributing factors can affect a nurse's ability to function as a safe nurse, and the importance of protecting the public, upholding the reputation of the profession, and, at times, in the nurse's best interest. The next section explores the participants' experiences of the "*systemic failure"* that can impact on early career nurses' performance.

7.5 "*Systemic failure"* (Participants 10, 11, 14, 18, 9, 17, 4)

Seven of the participants illustrated the importance of examining the environmental and external influences that may have contributed towards an early career nurse's error in the workplace. Healthcare settings are busy, highly complex areas with multiple factors that may hinder an individual's performance. Following an error, an initial investigation will establish the facts, to decide if the case warrants disciplinary action. Participant 11 clearly stated that if the investigation revealed systemic failure the nurse may receive a different outcome:

"They've illustrated the scene… We are trying to ensure that our investigating team do the fact finding and then establish the need for a disciplinary…If it is a ***systemic failure*** *than that needs to be exposed rather than a protracted suspension and then formal process" - Participant 11.*

This research identifies that this represents a change of culture from blaming the individual to looking for the root cause and systemic failure. In this vein, participant 11 was advocating the exposure of the culture and practice within the workplace, rather than blaming an individual:

"I think historically, in not just unique to our organisation, there would be an error, an investigating manager would then seek to you know to prove the allegation rather than do a fact finding and stand back and say … do you know what, … this was custom and practice.

The difficulty for us is when you are sat with the individual in front of you, if they did make that drug error the custom and practice is something aside that we need to investigate, but I think there are some missed opportunities and that is what we are addressing in the way that we investigate them. If it is a ***systemic failure*** *then that needs to be exposed rather than a protracted suspension and then formal process. But I don't think that is unique to us" - Participant 11.*

A number of participants described the level of support available for staff. Participant 14 reflected on a case of an early career nurse who transferred from the primary care setting into an acute hospital. There appears to be an expectation that registered nurses have the transferable knowledge, skills, and competence to move clinical areas. This research reveals the importance of supporting nurses within the first five years of registration during a period of transitional practice. This preventative approach may reduce the risk of errors in the workplace by establishing the training needs and support for new employees from outside the organisation.

"We've had a situation where a member of staff has made three errors that have been discovered. But whilst we have initiated an investigation we've also recognised the fact that this is a member of staff who hasn't worked in an acute setting for a while and the level of support that she needs probably is greater than we realised. And so we've put in remedial action now so she's clinically restricted at the moment. She can't administer drugs, and she's under clinical supervision. We're trying to provide support and further education for her. But we still have to investigate what she has done because there might be other learning outcomes from that. It's not necessarily always punitive. The action for that comes from an investigation. It is sometimes supportive and educational and it is a case of sometimes, no it's not actually a disciplinary offence, it is unfortunately a training need" - Participant 14.

This research has highlighted the ownership of patient safety at the same time as the balancing of the need to be a supportive and "*fair employer*"" for early career nurses during their transition into registered practise. Participant 9 gave an example of using a systematic approach following an error in practice, by asking a series of questions to ensure the nurse was fully prepared, supported and fit for practise:

''You have a public safety number one. But you also have to be fair and a fair employer. And you have to look at mitigating circumstances and are there any. Are there any system and process issues? Have we got something right? Have we supported that individual? Have we developed them? So I think I would always err on the side of you know, full facts and their kind of for want of a better word, they're innocent until we can actually ascertain. So I think the cases that I'm aware that we've referred here, you know we will do everything

we can … to protect the public but not necessarily refer as well and give people a chance. And to support them and redeploy them" - Participant 9.

The research has revealed health-care providers' responsibility for monitoring the culture, custom, and practice within the workplace and the possible impact of this on an early career nurse's performance and conduct. Participant 18 disclosed that her experience of a failure to recognise poor culture in a workplace left nurses "*vulnerable to disciplinary action".* This reinforced the concept the "*second victim is the nurse".*

"The culture of one of our units or wards, would have meant there have been a number … sadly, of nurses and non-registrant personnel who are then in a situation where they are vulnerable to disciplinary action. But the organisation then I feel has a significant role to fail because it has failed to recognise those issues and take action" - Participant 18.

Participant 4 also gave an example of the external influences that are outside the nurse's control yet impacted on their performance and conduct:

"Part of the investigation would look into terms of the staffing or other things or they would say the process is flawed" - Participant 4.

Again it could be argued that the "*second victim is the nurse".* Participant 10 remarks that:

"So you have to look at … why they're there and actually if it is an organisational issue about lack of support then you know, we're just as much to blame therefore as they are" - Participant 10.

Similarly, participant 14 states:

"We will explore the factors that have affected that particular incident" - Participant 14.

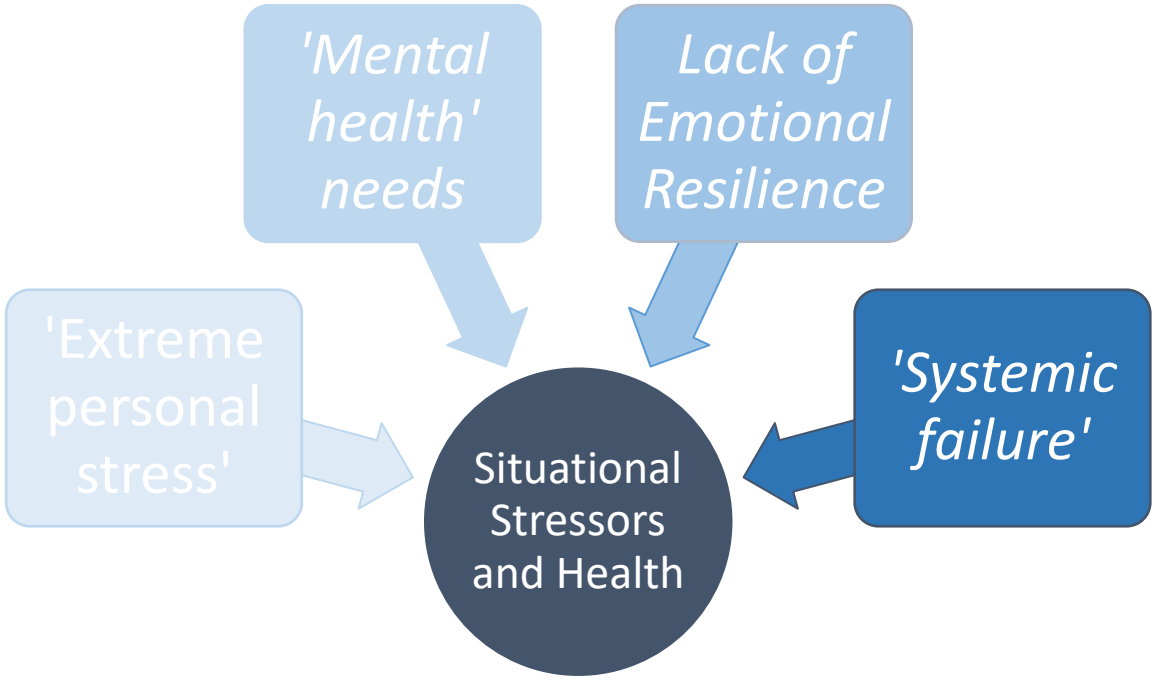
During this section the participants have described the "*systemic failure"* that significantly impacts on a nurse's performance, and which is, in some cases, outside of their control. This can leave the nurse being the "*second victim"* following an incident or error in practice. The participants described how recognised "*system learning"* is essential to support nurses and identify training needs rather than a punitive approach.

7.6 Discussion of Research Findings for Situational Stressors and Health Category with the Literature

This section will discuss the situational stressors and health needs that can be a contributing factor underpinning an error. It will take the reader through the understanding of the participant's experience of: the extreme personal stress experienced by some early career

nurses; mental health needs of the nurse; the lack of resilience; and finally, systemic failures, represented in diagram 32 below.

Diagram 32 Situational Stressors and Health



7.6.1 *'Extreme personal stresses'* and health needs

Nurses are human and therefore make errors. This research has identified two themes of mitigating factors: external and internal. External factors referred to the environment, system failure, increased technology, management of complex patients' care needs, and expectation of patients. The internal factors correspond with the emotional pressure, the nurse's own health needs, or trauma in their own personal life.

This research has identified some nurses "*admit to being human"* whereas others do not. The admission of an error with the nurse taking responsibility for their actions can simultaneously reveal a disclosure of underlying external and/or internal factors. Treiber and Jones (2010) analysed Registered Nurses' medication error accounts. They found that although nurses admitted responsibility for errors, they simultaneously identified a variety of external contributing factors. Following an error, nurse's acknowledged their mental fatigue, working

long hours, short staffing, and distractions thereby indicating that errors resulted from these external factors (Cohen et al, 2003; Hall et al, 2004). The Good Governance Institute (2015) reported that the 2014 NHS Staff Survey revealed that 39.5 per cent of NHS staff had suffered from work-related stress. The recent NHS Staff Survey data states health and wellbeing national average is 6/10 in 2016 (NHS Staff Survey Results, 2018).

However there are "background expectations" (Garfinkel, 1969) common to all nurses. Irrespective of the external and internal contributing factors nurses are expected to uphold professional standards, principles, and values. Yet, when a nurse is faced with the adversity of unexpected work based changes or life events, these core standards and values can be overlooked. Participant 4 described a nurse's significant mitigating personal factors that underpinned the allegations driving her to steal drugs from the organisation. Ultimately this conduct and behaviour was dishonest.

"I understand there will be circumstances where somebody was under undue emotional and potential physical pressure, to do something like that... Clearly sometimes it's related to the fact they may be going through their own sort of personal... I've been involved in a case where a nurse falsified a prescription to get a type of medication you use during IVF. Because they couldn't afford the payments but needed to go through IVF, so its stealing drugs" - Participant 4.

Throughout a nurses career they will care for sick and vulnerable people. However this does not mean that they themselves are not exposed to periods in their life when they are vulnerable too. Rosenorn-Lanng (2015) advocates that nurses do not have a "super immunity when they come into the caring profession". Rosenorn-Lanng (2015) continues to argue that it is acceptable to expect some nurses will be sick and experience genuine mitigating circumstances. There needs to be robust processes to recognise a nurse's genuine circumstances that may have influenced their decision-making at the time. This can be fostered by supporting nurse's to recognise and acknowledge when their personal circumstances are affecting their decision-making and ability to practice. This can be achieved with an open culture to ensure staff can disclose their situation in a safe place. Participant 1 recalled a case of an early carer nurse who had stolen medication from the workplace after a tragic bereavement:

"I had an incident where a nurse had stolen boxes of co – codamol, she had had a very traumatic personal bereavement in her family and tried to blame the fact that she had not been referred to occupational health… the team really had done everything to support and acknowledge her but at no point in any of the discussion was the acknowledgement of the responsibility she needed to take, we caught her on CCTV. There was no acknowledgement

that actually what she was doing was dishonest and the implication of how her colleagues would feel working with someone that had blatantly lied and blatantly stolen, and what the implications for patients was and that if she could lie about that and steal, then what are the (future) implications" - Participant 1.

Pugh's study (2011) in Australia describes how nurses dealt with an allegation of unprofessional conduct and focuses on understanding the vulnerabilities nurses bring to and experience in the work environment. The study revealed that "nurses experience personal and professional vulnerability in their practice contexts and these vulnerabilities can be distinguished firstly, as causal attributes to a fragmentation of decision making; and second, as a trigger to report the nurse to a nurse regulatory authority" (Pugh, 2011: 21). Pugh (2011: 23) highlights how during the "analysis of the data it revealed that some of the participants had an existing physical or mental health issue that influenced their ability to practice effectively in complex situations. These health issues also influenced how they were perceived."

The research has identified that there are key internal and external mitigating factors that may compound the situation that resulted in the error. The participants discussed the strategies to support nurses during the difficult times in their lives but this did not outweigh the need to protect the public, maintain public confidence, and uphold the reputation of the organisation and profession.

7.6.2 Lack of Emotional *"resilience"*

Over 1.3 million people work in the NHS, treating more than a million patients a day (Health Education England (2015). Health Education England (2015) emphases the importance of ensuring staff are equipped to deliver high quality care by understanding the fundamental principles that enable them to be flexible and resilient.

It was well established that many new nurses lack confidence to begin with and require positive feedback about their performance (Vessey et al, 2009), alongside the "*reality shock"* described by Kramer (1974). Duchscher (2009) builds on the theory of "*transition Shock"'* by outlining how the newly qualified nurse engaged in a professional practice role for the first time, confronted with a broad range of physical, intellectual, emotional, developmental and sociocultural changes that are mitigating factors within the experience of transition.

The participants gave examples of some early career nurses who were struggling to fit into the profession because of their "*odd"* character traits, who could be further disadvantaged by the transition period of moving into the nursing profession.

This research reveals how some newly qualified nurse's lack the ability to quickly integrate safely into the workplace and require a degree of support. Participants referred to running bespoke programmes to support newly qualified nurses:

"I've been running a trial programme for a small group of new qualifiers…they have a session together about … the emotional difficulties of … being a mental health student" - Participant 18

There appears to be a growing expectation for the nurse to meet the expectations of enhancing the patient experience, improving the health of the nation, with reduced resources. Odenheimer and Sinsky (2014) argues this has moved to "a quadruple aim", to include optimising health system performance. The participants experienced some nurses who required an additional level of support to function safely which was beyond sustainability. Participant 5 gave an example of a newly qualified nurse, who over an eight week period of supernumerary status could not function safely. As a consequence, this impacted on the nursing team who became increasingly anxious for the welfare of the patients. They voiced concerns about the degree of responsibility involved in supporting a significantly underperforming nurse, whilst working with their own extensive workload in a busy acute surgical setting:

> *"They (nursing team) are very good, and they're pretty good at saying, I'll give it time (explain) why we do things? But we weren't even allowing her to do much, she was on another planet, and they (nursing team) got very frightened I think because of safety" - Participant 5.*

Yet it is well reported that newly qualified nurses experience limited support on qualification (Brakovich and Bonham, 2012; Flinkman and Salantera, 2015), compounding the challenges for the nurse. In particular, newly qualified nurses tend to have greater risk for errors than the experienced nurses (Berkow and Virkstis, 2008). In addition, it has been reported between 49% and 53% of newly qualified nurses are involved in nursing errors (Smith and Crawford, 2003; Kenward and Zhong, 2006). Nurses who are not adequately prepared will be more prone to making significant mistakes as they begin to practice (Gibson, 2011).

Whereby, Brunton (2005) states that nurses must "stake out their emotional boundaries with patients, doctors, families, and each other, even in the face of incessant demands, crises, and mistakes". Hochschild (1983) describes people who handle emotional displays "ranging from superficial to deep acting levels". According to Larson and Yao (2005), healthcare professionals engage in emotional labour through deep acting by feeling sincere empathy before, during, and after interactions with patients. This work has been referred to as "emotional labour of nursing" by Pam Smith (1992). Thus, there has been a continuing attempt

to address the role of emotions in healthcare (Mark, 2005). Larson and Yao (2005) continues to describe the empathy should characterise health care professionals' interactions with their patients because, despite advancement in medical technology, the interpersonal relationship between physicians and patients remains essential to quality healthcare. Thereby, if a nurse is involved in an error, they too, can be injured. The pain inflicted on a nurse after making an error has been described as the “second victim” (Marmon, 2015; Micco, 1997; Wu, 2000).

However, the participants described the complexity of assessing and managing the risk of patient safety. This research has revealed internal mitigating factors do not outweigh the need to protect the public. Participant 4 gave an example of how an act of dishonesty can have a detrimental effect on the relationship between the nurse and the employer. This is discussed in the chapter – a chain of expectations:

“But you know, for me it’s a complete breakdown of trust between me and the employee and so also between me as an Accountable Officer and (registered) professional … beholder of professional standards within the organisation. It’s about whether I can trust them to practice in the future” - Participant 4.

Participant 9 gave a similar recollection:

“You’ve lost all trust then … regardless of the mitigation, if they’re living on the street or they’ve got ten kids to feed, it doesn’t make a difference. You know we’ve got mechanisms to support people …. But yeah it is completely unacceptable. It’s a breach of trust” - Participant 9.

A stressful environment can result from inadequate staffing and daily “hassles”, such as “hunting and gathering activities”, which restrict nurses from meaningful patient care (Beaudoin and Edgar, 2003); for example the time taken to find medications and supplies. These stressors can affect patient safety and adversely influence the nurses' perceptions of their work place environment (Paris and Terhaar, 2017).

“How can you make good clinical decisions under tonnes of pressure in those circumstances?” - Participant 14.

A healthy work place is identified by “an engaged nursing staff who exercise control over nursing-related issues, ground their practice in the evidence, and collaborate with colleagues from diverse disciplines” (Kramer and Schmalenberg, 2008). These positive environments are linked with favourable patient outcomes and an empowered workforce (Gallup, 2005).

7.6.3 Systemic Failure

Studies have reported the reasons for errors and found multiple system factors including human factors (Brady et al, 2009; Keers et al, 2013; Parry et al, 2015). Ulanimo et al (2007) highlights a key barrier to reporting an error was the fear of peers' reaction and fear of nurse managers' reaction. Similar findings (Mrayyan, et al, 2007; 2011; Mayo and Duncan, 2004) found nurses were afraid of the reactions from the nurse manager. The practical implications impact on the healthcare organisation's inability to collect data that is reliable to gather an accurate picture of problems in practice. If left unchecked, this may result in future otherwise avoidable harmful errors occurring (Secker-Walker and Taylor-Adams, 2002: 423; Amoore and Ingram, 2002). This leaves the organisation vulnerable to "latent factors" (Reasons, 1990).

The culture and the reaction of managers and staff create an organisational barrier that inhibit the reporting of errors (Vrbnjak et al, 2016). Vrbnjak et al's (2016) systematic review highlights a sense of fear, accountability, and characteristics of nurses as the personal and professional barriers that influence the reporting of errors. Therefore, a nurse needs an inner strength of personal and professional courage to disclose their deficiencies. This can be assisted by a real sense of confidence and motivation, commitment and engagement to disclose an error to their manager.

The culture of the workplace in relation to forms of bullying can have extreme negative impacts on the nursing workforce and patient care; this could be referred to as "horizontal violence" (McKenna et al 2003). Bullying in the nursing workplace has been identified as a factor that affects patient outcomes and increases occupational stress and staff turnover (Etienne, 2014; Cox, 2003). More recently, Lever et al (2019) systematic review concluded bullying occurs frequently amongst health care staff and is deleterious to health and occupational functionality. This has also been defined as inter-group rivalry, lack of unity and pride, and aggression turned inward (Cox, 2003; McKenna et al, 2003; Bartholomew et al, 2006). This could be a result of lack of leadership, role models, and performance management.

Moreover, bullying can be a major reason for leaving the profession (Etienne, 2014; Stark and DeMarco, 2011). One study found that almost half of new graduates had experienced a form of bullying, humiliation and rudeness across settings, and many had felt distress as a result of inappropriate supervision (Berry et al, 2012). These experiences were related to absenteeism and thoughts about leaving nursing, ultimately hindering performance and the ability to focus on developing their skills, knowledge and competence.

