An exploration of the socialisation of student mental health nurses in compassionate mental health nursing practice: A constructivist enquiry.

Joanne Sharpe

Faculty of Health and Life Sciences

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‘To the best of my knowledge I confirm that the work in this thesis is my original work undertaken for the degree of PhD in the Faculty of Health and Life Sciences, De Montfort University. I confirm that no material of this thesis has been submitted for any other degree or qualification at any other university.

Thesis Abstract:

This study aimed to develop in-depth understanding of the specific factors in practice placements that influenced student mental health nurse socialisation in compassionate practice.

As per the underpinning constructivist research paradigm and case study methodology, multiple sources of data were accessed through two phases of data collection. Phase one, utilised student mental health nurse focus groups. Phase two of the study; a single site case study of an area recommended by student nurses as facilitating their socialisation in compassionate mental health nursing practice, utilised triangulation of placement observations and semi-structured individual interviews with students, and case study site team staff during case study site access. A grounded theory approach to data analysis was implemented to enhance the robust analysis of data gathered.

Findings from phase one focus groups, presents two overarching themes uncovered in the data: *"All in this together"* and "Everyone for themselves*". "All in this together"* contains eight themes of student experiences in practice placements that supported student socialisation in compassionate nursing practice. The experiences resulted in students undergoing an opening up to compassion, in which they were able to internalise the value of engagement in compassionate practice as a giver of compassion. Students experienced a journey of socialisation in compassion from a recipient to a giver. The journey was underpinned by a sense of having permission to engage in compassionate practice. The eight themes explored under "Everyone for themselves" were the antithesis of the themes of *"All in this together".* The experiences of "Everyone for themselves" resulted in students undergoing a closing down to both the desire to be compassionate, and the scope for them to engage in compassionate practice. Students became introspective and abandoned their compassionate ideals to focus on self-protection and self-preservation.

Findings from the phase two case study, present the characteristics of the case and explores the factors that facilitated student socialisation in compassionate mental health nursing

practice. These were captured in the overarching themes *"That's what makes it such an amazing placement"* and *"It makes us what we are*". These themes identified specific factors present that supported the creation and sustainment of the team's ability to positively socialise students in compassionate mental health nursing practice.

Key findings are discussed in relation to A New Grounded Theory of Student Nurse Socialisation in Compassionate Practice (Curtis, 2015) and The Senses Framework (Nolan et al, 2006; Brown, 2005). The impact of leadership on a practice teams' ability to sustain the factors required to positively socialise students in compassionate mental health nursing practice is also discussed. Recommendations are made for practice, education, policy and research to support our student nurses of today to become compassionate mental health nurses of tomorrow.

“Compassion is the radicalism of our time”

Dalai Lama XIV

Dedication:

Eric Gerald Bird

(1948 – 1996)

Compassionate, embarrassing, so proud of all three of his children.

The man who believed in me and instilled in me the strength to achieve.

My Dad.

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Chapter One: Introduction

1.0: Background and rationale for the study

The term 'compassion' is used extensively in nursing and health literature (Durkin, Usher and Jackson, 2018). The provision of compassionate care is viewed as a fundamental part of nursing ethos (Bradshaw, 2009; von Dietze and Orb, 2000) and forms part of the contemporary nurses' identity (McCaffrey and McConnell, 2015). Evidence suggests that recipients of compassionate nursing care experience higher levels of care satisfaction and better health outcomes (Stone, 2008; Youngson, 2012; 2014; Barron, Deery and Sloan, 2017; Tehranineshat et al, 2019; Pettit et al, 2019). However, over recent years compassionate care in nursing has been under increased scrutiny, in part due to negative publicity over the past decade surrounding a perceived lack of compassion in nursing (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013; Barron, Deery and Sloan, 2017; Bond et al, 2018). The well-publicised Mid-Staffordshire NHS Foundation Trust Inquiry, commonly referred to as 'The Francis Report', identified major failures in care delivery between 2005 and 2009, including that care provided by registered nurses was lacking in compassion. The inquiry identified multiple factors that contributed to the poor standards of care delivery including a negative and unsupportive working culture, which was not conducive to the provision of high-quality compassionate care. There were frequent reports of bullying and consequent low staff morale and experience of burnout (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). At the height of publicity surrounding the inquiry, examples of numerous poor care experiences from multiple care environments across England were also reported by the Patients Association (2011). These reports highlighted that poor-quality nursing care, specifically care lacking in compassion, was not isolated to Mid-Staffordshire but had occurred on a national scale (Patients Association, 2011).

