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Title:

A hermeneutical study of professional accountability in nursing

Brief description of study

This hermeneutical study of professional accountability in nursing explores how registered nurses experienced and perceived their professional accountability in clinical settings. The findings suggest that professional accountability in nursing practice is a complex phenomenon, which can be compromised by many factors which are historically, socially or politically driven. Participants experienced challenges through a lack of resources and poor managerial support, which comprised their ability to deliver high quality patient care. However, collegiality strongly impacted upon resilience and positively influenced their wellbeing. Amid the challenges of the clinical workplace, a positive workplace culture with visible managerial support is a fundamental requirement in supporting professional accountability, development and retention of nurses. Findings highlight the view that leadership should be seen as a collective responsibility, which empowers staff to positively change the practice environment.

Short running title

Professional accountability in nursing

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A hermeneutical study of professional accountability in nursing

Aims. This paper presents findings from a hermeneutical study which sought to explore how registered nurses experienced and perceived their professional accountability in clinical settings.

Background. Professional accountability encompasses the ideals and standards of nursing practice. Nurses are accountable for their actions under civil, criminal and contract law to their; employing organisation, their regulatory body and the patients for whom they care-

Design and methods. This paper reports on a Heideggerian hermeneutical study involving seven registered nurses, working in clinical practice in the National Health Service in the United Kingdom. The study adopted purposive sampling, collecting data by means of in-depth interviews. Data was analysed using the hermeneutic circle. COREQ checklist was used as a reporting guideline for this study.

Results. The findings suggest that professional accountability in nursing practice is a complex phenomenon, which can be compromised by many factors which are historically, socially or politically driven. Participants experienced challenges through a lack of resources and poor managerial support, which comprised their ability to deliver high quality patient care. However, collegiality strongly impacted upon resilience and positively influenced their wellbeing.

Relevance to clinical practice. Amid the challenges of the clinical workplace, a positive workplace culture with visible managerial support is a fundamental requirement in supporting professional accountability, development and retention of nurses. Findings highlight the view that leadership should be seen as a collective responsibility, which empowers staff to positively change the practice environment.

Key words: Professional accountability, nurses, hermeneutics, phenomenology, culture

1. Professional accountability

Professional accountability in nursing can be defined as a universally held, and multi-faceted concept which incorporates legal, ethical and professional constructs. This means that nurses are answerable to themselves and others for their actions (ANA, 2014), and must satisfy formal obligations to the law, their employer, professional codes of conduct and their own moral principles (Rubio-Navarro et al, 2019). Nurses have a legal liability and duty of care to their patients for their own actions, omissions and quality of care, as well as being accountable to their employing organisation and regulatory professional body (RCN, 2017). The ideals espoused in delivering high-quality person-centred care are governed by the regulatory standards and responsibilities of nursing codes of conduct within both developed and developing countries (ICN, 2012). In the United Kingdom (UK) nursing (and midwifery) is regulated by the Nursing and Midwifery Council (NMC). The NMC Code contains the professional standards to which registered nurses must adhere (NMC, 2018), and is reflective of professional codes of conduct for nurses across the globe (Zahedi et al, 2013) Indeed, the International Council of Nurses lists professional accountability as a key part of ethical conduct. (ICN, 2012). Accountability also serves to outline organisational and societal expectations and boundaries for practice by which nurses are judged (Beardwood and Kainer, 2015).

Professional accountability defines the nurse's legal, professional and ethical responsibilities to themselves, their patients, regulatory body and employer (RCN, 2017). Inadequate staffing

(Berwick 2013) high workload (Hobgood et al, 2005) and the clinical practice environment (Yoder-Wise, 2014) impact on patient safety and the quality of care provision. These factors, which are often outside nurses' control, can influence their ability to be professionally accountable.