The transition from student to registrant is potentially challenging for nurses from all types of educational programmes, and has historically been shown to be a stressful experience (O'Shea and Kelly, 2007). The terms used to describe the transition from student to registered

nurse include “reality shock” (Kramer, 1974). The stresses affecting transition include individual accountability, the risks and consequences of making errors, and management issues such as prioritising care needs (Gerrish, 2000). It has long been said that "nurses eat their young" (Bartholomew et al, 2006), and if left unhindered these negative acts can further escalate the nursing shortage. Novice nurses are the face of the future; experiencing workplace bullying when entering the nursing workforce sets a negative precedent (Etienne, 2014). Overton and Lowry (2013) explains that talented individuals leave a career that has such a strong need for them, partially because of their lack of skills in dealing with conflict. Overton and Lowry (2013) argues that it is the fault of the nurse leaders who are not visible or do not provide the opportunity to learn these skills and foster an environment where conflict is not acceptable.

The evidence suggests that a nurse’s behaviour and misconduct can have serious consequences for their colleagues and patients in their care. There may be consequences for the nurse leader demonstrating a lack of management and leadership skills. The organisation needs a support strategy and effective performance management, with a clear view to support staff who use their duty of candour to report staff.

7.7 Conclusion

To conclude the situational stressors and mental health category, there is now a greater understanding of the meaning of the experience as a whole. The situational stressors and mental health have clarified the pre-understandings identified at the out-set of this study in relation to the human factors and professional regulation in the introduction chapter.

This chapter has challenged the pre-understandings in a different way, through theoretical sampling and constant comparison of the data, when exploring the factors that contribute to an employer referring a newly qualified nurse to the NMC. This research confirms that there are some cases when the “*second victim is the nurse”.* It is evident that there is a need for a culture of sharing experiences and reasonable adjustments that can be made to accommodate personal circumstances and/or their working environment. It is apparent that there is greater importance for employers to provide supportive strategies to manage the individual needs of their staff members whlist demonstrating they are a “*fair employer”.*’ However, in some cases, a nurse whose conduct and performance has been questioned, may have little or no evidence of mitigating circumstances to compensate for the nurses actions. The research confirms that protection of the public outweighs the nurse’s individual needs, no matter now traumatic for the nurse.

7.8 Key Findings for the Situational Stressors and Health Category

- The research confirms that there are multi-factorial situational stressors that significantly impact on a nurse's performance and conduct.
- The participants highlighted their experience of the employer investigating and learning from incidents and errors in practice to ensure a rigorous and fair process is followed.
- The participants' explain the early career nurse's behaviour and conduct, mental health, insight and mitigation can affect a nurse's ability to function as a safe nurse.
- The participants expressed the importance of protecting the public, upholding the reputation of the profession, at times, whilst in the best interest of the nurse.
- The participants describe cases of nurses who lack emotional "*resilience"* which can result in periods of "*sickness and absence and lateness".*
- The research highlights that some early career nurses are "*vulnerable to disciplinary action".*
- The research confirms the importance of a culture of support and sharing experiences and reasonable adjustments can be made to accommodate an individual's circumstances to relieve stress.
- It is evident that in some cases, a nurse whose fitness to practice is in question may have little or no evidence of mitigating circumstances to compensate for their actions.

Chapter 8 Core Category: A Decision to Refer

8.1 Introduction

A decision to refer emerged as the core category in this adapted constructivist grounded theory research. This chapter explains the contributing factors of why employers make a decision to refer an early career nurse to the professional regulator. The development of the core category discusses the three central themes the participants are grappling with and their perceptions of the situation: the employer's responsibility of public safety; which is underpinned by the values and expectations of the nurse; this is often exposes the early careers nurse's professional vulnerability to a referral to the professional regulator, displayed in diagram 33.

These central themes have emerged from the four categories which are the outcome of the study's aim and objectives and how this have generated into new knowledge and a deeper understanding of the phenomena, illustrated in diagram 34. This chapter also demonstrates how the formation of the four categories consolidated into the development of a form of constructivist grounded theory, by intertwining the fragmented concepts into hypotheses that work together to form the core category – a decision to refer, presented in diagram 41.

The study represents the key experiences, beliefs, perceptions, and opinions of the 20 participants. The theoretical codes emerged from the process of constantly comparing the data in the transcripts, field notes, and memos leading to the four categories which formed into core themes. Glaser, Strauss, Corbin and Charmaz debate the procedural matters of a core category and point out the benefits of one method versus another. In this study it is important that the grounded theory is not only emergent in terms of the theories developed but also in relation to the methods are transparent, credible and dependable. Thereby, reiterating the importance of staying close to the data.

Charmaz, (1994) outlines that a constructivist approach does not construct a core category in the studied phenomenon and this is an unconventional way compared to a true constructivist grounded theory approach. This study utilises Glaser and Strauss (1967: 40) approach that "during the research the emergent categories began to form patterns and interrelations which formed into the core of the emerging theory". Certainly, Glaser (1978) reinforces the importance of a core category because the requirement for the generation of theory occurs around a core category. He argues that without a core category the grounded theory study will drift away from relevancy and workability (Glaser, 1978).

Throughout this study it is clear how the core category emerged with "*public safety"* (P7) being the priority for healthcare employers, underpinned by the employer's fundamental

responsibility to protect the public. The participants experience highlighted how nurse's "vulnerability" and the employers values and expectations of a nurse whose fitness to practise is in question.

The core category illustrates fitness to practise decisions are based on a combination of factors: The **public safety** issues related to the situation and the response of the nurse, which can be influenced by the employer's **values and expectations**; the employer's perceptions of the employee and the employer's relationship with the nurse, which can lead to the nurse being **vulnerable,** this is based on the four categories:

- **Alarm bells** which signal that patient safety has been compromised either by a single or series of related events;
- The **characteristics and values** of a nurse that employers expect and appear to value following a concern about their fitness to practise;
- **Employers' expectations** of a nurse's reaction once an error has occurred;
- **Contributory multi-factorial stressors and health issues** of the nurse.

Diagram 33 The Central Themes of Public Safety, Values and Expectations and Vulnerability

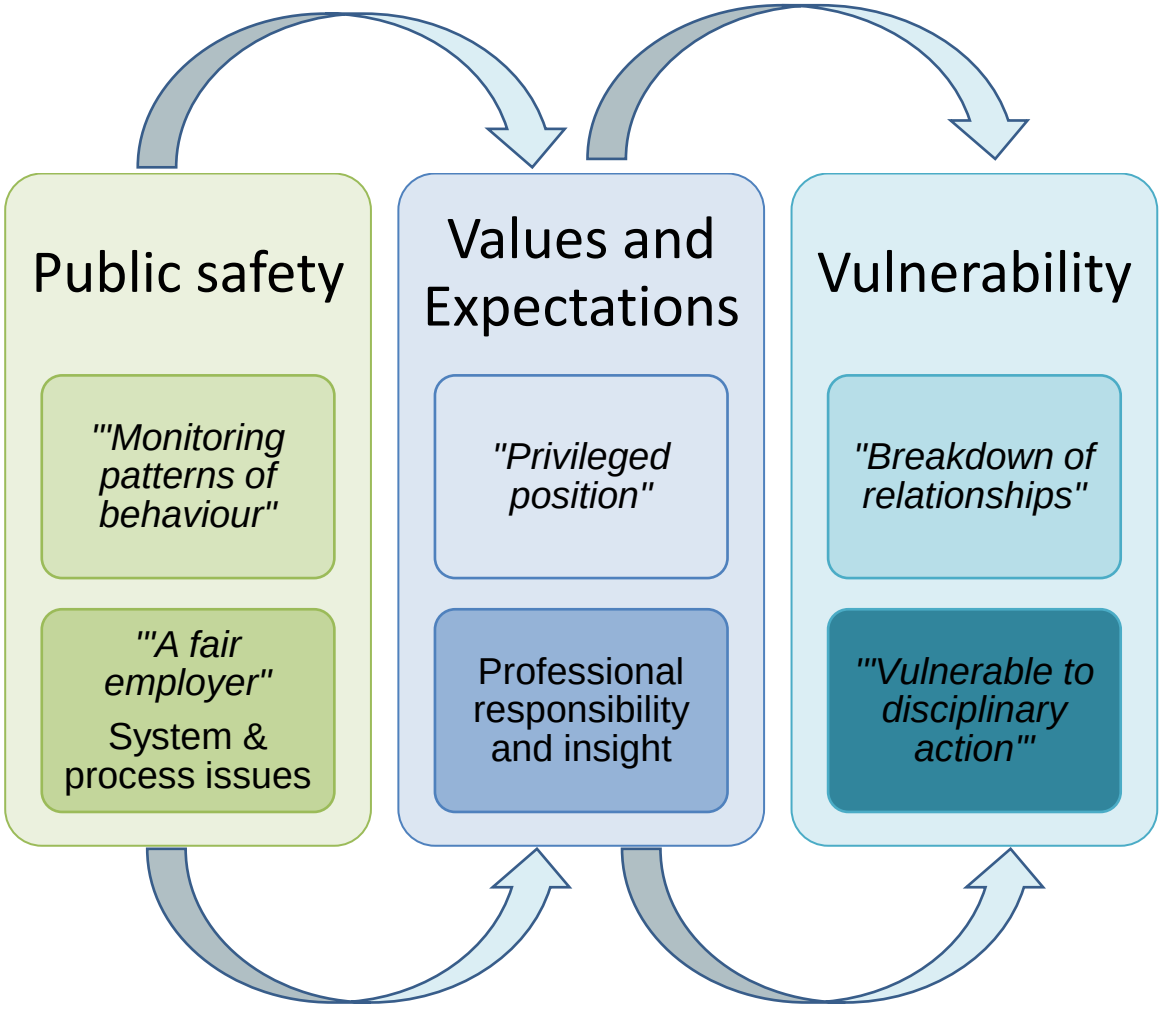
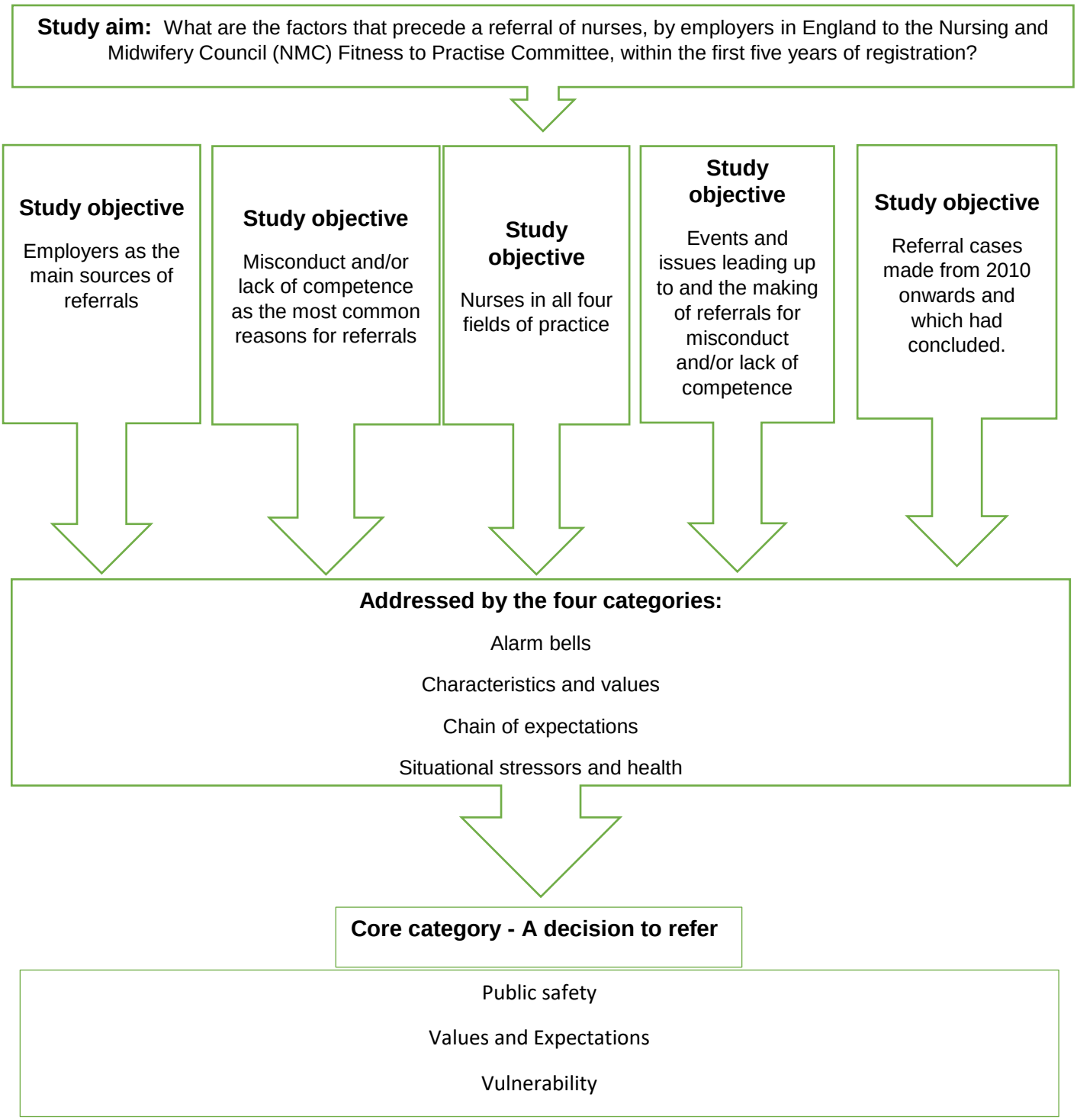


Diagram 34 The Aim and Objectives - Four Categories and Core Category

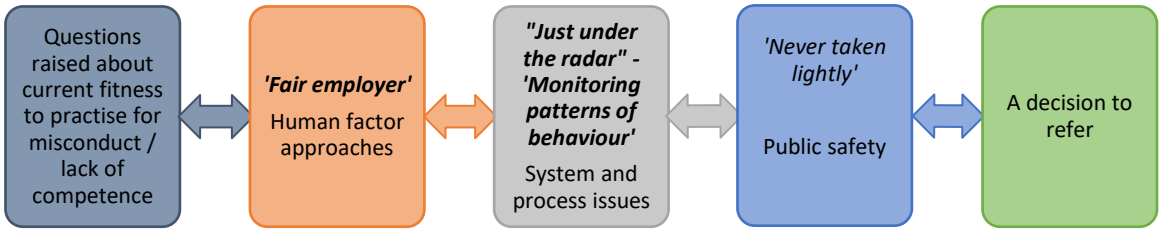


8.2 Public Safety - The Situation

This section discusses two key themes which emerged from the four categories. Firstly, the employer's responsibility for "*public safety"* whilst balancing the need to be a supportive, objective and a "*fair employer"* (P9). This is displayed through the identification of potential "*system and process issues"* by adopting human factors approaches, which may have impacted on the nurse's performance or conduct. Secondly, the importance of monitoring early career nurses "*patterns of behaviour" (P18)*, especially those whose low level performance and conduct is "*just under the radar" (P7).*

These two key themes of public safety are visually represented in diagram 35 which illustrates the complex decision-making process made by employers when there are questions raised about an early career nurse's current fitness to practise.

Diagram 35 Visual Representation of the Two Themes of Public Safety



8.2.1 "*A fair employer"* - System and Process Issues and *"Monitoring Patterns of Behaviour"*

Throughout the study the participants explained how they adopted a human factor approach to examine potential system and process issues, discussed in chapter 7. Therefore, following an error or incident in the workplace the starting point for a deeper investigation is the underlying factors, illustrated by participant 9.

> *"You also have to be fair and a fair employer… And you have to look at mitigating circumstances, Are there any system and process issues? Have we supported that*

individual? …We will do everything we can to protect the public but not necessarily refer. We give people a chance' – Participant 9.

The participants emphasised in chapter 4 health-care services are provided to patients in an environment in which there are complex interactions, such as the disease process itself, clinicians, technology, policies, procedures, often with limited resources. It is evident throughout the study that participants understand nurses there was a combination of highly complex factors can lead to unintentional errors in the workplace. Reason (1990) defines human error as a failure of a planned action or a sequence of mental or physical actions to be completed as intended, or the use of a wrong plan to achieve an outcome. Therefore, by definition, errors are a cognitive phenomenon because errors reflect human action that is rooted in a cognitive activity (Hughes, 2016).

The participants also acknowledged the situational factors of occupational stressors and personal concerns discussed in chapter 7, which may impact on the nurse who fails to act as they intend, because of the stress they are under. The level of stress may be linked to poor workforce planning and inadequate skill mix of staff. There have been high profile examples reported in the media, for example the Mid-Staffordshire NHS Trust inquiry (2013) and more recently the Gosport Inquiry Report (2018).

The National Quality Board (2017: 17) recommends that "staffing resource aligned to levels of patient acuity/dependency should be empirical and drawn only from quality assured services to avoid extrapolating from wards delivering suboptimal care."

Early career registered nurses have to deal with busy environments, make critical decisions, delegate, and multi-task on a day to day basis, alongside the intricacy of medicines management that may involve oral medication, intravenous preparation, and administration. This is illustrated by participant 15 and reinforced by 14 of the participants who made reference to medication errors.

'It's not just about the administration of those drugs from the trolley to them (patient), it's then about helping support them (the patient) to take those drugs…Very busy ward, people coming to interrupt you because only the registered nurses can do the drugs. So I think there are lots of compounding factors for drug errors' – Participant 15.

The participants throughout the study explained the difficulties of "*monitoring patterns of behaviour"* (P18) for nurses whose performance and conduct were *"just under the radar",* discussed in chapter 4*.* Carayon (2007), a human factors expert, argues that it is very rare for nurses to go to work with the intention of causing harm or failing to do the right thing. This research has reinforced that "c*ompetency is important. It's not woolly and fluffy" (P17).* Zientek

(2010: 147) states that “an obligation is required to confront any individual healthcare provider who may skirt protections already in place, or the provider who may repeatedly demonstrate poor judgment or be impaired”. However, there is “*something about people not being confident about dealing with poor performance” (P17).* The participants report a “*lack of courage perhaps or a lack of robustness, because it does happen if you’ve got weak ward managers or weak team managers” (P18).* Notwithstanding the complexities of monitoring competence and in some cases nurses, with low level concerns raised by the nursing team but “*nothing catastrophic” (P20).*

Nurse Leaders play a crucial role in monitoring patterns of behaviour by inspiring early career nurses to feel confident in reporting errors. This example is working towards the organisation adopting safe, sustainable, and productive staffing to avoid potential future implications for patient safety and enhancing staff experience.

It is evident that an early career nurse whose fitness to practise is in question responds in different ways depending on the management, leadership and culture within the organisation. This research reveals that employer’s believe it is the correct path to follow for an early career nurse to take responsibility for a genuine “*terrible mistake” (P9).* The participants confirm the complexity of monitoring behaviour but this can impact on the employer’s relationship and expectations of the nurse.