As a result of this negative publicity questions were asked about the quality of nurse education (NHS Future Forum, 2012; Royal College of Nursing (RCN), 2012; Bond et al, 2018). Some critics questioned the decision that all future pre-registration nurse education should be delivered at the minimum academic level of Batchelor's degree (Patients

Association, 2011; NHS Future Forum, 2012; RCN, 2012; Cleary and Horsfall, 2010; Shanta and Eliason, 2014; Bond et al, 2018) and suggested that degree level education was a root cause of the failure of nurses to demonstrate compassion (Patient Association, 2011; NHS Future Forum, 2012). They argued that the focus of nursing degree programmes was in developing intellectual skills at the cost of 'softer skills' such as kindness, empathy and compassion (Patient Association, 2011; NHS Future Forum, 2012). In response to this the Royal College of Nursing (RCN) commissioned 'The Willis commission report' (RCN, 2012), with the aim of identifying the essential features required of nurse education to ensure that nursing graduates were equipped to provide high quality, compassionate nursing care.

The Willis report (RCN, 2012) stipulated that nursing education should aim to produce nurses competent in clinical proficiencies, able to engage in critical thinking and decision making, and demonstrate compassion during nursing activities; identifying that nurses need to be skilled in each of these areas, *"not one or the other"* (Lord Willis, cited in RCN, 2012, pg4). However, the Willis report (RCN, 2012) did not identify any significant shortcomings in nurse education. In fact, the report stated that nurse education could not be held responsible for the perceived decline in the demonstration of compassionate care in nursing (RCN, 2012). Rather, it was suggested that graduate nurses were in fact key in supporting the development of improvements in health care provision, including supporting improvements in the provision of compassionate nursing care (RCN, 2012; Aitkin et al, 2014).

However, the Willis report (RCN, 2012) held a generic view of nurse education and did not consider any specific educational requirement for nurses from the four fields of nursing practice individually: Adult, Child, Learning Disabilities and Mental Health. Moreover, existing research exploring student nurse socialisation in compassionate practice (Curtis, Horton and Smith, 2012; Curtis. 2015) focused exclusively on adult nursing students. Although similarities in experience of socialisation in compassionate practice between the fields of nursing practice may well exist, it could be argued that there are differences in the experiences of mental health and adult nursing students. Differences in systemic challenges, and physical, psychological and emotional demands suggest that factors

underpinning socialisation in compassionate mental health nursing are potentially unique to that field of practice.

Mental health researchers have acknowledged the importance of compassionate interactions in mental health nursing care, in building hope-inspiring relationships that encourage and contribute to service user recovery (Spandler and Stickely, 2011). Mental health service users highly regard nurses who engage with them compassionately, recognising the positive impact that compassionate mental health care has on recovery (Hogan et al, 2020). This highlights the need for mental health care services and mental health nursing educationalists to develop and nurture contexts that cultivate compassionate interactions and interventions (Spandler and Stickley, 2011). However, there is a dearth of research focusing on compassion in mental health nursing. Research that does exist mainly focuses on characteristics of compassion, self -compassion and barriers to the engagement in compassion in mental health care contexts. To my knowledge, there is currently no research that explicitly explores the socialisation of mental health nursing students in compassionate mental health nursing practice.

Previous research that has been conducted on the socialisation of nursing students has identified two environments of learning; learning that occurs in the classroom and learning that occurs in clinical practice (Melia, 1987). It is still the case in the UK that 50% of nursing education occurs within clinical practice settings and 50% occurs within the academic setting; therefore, both aspects could have a profound impact upon student mental health nurse socialisation in compassionate practice.