2. Background

The World Health Organisation (2020) estimate that an extra nine million nurses and midwives will be needed worldwide by the year 2030. In England, there are currently 40,000 nursing vacancies (RCN, 2017) These shortages serve to highlight the need to retain and recruit Registered Nurses (RN's) around the world (Flinkman et al, 2010) Whilst this problem is multifactorial there is a need for healthcare providers to identify strategies to address these challenges. A recent systematic review of interventions aimed at reducing nurse turnover found evidence that strategies aimed at improving leadership, preceptorship and the overall practice environment would be beneficial (Halter et al, 2017). The clinical practice environment has a direct impact upon staff wellbeing, patient safety and quality of care (Bates, 2009; Yoder-Wise, 2014) and is adversely affected by; insufficient staffing levels (Aiken et al, 2008) workplace bullying (Houck and Colbert, 2017), a lack of autonomy in clinical decision making and poor organisational support (Ausserhofer et al, 2013; Van Bogaert et al, 2014). Hayes et al (2006) conclude that strategies designed to improve the quality of the practice environment, have a greater impact on staff retention and staffing levels than salary increases or recruitment. However, establishing a workplace environment which prioritises high standards of patient care through effective governance and professional development is dependent upon a positive culture, which instils openness, collegiality, and professional ideals. Aiken et al (2011) reports that a positive culture within the practice environment may improve nurse retention and quality of patient care. Furthermore, nursing leadership plays a pivotal role in developing a positive practice environment (Twigg and McCullough, 2014) and encouraging nurse autonomy (Chan and Lai, 2010).

In establishing a positive culture in the workplace environment, nurses must have support from colleagues and managers, underpinned by the essence of professional caring, which fosters respect through the establishment of professional relationships (Brilowski and Wendler, 2005). However, the antithesis of caring is workplace bullying which has long blighted the nursing profession and been the subject of debate in nursing literature for decades, supporting the assertion by some that "nurses eat their young" (Meissner, 1986; Simons and Mawn, 2010). Workplace bullying in nursing can cause physical and emotional health problems amongst nurses, retention and recruitment issues (Sellers et al, 2009) and be detrimental to patient safety and quality of care (Berry et al, 2012). These problems are well documented, yet the presence of workplace bullying amongst nurses continues to rise (Granstra, 2015) and is prevalent across all levels of seniority (Edmonson and Zelonka, 2019) age, gender, and experience (Dellasega, 2011). Indeed, the American Nurses Association observed that bullying threatens not only the safety of nurses and patients but also the nursing profession as a whole (ANA, 2015).

A fundamental requirement in establishing a healthcare environment which is safe, effective and sustainable requires the development of appropriate organisational leadership (Baker, 2011). This is reflected in the body of evidence, which reports that many of the problems linked to failures in health care systems are due to poor leadership (Weberg, 2012). Certainly, effective leadership has been shown to facilitate the development of shared values, and the articulation of a future vision (Calarco, 2011) Further, effective leadership improves efficiency, staff morale and retention, as well as underpinning the presence of the organisational safety culture (MacPhee et al, 2013; Day et al, 2014). Shared governance structures that engage staff and facilitates information sharing between clinicians and managers has been shown to lead to empowered workplace environments (Kramer et al., 2009). In contrast, a negative

management style has been directly linked to nurses' absenteeism and staff retention (Hahtela et al, 2015).

Few studies have examined professional accountability from the contextual standpoint of registered nurses working in clinical practice, and the challenges which they face in upholding professional standards. The aim of this study was to explore the influence of the clinical practice environment on nurse's accountability and the subsequent effects on patient care provision.

3 Methods

3.1 Study design

The study aimed to explore how registered nurses, working in the United Kingdom (UK) National Health Service (NHS) experienced professional accountability in their everyday working lives from a cultural and environmental perspective. A phenomenological design was selected to allow the exploration of participant's thoughts and feelings. Phenomenology explores the meanings of our conscious experiences, from a subjective standpoint. It looks at the ways in which we experience things, how things appear to us, and can provide valuable insight into human behaviour, making it highly relevant in social science research (Cohen and Omery, 1994). Hermeneutics is a branch of phenomenology, developed by the philosopher, Martin Heidegger which stresses the importance of looking at the very 'question of being' and the fact that as individuals we are part of the world in which we live, and as such we influence and are influenced by the world, through historical, cultural, political, social and economic factors. Heidegger's (1927/2010) work narrates his views and observations of the ways in which we cope with life, interact with others and behave in our daily lives This approach was therefore considered a good fit for this study, allowing for the discovery of new meanings and different perspectives surrounding professional accountability.