8.3 Professional Vulnerability - the Employer’s Perceptions of the Employee and the Employer’s Relationship with the Nurse

8.3.1 Introduction

This section highlights two key themes which emerged from the four categories. Firstly, an early career nurse can be placed in a vulnerable position and subject to a referral to the NMC because of the “*irretrievable breakdown of the relationship” (P1)* between the nurse and the employer. In some cases this can be due to a fundamental lack of trust in the nurse to provide safe and effective patient care, whereby the employer is unable to mitigate against the risk of repetition.

Secondly, the employers recognise that some early career nurses can be “*vulnerable to disciplinary action” (P18).* The employer’s perception of the nurse who displays “*odd” (P15)* or “*difficult” (P4)* personality traits following an error or incident can be one of the contributing factors which leads to a referral. In some cases, the challenges of early career progression and transition into the profession, plus a question about their fitness to practise, can result in the nurse having a “*broken spirit” (P18)* and/or feeling like the “*second victim” (P9).* One participant disclosed their own experiences of responding to stressful situations: “*I’ve been in*

extremely stressful situations and acted in a way that I wouldn't normally have reacted to" (P15).

The key themes of the early career nurse's professional vulnerability to a referral to the NMC are represented in diagram 36. This illustrates the complex decision-making process made by employers when there are questions raised about an early career nurse's current fitness to practise.

Diagram 36 Visual Representation of the Two Themes of Professional Vulnerability

8.3.2 "*Cracks in the relationship"* between the Employer and the Nurse (P19)

This research has provided a new understanding of the three situations explained by the participants when they described how a relationship between the nurse and the employer is at risk of irretrievable breakdown.

Firstly, following an incident or error in practice the relationship between the nurse and the employer needs to be built on the foundations of trust and assurance that the situation will not be repeated to protect the public. In this situation the nurse needs to demonstrate that there are strategies in place to prevent a reoccurrence and reduce the risk to patient safety. This assurance is often provided by the nurse's acceptance of the need for support, engagement with education, and retraining and taking responsibility for their actions, that it is evident that the trust and relationship between the nurse and employer could continue.

Secondly, it is evident that there are certain circumstances where employers anticipate that there are no measures to minimise the risk of repetition. The participants describe a "*zero tolerance" (P1)* to acts of dishonesty by clearly articulating their experiences of "*don't make things worse for yourself, by lying"* (P17). "*It wasn't a grey area or something minor or insignificant. It was a deliberate act, it was quite serious" (P16).* In these situations this study

reveals a new understanding which highlights how the trust in the relationship between the nurse and employer has the potential to irretrievably break down. Ultimately, "*dishonesty can be is very hard to remediate, so how do you prove that you will not steal medication again?" (P17).*

Finally, the participants explain the difficulties of managing and monitoring early career nurses whose patterns of low level behaviour, skill and competence often fall just "*under the radar" (P7).* In this situation, their low level of performance is often highlighted by a significant error which results in potential/actual patient harm, illustrated in the Alarm Bells chapter. The participants described how employers often gave early career nurses the "*benefit of the doubt" (P19)* irrespective of clinical deficiencies, described by participant 19:

'We'll give him the benefit of the doubt, let him settle in...and then same sort of thing, not doing stuff, blaming other people, complete disregard … for finishing his jobs on time, drug errors…lots of things' – Participant P19.

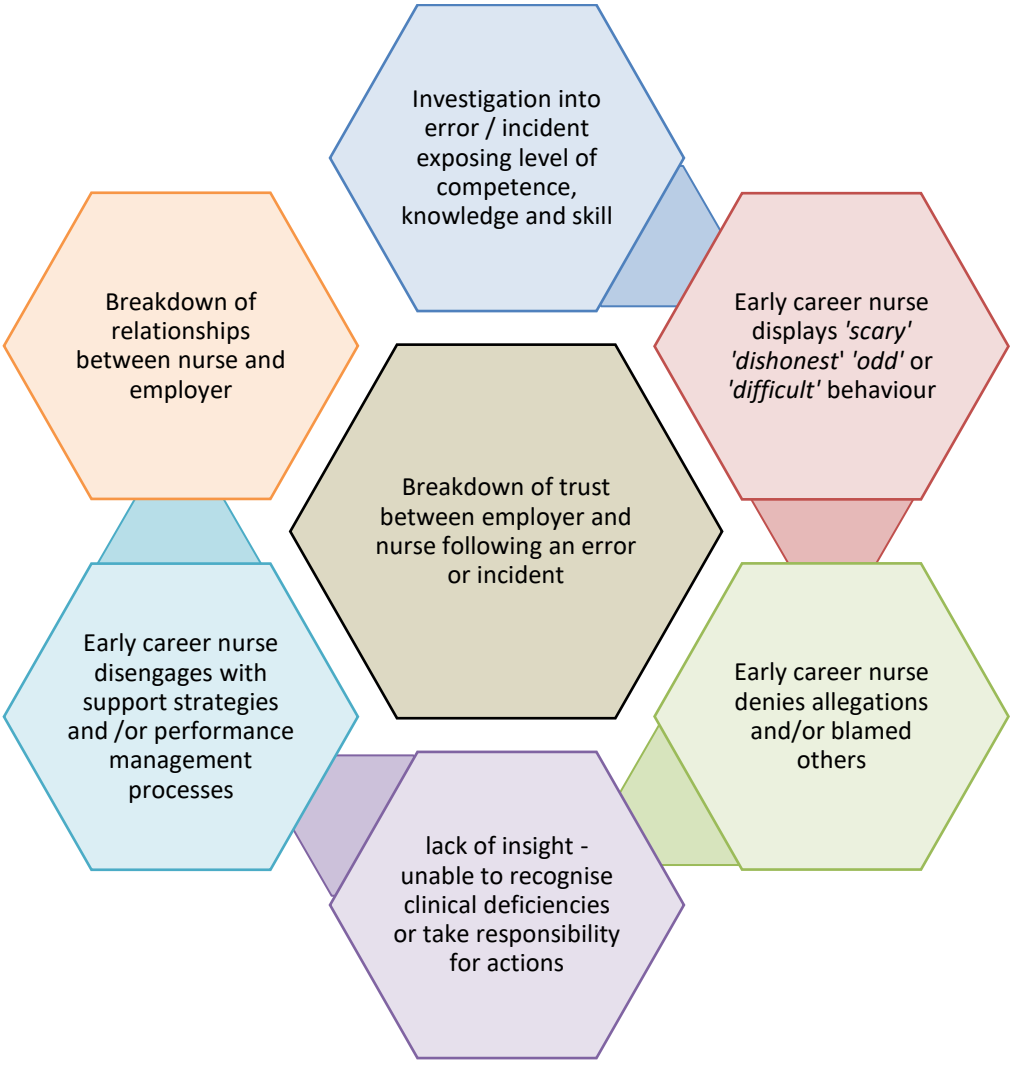
However, the participant's described a nurse "*just under the radar" (P7)* often lacked insight into their clinical deficiencies, therefore they are unable to demonstrate how they can remediate against their actions. In this situation, the participants gave examples of the nurse disengaging from support strategies, performance management processes, and/or formal disciplinary action. This often resulted in the employers asking questions, for example "*would I feel safe in their hands?" (P14).* The cycle of events is captured in diagram 38 illustrating the participants examples of an early career nurse who "*display odd behaviour" (P14),* or are "*quite difficult" (P15).* These character traits can result in a breakdown in the relationship between the nurse and the employer.

This research reveals a nurse "*just under the radar" (P7)* whose fitness to practise is under scrutiny can "*blame others" (P7)*, this is perceived by the employer as an inability to take responsibility for their actions and a lack of insight. In this situation the nurse's reaction and response can hinder the relationship with their employer. Eley et al (2015: 569) reports that nurses with certain character traits tend to "look out for themselves." Whereas, Case (2011) reports a similar finding of an impairment of fitness to practise was made on the basis that the doctor continued to deny the allegation. However, Pugh's grounded theory study (2009: 2032) reports findings where the nurse had "the ability to preserve the self and minimize deconstruction was illustrated by assuming a stance, taking a stance and searching for meaning." Interestingly, Pugh's (2009: 2032) study found "truth-telling as a way of assuming a stance was common to those participants who admitted to making an error, for example: 'I am not going to blame anybody else, there may have been extenuating circumstances but I was responsible (Participant 18)".

This research has provided new insight into the importance of the relationship between the early career nurse and the employer. If this relationship irretrievably breaks down, the nurse is more likely to be referred to the NMC because of the lack of trust in the nurse to provide safe and effective patient care. Participant 14 confirms: "*sometimes it is still a situation whereby the trust is broken so much you can't, you end up having to dismiss anyway".* Participant 16 reinforces the privileged position of a nurse discussed in the Wanted and Unwanted Values and Characteristics in Nurses chapter.

"The nurse treating patients has to be the best ….and that you can trust them" – Participant 16.

Diagram 37 The Cycle of Events Leading to a Breakdown of the Relationship between an Early Career Nurse and their Employer



This research reveals a new understanding of an early career nurse whose fitness to practise is in question. It has demonstrated that the process can expose their "*odd" (P15)*, "*scary" (P4)*, "*dishonest" (P1)* and/or "*difficult" (P4)* characteristics and values. Furthermore, the participants

reflect that some nurses can be "*vulnerable to disciplinary action" (P18)* because of the behaviour and conduct displayed to the employer.

8.3.3 "*Vulnerable to disciplinary action" (P18)*

Nearly half of the participants reflected on their observations of nurse's characteristics and values, participant 4 stressed that there appears to be no distinct pattern that could help prevent an early career referral to the NMC. This research reveals a new understanding of the wanted and unwanted characteristics of a nurse and provides a tool to identify those at risk of referral.

"I see the broad range, I see newly qualified nurse, I see experienced practitioners, I see boys, girls, I see the whole remit of people who make either errors or professional standards issues within practice. And I've never come across anything that's a particular pattern" – Participant P4.

This research reveals the participant's experiences of managing and supporting early career nurses who may be vulnerable because they have exposed characteristics deemed as "*odd"* or "*difficult"* following a question about their fitness to practise.

A number of the participants describe a wide range of cases they have internally managed, either through the performance management, investigation process and/or disciplinary hearings. These internal processes tend to highlight some of the unwanted characteristics and values displayed by nurses. The participants reflected on the nurse's conduct and behaviour when under the spotlight "*they may be an excellent nurse but have some sort of a personality trait for example they might be abrupt or difficult or a bit too over-familiar, a bit loud versus other people who are a pain in the backside from day one" (P4*). Yet, little is known about nurse's personalities (Williams et al, 2010).

This research reveals that one of the contributing factors towards a referral to the professional regulator is when the employer perceives the nurse to display unwanted characteristics. Five of the participants in this study attempt to rationalise an early careers nurses "*odd"* behaviour by labelling them with "*autism" (P19)* or a "*personality disorder" (P2).* One of the participant's referred to the "*professional misfits" (P18)* in nursing, illustrated in memo 18 below. The participants explained that they retrieved the interview notes from the recruitment process

MEMO 18
*The participant highlighted there are **'professional misfits'** in nursing. Strategies are needed to support individuals to enhance their strengths and qualities.*

when supporting an early career nurse with "*odd"* character traits, which revealed during the interview "*she scored exceptionally high at interview" (P1),* yet in the workplace they struggled to interact and develop relationships with colleagues and patients. Pugh's (2011: 25) grounded theory research reflects a similar concept with descriptions of participants feeling ''outside of the group," illustrating the dimension of their "face doesn't fit". Pugh (2011: 25) reports verbatim quotes of participants saying "right from the start, some of the nurses in the unit made it clear that they didn't like me and they didn't want me there."

Ultimately, this highlights the vulnerable position of nurses who display specific personality and character traits when their fitness to practise is being questioned. It is apparent that the formal processes led by the employer following an error in the workplace can exacerbate the rawness of an individual's characteristics and values, because the nurse is "*fighting for their livelihood" (P1).* Participant 15 acknowledged *"definitely sometimes in extremely stressful situations it can bring out certain personality … traits in you that you sometimes …you never knew you had!"* This could result in some nurses having a "*broken spirit" (P18)* early in their career and feeling like the "*second victim" (P9)*.

8.3.4 "Second victim is the nurse" (P9)

This research confirms that employers are committed and take full responsibility to protect the public in their own organisation, and in some cases, the wider community. It is evident that "*terrible mistakes" (P9)* occur in health-care settings. The participants recognise that "*nursing can be extremely stressful and emotional" (P15).* One of the participants referred to "*compassion fatigue" (P17)* and the huge impact and "*an overwhelming sense of evidence that twelve hour shifts is terrible" (P17).*

This research illustrates how genuine mistakes can be made by confident and competent nurses, who may have no history of previous clinical errors. It is evident that this is often a shock and surprise to the nursing team, who see the nurse as "*friendly" (P17)* and hard-working, often referring to the nurse as being cooperative and empathic, principled and a highly regarded nurse. The nurse's characteristics and values contribute towards their ability to acknowledge the consequences of their actions, say sorry and demonstrate a level of remorse. The nurse takes responsibility for the actions needed to rectify their deficiencies. In this case, the nurse responds appropriately to the wheel of redemption and chain of expectations of the employer to manage the risk to future patients, discussed in Chapter 6.

Even though this is a one-off incident, it often results in a referral to the professional regulator, due to the severity of patient harm, because the employer came to the conclusion that they have "*no choice but to refer" (P9)*. It is evident that the employer acknowledges "*the first victim is …obviously the patient and their family. But the poor nurse and the colleagues are the*

second victim…nobody goes to work to cause harm" (P9). Wu and Steckelberg (2012: 267) highlight the impact of adverse events on healthcare workers is an important consideration with staff often described as the "second victims" of adverse events. The high profile case of Pillai v Messister (Pillai v Messister 1989) highlights a medical practitioner who appealed to the Supreme Court of New South Wales USA after being struck off the register for wrongly transcribing a drug which contributed to the death of a patient (Staunton and Chiarella, 2003). The Supreme Court held that "mistakes can happen to the most conscientious professional person" (Staunton and Chiarella, 2003). Johnstone and Kanitsaki (2005: 372) clearly advocates that the "nursing regulators may in fact be doing a disservice to nurses by disciplining them for honest mistakes, and that these nurses should not be reported."

8.3.5 *'Broken spirit' (P18)*

The participants reflect how some early career nurses' experience of early integration and socialisation into the nursing profession can be a bumpy ride, even with support. The participants reflect on how the culture in a workplace is hard to "*unscramble" (P18).* The nursing media reports that during the initiation period "nurses eat their young" (Gillespie, 2017: 11). There are further reports that some nurses are "Pit bulls, scorpions, and snakes who create conflict in an effort to feel powerful" (Lathrop, 2007: 8). If the notion of "snakes at the nursing station" is tolerated, the workplace can become toxic (Lathrop, 2007: 8). Pugh (2011: 25) reports participants stating "I would be ridiculed for anything I said, any idea I had, or any opinion I gave." This must be a concern for the nursing profession especially with reports outlining that the retention of nurses and other healthcare staff is a "far greater challenge" for the NHS than recruiting enough students for undergraduate training (Merrifield, 2017).

Ultimately, early career nurses may be "*vulnerable to disciplinary action" (P18)* and at a higher risk of referral to the Nursing Midwifery Council because of their individual personality traits and their level of knowledge, skill, and competence. A participant raises a valuable point: "*what have we done from that day of graduation and that shining new preceptor, to somebody who's broken in spirit and so demoralised?" (P18).* Jackson et al (2007) acknowledges that a negative workplace environment and culture can result in stress and burnout. This is reflected by the participants who acknowledge that "*it is never straightforward because you're dealing*

MEMO 2
After the interview the participant reflected on her senior role and her own nursing career. She stated that the only professional development nurses receive is mandatory training because they are the "work horses and we all need work horses".

*with a deep-rooted culture" (P18).*This research highlights an example of a deep rooted culture

displayed by a senior nurse who referred to the nursing workforce as the "w*orkhorses" (P2)* described in the memo 2 above; ultimately implying that they require the minimum professional development, education and training to function in their role.

The literature indicates that early career nurses rely on role models and preceptorship approaches to help with this transition into professional practice. Johnson et al (2012) argues that nurses' professional identity develops throughout the longevity of their career from entry onto the pre-registration programme evolving throughout their clinical experience. Professional socialisation takes place when nurses are made to feel part of the team, promoting confidence and interest in their profession (Feng and Tsai, 2012).

The participants report the transition into the nursing profession needs to be with "*a soft landing for those new qualifiers … in what are complex situations" (P18).* This applies to all personality types including the "*friendly"* nurse, the *"odd"* nurse or the "*difficult"* nurse. Recognising a nurse's characteristics and personality traits is essential to assist with the challenges of early career progression and transition into the profession. The participants clearly recognised that "*there was a variety of things that had been done to try and ease what she felt was pressure and stress" (P14).* Notwithstanding if an early career nurse is involved in a genuine "*terrible mistake" (P9)*, it can help them cope with the consequences of their actions and prevent some nurses feeling like the "*second victim."*

8.4 Values and Expectations – the Response of the Nurse

8.4.1 Introduction

This section of the core category highlights the two key themes which emerged from the four categories. Firstly, one of the contributing factors to refer a nurse to the Nursing Midwifery Council is underpinned by the employer's perceptions of a nurses "*privileged position" (P8)* in society, aligned with the employers' responsibility to uphold the reputation of the organisation and profession.

Secondly, it is evident that employers report a chain of expectations of a nurse whose fitness to practise is in question, illustrated as the wheel of redemption. This model explains how the nurse is expected to admit to the incident, demonstrate remorse and say sorry, possess insight, and provide evidence of taking responsibility and remediation. Thereby displaying to their employer they have the awareness and insight to remedy their deficiencies in the workplace.

The key themes of the early career nurse's values and expectations are represented in diagram 38 below. This illustrates the complex decision-making process made by employers when there are questions raised about an early career nurse's current fitness to practise.

Diagram 38 Two Themes of the Values and Expectations of an Early Career Nurse

8.4.2 A Nurse's *"Privileged Position"* in Society

Nurses provide the care for people when they are sick and vulnerable, they are often exposed to situations when people are physically defenceless and emotionally sensitive. In this context, nurses are trusted by patients and society, not to exploit or abuse those whom they care. This research confirms a new understanding that employers believe nurses are "*privileged"* (P8). Therefore, when considering a nurse's fitness to practise and a decision to refer to the regulator, the employers' opinion is that the nurse has "*not lived up to those values and I don't think they deserve to be a nurse"* (P8).

Professional values and status was originally forged by the Medical Act 1858. This is now underpinned by self-regulation, to safeguard the public, yet it has been argued that it is a privilege to benefit the profession rather than the public (Culley, 2014). It is the Code (NMC 2018) which reminds registrants to uphold the reputation of the profession, this should lead to trust and confidence in the profession from patients, people receiving care, other healthcare professionals and the public. The employers' perception is "*based on the Code and which elements of the Code, so my criteria will be where has the Code been breached and if it is a fundamental breach of the code" (P1).*

The privileged position held by nurses is linked to power because of the clinical knowledge, information and skill, on which the patient depends on. Peplau (1999; 13) states that nursing is a "significant, therapeutic, interpersonal process.' She defines it as a "human relationship between an individual who is sick, or in need of health services, and a nurse specially educated to recognize and to respond to the need for help." Peplau (1999) argues that the patient and

the nurse may initially meet as equals but the power balance may change over time. Patients need to be able to rely on the nurse and have confidence in the work they are doing. Yates (2015: 99) states “nurses are in a privileged position and the public need to be able to trust that their conduct will always be at a high standard.” The patient is often in unfamiliar environments and afraid of the unknown, leaving them to feel vulnerable. Patients are expected to engage in highly invasive procedures, exposing their dignity. 'Trust' is the most important and influential factor in the nurse-patient relationship. It is evident that if a nurse acts dishonestly towards their patient this impacts on the nurse – patient relationship.