Research focused on adult student nurses suggested that practice experiences had a negative impact on student nurses' caring behaviours, which were shown by some to diminish near the end of the nursing programme (Mackintosh, 2006; Murphy et al, 2009; Brown et al, 2008). This particularly occurred where students experienced poor standards of care and negative attitudes towards patients (Brown et al, 2008). It has been recognised that the quality of practice experience can be influenced by a range of factors, such as the nurse as an individual, the environment in which nursing care takes place, and leadership in

practice (O'Driscoll et al, 2010). Other characteristics such as cultural influences of clinical placement environments, societal influences, age, level of maturity and cultural and spiritual aspects of an individual's life, have also been shown to influence exposure, understanding and personal and professional experience and perception of compassion (Sarason, 1995).

1.1: Impetus of the study

A constructivist approach was adopted for this study[1]. Constructivism is consistent with both my own personal values and beliefs. It is also consistent with the values of mental health nursing, in which aiming to develop understanding of individual experience and reality, and consideration of the impact of external social influences, is viewed as paramount for holistic care (Michie and Abraham, 2004; Clarke and Walsh, 2009). Within constructivism it is recognised that the experiences and values of the researcher influence data collection and data analysis (Wahyuni, 2012). Dodgson (2019) identifies that due to the impact of this on the research conducted, the researcher needs to provide transparency and clarity regarding their positionality to the study. This links in with the concept of reflexivity, in which the researcher is required to examine their own beliefs, assumptions, judgements and experiences, and consciously explore how these may influence the research conducted (Finlay, 1998). Reflexivity requires the researcher to be open about these elements due to the researcher being recognised as an integral part of the research process (Finlay, 1998). A reflexive approach was embraced throughout this study, and as such this section explores the personal aspects that relate to the impetus for the study, to support clarity of my position as a researcher.

I commenced my journey as a student mental health nurse at the age of 18. I had never considered nursing as a career until I was 17 years old and I was studying A-levels in Theatre Studies and English Literature. It was through my studies at this time that I was introduced to two plays (Mary Barnes by David Edgar and After Easter by Anne Devlin) which explored the experiences of characters with significant mental illness (psychosis). These ignited an interest in mental illness, specifically psychosis, which has remained with me throughout the

[1] In-depth rationale for this approach is provided in Section 3.3: Paradigm, pg74,

rest of my adulthood. At around the same time as being introduced to the plays, I was also experiencing difficulties with my own wellbeing due to the death of my father the year before. I recognised the isolation and loneliness that affected some people and this, in combination with the empathy I developed for those with psychosis through reading the plays and learning more about the experiences of psychosis, resulted in the desire to do more to help people with serious mental health illnesses. This was the beginning of my journey as a mental health nurse. As both a student mental health nurse and a nursing registrant, I have had exposure to a variety of different mental health care settings including: acute adult inpatient services, community mental health services, older persons services, rehabilitation services, forensic services, perinatal services, assertive outreach services and early intervention in psychosis services. I have had the privilege of working with people from diverse backgrounds with unique life experiences, and have also experienced diverse mental health care delivery. I have witnessed service users flourish in their recovery journey when they have experienced compassion-enriched care. I can recall many examples of compassionate nursing care with ease; for example, the nurses who worked as a team to comfort, reassure and hold the hand of a patient with needle phobia while he received his fortnightly intramuscular injection, despite the same patient often being frequently violent and aggressive towards those nurses. Likewise, I have witnessed service user distress, suffering and vulnerability exacerbated when compassionate care has been lacking and unfortunately, I am also able to recall witnessing experiences where staff have not engaged in compassionate care. Examples of care lacking in compassion that stand out to me upon reflection include staff blaming service users for presentation of challenging behaviours, and demonstrating disinterest and being rude to towards service users.

I have had the experience of working with some mental health professionals who successfully engaged in compassionate mental health care and also those that appeared entirely void of compassion for those with mental health illness. Furthermore, I have witnessed a ‘shift’ in some staff who have previously appeared to be compassionate but who at a later date, have appeared to be lacking or void of compassion towards service users. This has led me to speculate about the factors that create this apparent change in engagement with compassionate mental health nursing care. However, due to my

experiences and what I have witnessed, I hold the personal belief that the majority of individuals who enter the mental health nursing profession do so with intentions of engaging compassionately and positively helping service users in their recovery journey. I also believe there are factors within the working environment which can either enhance or hinder engagement in compassionate care mental health nursing care.