3.2 Ethical aspects

Ethical approval was granted by the Ethics Committee of a University in North West England in the UK (Ethics number 1244). Participants were recruited through advertisements placed on the University's Continuing Professional Development website, and emailed advert from the Research and Development department of a nearby University teaching hospital. Potential participants were provided with an information sheet pertaining to the study, at least one week prior to the interviews taking place, and given an opportunity to ask questions or seek clarification. All those who volunteered to take part were interviewed and no participants withdrew from the study. Informed consent was obtained prior to each interview and all participants given the right to withdraw from the study at any time. The anonymity of the participants was assured, with pseudonyms assigned to each participant. The COREQ checklist was used as a reporting guideline for this study.

3.3 Study participants

Participants were purposely selected and included those with an experience of nursing in the UK NHS, allowing the researchers to gather rich data which related to professional accountability (Cresswell and Plano-Clark, 2011) The seven participants had a range of experience and came from several specialisms. Reflecting the philosophy which underpins the study, the number of participant interviews were few to allow in-depth understandings to emerge (Cresswell 2013). The table below depicts participants age and experience and area of practice. A reflective journal was kept throughout the study, allowing the primary researcher to reflect on her experiences and changing perspectives in the context of the research journey.

This process enhances credibility as it enables transparency in respect of the research process which was followed.

Table 1 Participants involved in the study

<i>Pseudonym</i>	Age Range	Time qualified	Area of practice
<i>RN1</i>	40–50	25 years	Primary care setting
<i>RN2</i>	60–65	35 years	Primary care setting.
<i>RN3</i>	50–60	28 years	Employed in three part-time jobs: in private practice and primary care.
<i>RN4</i>	30–40	15 years	Acute care setting.
<i>RN5</i>	40–50	21 years	Acute care setting.
<i>RN6</i>	30–40	10 years	Acute setting since.
<i>RN7</i>	20–30	10 months	Acute care setting.

3.4 Data collection

Data were collected using in-depth face-to face interviews which lasted up to 90 minutes and took place in a mutually convenient location, in private rooms, either close to the participant's place of work or on the University campus. A conversational style was adopted to encourage participants to be open and share their experiences. The primary researcher (LC) disclosed to all participants at the time of the interview that she was a registered nurse, working in clinical practice. The purpose of this was to reassure the participants that the researcher would understand their perspectives and experiences, as she was in a similar situation. Each interview commenced with the same question, 'Tell me about your nursing career, the highs and the lows' to encourage participants to talk openly about their experiences of nursing, their memories, celebrations and challenges. In this way participants gave a historical, and contextual account of their experiences of nursing and shared, often raw emotion of how events had been managed and how those incidents had shaped their futures. Throughout the interviews, comments were clarified and probing questions used, such as: 'Could you tell me more about that?' to encourage participants to expand upon comments and allow the conversation to move back and forth. An interview guide was used as an aid memoir for the researcher, and to ensure a consistent approach was taken with each of the interviews (See Figure 1). All participants were reminded of the NMC (2018) professional Code, and the researcher's obligations to report any safeguarding issues during the interview.