One example of abuse of nurses’ privileged position is dishonesty which is cited by 10 participants in this study. They describe a nurse’s act of dishonesty as a violation of trust while in a “*privileged position” (P9)*. This is evident in Case’s (2011) work who analysed 371 fitness to practise cases covering the period of August 2009 to July 2010 at the General Medical Council (GMC). Case (2011: 603) describes how “some dishonesty cases were effectively excused by the GMC Fitness to Practise panel for reasons of working under intolerable pressure and difficult personal circumstances, or being overtaken by panic.” Thereby, an act of dishonesty could have been the decision the nurse made because they felt they needed to protect themselves, irrespective of the consequences for the patient or if they were putting themselves in a compromised position. Some of the dishonesty cases the GMC Fitness to Practise panel’s concluded were due to a character flaw or attitudinal issues (Case, 2011). Overall, Case Law from General Medical Council Fitness to Practise cases utilised “a rhetoric which suggested a zero tolerance approach to dishonesty in members of the medical profession,” for example in the case of Singh *V* GMC, (Case, 2011: 604). This is highlighted by participant 9:

“It’s integrity isn’t it and you have entrusted, privileged positions and if you’re stealing form the tax payer, i.e. the NHS or if you are stealing from a vulnerable patient, that’s completely unacceptable” - Participant 9.

The participants agree the importance of an early career nurse who is authentic and honest when their fitness to practice is being challenged, as a sign of great professional integrity. An early career nurse whose fitness to practice is in question is often under the spotlight exposing their values and characteristics, knowledge, competence and skills, highlighting their ability to demonstrate “*professional responsibility and insight”* into the situation.

8.4.3 “*Professional responsibility and insight”* - The Wheel of Redemption

The research reveals the significant level of responsibility on the employer to rigorously make an assessment of the nurse’s fitness to practise. This is reiterated by participant 5 “*you pussy-*

foot about a bit at first, don't you, don't frighten people, but we did have to sit and say you know, this is serious." A decision to refer an early career nurse is "*never taken lightly" (P1).* The employer has to trust the nurse is safe, "*I didn't quite know how I was going to make her into a … not even a surgical nurse, but as a safe nurse" (P5),* with confirmation the risk of repetition can be managed or reduced. The public need to have "*confidence in the nurse" (P16)* who is treating them. It is evident that the employer understands the serious nature of the decision to refer a nurse to the NMC, the potential outcome for the nurse could be "*career ending and it is people's livelihoods, all they've trained for" (P16).*

This research reveals how the interaction between a nurse and employer often dictates the decision to refer to the NMC. It is evident that employers have a chain of expectations of nurses whose fitness to practise is being questioned, explained in A Chain of Expectations chapter. These expectations can be described as an example of Braithwaite and Ayres (1992) responsive regulation based on a redemption model of professional discipline and theories of regulatory compliance (Makki and Braithwaite, 1991). The employers expect the nurse to admit their deficiencies, demonstrate remorse and say sorry, possess insight, and provide evidence of taking responsibility and remediation – the wheel of redemption. Thereby the nurse can display to their employer they have the capacity to remedy their practice.

This research has generated new knowledge following the analysis of the 20 interviews which has uncovered two types of decisions. Firstly, the decision to refer because of the nature of the incident itself, where seven of the participants refer to a "*clear cut"* case, for example, a serious criminal conviction or a dishonest conduct. Secondly, when the employer is considering a nurse's behaviour and conduct there is the opportunity for the nurse to display the values of remorse and saying sorry, taking responsibility for their actions and demonstrating insight. This can be described as the employer using the wheel of redemption when making a decision to refer an early career nurse to the professional regulator. This is mirrored by the GMC Fitness to Practise sanctions set out in 35D of the Medical Act 1983, who advocate doctors to "demonstrate the values of cooperation, remorse, contrition, remediation and rehabilitation".

This research reveals how employers use the wheel of redemption when considering a nurse's fitness to practise and a referral to the NMC. The employer expects a nurse to:

a) Admit the mistake;

b) Challenge but don't deny it;

c) Demonstrate a level of insight;

d) Say sorry;

e) Take responsibility and look at other options

Employers appear to be adopting this redemptive approach when making a decision about an early career nurses fitness to practise. Case (2011: 614) reports a similar phenomenon with the GMC Fitness to Practise panel decisions as 'the unifying concept of "impairment". This was introduced to "ease the difficult nature of resolving complaints against doctors, which has brought with it a style of fitness to practise proceedings characterised by offering doctors opportunities for redemption" (Case, 2011: 614). Case (2011: 614) continues to argue that a "redemptive style of resolving professional discipline issues is beneficial to doctors, patients and the general population, by encouraging the notion of remorse, insight and remediation could have implications for professional integrity and honesty".

Yet, the research reveals, in some cases, there is a lack of insight by early career registered nurses of their level of accountability and responsibility. "*People need to understand ... actually you've got a huge amount of responsibility and you are a professional, you're a graduate, you know people trust you" (P17).* This is mirrored in Pugh's research (2009: 2032) who found some of the participants in her study "were not able to learn the lesson because of a lack of insight into their role in the events surrounding the allegation".

This research reveals that the employer expects the nurse to have insight if they are "*finding it very stressful...they can't cope in the environment…they should move to a different environment where you can nurse safely" (P8).* They clearly expect the nurse to understand that they cannot "*continue to come to work somewhere where you are not safe" (P8).* The research indicates that the early career nurse needs to "*recognise that they've learnt a lesson and oh my goodness, you know I would never make that decision again. That's half the battle"* (P7). Pugh's (2009: 2033) study recognises that the "lessons learnt included the ability to identify vulnerability, the ability then to minimize vulnerability, and a consequent relearning of accountability".

8.5 Conclusion

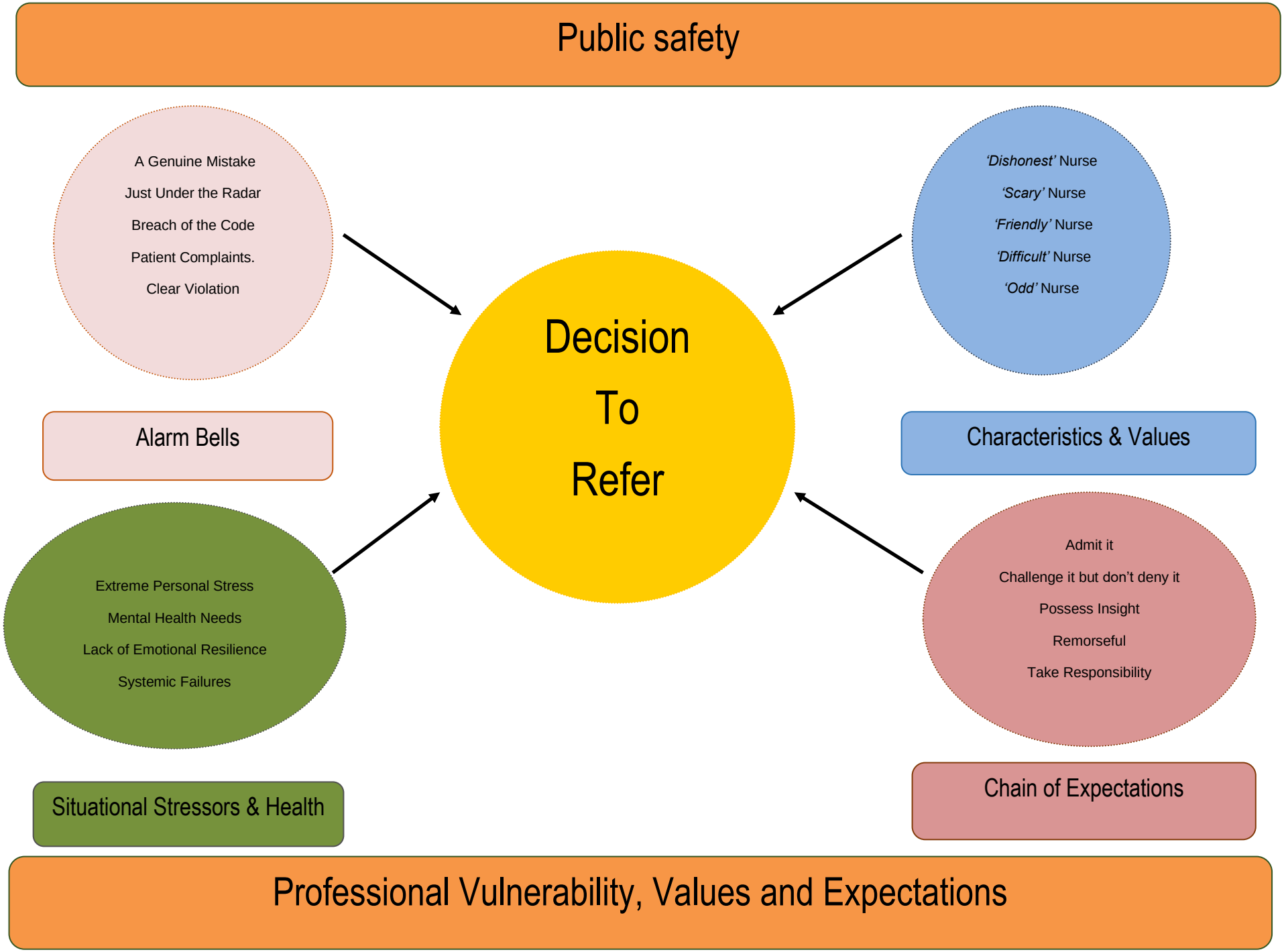
To conclude the core category is represented in diagram 39, a decision to refer an early career nurse to the Nursing Midwifery Council Fitness to Practise Committee. A referral is based on a combination of factors, which are centrally focused on three central themes: public safety; values and expectations; and professional vulnerability. Overall, this research reveals new insight into how the employer's responsibility to protect the public led to the identification of the alarm bells, which signal that patient safety has been compromised either by a single or series of related events resulting from a nurse's actions. This research confirms that "*patient safety is number one"* for employers to protect the public in their own organisation, and the

wider community, yet they are committed to being a "*fair employer"* who can identify "*system and process issues".*

There is a new understanding of employers who regard nurses as being in a "*privileged position"* in society. Employers expect a nurse to exhibit specific values and behaviours. Some nurses' display unwanted characteristics and values when their performance and conduct is under the spotlight. The employer expects the nurse to show "*professional responsibility and insight"* into their actions, illustrated by the wheel of redemption which highlights the nurse is expected to admit to the error, say sorry and demonstrate remorse. However, a mismatch between the employer's expectations and the nurse's response can cause an "*irretrievable breakdown of relationships"* between the nurse and the employer.

In some cases, an early career nurse can be placed in a professionally vulnerable position, due to the multi-factorial situational stressors that can impact on their performance. From an employer's perspective in this study it was described how nurse's experience the challenges of early career progression and transition into the profession, which can result in them having a "*broken spirit",* and feeling like the "*second victim".* The research highlights the participants felt it was salient to mention the impact of *"physical and mental issues"* some nurse's experience but employers understood their responsibility to protect the public, which outweighs the individual needs of the nurse, no matter how traumatic.

Diagram 39 Core Category – A Decision to Refer

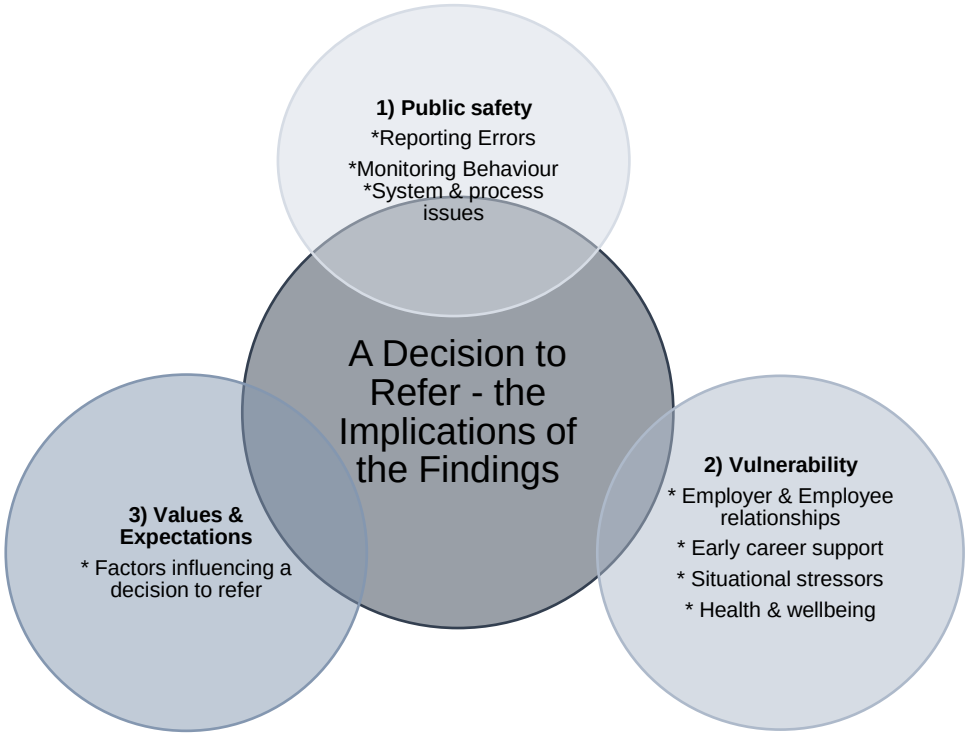


Chapter 9 Implication of the Findings

9.1 Introduction

This chapter examines the implications of the findings from this constructivist grounded theory research study which explains why employers make a decision to refer an early career nurse to the professional regulator. This chapter is divided into the three central themes of the core category, which originally emerged from the four categories (Chapters 4, 5, 6 and 7). Diagram 40 below illustrates the key elements of the core category (Chapter 8) and the implications of the research findings: 1) public safety; 2) vulnerability; and 3) values and expectations.

Diagram 40 Three Central Themes from the Core Category and the Key Elements to the Implications of the Findings



9.2 Public Safety

This constructivist grounded theory illustrates that a decision to refer an early career nurse is "*never taken lightly" (Participant 1),* it is underpinned by the employer's fundamental responsibility for "*public safety" (P7).* This section highlights three key implications of the findings:

- The culture of reporting errors

- Complexity of monitoring behaviour
- Investigating system and process issues

9.2.1 The Culture of Reporting Errors

Early career nurses are frontline staff compared with other members of the health-care team; it is part of the nurse's role to spend time with their patients to provide continuous care. Therefore, this relationship can expose nurses to a higher risk of making errors because of the systems and environments they work in (Thomas, 2010). With this in mind, early career nurses can make mistakes, which could call into questions their current fitness to practise.

This research reinforces the highly complex nature of errors in the workplace, it acknowledges the mitigating factors which impact on the nurse's performance and conduct at the time. The professional regulators stipulate that senior practitioners have a commitment to lead by example and promote openness and honesty in reporting errors, by fostering a culture of learning, development, and improvement (NMC, 2018).

There is a deeper understanding of employer's shifting from individually blaming one person, to identifying process and system issues following an error. This is supported by the literature which highlights the progress of identifying systemic issues in healthcare institutions (Zientek, 2010). This illustrates how organisations are encouraging a moral obligation to report errors, and thereby protecting those who report an error (Zientek, 2010). Roth et al (2015) and Santos (2010) also report a new approach to analysing nursing errors which moves away from the individual who is to blame for the error. Instead, there is a recognition that an error involves many people and is a result of a longer chain of events (Reason, 2000).

The importance of promoting a safe environment for error reporting (Koohestani et al 2008), NPSA Patient Safety Alert – Being Open (NPSA, 2010), having a supportive manager (Mazor et al, 2006; 2004; Robbennolt, 2003; 2006), recognising the emotions after an error (Pereira, 2009), understanding professional vulnerability (Pugh, 2011), and encouraging a positive emotional response (Maezor et al, 2004). This is represented in the diagram 42 of how to overcome the hurdles of reporting an error in the Recommendations Chapter. Further to this, the culture of reporting errors aligned with a clear recognition of system and process issues, could assist with the complexity of monitoring patterns of behaviour.

9.2.2 Complexity of Monitoring Patterns of Behaviour

A new understanding of the strategies required to monitor patterns of behaviour of nurses, especially those who are "*just under the radar",* by promoting a positive reporting culture so early career nurses feel confident to report errors. Oritiz's (2016: 9) study of 12 newly qualified nurses recommends the 'development of professional confidence' within the first year of

registration. In accordance with the NMC Duty of Candour (NMC 2018) it encourages nurses to report errors and near misses. However, this study highlights the complexity of early career nurse's performance and conduct which was "*never does anything quite bad enough"* (P8) to cause concern but often other staff lacked confidence to take action and report, despite feeling interventions were needed. The participants recognise there is a growing importance of "*giving the staff around them the confidence to report them"* (P8).

The NMC (2018) clearly states that a Fitness to Practise panel is likely to consider a more serious sanction if there is evidence of a failure to raise a concern, or of an attempt to cover up. There have been a number of high profile cases, for example the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013) recommendation 195 advised "Ward Nurse Managers should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal". The National Quality Board (2017: 30) also advocates that the ward manager or team leader should be "responsible for assessing individual team members' training requirements as part of an annual training needs analysis".

In some cases, the employer was increasingly concerned about the nurse's ability to practice safely, to the extent that the nurse is deemed to be "*scary"* to work with. The participants reported others were reluctant to work alongside them. This impacted on the employer-employee relationship with managers providing additional informal support with little effect. This was illustrated by participant 5 who described the conversations with a newly qualified nurse on her ward. "*I had lots of chats with her in the office, trying to be kind but firm because I could also see there was a massive concern, that if we let her loose, when do we let her loose?"* This situation re-emphasises the employer's level of responsibility to protect the public to have the management and leadership skills to have those difficult conversations. The National Quality Board (2017: 30) recommends that "nurse leaders and managers need to have the opportunity for professional development, with adequate support to ensure staff deliver high quality and efficient services." Participants reflected on how the leadership and management of the organisation can influence and promote "professional confidence" (Oritiz, 2016: 19) of how an early career nurse reports, reacts and responds to an error in the workplace, by demonstrating that they are a "*fair employer"* who investigates system and process issues.

9.2.3 Investigating System and Process Issues

Latent factors could explain why in some cases genuine "*terrible mistakes"* can be made by highly performing and competent nurses, who had no previous clinical or conduct concerns,

thereby, the "*second victim"* is the nurse. Zientek (2010: 146) states that "what I will call preventable error might in common parlance fall under the term ''honest mistake'". Roth's (2015: 253) study identifies an example of how "medication errors in nursing arise from a complex distribution system that was fraught with opportunities for human input, increasing the risk for errors".