When working in the practice context, I was also a student mentor. I thoroughly enjoyed this role and gained great satisfaction from supporting students to develop into compassionate mental health nurses. However, it became apparent that some students demonstrated early signs of compassion fatigue/compassion cynicism, which impacted their ability to engage in compassionate care. I felt limited in helping students to overcome this in my role as a mentor but recognised the importance of positively influencing as many students as possible, so they could engage in future compassionate practice. It was the opportunity of being able to reach more students that resulted in my journey as a nurse educator.

Within my professional life (both in clinical practice and in education), I have always strived to engage in compassionate mental health nursing care and support students, practice staff and academic staff to enact their compassionate ideals. I always aim to embrace diversity and equality. I actively look for "the good" in those that I work with, and recognise that this is something that I was encouraged to do as a child by my parents at times when I identified I did not like others. Indeed, some colleagues have commented on my ability to see "the diamond in the rough". In my professional life, this helps me to recognise individual strengths and accept others despite differences that could otherwise create a barrier to compassionate interactions. In turn, this has positively impacted collaborative working, and empowerment of service users and students alike. A further personal quality that has transitioned in to my professional career is having the courage to 'stand up' for those whom I perceive as experiencing vulnerability and this is something that has inspired much of the compassionate care that I have engaged in. I am able to acknowledge that this comes from having a close family member who has been bullied and ill-treated by others due to their experience of Autistic Spectrum Disorder and feeling the need to 'stand-up' for them

through both my formative and adult years. However, I recognise that this is not always easy. I recall an incident in practice in which two junior nurses were professionally threatened by a manager. Witnessing their distress and vulnerability evoked the feeling that I had a duty to stand up for them. This resulted in the manager diverting the negative attention towards me. I therefore recognise that engaging in compassionate actions may result in negative consequences and that to be truly compassionate, it often requires courage and sacrifice.

Reflecting on my personal experiences as both a mental health nurse and nursing academic, I recognised that although I aim to be consistently compassionate there have been occasions throughout my career in which my capacity for compassion has been diminished. This has been especially apparent in situations where I have felt threatened (by staff, students or service users) or unsupported (by colleagues or the organisation). I recognised that in these situations, my compassion towards others became impaired, despite the struggles they may have been experiencing themselves.

In combination, all of my previous experience has ignited my interest in socialisation in compassionate mental health nursing practice and the factors that underpin individual capacity to engage in compassionate care. I have been able to draw on a rich professional career and professional knowledge and experiences in developing and conducting this study.

A key driver for this study was the hope that findings and ultimate recommendations would support positive student socialisation in compassionate practice. My hope is this will contribute to our nurses of the future having the capacity and ability to engage in compassion enriched mental health nursing care, and therefore improve the care of mental health service users.

1.2: Research aims and objectives

Recognition of the importance of supporting compassionate environments and relationships in mental health care contexts (Spandler and Stickely, 2011), combined with the dearth of

research that explicitly considers the experience of socialisation in compassionate nursing practice for mental health nursing students and my professional experiences, were the motivations for this study. As such, this study investigated factors that influenced undergraduate mental health nursing student socialisation in compassionate practice.

The original aim of the study was to develop understanding of the whole praxis of factors that facilitated and supported engagement in compassionate practice, including personal, theoretical and practice exposures. However, as the study progressed, the focus of the research questions and aims were amended due to student participant responses. Indeed, student participants experienced difficulties in articulating how their personal and theoretical exposures impacted socialisation in compassionate practice. Furthermore, some participants felt very strongly that theoretical exposure had no bearing on their socialisation in compassionate practice. In contrast, participants recognised the impact of practice experiences and were able to draw upon many of these to discuss socialisation in compassionate mental health nursing practice. Therefore, as consistent with a constructivist approach (Charmaz, 2014) and being led by the data, the research questions, aims and objectives were amended.

The aims of this study were to answer the following research questions:

- What are the experiences of compassion for student mental health nurses?

- What are the factors in practice placements that influence student mental health nurses in their development as compassionate mental health nurse practitioners?

And;

- How can placement providers facilitate positive socialisation in compassionate mental health nursing practice for mental health nursing students?