3.5 Data analysis

Data analysis was guided by the work of van Manen (1984) which enabled a deeper understanding of the participants experiences. The following steps were taken: All interviews were audio recorded and manually transcribed verbatim by the first researcher. Manual transcription enabled greater immersion in the text and provided an opportunity to begin interpretation. All text was read, reread, and annotated. Alongside this, field notes and a reflective diary were kept, enabling the research team to reflect and discuss interpretations (Diekelmann et al, 1989). As the primary researcher started to explore the text, initial themes emerged. However, these changed through the analytical process as other more dominant themes were found, for example, all participants discussed their pre-registration preparation in some detail, and initially this was defined as a main theme. Through the hermeneutic circle, other themes emerged, which related to, but differed from pre-registration preparation. These included experiences relating to fear and collegiality and participants were unable to explore the 'whole' of their pre-registration preparation without reference to the 'parts' of their experience. Moving from whole to parts and back again, enabled greater and more coherent understanding of the data and provided a more complete analytical picture. This process of data analysis is briefly detailed in Figure 2 where initial thoughts changed as the researcher entered the hermeneutic circle. The data were then arranged into themes and broader patterns of meaning. This process was discussed and agreed with the research team, in line with the process suggested by Diekelmann et al (1989).

3.6 Interpretation and understanding

From a hermeneutical standpoint, interpretation and understanding are very much linked to one another. This is due to the assertion that understanding is only reached following interpretation, and vice versa. Heidegger (1927/2010) describes the process of interpretation metaphorically as the 'hermeneutic circle'. The hermeneutic circle enables the researcher to adopt a reflexive approach and embrace pre-understandings about the research area to inform analysis of the text. The process involves moving from our understanding of the whole, to part of the text and back again, with the aim of reaching a different understanding of the text. This process values and combines the position of the researcher and their experience of the phenomena and is seen by Dahlberg et al (2008) as a way of creating a hermeneutic vision of wholeness, as understanding is gained from parts of the text, as they relate to the whole and vice versa. By exploring the participants individual experiences of the world in which they live, and their thoughts and feelings, different interpretations and viewpoints can emerge. However, prior to entering the hermeneutic circle it is important that the researcher makes visible their own preunderstandings relating to the phenomena being explored and is aware of the potential influence these may have upon the interpretive process. The primary researcher's pre-understandings were discussed with the research team prior to data collection and were based on several years of clinical nursing experience, and the belief that professional accountability was poorly enacted within the practice environment.

3.7 Maintaining quality through rigor

Van Manen (1990) suggests four standards of rigor when undertaking qualitative research and these have been applied to this work. Van Manen (1990) describes the richness of the study as related to the aesthetic quality of the participant data used to describe participant perceptions. Strength pertains to the ability of the data to represent meaning and convey understanding of the participant's text through the researcher. Depth concerns the ability of the text to describe participants perceptions, whereas, orientation describes the researcher's

involvement in the world of the participant (van Manen, 1990). In order to promote rigor, the decision making was made clear for example the use of the hermeneutic circle to interpret the data, detailing the processes which were followed, such as the way in which the primary researcher used the hermeneutic circle to interpret the data and arrive at new understandings. Throughout the study, participants experiences have been presented through verbatim quotes and descriptions which remained true to their story, and importantly were not removed from context. An example of this was the way in which the participants described their emotions, within the context of the practice environment.

4. Findings

Findings revealed the complex nature of nursing practice and the diverse challenges which participants faced daily. Articulating their compassion and dedication alongside their frustrations and anxieties, they described how they coped with the situations in which they found themselves in, and how they were influenced by the 'world' in which they were contextually linked. Four key themes were identified: Negative culture; Lack of Managerial support; High workload and low staffing levels; and Coping strategies.

Negative culture

Participants described their experience of a negative practice culture and this often manifested in colleagues' behaviours. Participants experienced the culture through their everyday working lives and often used negative terms to describe their treatment by more senior staff. Participant's used words such as: *crucified*, *blamed*, and *punished* and held a common view that they were often blamed when problems occurred. Subsequently, feelings of blame became a barrier to them voicing their concerns.

If something happens the first thing they look for is someone to blame. They will always scapegoat someone...No one ever wants to make a mistake, not in their wildest dreams do they. (RN 5)

If an incident happens it definitely finds blame. We fill in incident forms; we reflect on it; we feel like we are punished. (RN 6)

Participants experienced a 'blame culture' in which staff felt unvalued. A blame culture is often conceptualised from an organisational perspective, as an environment where staff are reluctant to speak out, accept responsibility or take risks because they fear retribution or criticism (Khatri et al, 2009). The next exemplar refers to the long-established mantra, that the UK NHS has a 'no-blame culture'.