The study of human error is comprehensive and intricate. Reason (1990: 768) describes "two kinds of errors, "active" or 'latent.'" "Active errors" result in instant results or consequences and involve healthcare systems. "Active failures are the unsafe acts committed by people who are in direct contact with the patient or system, for example, they take a variety of forms: slips, lapses, fumbles, mistakes, and procedural violations" state Reason (2000: 768). Latent factors are embedded in and imposed by systems and can be hidden for many years until an opportune moment of a combination of active failures and local triggers create an accident (Hughes, 2016).

Latent factors can have two kinds of adverse effects. Firstly, these are defined as heavy workload, understaffing, fatigue, and inadequate equipment leading to error, provoking conditions within the workplace. Secondly, the long-lasting weak structure of the organisation, for example unworkable procedures and design deficiencies. "Hence latent factors can lead to latent failures: human error or violations" (Health Safety Executive, 2012: 11).

This research highlights the "*alarm bells"* which can trigger a concern about an early career nurse who demonstrates a low level of knowledge, skill, and competence. It is important to acknowledge Reason's (1990: 9) identifies that "errors can be further divided as a failure of expertise and a lack of expertise". This concept has been highlighted by the Health and Safety Executive which acknowledges that anyone can make errors regardless of the amount of training and experience which is possessed or the level of motivation to do it right (HSE, 2012).

The Health and Safety Executive (2012: 11) explain that "latent conditions are the managerial influences and social pressures that make up the culture ('the way we do things around here'), influence the design of equipment or systems, and define supervisory inadequacies." Nurses and Nurse Leaders play an essential role in rectifying patient safety (Chipps et al, 2011), whilst reiterating the importance of being a "*fair employer"* to investigate system and process issues in the workplace and having rigorous procedures and policies in place to demonstrate that a "*fair"* and transparent process has been followed.

9.3 Vulnerability

This constructivist grounded theory illustrates that a decision to refer an early career nurse is "*never taken lightly" (Participant 1),* yet in some cases the nurse can be "*vulnerable to disciplinary action"* (Participant 18). This section highlights five key implication of the findings:

- Employer and employee relationship
- Early career support
- Situational stressors
- Health and wellbeing

9.3.1 Employer and Employee Relationships

New understanding of the interaction between the employer and employee emerged from this research helping to establish if there is a risk of repetition following an error or incident. It can be a difficult process to weigh up all the elements that contributed towards the error, alongside taking into consideration the nurse's reaction and response to the error. The level of risk is often managed by the nurse demonstrating insight into their deficiencies, a commitment to accept support, engaging with education and retraining and taking responsibility for their actions. In this case, this research study has provided new insight into the trust and relationship between the nurse and employer.

This study identifies belief in the importance of early support and intervention, the management and monitoring of newly qualified nurses who demonstrated a lack of knowledge, skill and competence. There is a balance between "*a genuine mistake that you own up to or there is wanting to go against trust policy"* (Participant 10). Employers' respond differently to a nurse who admits the error, is genuinely remorseful and demonstrates the insight into their deficiencies.

New knowledge was identified that the trust between the employer and employee can break down if the nurse is dishonest and/or denies the allegations, or if they cannot understand their mistake. Gallagher et al's (2015: 209) retrospective study of General Pharmaceutical Council fitness to practise hearings, states that the "risk of harm and dishonesty are considered to be among the most severe aggravating circumstances described in the General Pharmaceutical Council Indicative Sanctions Guidance for the Fitness to Practise Panel."

In these situations, it appears extremely difficult to provide support and developmental opportunities to those who have no insight or self-awareness. Ultimately, a nurse may "*go through the whole performance management process, you try and give them a chance, and you try and support them. But if at the end of the day they are not safe to continue to deliver patient care in your eyes, then you need to refer them"* (Participant 15).

9.3.2 Early Career Support

It is evident that the employer adopts a similar model to the Regulatory Pyramid (Braithwaite et al, 2017; Healy, 2011) discussed in A Chain of Expectations Chapter. In reference to the bottom of the pyramid the participants discussed the time invested by offering early support and intervention, open dialogue to discuss their options and measures to address the nurse's lack of skills, knowledge and competence. Effective and good leaders can help people to "survive and thrive" (Wren, 2006). To generate a high quality and performing workforce, leaders need to reflect on the needs of their employees, steering clear from the culture of self-centredness and cut-throat competition (Dambrun, 2017).

This research has revealed a deeper understanding of the impact of some nurse's lack of engagement with early intervention support. This mirrors concerns raised by the medical profession who report that there is inadequate support available while doctors are under investigation (Hawton, 2015). This is supported by Pulakos et al's (2008) survey which reported that 30 per cent of employees perceived their performance management review assisted their performance, with less than 40 per cent stating the system developed their performance goals and generated transparent feedback. Armstrong (2000) recommends managerial commitment to performance management will foster a positive response from staff. It is more likely staff will engage and improve if they share in the process of defining their competencies and implement plans to develop their skills and for the employer to provide managerial support and support (Armstrong, 2000). Kochanski (2007) found that high performing organisations had strong leadership support for performance management.

This research highlights that there are situations when some nurses do not actively engage in the early intervention process. Participants describe the nurse as "*a pain in the backside from day one"* (Participant 4), with characteristics that reflect traits of the "*scary"* nurse who would "*scare the bejesus out of me"* (Participant 4), by blaming others and being unreliable.

Yet there is limited literature linking a nurses characteristics and values which contribute to unsafe knowledge, skills and competence in the practice setting and the ability to predict clinical performance (Wong and Li, 2011). Competence is a critical determinant of performance, but other factors influence and impact on a nurse's ability to safely practice in the workplace which are often difficult to disentangle (Gillespie et al, 2015). It has been reported that "demographic characteristics, such as age, gender, experience, education, nursing classification, hospital settings and speciality have a bearing on nurses level of perceived competence" (Gillespie et al, 2011: 79).

9.3.3 Situational Stressors

The nursing profession has to recognise the need to provide mechanisms to enhance "*resilience"* (Participant 18), and reduce situational "*burnout"* (Participant 18) for early career nurses. The challenges of workplace conditions leave nurses vulnerable to dealing with adversity (Duddle and Boughton, 2007; Edward and Hercelinskyj, 2007,). Following an error, nurses acknowledge their mental fatigue, working long hours, short staffing and distractions, thereby indicating that errors result from these external factors (Cohen et al, 2003; Hall et al, 2004). It is important to recognise that it has been reported that if a health-care organisation is experiencing a period of financial hardship, with an over-reliance on agency staff, a reduction in staff completing statutory and mandated training, aligned with staff burnout, recruitment and retention problems, it can impact on patient safety and the quality of nursing care and delivery (National Quality Board, 2017).

This study provides a deeper understanding of the increasing emphasis on ensuring that newly qualified nurses are personally and professionally supported to perform well in their role. Therefore by fostering the concept of the organisation investing in and nurturing their early career nurses, they can focus on providing high quality care for their patients. If not, their "*emotional labour"* (Participant 18) may be threatened, potentially impacting on their professional job satisfaction. The employer needs to recognise when nurses display signs from the effects of workplace adversity, such as fatigue, pressure, stress and emotional labour (MacDonald et al, 2011) and take action.

Garrosa et al's (2010) temporal and cross-sectional study explored the effects of job stressors, hardy personality and coping resources on burnout dimensions among 98 nurses. It is important to help early career nurses explore the coping strategies they require to prevent some of the unwanted characteristics and values being exposed if a question is raised about their fitness to practise. The research provides a greater understanding of individuals "personal resources" to cope with the challenges within the workplace (Peterson and Seligman, 2004, Snyder and Lopez, 2006). Resistance to "burn out" has been linked to "optimism" (Grau et al, 2005), "self-esteem" (Browning et al, 2006), "hardy personality" (Garrosa et al, 2008), "sense of coherence" (Kalimo et al, 2003), and "self-efficacy" (Xanthopoulou et al, 2007).

9.3.5 Health and Well-being

A deeper understanding of the multiple factors that can affect an individual's performance in the workplace, such as the organisational culture, leadership, and team-working. The nurse's physical and psychological health, personality, attitude, values and beliefs can further influence their performance, especially when faced with excessive workload, variance of shift

patterns and sleep loss. Workplace performance can be affected by personal and situational factors, including the physical environment, leadership and team dynamics (Institute of Medicine, 2012).

The effect that excessive and high intensity workload, sleep loss and routinely working long shift patterns can have on an individual's performance cannot be under-estimated, often resulting in fatigue (British Medical Association, 2018). Excessive workload, for example, affects the individual's ability to function effectively, impacting on their decision-making, attention span, fine motor control and level of motivation (Mahmood, 2012). Poor quality of sleep and sleep deprivation can lead to decision fatigue and burnout (Vela-Bueno et al, 2008). It is reported that it is difficult to determine the full impact of different types of shift patterns, although it has been agreed that longer shifts of 12 hours or more are associated with a 25-30% higher risk of errors and accidents than an eight-hour shift (Folkard and Tucker, 2003; Folkard and Lombardi, 2004; Folkard et al, 2007). More recently, Ball et al (2015) literature review of 26 papers concluded the majority of the studies reviewed showed some degree of negativity, either for nurses, patients, or both, towards 12-hour shifts: many of the adverse outcomes are fatigue related.

These adverse factors can significantly impact on an individuals' health, wellbeing, and performance, and thus the safety of their patients (Keckland and Axelsson, 2016; Bannai and Tamakoshi, 2014). Ultimately, there is growing evidence of the long term effects of impaired health, for example, cardiovascular disease (Vyas et al, 2012), psychological well-being (Virtanen et al, 2011), including risky coping mechanisms such as alcohol and drug misuse (Fernandes and Gherardi-Donato, 2017).

The participants explained the extensive "*significant mitigation"* experienced by some early career nurses, including mental health issues. The research demonstrates that these contributing factors can affect a nurse's ability to function as a safe nurse. In some cases, the nurse was unable to recognise their deficiencies and on occasion displayed behaviour that reflected "*it was all about them" (Participant 9)*. "*Emotional resilience"* (Participant 15) is seen as a fundamental requirement to tackle the early career battles of progression and transition into the profession. However, this research reveals how nurses tend to cope by taking periods of "*sickness and absence".*

9.4 Values and Expectations

This constructivist grounded theory illustrates that a decision to refer an early career nurse is "*never taken lightly" (Participant 1),* highlighting the importance of considering the factors which may influence the decision making process.

9.4.1 Factors Influencing a Decision to Refer – Expectations of the Employers

This study reveals a new understanding of the interaction between the early career nurse and the employer following an error is taken seriously, in particular by placing great weight on the nurse saying sorry and demonstrating remorse, thereby acknowledging the severity of the incident and subsequent impact on the patient and their loved ones. Lazare (2004) states that a true apology has three components: taking responsibility; showing remorse; and making amends. The chapter 6 chain of expectations and the following sections will explore how saying sorry and demonstrating remorse is deeply rooted in historical religious practices, thereby impacting on the criminal justice system and other disciplinary proceedings, a definition of what we mean by saying sorry and demonstrating remorse; and consequently how this has influenced healthcare investigations into errors in practice.

The literature reflects how religious origins have become embedded in today's justice system. There have been significant criminal cases in the media, where speculation has arisen from the lack of remorse during a trial. In the autumn of 2000, a well-respected plastic surgeon Robert Bierenbaum was on trial for the murder of his wife following her disappearance in 1985, from the couple's apartment in New York. During the trial Bierenbaum sat "motionless and silent". He maintained his innocence, yet he was convicted of murder. The judge reportedly said "I can only look at the defendant's cold-blooded behaviour after the fact". He continued, "He is not rehabilitated - which means accepting, admitting, and expressing remorse" (Finkelstein, 2000). Finkelstein (2000) reported instead of the minimum sentence, Bierenbaum was imprisoned for 20 years.

This is not a unique case, in more recent years Amanda Knox, the young 20 year old American student was convicted by an Italian court for murdering her roommate. In 2007, Knox maintained her innocence during the trial, however her lack of remorse was widely criticised. Apostle (2010) makes the relevant point that remorse is "a slippery concept to pin down." She raises the point that genuine feelings of regret are a subjective response. This requires certain skills in articulating emotions which early career nurses may not have developed, illustrated by participants experiences of *'the ones I've met are really loud and like I say there's not much remorse. They think they're better than what they are' (Participant 19).* Apostle (2010) reinforces that "the most remorseful defendant may not have the skills to demonstrate such remorse". Moreover, the defendant may feel remorse, but find it undignified to talk about the situation, highlighting how the cultural barriers and misunderstandings of the situation may inhibit their response.

This study reveals a new understanding of how employers tend to favour a nurse who says sorry and demonstrates genuine remorse, illustrating that they are taking responsibility for

their actions and attempting to make amends. Thereby having a positive effect on the expectations and intentions for a future relationship between the parties (Mazor et al, 2006; 2004; Robbennolt, 2003; 2006), playing a role in restoring trust between the employee and employer (Mazor et al, 2004; 2006), reducing a negative emotional reaction, such as anger (Robbennolt, 2003; 2006; Takaku, 2001), and inducing favorable physiological responses in both parties (Witvliet et al, 2001).

However, it is important that the employer understands the nurse's reason for not saying sorry may be more complex than originally perceived, potentially impacting on the nurse feeling professionally vulnerable. "*Some people become very hard-faced and step away from their actions and are not acknowledging of what they've done. And perhaps that was her method of dealing with it. I don't know. If she's in denial then, then it didn't happen" (Participant 14).*

To conclude, the participants in this study acknowledge that saying sorry and demonstrating remorse during a disciplinary hearing or following an incident is taken seriously. It is debatable the weight this carries when making a decision to refer a nurse to the NMC, due to the complexity of each case. However participant 8 and eight others indicate they would take into account a nurse's ability to demonstrate remorse. "*There's always a bit at the end (of the disciplinary hearing) where people say you know, they're terribly sorry and they're never going to do it again… And of course, I absolutely will take that into consideration" (Participant 8).*

Therefore, the decision making is based on the referrer's previous experience and professional judgement of employment proceedings, yet potentially questioning the reliability and validity of decisions, mainly due to the variance of skills, clarity of judgement, understanding and considering alternatives, and firmness of decisions.

9.5 Conclusion

To conclude, this chapter examines the eight implications of the findings of this constructivist grounded theory research study, which have emerged from the three central themes of the core category. These are public safety, vulnerability of the nurse to a referral and the values and expectations of the employer. This study provides a deeper understanding of the employer's perspective of an early career nurse's "*privileged position"* (Participant 9) in society; it confirms the importance of promoting a culture of reporting errors, due to the complexity of monitoring nurses "*patterns of behaviour"* and the emphasis of being "*a fair employer"* by identifying system and process issues that may impact on a nurse's performance in the workplace.

This study reveals a new understanding of the importance of the employer and employer's relationship, when an early career nurse's fitness to practise is in question. This is driven by

the employer's chain of expectations of professional responsibility and insight – the wheel of redemption. This study clearly identifies the nurse's response to an allegation can result in "*cracks in the relationship"* between the employer and employee. It is evident that the decision to refer an early career nurse is based on a combination of factors, yet in some cases, it was reported that nurses are "*vulnerable to discipline action."* This may be due to the situational stressors, the difficult transition into professional practice and balance of health and well-being. This constructivist grounded theory illustrates that a decision to refer an early career nurse is "*never taken lightly" (Participant 1),* highlighting the importance of considering the factors which may influence the decision making process.

Chapter 10 Quality, limitations and recommendations

10.1 Quality and Limitations of the Study

This section will focus on exploring the limitations and quality of the study using the specific criteria for critically appraising qualitative research, by assessing the credibility and dependability, confirmability and transferability of the study, defined by Hannes (2011) as part of the Cochrane Collaboration Qualitative Methods Group (2011).

10.1.1 Limitations of the Study

Constructivist grounded theory uses an inductive approach that attempts to explore and understand what people do and say. This is important in health because it provides the researcher with the opportunity to construct a useful explanation of the phenomena in question. A constructivist grounded theory approach produces nursing research which is a "viable means of generating theory grounded in the realities of everyday clinical practice" (Elliot and Lazenbatt, 2005: 2711). To enhance the quality of constructivist grounded theory research the fundamental methodological principles need to be applied, by using concurrent data collection and constant comparative analysis, theoretical sampling, and memo-ing, coding and categorising as part of the research process. This in-depth relationship with the process assists with the security of the findings and the theory developed.

Scientific rigour is paramount when determining the quality of empirical research yet Myers (2000) argues that qualitative research has been continually criticised for its lack of objectivity. Elliot and Lazenbatt (2005) state that there does not appear to be an international or national criteria to evaluate the quality of research, because it tends to favour the positivist model of validity and reliability. It appears that there have been attempts to apply positivistic criteria to qualitative research (Golafshani, 2003). Consequently, Mays and Pope (2000: 50) argue that "an inductive research approach is so distant from a positivistic ontology they are exempt from such criteria". Yet, it is important to assess and demonstrate the rigor and trustworthiness of this study. Interestingly, Spencer et al (2003) acknowledge the necessity to define these terms in the context of qualitative and quantitative research. These concepts are used in table 23 which is based on Lincoln and Guba's (1985) translation of criteria to evaluate the trustworthiness of findings.

Table 21: Criteria to Critically Appraise Findings from Qualitative Research

Aspect	Qualitative Term	Quantitative Term
Truth value	Credibility	Internal Validity
Applicability	Transferability	External Validity or generalisability
Consistency	Dependability	Reliability
Neutrality	Confirmability	Objectivity

(Reference Hannes, 2011)

Charmaz (2006) explains the basic strategies used by grounded theorists by grounding her discussion in materials from her own research, she offers key criteria that can be asked of any grounded theory. Charmaz's criteria advocates "credibility and originality, its connection to the worlds of lived experience, the studies usefulness and its contribution to a better society" (Charmaz, 2014: 338).

This study was conducted using a constructivist grounded theory approach, which adopts a relativist ontological position, sustained by placing attention on the construction of meaning. Qualitative terms will be used to demonstrate scientific rigour within this study, highlighted in table 23. Charmaz's (2006) criteria of credibility, originality, resonance, and usefulness, was considered in order to evaluate the quality. Furthermore, Hannes (2011) critical appraisal of qualitative research with contemporary links to the Cochrane Collaboration Qualitative Methods Group provides a useful assessment of the credibility and dependability, confirmability and transferability of the study. This assessment reinforces the rigor, truth, and trustworthiness of this constructivist grounded theory, adding weight to the study's findings and recommendations.

10.1.2 Assessing Credibility and Dependability

It is important to reflect on the journey when considering the reader's interpretation of the research design and methods used to complete the work (Charmaz, 2006). Strauss and Corbin (1990) recommend two sets of criteria to evaluate a grounded theory study: the research process; and the empirical grounding of the findings (Elliot and Lazenbatt, 2005). Charmaz (2006: 182) continues to highlight that the evaluative criteria questions should address a number of questions when considering the credibility of the study:

> "Has your research achieved intimate familiarity with the setting or topic? Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data. Are there strong logical links between the gathered data and your

argument and analysis? Does your research provide enough evidence for your claims to allow the reader to form an independent assessment and agree with your claims?"