In order to answer these questions, clear objectives were developed. The study aims and objectives are detailed in table 1.1 below.

Table 1.1: Study aims and objectives

Study aim:	Objective:
To answer the research question of: *What are the experiences of compassion for student mental health nurses?*	Student mental health nurse participant focus groups with students from years 1, 2 and 3 of a nursing programme used to: • develop an understanding of the experiences, opinions and perceptions of student mental health nurses of factors that influence their socialisation in compassionate mental health nursing practice • develop in-depth understanding of the ways in which student nurses are socialised in compassionate mental health practice • develop in-depth understanding of the way in which student socialisation in compassionate practice is inhibited Student experiences of positive and negative impact of placement experiences on socialisation in compassionate practice explored. Case study of a single case study site nominated by focus group participants as a placement that has supported positive socialisation in compassionate practice. Case study methods of individual interviews and observations utilised to identify additional factors that influence student socialisation in compassionate mental health nursing practice: • develop deeper understanding of the ways in which student nurses are positively socialised in compassionate mental health practice in compassion enriched practice placements
To answer the research question of: *What are the factors in practice placements that influence student mental health nurses in their development as compassionate mental health nurse practitioners?*	
To answer the research question of: *How can placement providers facilitate positive socialisation in compassionate mental health nursing practice for mental health nursing students?*	Case study of a single case study site nominated by focus group participants as a placement that has supported positive socialisation in compassionate practice. Case study methods of individual interviews and observations utilised to explore the factors present in placement area that create and sustain the teams' ability to positively socialised students in compassionate mental health nursing practice: • develop in-depth understanding of the factors that support the development and sustainment of practice areas as compassion enriched learning environments.

1.3: Outline of the thesis

This qualitative constructivist study explored the complex process of student mental health nurse socialisation in compassionate mental health nursing practices. The settings for the study were a Higher Education Institution (HEI) and a mental health care community team, where student mental health nurses had accessed practice placements to develop their practical mental health nursing skills and knowledge.

Findings from phase one focus groups suggest that students were exposed to a range of placements during their programme of education and these placement experiences had a

direct impact upon their socialisation in compassionate practice. When students were exposed to environments that fostered socialisation in compassionate practice, they engaged in a journey in which they experienced compassion as a recipient, and therefore developed the skills and knowledge to be a giver of compassion. However, when students were exposed to negative practice experiences, they went through a retrogress journey of compassion, in which compassionate ideals were abandoned in favour of acts of self-protection. At the furthest extreme, students reported mirroring negative practice staff attitudes and behaviours in an attempt to feel included and accepted. For some, this resulted in internalisation of these negative practices as the norm of mental health nursing, leading to the replication of care lacking in compassion and perpetuation of a cycle of care absent of compassion. Findings from Phase two, the case study identified the elements that underpinned the case study teams' ability to create and sustain the conditions required to support socialisation in compassionate practice, and these are also presented.

The thesis suggests that student socialisation in compassionate mental health nursing practice was influenced and affected by student exposure to compassion enriched care environments. These environments were underpinned by practice staffs' ability and willingness to engage in compassionate relationships with service users, co-workers and students. Compassion impoverished care environments were underpinned by negative relationships which acted as a barrier to student nurse socialisation in compassionate practice. Compassionate leadership was identified as fundamental in creating and sustaining the conditions required for students to experience positive socialisation in compassionate nursing practice. Where compassionate leadership was present, practice staff experienced enhanced feelings of safety, significance and compassionate purpose. This provided a solid foundation which not only supported practice staffs' continual socialisation in compassionate practice, but also enabled them to facilitate socialisation in compassionate practice for students.

The anticipated key audiences for this thesis include nursing educationalists, student mental health nurse practice educators (supervisors and assessors), front-line mental health service

workers, leaders and managers, and professional bodies who influence standards of nursing education.