Well they say it's a no-blame culture, but it IS a blame culture. The blame culture is there. The NHS has changed since I came into it 10 years ago. They don't treat staff well. They don't value staff... No one goes into nursing to make mistakes and do wrong. Nurses come into this job to give good care to patients. (RN 4)

The participant described his current experience against the historical context of the NHS, one which he believed was less blaming and more supportive. This had implications as evidenced by the next excerpt which suggested that cultural influences would stop him from raising concerns.

I could use the whistleblowing policy but I would not win. You can't touch the top people; [workplace name] is a powerful place. (RN4)

Participants observed their experiences, not in isolation of events, but in the context of their own history, culture and experiences, which shaped their views and emotions.

Participants described feeling frightened to make mistakes as this might lead to repercussions. The following excerpt observes the way that one participant had experienced a culture of fear when she commenced her clinical education.

We were frightened of the ward sister. We were frightened of being late; we were frightened of having a hair fall out of place; we were frightened and had a fear of things "that shouldn't be", like if the bed cradles were under the bed or on the floor; you know, flowers being properly arranged and not dying in the vases. I think the patients were frightened as well of the doctors and the ward sister (RN 2)

The next two excerpts describe how other participant's experienced fear in their everyday working lives, and how they perceived it had affected themselves and colleagues.

Working in hospital for years, you get institutionalised. You are afraid to speak up. (RN 6)

Three nurses had all made a minor error and they were all crucified for it. It was complete overkill. It broke them all. They will never have the same confidence (RN 7)

In the above excerpts, participants spoke of being fearful of making mistakes or raising concerns. It was clear that the actions and behaviours of colleagues and senior staff impacted upon participants wellbeing and professional accountability.

Lack of Managerial support

Participants spoke of feeling unsupported by senior managers in clinical practice. They described managers as ineffective, observing that they were neither visible nor accessible to staff.

I feel that the management is remote and indeed I coined the phrase "management by mouse" because there's more management and communication by email. You know, I think it would be a lot nicer for people to pick up the phone or even get out from behind their desks and come and see your face in the clinic. (RN2)

The excerpt above observes that managers were seen to be no longer physically present in clinical practice, as they had been historically, instead giving instructions via email. Similarly, in the next excerpts other participants observed that senior managers were seen only at official events, with the inference that they were 'on show' to the public.

The senior manager here you don't see. You get information cascaded via email. If you don't go and look for it you never get to know it. The modern matron I have only seen once on International Nurses' Day. The information only comes so they can say 'they told you so' (RN 5)

The managers are visible at official events. Not on a daily basis (RN 6)

Ineffective management was another common concern, with participants describing the failure of managers to act when informed of concerns, and the perception that managers were aware of clinical areas which had negative cultures, and poor care delivery, but did nothing to change the culture or practice.

Well you raise concerns about the workload, but it's just frustrating when nothing seems to happen to alleviate the concerns (RN1)

There are bad wards in the hospital; we all know which they are. It comes from the ward sisters and the environment never changes. New staff get jobs there, and they either don't stay long, or they conform to the ward culture. I can't understand why it's allowed to continue. (RN 6)

It is common knowledge which the good wards are. You wouldn't apply for a job on those bad wards. Staff apply who don't know how bad they are, or that is the only place with jobs. It is ridiculous that we all know which the bad wards are, but they [the management] don't do anything about them. (RN 5)

The nurses in the study articulated their need for strong management, which could be trusted to effect change when required. Reviewing the excerpts above, participants were visibly outraged and frustrated by the fact that certain clinical areas were known to have poor standards of care, and that this situation was not addressed by managers. Participants compared this to their own professional accountability, where they were held responsible for their own actions and omissions, whilst they could see that others were not.