In this study, credibility has been maintained by articulating a transparent, logical, and traceable record of the research methods in Chapter 3. This chapter provides the fundamental principles of a constructivist grounded theory method, exploring the use of different methodological approaches that were rejected, emphasising the clear rationale of the decision to use constructivist grounded theory. The chapter includes examples of coding practice: initial coding and fracturing the data; theoretical focused coding and categorising. On reflection this was a time consuming yet exhilarating experience, especially when participants, from different parts of the country, were using the same language, one example is how a decision is *"never taken lightly."* Chapter 3 explains the job profiles and fields of practice of the participants, including the study's regional engagement. This chapter highlights the level of expertise of the participants to explore their experiences and professional understanding of this complex issue.

Chapters four, five, six and seven explain the four categories that represent the research findings, this documents verbatim quotes to ensure the findings are grounded in the data. Chapter 3 illustrates the use of reflexivity, highlighting the preconceived ideas, beliefs, and views of the researcher. There are extracts of memos throughout the findings, highlighting the theoretical construction of the theory through the constant comparison of the data. Elliot and Lazenbatt (2005: 51) advocates "writing memos is considered important by encouraging analysis that is grounded in the data because the researcher must consider how the codes and their properties relate to each other and provide evidence of this from the data."

Each of the theoretical categories represent a logical link between the findings, memos and analysis with the literature. This stage took time to think through the complexity of what the participants were describing the preceding factors leading up to a referral to the NMC. Throughout the research process the evaluation techniques include the supervisory team, acting as internal auditors. The team provided scrutiny and opinions about the constant comparison of the data, theoretical sampling and memoing, ultimately, resulting in the development of the three central themes leading to the construction of the theory, described in chapter 3. Another useful evaluation technique during the study was presenting at national and international research conferences to provide mechanisms of peer debriefing. Table 24 explains the methods adopted throughout the thesis to demonstrate the credibility and dependability of this study.

Table 22 Credibility and Dependability of this Study.

Quality of the Study	Methods Adopted	Location within the Thesis	How Methods Promote Credibility and Dependability
Credibility and dependability (Explanation of the process with rationale for decisions made)	Reflexive practice is discussed illustrating the decision-making process	Chapter 3	Provides an audit trail of decisions made.
	Reflection on my position within the study	Introduction Chapter	Situates the researcher in the research process.
	Methodological discussions with supervisors and presentations of study to peers, abstract for 7th International Nurse Education Conference 2018.	Chapter 3 Appendix One	Methodology and decisions questioned and tested.
	Illustration of the implementation of a systematic research process	Chapter 3	Helps inform the reader of how the study was conducted so they can make judgments on the credibility of the findings.
	Ethical principles considered throughout.	Chapter 3 plus throughout the thesis Appendix 2, 3 and 4	Demonstrates the study has been conducted in a way that is ethically sound.
	Study strengths and limitations discussed	Chapter 10	Clearly outlines the limitations of the study and its reflexive nature.

10.1.3 Assessing Confirmability

Grounded theory is well established and can aid the development of nursing theory to describe, predict, and explain the phenomenon of nursing relevant to nursing practice and research. “Confirmability evaluates the extent to which findings are qualitatively confirmable through the analysis being grounded in the data and through examination of the audit trail” (Hannes, 2011: 4). This study focuses on the factors that precede a referral to the NMC; by using a symbolic interactionist perspective, constructivist grounded theory provides a way to study this dimension of human behaviour and interaction.

Chapter 3 reports the assessment of the decisions made during each step of the research process, including the methods of reflexive practice. During this process, the researcher was

concerned with developing theoretical concepts informed by interpretations, in order to build a theory to understand the preceding factors that resulted in a referral to the NMC. This led to the rationale for recruiting employers involved in a referral to the NMC. Appendix three illustrates the verbal and written background information provided to the participants at the beginning of each interview, regarding the researcher's previous professional experiences, education, roles and responsibilities, exposing any assumptions or influences.

10.1.4 Assessing Transferability

This study provides new knowledge and a deeper understanding of the preceding factors that result in a registered nurse in England, within the first five years of registration, being referred to the NMC. A constructivist grounded theory approach generates theory in a practice profession, which can focus on public safety. The study reveals the values and expectations of nurses whose fitness to practise is in question by employers, including the acknowledgement that early career nurses are vulnerable to a referral to the NMC. This study focuses on employer's experience of referring their employee to the NMC.

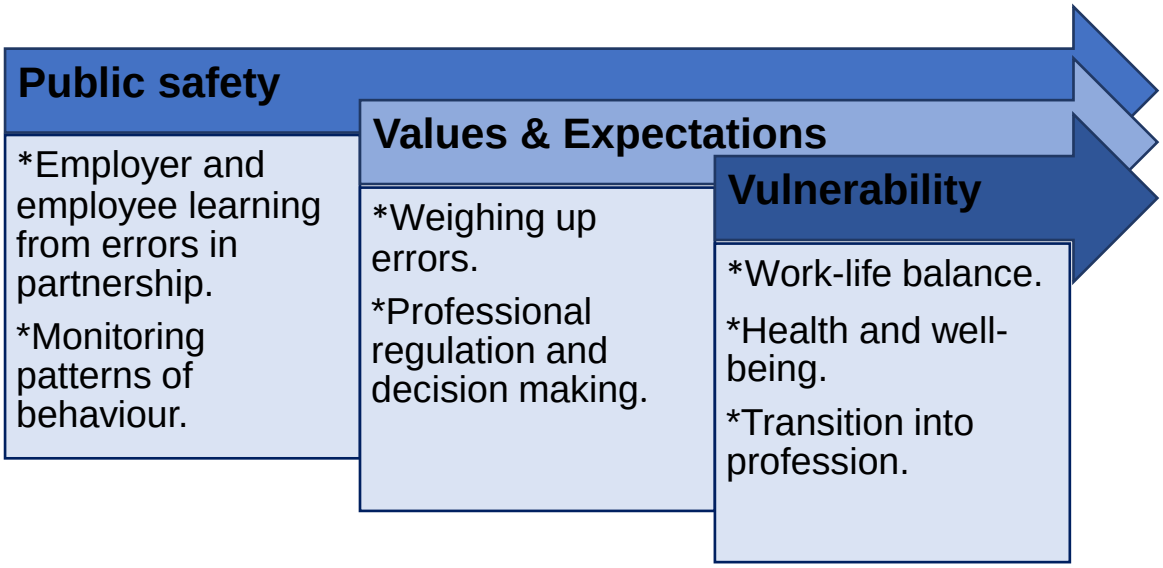
There is evidence that early career nurses' fitness to practise can be questioned for a wide range of reasons, from criminal convictions to misconduct, lack of competency and health issues. These allegations could have serious consequences to patients in their care and ultimately for public safety. This research is transferable to other registered health professionals. Chapter X illustrates there is a lack of empirical evidence to identify health professionals at risk of referral and the preceding factors leading to a referral to the professional regulator. This is highlighted in the Francis Report (2013: 87), with one of the recommendations outlining the "fundamental standards of behaviour and the responsibility for regulating and monitoring and compliance to these fundamental standards." There are further recommendations which identify "a requirement for a nationwide system to protect patients and care receivers from harm" (Francis Report, 2013: 213). Chapter 2 highlights the number of fitness to practise referrals across the professional regulators to ensure the protection of the public. Chapter 10 recommends using an early career nurse self-assessment check list to start discussions with their Mentor/Line Manager to identify practitioners who may be at risk of referral to the professional regulator. This could trigger the support strategies required to protect the registered professional, patients, and the public.

10.2 Recommendations

10.2.1 Introduction

This chapter highlights the recommendations which evolved after analysing the data and constructing the implications of the findings, outlined in previous chapters. This chapter is underpinned by the four categories: the **alarm bells** triggered by an incident in practice; this often exposes the **wanted and unwanted characteristics and values in nurses;** an allegation of impaired fitness to practise revealed a **chain of expectations of staff;** The participants explained the preceding factors to a referral to the NMC can expose the **situational stressors and mental health** of the nurse. Three central themes emerged from the four categories, which underpin the recommendations, these are: **public safety; vulnerability;** and **values and expectations**. From the three central themes, seven recommendations were identified from this study, illustrated in diagram 43.

Diagram 41 Three Central Themes with Seven Recommendations for this Study



10.3 Public Safety

10.3.1 Employer and Employee Learning from Errors in Partnership

This study recommends the investment of human factor approaches to improve patient safety with a positive move away from an individual blame culture to a joint approach of the employer and employee to learn from errors in partnership. Thereby, allowing the organisation to rectify system and process issues, whilst supporting the individual to remediate against their

deficiencies in clinical practice and demonstrate insight, aligned with the wheel of redemption, explained in Chain of Expectations chapter. This mirrors “a just culture” which reflects the balance between no blame and accountability, with the latter being needed to successfully implement safety strategies through individuals being accountable for their role within a safety system (Wachter, 2009: 1401).

Participant 10 made a profound comment during the interview which highlighted a crucial component following an allegation of impaired fitness to practise about a nurse within their organisation. The participant highlighted the importance of the employer and the employee learning and taking joint responsibility for errors in the workplace, specifically detailing “*So you have to look at … why they’re there and actually if it is an organisational issue about lack of support then you know, we’re just as much to blame, as they are”.*

The concept of learning from each other is replicated in the literature which highlights the importance of learning from other disciplines (The Institute of Ergonomics and Human Factors, 2017). The Institute of Ergonomics and Human Factors (2017: 4) define human factors as “helping people do the ‘right thing’ this can be achieved by looking at the factors from other disciplines, such as psychology, engineering, design and statistics, this combination will help to understand the nature of human interactions and its complex systems. This will provide an inter- and multi-disciplinary theoretical understanding of all human-technology-systems interactions.

10.3.2 Monitoring Patterns of Behaviour

It is recommended that early career nurses who are struggling in practice should be supported and managed efficiently and pro-actively, to ensure patient care is not compromised. Early career nurses competence should be measured through appropriate local professional and educational performance routes in the workplace to achieve their agreed goals. This course of action will consider any issues with members of staffs’ capacity and capability, and act accordingly. This approach also encourages members of the team to report staff who are struggling or in difficulty, who may require further training and additional support, illustrated in table 21. Table 21 describes a list of flags which should raise a concern that a Practitioner is struggling, indicating a possible cry for help (Paice, 2006: 89).

Table 23 Category Markers of a Practitioners in Difficulty

Work based: Absence from duty, persistent lateness, poor time management, and backlog of work, failure to learn and change.
Clinical performance: Over and/or under investigating, poor decision making, poor record keeping, complaints, failure to follow guidelines, missed diagnosis.

Psychological/personality: Irritability, unpredictability, forgetfulness, high self-criticism/ perfectionism, arrogance, lack of insight/denial, risky/impulsive.

Social Isolation: withdrawal, poor personal interactions.

Cognitive Memory problems: poor problem solving/ reasoning, decision making difficulties, poor concentration/ attention, learning problems.

Language/culture Poor verbal fluency, poor understanding.

Source: Paice (2006)

The level of support needs to be based on the acknowledgement an early career nurses are frontline staff, who have to deal with the numerous changes within complex health care systems and the working environment. This can provide an added level of stress and strain on the nurse to be efficient, safe and productive to meet the needs of patient specificity. Additionally, the advances of new technology and equipment, and multiple professional working delivered in different healthcare environments (Thimbleby, 2013).

It is recommended strategies are adopted to support members of the team who are underperforming or struggling with the complexities within the workplace. The research findings link to seven early signs illustrated below. These specifically link to the characteristics and values of a nurse and their ability to demonstrate insight. These are for staff to identify any underlying factors to allow the opportunity to set goals for improvement.

1. The disappearing act – disappearing from the workplace; lateness; frequent sick leave.

2. Low work rate – slowness in doing procedures, making decisions; arriving early, leaving late and unable to finish all the tasks.

3. Ward rage – burst of temper, shouting matches with other members of team.

4. Rigidity – poor tolerance to healthy criticism, inability to compromise, difficulty prioritising, inappropriate whistle blowing.

5. Bypass syndrome – junior colleagues and nurses find ways to avoid seeking their opinion or help.

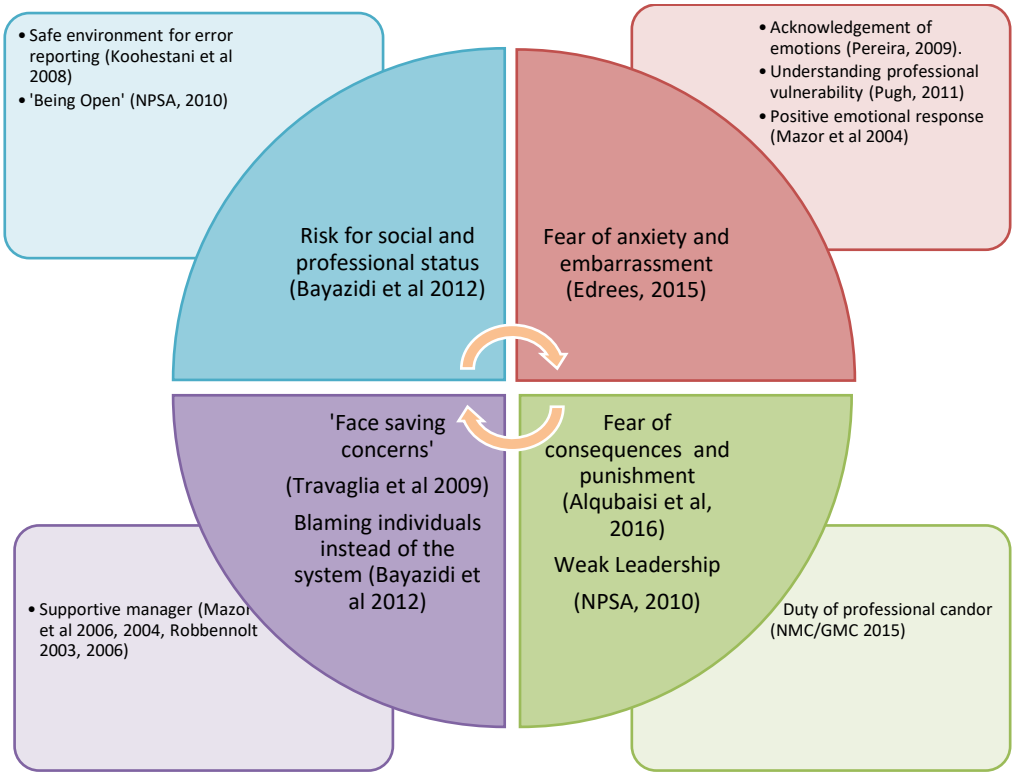
6. Career problems - difficulty with exams, uncertainty about career choice, disillusionment with profession.

7. Insight failure – rejection of constructive criticism, defensiveness, counter challenge.

Adapted from Mahmood (2012: 20)

It is recommended employers need to consider the barriers of reporting an error due to individual nurse's feeling vulnerable to disciplinary action. Diagram 42 represents the literature which attempts to address the barriers of reporting an error and the measures needed to promote an open and transparent reporting culture. Without these mechanisms a nurse may feel they are placing their professional reputation at risk and exposing their "professional vulnerability" (Pugh, 2011: 30). The success of a disclosure is based on mutual trust with their manager who helps to create a "being open" culture within the organisation (NPSA, 2010). The aim is to prevent the reality of the "*second victim is the nurse" (P9),* and the "fear of anxiety and embarrassment" (Edrees, 2015) and the consequences of the error and punishment (Alqubaisi et al, 2016).

Diagram 42: How to Overcome the Hurdles of Reporting an Error.



10.4 Values and Expectations

10.4.1 Weighing up Errors in the Workplace - a Terrible Mistake *Versus* Gross Misconduct

It is recommended that employers carefully consider if they need to refer an early career nurse who has made a *"terrible genuine mistake*". This research reveals that in the circumstances of a genuine "*terrible mistake"* the employer needs to acknowledge the response of the nurse and understand the human factors surrounding the situation. Participant 4 recalls "*a good example where I had a nurse went through a capability process, clearly had insight and so*

expressed remorse for the incident itself. It did result in patient harm. Clearly understood that they had made an error of judgement, had implemented their own rectification plan".

On the other hand, this research reveals the importance of making a decision to refer if the employer has little or no evidence of the mitigating circumstances to compensate for their actions. This research confirms protection of the public outweighs the evidence of nurses' mitigating factors, no matter now traumatic the situation, for the nurse or the employer, illustrated by the first participant to take part in the study.

"It was tragic. I was very sad that we had to do that but would I feel safe leaving my patients in her care? No, and before I make a decision to the NMC, then that is what I genuinely ask myself, would I be happy to leave this registrant to look after my mother? and if the answer is no, and there is enough evidence then that is enough to refer you" - Participant 1.

This decision should be reinforced by the employer supporting staff to use their duty of candor to report and escalate any concerns in a timely manner. To prevent "*some individuals do genuinely have poor practice but actually some people don't raise it"* (Participant 4). In this situation there are early career nurses who breach the Code (NMC, 2018) because they lacked the competence, skill and knowledge required, repeatedly demonstrated poor attitude and behaviour, which had serious consequences for their colleagues and patients in their care, yet not everyone reports any concerns.

These recommendations align with the NMC's new approach to Fitness to Practise, with the publication of the NMC's (2018) new strategy for Fitness to Practise, which emphasises the importance of:

• Putting people at the heart of fitness to practise

• Redefining the purpose of hearings

• Emphasising the need to give nurses the chance to remedy and address the concern

• Looking at ways employers can deal with complaints at a local level

• Underlining the importance of considering the context of a case (NMC, 2018).

10.4.2 Professional Regulation and Decision-making

It is recommended that strategies are needed for the employer to reward an early career nurse who demonstrates remorse, accepts responsibility for their clinical deficiencies, and shows insight following a question about their fitness to practise. This evidence could be used at the point of revalidation, to assure the professional regulator that a rigorous employment process has been followed, to protect the public and uphold the reputation of the profession. This

model lends itself to a light touch to professional regulation advocated by other health professions.

This is highlighted in Quick's (2017: 361) study who "evaluates the role of professionalism, regulation and law in seeking to improve safety, he argues the 'medical dominance' model is ill-suited to this aim, which instead requires a patient-centred vision of professionalism." Whereby, the professional and educational development of the individual can help with the internalisation of values and critical evaluation to put the patient first. Case (2011: 599) describes "these gains, if realised, can improve the capacity of the professional to become 'self-regulating' at the micro level."

Secondly, the recommendation that employers and nurse leaders start to acknowledge and critically consider challenging their own values and beliefs of how they expect an early career nurse to respond and react following an error in the workplace, to mitigate against any negative influence of bias within organisations. This study illustrates employers' expectations through the wheel of redemption, explained in A Chain of Expectations Chapter. A fundamental finding is the expectation a nurse will demonstrate remorse and say sorry following an error in practice which leads to disciplinary action. It is evident that a deeper understanding and further research is needed of what reaction and response should be displayed by early career nurses taking into consideration the cultural and diverse backgrounds of the UK's nursing community.