High workload and low staffing levels

Participants described how their ability to provide high quality care was compromised by external factors such as lack of time and low staffing levels. This presented the nurses with ethical dilemmas, as they witnessed patients' needs being unmet. Participants described being unable to nurse holistically because of time and staffing constraints.

Where they're saving money by not filling vacancies, it's affecting patient care. There's less bodies on the floor, and patients are not getting as many drinks, they're struggling to get round and feed them all, and the care's lacking. It's not that staff are lazy or mean or incompetent, but how are they expected to get round everyone when there's hardly any staff?... when somebody ends up really ill because they haven't been given enough fluids and they're dehydrated, they get a UTI and they're really ill and it's a lack of care that's caused it, I'm not being funny, but you know, no mincing our words these things are avoidable, these things shouldn't happen (RN 1)

The participants described how the wider issue of cost saving had an impact on an individual level and lead to patient care being compromised. The effects of inadequate staffing and high workload were observed in the above excerpt as being the consequence of financial cuts to staffing budgets. The next participant described the anguish she felt at having to rush through community visits because of high workload demands.

When you visit patients, you don't want to see the other little things as you don't have the time to and you're feeling bad about it because you know the commitments you have and you don't just have that extra few minutes... You know that you are under pressure or the teams are under pressure you are kind of short-changing them [the patients] I think on the communication front. (RN 2)

The participant was distressed at having to compromise her own ideals to meet the demands of the organisation. As described in previous excerpts, the wider issue of cost-cutting, and reduced staffing levels resulted in staff not having enough time to carry out patient centred care. Whilst care standards were negatively impacted, nurse's wellbeing, morale and stress

levels were equally affected. Below, this theme continues, as one participant described the impact of working long shifts on nurses' health, wellbeing and decision-making.

It shouldn't be allowed that nurses work 12-14-hour shifts. I wouldn't want a nurse looking after me after she had worked 12½ hours. You can't recognise how tired you are. After 12 hours and you hadn't eaten, just some biscuits off the trolley. But I would be to blame for not delegating properly (RN6)

The ethical dilemmas which the participants experienced were accompanied by anger and distress, as they recounted patient needs not being met, and how being compromised jeopardised their own professional accountability or that of their colleagues. All the participants described their own nursing ideals as being non-negotiable, and the fact that they were being compromised by workload demands caused some to want to leave the profession.

Coping strategies

Participants reflected on the complexity of their roles and the daily competing pressures. When faced with environmental challenges, participants found ways to navigate these issues, striving to deliver effective care. This can be observed when participants talked about collegiality, which was seen as a central element in their ability to cope with these daily tensions. In the following excerpt one participant described the deteriorating levels of staffing, and how this wider issue had impacted on patient care, and ultimately staff retention. She observed how peer support had become a crucial element in preventing further decline in numbers of staff.

I think certainly in the last five years staffing has got worse... I've seen how hard they work and how much pressure they are under and the extra hours that they put in that probably isn't paid or given back in time. If the staff didn't look after each other, there wouldn't be anyone left. I know staff look for other jobs because it's just relentless, the pressure. (RN 2)

All participants described how they had experienced various forms of bullying. For some this was a social norm, which was part becoming a nurse. Colleague support was often the sole mechanism which enabled individuals to deal with such incivility, as there was little support from managers.

I've gone quite a long way in my career, and I've worked with some good people who've helped me along the way...When I was bullied it was just horrible, and it was the others who supported me. (RN 1)

From a broader perspective, the participant referred to the fact that it was the support of other staff which gave her the personal strength to cope with being bullied. The next participant observed how bullying was *part of the course*, in nursing, at a time when nursing students were taught by fear and humiliation.