Further research is needed to explore who benefits from saying sorry and demonstrating remorse when it is apologetic language that can have a multitude of meanings, from an admission of fault to a degree of empathy. The majority of participants in this study acknowledged that saying sorry and demonstrating remorse during a disciplinary hearing or following an incident was taken into consideration when making a decision about the cause of action to be taken. A consistent approach to employers' expectations may impact on and improve the reliability of decision making during employment investigations and disciplinary proceedings. A variance may occur due to the complexity of each individual case which is based on the employer's understanding and considering all the alternatives, firmness of decision making, previous experience and professional judgement. Therefore, embracing this concept within the decision-making process prior to a referral to the NMC could improve the inter-rater and intra-rater reliability of decision making for nurses and midwives whose fitness to practise is in question and reduce professional vulnerability.

10.5 Vulnerability

10.5.1 Work-life Balance

The first recommendations reflects the importance of nominated senior leaders who are visible in the workplace, to strengthen the level of support for early career nurses especially during the preceptorship period or transition into a new role. This senior leadership role is an identified person who has dedicated time to help promote a positive working environment and to proactively deal with any conflict in the workplace, with appropriate training and education. Overton and Lowry (2013) explains it is the fault of the nurse leaders who are not visible or they are not provided with the opportunity to learn conflict resolution skills to foster an environment where conflict is not acceptable. If workforce conflicts are left unchallenged these negative acts can impact on recruitment, with further implications on the nursing shortage. Etienne (2014: 7) highlights “novice nurses are the face of the future; experiencing workplace bullying when entering the nursing workforce sets a negative precedent.” Overton and Lowry (2013) describes talented individuals leave a career that has such a strong need for them, partially because of their lack of skills in dealing with conflict.

The senior leadership role can provide additional support to help early career nurses face the stresses affecting transition, including the reality of individual professional accountability, the risks and consequences of making errors, and breadth of management issues, such as prioritising care needs. The role could address the transition from student to registrant is possibly an additional burden for nurses at the point of registration, and has historically been shown to be a stressful experience (O’Shea and Kelly, 2007). The terms used to describe the transition from student to registered nurse include “reality shock” (Kramer, 1974: 1). The National Quality Board (2017: 31) recommend that “the requirement for preceptorship should be factored in for newly qualified nurses, which includes time away from the workplace and support.” Additionally, the National Quality Board (2017: 31) advocate “clear policies should be in place to define staff who are supernumerary due to their learner status and systems in place to ensure this is factored into planning.”

It is recommended that the assessment of the opportunities available to manage work-life balance could support and help retain early career professionals. This is aligned with two studies that reflect the next generation of nurse’s expectations: Mind the Gap (Jones et al, 2015) and Narrowing the Gap (HEE, 2016). These reports found to retain all generations of staff it is essential to provide nurses with the flexibility to manage their work-life balance and enhance their professional autonomy. One example is Ball et al’s (2015: 25) literature review which reports “12-hour shifts as potentially more cost-effective as they reduced shift overlaps and the number of handovers for the organisation.” The literature review highlights staff benefit

by working a compressed week, however, these benefits are partly counteracted by reports of increased fatigue, errors and decreased alertness (Ball et al, 2015). Ball et al (2015: 35) recommends the "consideration of these factors when workforce planning, and identify measures to monitor impact and outcomes on patients and staff of 12-hour shift working". This is reinforced by participant 12 who discussed their experience of "*quite a lot of people have brought up this notion of working hours and long days and whether that then puts significant pressure due to tiredness, exhaustion, in relation to errors that happen in the workplace, specifically around medication".*

It is recommended that early career nurses should be encouraged to report and feel able to escalate feelings of stress and fatigue in a safe environment. Thereby, an early career would feel empowered to use their professional duty to put the interests of the people in their care first, and feel confident to report any concerns, if they consider they may be at risk (NMC, 2016). Additionally, the employer should be more proactive in monitoring staff experience, The National Quality Board (2017: 38) report that health-care organisations should be monitoring the staff experience and if there is any impact on the quality of patient care. They recommend employers should consider analysing the following key areas:

- Patient and staff outcomes (e.g. infections, falls, pressure damage and serious incidents).

- Patient and staff experience (e.g. patient and staff survey, Friends and Family Test and complaints).

- Staffing data (e.g. appraisal, retention, vacancy, sickness).

- Process measures (e.g. hand hygiene, documentation standards).

- Training and education (e.g. mandatory training, clinical training).

Notwithstanding, a recent report published by the NMC (2018) emphasises that health-care is changing, there is a greater emphasis on nurses providing integrated care across different settings and working closely with other professionals. Nurses are caring for an increasingly diverse population with complex needs and need to keep up with the advances in technology. This announcement place an increasing focus on an early career nurse's ability to cope with stress and burnout.

10.5.2 Health and Well–being

There appears to be an absence of studies that compares the personality traits for nurses with matched data on their performance and conduct throughout the early stages of their career. Wong and Li (2011: 228) identifies that the "specific personality characteristics necessary in clinical practice remain undefined." It is recommended additional research is required to

understand if a nurse's characteristics and values can impact on their ability to function as a safe practitioner, especially when faced with adversity and the required expectations of professional standards.

Previous research has found a relationship between "hardy individuals" and decreased levels of stress and burn out (Topf, 1989). Researchers continue to define hardiness as comprised of three personality traits: commitment, control, and challenge (Kennedy et al, 2014.) It is well known that burnout has an impact upon job satisfaction, therefore this personality trait may influence the nurse's decisions to remain within the workforce (Laschinger et al, 2009).

Diagram 44 is the theoretical model – a decision to refer illustrating the three themes of the core category and their inter-relationship with the four categories. This theoretical model can be used in conjunction with the adapted self-assessment checklist which aims to help recognise if intervention is needed by offering support as an early indicator to prevent an early career referral to the NMC. Like other health professionals, most nurses work hard, strive to achieve high standards, and provide excellent services for their patients. Yet, it is inevitable that some nurses may not meet reasonable standards. It is important to establish why this happens. The reasons are complex and rarely as simple as a lack of knowledge and skills. It is vital to understand the factors that cause a nurse who can practise safely, not to do so. It is evident some nurses are able to successfully address their difficulties and others are not.

The checklist sets out some answers to these questions. It is set out in a way to assist those to self-assess and identify the triggers that could lead to or result in difficulties during their early career. The checklist aims to help nurses to recognise what may lead to difficulties and how best to rectify and remediate against their deficiencies. The checklist can help nurses to make decisions and, where possible, assist in bringing about any necessary changes more quickly, so that problems are less likely to cause patient harm, or become fortified and therefore more difficult to mitigate against.

This checklist only anticipates the risks and situation e.g. fluctuating conditions – mental health. This is an enabling guidance to work with early career nurses to help identify the risks and help a staff to disclose if they have any health factors. This checklist is facilitative in order to consider the reasonable adjustments for each case.

It is important that the early career nurse recognises the impact these factors can have on their performance. In the event of a serious mental health problem, for example, the nurse may not be aware of these effects on their health, well-being and behaviour. Sometimes, part of being mentally unwell means that the nurse's judgement may be impaired; they may lose some of their rationality; and they may make poor or risky decisions. In the event of the nurse becoming unwell in the workplace, there is a risk that this could have a seriously adverse effect

on patients. Finally, it is recommended future research is needed to evaluate the effectiveness to this self-assessment tool.

10.5.3 Transition into the Profession – Work-place Allocation to Fit the Nurse's Personality.

Further research is needed to explore and understand the impact the characteristics of a nurse have on their clinical performance, behaviour, and conduct. The research needs to focus on how these individuals with low score traits can be managed and supported in the workplace, maximising the nurses strengths and positive attributes that could benefit patients, the team, healthcare organisation and the profession. It appears that the behaviour and conduct of the "*odd"* nurse, "*difficult"* nurse, "*friendly"* nurse, "*dishonest"* nurse described by participants are linked to the temperament and characters of the overall trait profile of nurses in Eley's study.

However, there is little research about why people became a nurse, personality traits and reasons for entering nursing (Eley et al, 2012). Eley et al (2012: 1554) recommends further exploration of the "reciprocal impact that exists between personality traits, which influence our behaviour, and the myriad of life circumstances that impact an individual's decisions, perspectives and subsequent actions." Such intelligence could assist with a greater understanding of how newly qualified nurses respond and react to situations, especially when supporting an early career nurse who is struggling to integrate into the workplace because they are perceived to have "*odd"* or "*difficult"* characteristics, especially when aligned towards extremely low temperament and character dimensions. Cloniger et al (1993; 1994) describes the descriptor of extreme low variants of the temperament and character dimensions (Cloninger et al, 1993; 1994), illustrated in table 22. In order to support nurses with these character traits, a tailor-made model of preceptorship and work-place allocation may be needed to fit the nurse's personality.

Table 24 Descriptors of extreme low variants for temperament and character dimensions adapted from Cloninger et al (1993 and 1994)

Temperament dimension	Descriptor of extreme variants Low
Harm Avoidance	Optimistic, Daring, Outgoing, Energetic
Novelty seeking	Reserved, Rigid, Frugal, Stoic
Reward Dependence	Critical, Aloof, Detached, Independent
Persistence	Lazy, Spoiled, Un-achieving, Pragmatic

Character dimension	Descriptors of extreme variants Low
Self-directedness	Blaming, Aimless, Inept, Vain, Undisciplined

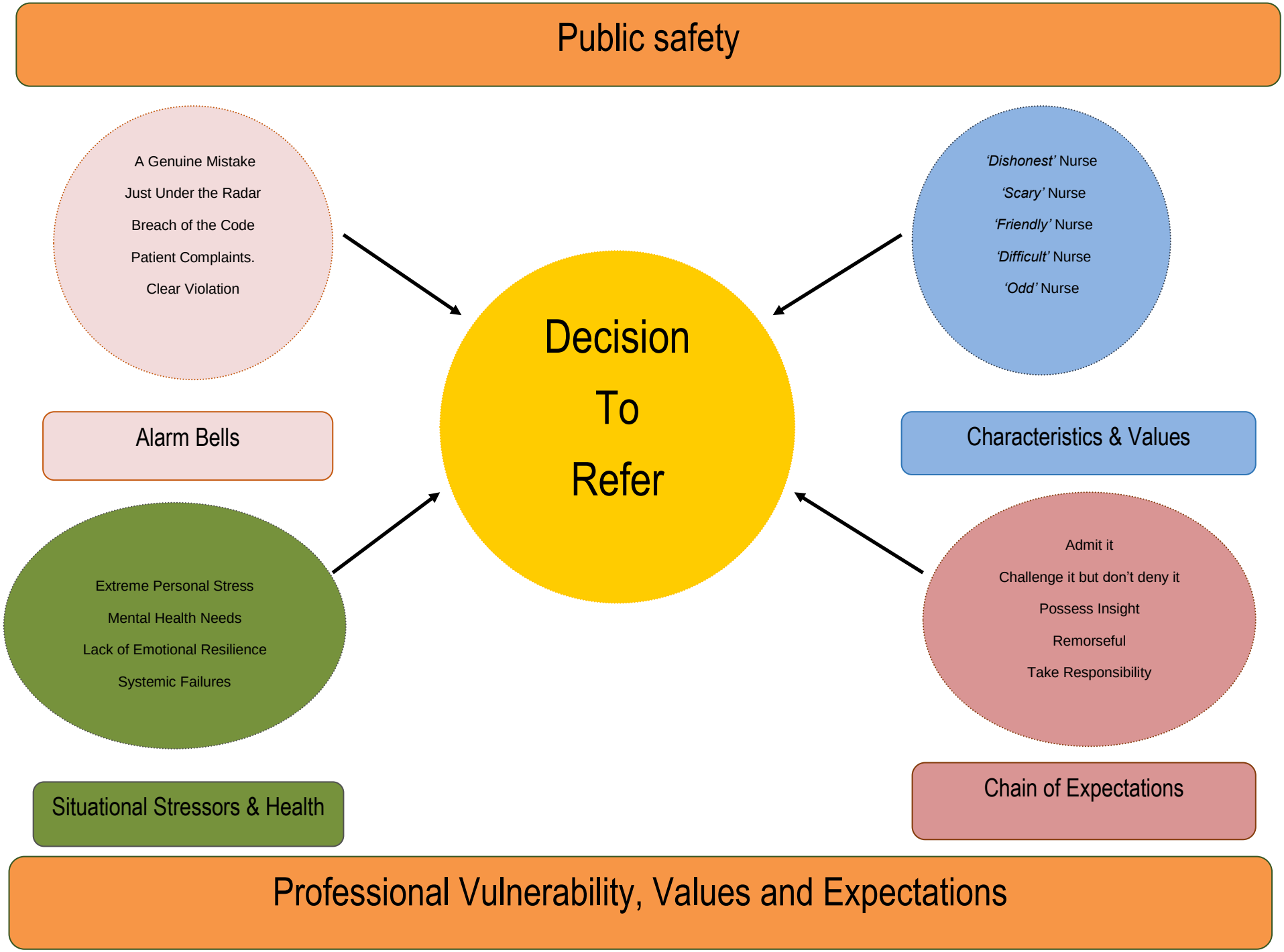
Cooperative	Intolerant, Insensitive, Hostile, Revengeful, Opportunistic
Self-transcendent	Unimaginative, Controlling, Materialistic, Possessive, Practical

10.6 Conclusion

This study has provided new knowledge and a deeper understanding of the contributing factors leading up a referral of an early career nurse to the Nursing Midwifery Council Fitness to Practise Committee. To conclude here are seven take home messages:

- There needs to be an investment of human factor approaches to improve patient safety, with a positive move away from an individual blame culture to a joint approach of the employer and employee to learn from errors in partnership.
- Alternative options are needed for early career nurses who are struggling in practice, so they can receive early pro-active supportive interventions and bespoke work allocation, to ensure patient care is not compromised.
- Employers should consider if it is essential to refer a nurse who has made a *"terrible genuine"* mistake, alternatively managing the situation within the organisation.
- Employer needs to acknowledge the response of the nurse and understand their characteristics and values, mitigating and human factors surrounding the situation.
- Strategies are needed for the employer to reward an early career nurse who demonstrates remorse, accepts responsibility for their clinical deficiencies, and shows insight following a question about their fitness to practise
- There needs to be an emphasis on the importance of nominated Senior Leaders who are visible in the workplace, who are role models, mentors and coaches. To strengthen the level of support for early career nurses especially during the preceptorship period or transition into a new role.
- Research is required to understand if a nurse's characteristics and values can impact on their ability to function as a safe practitioner, when faced with adversity in the workplace, to meet the required expectations of the professional standards.

Diagram 44 Theoretical Model - A Decision to Refer



Early Career Nurse check list – Self-assessment for discussion with Mentor / Line Manager / Preceptor / Senior Leader					
CATEGORY	**SUPPORT INDICATORS**				
	Support factor	**Level of Support Needs Required**			
		None/Low Support	**Medium Support**	**High Support**	**Immediate Action**
Capability	Reports of errors/incidents	No errors / incidents reported	One off error / incident reported	Repeated errors and / or incidents reported	Adverse error / incident
	Relationships with peers	Positive + no concerns	Isolated experience of concerns regarding relationship with peers	Repeated experience of concerns regarding relationship with peers	Formal complaint / HR involvement
	Therapeutic Relationship with Patients	Positive + no concerns	Isolated experience of concerns regarding relationship with patients	Repeated experience of concerns regarding relationship with patients	Formal patient complaint
Conduct	Punctuality	On time	Occasional lateness	Regular lateness	Disengaging
	Attitude	Motivated & responsive	Difficulty responding to comments	Resistant to learning, aggressive	Incident witnessed by patients, colleagues. Patient complaint
Personal circumstances	Care/parental responsibilities/ personal circumstances / recent change of relationship	Managing responsibilities well	Some minor difficulties	Experiencing significant issues relating to managing responsibilities	
	Finances	No financial hardship	Single episode of financial difficulty	On-going financial difficulties	
	Travel	No travel difficulties	Isolated problem with travel	On-going difficulties with travelling	
	Accommodation	No accommodation issues	Isolated problem	On-going difficulties	
Health	Health and well-being	Managing well	Isolated mental/ physical aspects &/or disabilities disclosed	On-going Mental/ physical aspects &/or disabilities disclosed	
	Stress	Managing well	Low/medium levels of stress disclosed	High levels of stress disclosed	
	Anxiety	Managed well	Low/medium levels of anxiety disclosed	High levels of anxiety disclosed	
	Sickness and absence	Compliance with organisations policy	Non-compliance with organisations policy	Non-compliance with organisations policy despite meetings	Disengaging
Date:		**Early Career Nurse Signature :**	**Date:**		**Mentor signature:**
Actions taken:					
To consider:	What actions has the early career nurse taken to resolve any factors that have arisen?				

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Appendix 1 – Oral Presentation Abstract Accepted for NETNEP 2018 International Conference

Title: The friendly, the difficult and the dishonest nurse: the factors that precede a decision to refer an early career nurse to the Fitness to Practise Committee

Introduction: The nursing profession need to understand the nature and causation of impaired fitness to practise and the decision for reporting an early career nurse for lack of competence and misconduct to the professional regulator. Taking into account the UK Nursing and Midwifery Council (NMC) reported the number of concerns continue to increase year on year (NMC 2015/16). In 2016/2017 the NMC received 5,476 new referrals, an increase of 1 percent from 2015/2016. The total number of concerns received represent approximately 0.8 percent of registered nurses and midwives. In 2010 approximately 16% (n=607) of the 3,596 new referrals in England to the NMC were registrants who had been registered for five years or less. This must be a concern to the profession. Early career referral rates potentially reflect standards of pre-registration education, early post registration career progression and have implications for public protection and is in the public's interest.

Methods: This qualitative research study explored the factors that precede the referral of early career nurses to the professional regulator. Grounded theory qualitative interviews were conducted with 20 healthcare employers in different regions of England across the fields of nursing practice. Data collection and analysis took place concurrently with the development of codes and categories.

Results: Findings highlighted four categories: alarm bells; wanted and unwanted characteristics and values; a chain of expectations; and situational stressors and health needs. The core category illustrated the ownership of public protection on the employer when making a decision to refer an early career nurse to the professional regulator.

Discussion: This research has revealed the alarm bells that identify a nurse at risk of a referral to the NMC. It has identified the wanted and unwanted characteristics and values displayed when a nurse's performance and conduct was under the spotlight. The employers disclosed the chain of expectations of a nurse whose fitness to practise was being questioned, often based on 'responsive regulation' (Braithwaite and Ayres, 1992), aligned with the 'redemption model' of professional discipline (Case, 2011). Notwithstanding employer's acknowledgement of the situational stressors and health needs that impacted on a nurse's performance in the workplace. It was evident, at times, the 'second victim was the nurse'.

Conclusion: This research highlighted the educational strategies needed to support early career nurse's resilience and transition into the profession and the workplace. These have

been linked to the analysis of human factors (Reason, 2012), alongside the development of a predictive model that can be used by employers and registered professionals to help to identify practitioners at risk of referral to the professional regulator.

Braithwaite, J. Ayres, I. (1992). Responsive Regulation, Transcending the Deregulation Debate. Oxford, Oxfordshire University Press.

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Nursing Midwifery Council. (2017). Annual Fitness to Practise Report 2016-2017. London, Nursing Midwifery Council.

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Reason, J. (2012). Human error. Cambridge, Cambridge University Press.

Appendix 2 - Oral Presentation Abstract Accepted for the RCN Education Forum Conference & Exhibition 2019

e) Specify the title and aim of your paper.

Title of paper	The friendly, the difficult and the dishonest nurse: the factors that precede a decision to refer an early career nurse to the Fitness to Practise Committee
Aim of paper	To explain the factors that precede the referral of nurses to the NMC Fitness to Practise Committee, within their first five years of registration, by healthcare employers across England.

Please provide an abstract of your presentation - concurrent, ViPER, and poster submissions (350 word limit).

The nursing profession needs to understand the nature and causation of impaired fitness to practise and the decision for reporting an early career nurse for lack of competence and misconduct to the professional regulator. The total number of concerns received represent less than one per cent of registered nurses and midwives (NMC, 2016-2017), of these a small percentage are nurses who have been registered for five years or less. Early career referral rates potentially reflect on standards of pre-registration education, early post registration career progression and have implications for public protection. Grounded theory qualitative interviews were conducted with 20 healthcare employers in different regions of England across the fields of nursing practice. Data collection and analysis took place concurrently with the development of codes and categories. The findings highlight four categories: alarm bells; wanted and unwanted characteristics and values; a chain of expectations; and situational stressors and health needs. The core category explains the employer's complex decision of referring an early career nurse to the professional regulator. This research reveals new insight into the employer's responsibility to protect the public leads to the identification of the alarm bells; the wanted and unwanted characteristics and values displayed when a nurse's performance and conduct is under the spotlight; and the employer's disclosure of a long chain of expectations of a nurse whose fitness to practise is being questioned. Yet employers acknowledge the situational stressors and health needs that impact on a nurse's performance in the workplace. This research highlights the educational strategies needed to support early career nurse's resilience and transition into the profession and the workplace. One recommendation of the study is to adopt a predictive model which can be used by employers and

Please provide an abstract of your presentation - concurrent, ViPER, and poster submissions (350 word limit).
registered professionals to help to identify early career practitioners at risk of referral to the professional regulator.

Appendix 3 - Oral Presentation Abstract Accepted for the NET Conference 2009

Theme Paper Title: Fitness for Practice is everyone's business: The reality of failing to fail a student nurse.

Abbie Barnes

The Nursing Midwifery Council Fitness to Practice Annual Report in 2007/2008 alerted to 1,487 potential new cases against nurses and midwives. Anyone can make a complaint, but in practice over 50% come from employers, many in association with disciplinary proceedings at the workplace. The Nursing Midwifery Council Fitness to Practice panel will decide whether a registrant's fitness to practise is impaired by reason of:

- Misconduct
- Lack of competence
- A criminal offence
- Mental or physical health
- A determination by a health professions body in the UK that fitness to practise is impaired

The Conduct and Competence Committee has a range of powers. In relation to its final sanction, it can decide to:

- Strike off the practitioner's name from the register
- Suspend the practitioner's registration for a specified period not to exceed one year
- Impose a conditions of practice for a specified period not to exceed three years
- Issue a caution for a specified period of between one and five years
- Conclude that the case is not well founded and therefore take no further action
- Decide, taking into account all the circumstances of the case, it is not appropriate to take further action

These registrants have at some point entered the register as competent and meeting the essential criteria to be a registered practitioner. Kathleen Duffy received a UKCC scholarship in 2001 to study the issue of failing students. The study highlighted how failing students are given the benefit of the doubt and the dilemmas mentors have in practice about failing students.

Passing students in hope that they will improve later in the course or as a newly qualified nurse has serious consequences for patients, students and future mentors. Passing students who should have failed does not protect the interests of the public and puts the patients who are under their care at risk. The reality of mentorship is challenging, complex and a demanding role. The clinical environment can provide numerous learning experiences. Student nurses highly value clinical practice and the possibilities if offers in the process of becoming a nurse and, moreover a professional. Nevertheless, the clinical environment is unpredictable and constantly changing, making it difficult to plan an optimal clinical learning environment for

students. Add in the issue of a problematic under achieving student and it can be overwhelming for the mentor.

With the rise of complaints to the Nursing Midwifery Council regarding fitness to practice ranging from newly qualified nurses to experienced qualified nurses, failing to fail student nurses needs to be acknowledged and debated in a professional forum (Refer to Model 1). To discuss and critically appraise the nature of a high achieving student nurse, a moderate achieving student nurse and an underachieving student nurse and whether giving the student the benefit of the doubt encourages the student nurse to excel and develop into a competent qualified nurse, or whether the under achieving student nurse continues to be an under achieving qualified nurse (Refer to Model 2). Moreover critically analysing the relationship between the student nurse level of competence and their future fitness to practice as a qualified nurse.

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Appendix 4 – Consent form

Attachment FREC 2

Study Number:

Participant Identification Number for this study:

CONSENT FORM

Title of Project: Referral to the Nursing and Midwifery Council Fitness to Practise Committee.

Name of Researcher: **Abbie Fordham Barnes**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **[Insert Date]** (version **[VERSION NUMBER]**) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I understand that relevant sections of information collected during my interview, may be looked at by the researchers supervisors from Birmingham City University. ☐

4. I consent to use of audio taping during the interview. ☐

5. I understand that information collected during my interview, may be anonymised and extracts from the interview may be used in reports. ☐

6. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

Appendix 5 – Participant Letter

Attachment FREC3 – Letter and Participant Information Sheet for Director of Nursing or Senior Nurse Manager

Address for Correspondence

(Date)

(Name) (Director of Nursing or Senior Nurse Manager)

(Address)

Dear

Referral to the Nursing and Midwifery Council Fitness to Practise Committee

I am a Practice Quality Lead Nurse Lecturer and I am doing a PhD at Birmingham City University. I sit on the Nursing and Midwifery Council Fitness to Practise Committee as a registrant panel member. My research focuses on the perspective of employers and staff who have referred nurses to the Nursing Midwifery Council (NMC) Fitness to Practise Committee for an allegation of a lack of competence or misconduct. In particular I am trying to establish the factors that precede the referral of a nurse to the NMC Fitness to Practise Committee within their first five years post registration.

The purpose of this letter is to invite you to take part in the study with regard to your involvement in making a decision and/or making a referral to the NMC. Please find enclosed an information leaflet which explains why the research is being done and what taking part will involve. Part 1 tells you the purpose of the research. Part 2 gives you more detailed information about the conduct of the study. Please contact me if there is anything that is not clear. A favourable ethical opinion has been obtained from …….and indemnity insurance has been arranged through Birmingham City University.

If you or a colleague is able to take part in this study please email a.fordham-barnes@keele.ac.uk. Any information you provide will be anonymous. Neither you nor your organisation will be identifiable in any way. A copy of the executive summary of our report about this study will be sent to you regardless of whether or not you decide to take part.

Thank you for taking time to read this letter.

Yours sincerely

Abbie Fordham Barnes

RGN, RNT, MA, BA, Post Graduate Dip Ed

Appendix 6 – Participant Information

Participant Information Sheet

Study title: Referral to the Nursing and Midwifery Council Fitness to Practise Committee.

Invitation to participate in a research study

You have been invited to take part in my research study. The aim of this study is to explore the factors that precede a referral of nurses, by employers in England to the Nursing and Midwifery Council (NMC) Fitness to Practise Committee, within the first five years of registration.

Please talk to others about the study if you wish or contact me if you need any further information.

Part 1 of the leaflet tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Part 1 of the Information Sheet

What is this research about?

Nurses in England have an increased risk of referral to the Nursing Midwifery Council (NMC) Fitness to Practise Committee because of an allegation of impaired fitness to practise within the first five years of registration. This study aims to try to find out why this is happening from the perspective of nursing staff, managers or HR personnel who have referred nurses to the Fitness to Practise Committee. I am trying to find out about the types of events that lead up to this sort of referral and not the ensuing NMC investigation or outcome.

Why have I been invited?

The NMC website (insert link) states that you referred a nurse to the Fitness to Practise Committee in year (add year)

Do I have to take part?

It is up to you to decide to take part. If you wish to take part please sign and return the enclosed consent form in the reply-paid envelop provided. You are free to withdraw at any time, without giving a reason.

What will I have to do?

If you agree to take part I will interview you about your involvement in making a decision and/or making a referral to the NMC. The interview will take place at a time and place convenient to you and it will be recorded. Any information you give me will be treated in the strictest confidence and anonymised so no one will know what you have said.

What are the possible disadvantages and risks of taking part?

There are no risks in taking part in this research. Any information you feel able to give will be treated in the strictest confidence. I am aware that during the interview I might touch upon difficult and challenging issues that you and your organisation have experienced. If you do not want to answer certain questions, that is fine. You can finish the interview at any time you wish. Every care will be taken to ensure that you are comfortable with the content of the interview.

I may use anonymised extracts from your interview in my report but neither you nor your organisation will be identifiable in anyway.

All information you give will be anonymous and managed in the strictest confidence.

What are the possible benefits of taking part?

You will not benefit personally from taking part but the information you will give me will help to develop a better picture of the factors that precede a referral to the NMC. This is an under addressed subject and your experiences could inform standards of pre-registration education and early post registration

career progression. The findings of this study will help develop a predictive model to identify nurses at risk of referral that can be used by employers and health professionals.

Will my taking part in the study be kept confidential?

Yes, any information you give will be anonymous. Neither you nor the trust/organisation will be identified in anyway in any reports arising from this research. During and after the study information you give me will be managed in accordance with the Data Protection Act. I will follow ethical and legal practice and all information about you will be handled in confidence.

Part 2 of the information sheet

What will happen if I don't want to take part or carry on with the study?

You are free to withdraw at any time, without giving a reason.

What if there is a problem?

If a problem arises as a result of, or in connection, with the research please contact me first and I will try and sort the matter out.

Abbie Fordham Barnes

Practice Quality Lead Lecturer

School of Nursing and Midwifery

Keele University

Clinical Education Centre

University Hospitals of North Staffordshire NHS Trust

Newcastle Road

Stoke-on-Trent

Staffordshire

ST4 6QG

Tel: 0782 568 2954

Email: a.fordham-barnes@keele.ac.uk

If you feel this does not resolve the problem please contact my research supervisors

Professor Paula McGee

Faculty of Health

Birmingham City University

City South Campus

Westbourne Road

Edgbaston

Birmingham B15 3TP

Tel: 0121 331 6127/6105

Email: paula.mcgee@bcu.ac.uk

Professor Alan Finnegan

Faculty of Health

Birmingham City University

City South Campus

Westbourne Road

Edgbaston

Birmingham B15 3TP

Email: alanfinnegan526@mod.uk

Or the research sponsor

If you feel that this does not resolve the problem please contact the research sponsor at

Professor L. Land

Faculty of Health

Birmingham City University

City South Campus

Westbourne Road

Edgbaston

Birmingham B15 3TP

Tel: 0121 331 6196

Email: lucy.land@bcu.ac.uk

What will happen to the results of the research study?

The findings will be published and presented at conferences and a report will be written for the Nursing Midwifery Council. The final thesis will be available on the British Library catalogue, Royal College of Nursing and Nursing Midwifery Council.

A written summary of the study will be sent to you by post, with the offer to discuss the outcomes of the study by telephone / face time / Skype.

Who is organising and funding the research?

This is an independent PhD study, no funding has been sought. I am self-funding the study, for example travel, postage.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by _____Research Ethics Committee.

Further information and contact details

Abbie Fordham Barnes

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ST4 6QG

Tel: 0782 568 2954

Email: a.fordham-barnes@keele.ac.uk

Thank you for taking time to read this leaflet. If you decide to take part please complete the consent form and return in the reply-paid envelope provided.

Abbie Fordham Barnes

This information sheet has been written by Abbie Fordham Barnes PhD student in line with the NRES guidance. http://www.nres.nhs.uk/applications/guidance/consent-guidance-and-forms/?1311929_entryid62=67013

Appendix 7

31st July 2018

POSTCARD

Dear PhD on a Postcard,

A decision to refer an early career nurse to the Nursing Midwifery Council, Fitness to Practise Committee is based on a combination of factors: the situation and the response of the nurse; the employer's perceptions of the employee and the employer's relationship with the nurse.

This research reveals new insight into how the employer's responsibility to protect the public led to the identification of the alarm bells, which signalled that patient safety had been compromised either by a single or series of related events resulting from a nurse's actions. This research confirms 'patient safety is number one' for employers. They take full responsibility for protecting the public in their own organisation, and in some cases, the wider community yet they are committed to being a 'fair employer' who can identify system and process issues.

Employers regard nurses as being in a 'privileged position' in society. Employer expect a nurse to exhibit specific values and behaviours. Some nurses' display unwanted characteristics and values when their performance and conduct is under the spotlight. The employer expects the nurse to show 'professional responsibility and insight' into their actions, admit to the error, say sorry and demonstrate remorse. A mismatch between the employer's expectations and the nurse's response can cause an 'irretrievable breakdown of relationships' between the nurse and the employer.

This research reveals a new understanding of how a nurse's reaction to an allegation that questions their fitness to practise is taken very seriously. This research confirms that a decision to refer an early career nurse is 'never taken lightly.'

This research reveals new information about employer's recognition that early career nurses can be placed in a professionally vulnerable positions, due to the multi-factorial situational stressors that can impact on their performance. Nurse's experience the challenges of early career progression and transition into the profession, which can result in them having a 'broken spirit,' and feeling like the 'second victim'. The research highlights some nurses do experience 'physical and mental health issues' but employers have a responsibility to protect the public, which outweighs the individual's needs of the nurse, no matter how traumatic.

Best wishes

Abbie Fordham Barnes PhD student

To

Professor Paula McGee

Dr Chris Inman

Professor Alan Finnegan

Faculty of Health, Education and Life Sciences

Birmingham City University

Appendix 8 – Minor Amendments following Viva

Page	Revision request	Amendments
5 - 9	Contents pages	Updated
23	Briefly qualify the approach of the literature review e.g. after Gough as an integrative, explorative review to avoid confusion with a systematic approach.	An integrative, explorative review was adopted for the initial literature review for this study and was conducted prior to data collection and analysis.
24	Briefly qualify the approach of the literature review e.g. after Gough as an integrative, explorative review to avoid confusion with a systematic approach.	The search strategy was designed to employ a recognised and replicable procedure to find, evaluate, and draw together the findings of relevant research (Gough et al, 2012) culminating in the integrative, explorative review.
37	Briefly qualify the approach of the literature review e.g. after Gough as an integrative, explorative review to avoid confusion with a systematic approach.	The integrative, explorative review revealed a surprisingly low number of research studies which were related to fitness to practice. Consequently, after a meeting with the Faculty Librarian, a second search was conducted. This applied different search terms which represented the three categories identified by the NMC Fitness to Practise Committee (Table 5). This led to the identification of 50 more items that were suitable for inclusion.
56	With regards to Chapter 5 concerning the value judgments made of nurses articulate a critique drawing on some reference to the literature e.g. on unconscious bias	Grounded theory is recognised methodology in nurse education (Parahoo, 2014) in order to systematically collect and analyse data to conceptually explain the phenomena of interest. It is important that grounded theory research is credible, whereby the researcher recognises, firstly that data does not stand alone, and secondly, an emergent analysis can take various forms which may or may not be dependent on what the researcher consider as credible data (Engward and Davis, 2015). The understanding of data maybe framed by the researcher's presumptions which need to be explored through reflexivity. The use of Alvesson and Skolberg (2009) model of reflexivity in research can help to consider levels of reflexivity from a more critical perspective to strengthen the research process, especially to reflect on the findings in chapter 5. This model is based on gaining a critical perspective of the researcher's position in the research, and the awareness of how their beliefs, values and previous experiences impact on the data, an important factor in qualitative methodologies. During the research project the researcher developed a greater sense of self-awareness and recognised the concepts of power, knowledge and subjectivity of

		participant's experiences, which may have been influenced by the culture and constraints of the healthcare organisation.
135	With regards to Chapter 5 concerning the value judgments made of nurses articulate a critique drawing on some reference to the literature e.g. on unconscious bias	This chapter is grounded in the data and represents the voice of the participants, with verbatim quotes and memos, but it is important to reflect on the perceived unconscious biases disclosed by the participants when describing the characteristics and values wanted and unwanted in nurses (Persaud, 2019). It could be argued we all have unconscious biases, which are learned stereotypes that are automatic, unintentional, deeply engrained within our beliefs, universal, and have the ability to affect our behaviour. The researcher acknowledges it has exposed the participant's views of nurse leaders who could be considered to be ethically responsible for creating diverse and inclusive spaces for early career nurses. It is crucial leaders openly acknowledge and address the negative influence of bias and prejudice when managing an early career nurse whose fitness to practise is in question, which may stem from the culture within the organisation. This process begins with an in-depth examination of one's own biases and continues through actions at the individual and organisational levels (Persaud, 2019), which is aligned to one of the recommendations of this study. Persaud (2019) promotes that nurse leaders are well positioned to address and mitigate the negative influence of bias within organisations. This is reflected by one of the participant who strongly advocated *"there are people that are a bit different, that perhaps are going to be the leaders in the future …because they are a bit different"* (Participant 15). Other participants described certain early career nurse's behaviour and characteristics as *"odd"* and *"difficult", "scary"* and a *"personality disorder".* From a critical perspective the participants who appear to hold unconscious beliefs and biases are displayed by categorising the nurse's behaviour and conduct as an unwanted characteristic or value. In this case this could be perceived as constraining the early career nurse's opportunity to be innovative and creative, which could be an essential quality for leaders of the future who '*think outside the box'* to react to the rapidly changing healthcare needs and policy. This constructivist grounded research is not about power, status, prestige, manipulation, the rule of experts, fear, insecurity, but is based on a strong, well-founded argument. It is up to the reader to decide if the participants provide a

		reasonable and authentic argument which can be perceived as appropriate for this research. Alvesson and Skoldberg (2018; 189) describe the importance of considering if participants views carry “equal weight”. This can be dependent on a number of factors, including knowledge and experience, wisdom and the basis of their authority, their closeness to clinical practice and understanding of the reality and challenges faced by early career nurses. In this study the participant’s inclusion criteria required experience of making a referral to the NMC, therefore ascertaining the scope, relevance and reliability of statements made by experts in the field and it could be argued reasonable weight can be ascribed to them.
232	With regards to Chapter 5 concerning the value judgments made of nurses articulate a critique drawing on some reference to the literature e.g. on unconscious bias	Secondly, the recommendation that employers and nurse leaders start to acknowledge and critically consider challenging their own values and beliefs of how they expect an early career nurse to respond and react following an error in the workplace, to mitigate against any negative influence of bias within organisations.
253, 240, 249	With regards to Chapter 5 concerning the value judgments made of nurses articulate a critique drawing on some reference to the literature e.g. on unconscious bias	References added
253, 251	Review the alignment of in text citation / discussion (Gough and Gadamer) and bibliography	References added