Back then we all felt bullied but it was just part of the course you know. You were not singled out and you know the ward sisters, not all of them, but you know there were a few characters and a few staff nurses as well where they would make your life hell. They weren't shy about yelling at you in front of the whole ward (RN 2)

The next participant, who was a newly qualified nurse, spoke about the impact of one senior manager on her career, and the positive effect of having a role model in nursing:

I think she was a really good role model, certainly to me. She made time to listen and seemed to know about everyone, you know things that were going on with them. I think that's important. I think when she went everyone just went back to relying on each other (RN 7)

The influential nature of managers was also reflected in the next excerpt, where one participant described how changes in leadership negatively influenced the practice environment, causing colleagues to leave:

They have brought in two new managers and neither has worked in that area before. The clinical lead just sits in an office, and the new sister has only been qualified a couple of years. Neither of them understands the unit or the staff. They have brought in new rotas which people are struggling with. They don't listen, and good staff leave. Everyone has withdrawn their goodwill now. Others will leave, it's a shame. (RN 3)

The contrasting concepts of incivility and collegiality were central themes for all participants, and the golden thread which ran through each participant's story was the strength that each person gained through peer support. All participants had developed different ways of navigating the challenging demands of the practice environment, but all relied on colleagues to tackle adversity.

5. Discussion

This study focussed on nurses' experiences and perceptions of professional accountability within the context of the clinical practice environment. Professional accountability was influenced by environmental factors such as culture, inadequate managerial support, high workloads and organisational cost-cutting, which had negative consequences for patient care. Fear, blame, bullying, and poor staffing levels were issues which were prevalent across the dataset and had a detrimental impact on the nurses in this study. Findings showed that the participants felt powerless to change these issues, and constantly looked towards managers to address these problems. This behaviour could be linked to feelings of being unvalued, and their sense of isolation from any decision-making process, which was also visible. Roberts et al (2009) observes that nurses are an oppressed group, who share low self-esteem and negative behaviours, resulting in oppressed group behaviours, which can be linked to fears of speaking out, and challenging the system.

It was apparent in all participants texts, that bullying was a phenomenon that they had all experienced, often viewing it as a normal part of nursing practice or a rite of passage. This observation is reflected in the literature, with students perceiving harassment and bullying as being 'part of the job' (Birks et al, 2017:19). Indeed, Cooper and Curzio (2012) assert that bullying has become ingrained within the nursing profession, with the perpetrators widely recognised as being other nurses or healthcare professionals. Bullying is publicly acknowledged, and visible (Adams and Maykut, 2015). It has become part of the professional socialisation process, whereby students are potentially socialised to have a tolerance towards it, which perpetuates its survival (Hutchinson (2013). Oppression theory is prominent in research around the causes of bullying, with Croft and Cash (2012) suggesting that nurses perceived lack of power and autonomy leads to anger and fear which manifests in bullying behaviours.

Participants in this study appeared detached and disempowered from decision making, and involvement in clinical management, perceiving leadership to be the responsibility of senior staff. This finding was consistent in all participant texts, regardless of their length of experience in nursing. This has implications for the nursing profession, as research recognises the consequential nature of leadership on patient care (Bianchi et al, 2018) and the need to make leadership everyone's business (Salvage and White, 2019). Certainly, the need to improve

the standards of leadership has become a global concern, leading to calls to better equip undergraduate nurses (WHO, 2016) making leadership theory and competence an integral part of pre-registration education (Scammell et al, 2020)

Participants described clinical managers as remote, inaccessible and unconcerned with the stresses experienced by frontline staff. This lack of support appeared to have a huge impact on their emotional health and wellbeing. It was observed that communication by managers occurred through email, as oppose to face to face, compounding feelings of being unvalued, and fostering the impression of being isolated from decision making. Nursing and Healthcare management literature have previously noted that managers often ignore staff concerns (Jones, 2016) or exercise avoidance strategies, which then make staff more reluctant to raise concerns (Attree, 2007). Blenkinsopp and Snowden (2016) suggest that when managers respond to concerns with hostility, or avoidance, a culture of silence can manifest itself. Positive practice environments, which support learning and professional development have beneficial consequences on patient care and mortality rates (Aiken et al, 2008) whilst also improving nurse retention (Twigg and McCullough, 2014; Clarke and Aiken, 2008). Findings from this study mirror existing literature showing that retention and job satisfaction in RN's require a supportive and visible management system (Naude and McCabe, 2005) involving staff in organisational decision making (Chan and Lai, 2010). Management and leadership are integral factors in the delivery of safe healthcare. Indeed, a study by Hahtela et al (2014) found nurses absentee rate, occupational injuries, overtime and staff retention were related to negative styles of management while, Schreuder et al. (2011) also found that managers' leadership styles in nursing were related to staff sickness rates.

Participants in this study expressed a need for strong governance in healthcare, which was required to establish a safe environment through staff engagement and effective management. Denis (2014) asserts that whilst clinical governance has the intention of standardising clinical practice, and clarifying accountability, the ethos of learning from mistakes is hampered by the risk of control and sanctions. Certainly, there is arguably a need to redress the balance of accountability, in favour of organisations being called to 'give account' and therefore provide adequate resources (Pollitt, 1990:151) Taylor (2016a:20) argues that shared governance may provide a more effective alternative, through 'collective ownership', creating partnerships based on equality (Hess and Swihart, 2013) and leading to increased patient safety and greater staff retention (Kutney-Lee et al, 2016).

6. Conclusion

From the context of professional accountability, this study reflected on the complexity of the nurse's role and the competing pressures that individuals faced daily which often compromised their professional ideals. Participants spoke of their experiences of negative practice environments, which operated through a culture of blame, and were not conducive to learning, development or civility. In order to support, and therefore retain staff, a supportive system of management which values staff, and provides adequate resources and effective operational systems is required. There is a need to view leadership as a collective responsibility, which empowers staff to positively change the practice environment. Leadership theory should be introduced early into pre-registration programmes, allowing it to become embedded in practice and impact evolving culture. However, this study acknowledges that changes to the culture of nursing must primarily come from within the profession and be instilled within the socialisation process, building upon the current good cultural practices that do exist in nursing.

Relevance to Clinical practice

- Professional accountability is being compromised by limited resources in the UK NHS. Organisations should be held accountable for these shortfalls by the NMC nursing regulator and central government.
- Changes in culture and education need to reflect that leadership is a shared responsibility. For example, by embedding leadership theory into practice through pre-registration education.
- Professional accountability is reliant on effective managerial support, to create an environment which values staff, professional development and an open culture

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Figure 1

Interview guide

A brief description of the research project will be given to the participant and a chance to ask any questions.

- Warm up questions
- 'Can you tell me about your nursing career, the highs and the lows'

Prompts/probes

- Training
- Professional development
- Personal experiences
- Changes in nursing
 - Broad theme: Culture

Prompts/probes

- Environment
- Morale
- Communication process
- Management structure
- Staff retention
- Workload
- Resources
- Personal feelings
- Work day experiences
- Gender
 - Broad theme: Practice environment

Prompts/probes

- Staffing levels
- Resource allocation
- Management structure
- Change in attitudes
- Whistleblowing policy
 - Broad theme: Accountability

Prompts/probes

- Personal, professional, organisational accountability
 - Broad theme: Experience of professional regulation (NMC)
 - Broad theme: Experience of nursing
 - Is there anything else that you would like to tell me?
 - Is there anything you would like to ask about the interview?

Figure 2

Verbatim extract	First interpretation	Early theme	Final theme
<i>We were frightened of the ward sister. We were frightened of being late; we were frightened of having a hair fall out of place; we were frightened and had a fear of things "that shouldn't be", like if the bed cradles were under the bed or on the floor</i>	Experiences of pre-registration training	Fear	Negative culture of the practice environment
<i>It is common knowledge which the good wards are. You wouldn't apply for a job on those bad wards. Staff apply who don't know how bad they are, or that is the only place with jobs.</i>	Poor governance	Raising concerns/ concerns not being addressed	Poor management
<i>I've gone quite a long way in my career, and I've worked with some good people who've helped me along the way.. ...When I was bullied it was just horrible, and it was the others who supported me.</i>	Bullying	Bullying/Collegiality	Coping strategies