The overall structure of this thesis is as follows: Chapter Two presents a narrative literature review. The aim of this chapter was to deepen knowledge relating to the meaning, origins and scope of compassion in contemporary nursing, and provide greater understanding of the issues that influence student nurse socialisation in compassionate practice. Chapter Three is a discussion of the methodological philosophy and decisions underpinning the thesis. The choice of methods utilised for data collection are described and rationale provided to support the developed research design. The findings have been separated into two chapters. The first (Chapter Four) explores findings from student focus groups and Chapter Five presents' findings from a practice case study. Chapter Six engages in discussion of the findings and is followed by Chapter Seven which provides a conclusion to the study and in which recommendations are made for nursing education, practice, policy and research.

1.3.1: Brief summary of chapters

Chapter One presents background and rationale for the study, identifying key issues including negative reports of nursing care over recent years, resulting in increased scrutiny surrounding a lack of engagement with compassionate care within the nursing profession. An outline of the thesis as a qualitative, constructivist study is provided and research questions underpinning the study are identified. A brief summary of findings and outcomes of the thesis is provided and impetus for the study is presented.

Chapter Two explores the findings of a narrative literature review of key research focused upon compassion and mental health nursing. The purpose of the literature review was to:

i. Explore what is currently known regarding the origins of compassion
ii. Critically analyse what is currently known about the scope of compassion in contemporary nursing practice
iii. Identify a definition of compassion in nursing for the purpose of this study

iv. Critically analyse what is known about student nurse socialisation in contemporary compassionate practice.

Chapter Three outlines the philosophical underpinning of the study, exploring the constructivist methodology utilised within the study and rationale for the selected research paradigm. Discussion surrounding the ontological, epistemological and axiological position of the research is presented. The rationale for the methods utilised (namely student focus groups and a case study of a student mental health nurse placement area), and participant recruitment strategies are discussed. Ethical issues that have been considered throughout the research process are also presented. The rationale for utilising a grounded theory approach to data analysis, drawing upon the writings of Stake (1995, 2006) and Charmaz (2000, 2006) is also discussed, and data analysis methods utilised are described and explored. Evidence that the study meets quality assurance standards is also presented.

Chapter Four presents the findings from student mental health nurse focus groups, in which students from years 1, 2 and 3 of a mental health nursing programme participated in year specific focus groups. The aim of the focus groups was to develop understanding of the experiences and perceptions of student mental health nurses regarding their socialisation in compassionate practice. Grounded theory generated by Curtis (2015) was utilised as a sensitising framework to categorise data obtained from student focus groups. The original intention of the research was to explore personal, theoretical and practice exposures that influenced student socialisation in compassionate practice. However as consistent with the constructivist approach, data collected was prioritised over the initial research assumptions, and the attention of the study was amended to focus on the impact of practice experiences on student socialisation in compassionate mental health nursing practice. Findings include examination of two overarching themes – "*All in this together"* and *"Everyone for themselves"*. Themes were identified in each overarching theme and the factors that both foster and inhibit socialisation in compassionate mental health nursing practice are presented.

Chapter Five presents the findings from a single-site case study, which was recommended by student participants in phase one focus groups as assisting their socialisation in compassionate mental health nursing practices. The overall aim of the chapter was to develop deeper understanding of the ways in which student nurses were socialised in compassionate mental health practice. Furthermore, the factors that created and sustained the clinical team's ability to assist in the positive socialisation of student socialisation are examined. Theoretical understanding of the key conditions required in the practice context to nurture socialisation in compassionate mental health nursing practice were explored.

Chapter Six begins by identifying the strengths and limitations of the study against the amended authenticity criteria (Nolan et al, 2003). This is followed by discussion of significant themes identified in the findings. Key findings of the study are discussed against the New Grounded Theory of Student Nurse Socialisation in Compassionate Practice (Curtis, 2015). The Senses Framework (Nolan et al, 2006; Brown 2005) is utilised as a theoretical framework by which to increase understanding of the findings of the study. The impact of leadership on a practice teams' ability to sustain the factors required to support socialisation in compassionate mental health nursing practice is discussed. Furthermore, a definition of compassion as relevant to mental health nursing is provided and finally, the study contribution to theory is presented.

Chapter Seven concludes the study. The extent to which the research questions have been answered is considered. Recommendations are made for practice partners, Approved Educational Institutions (AEI's) and policy makers. Finally, a personal reflection on the research process is provided[2].

[2] Please note at the time of data collection, students were educated under the Nursing and Midwifery Council (NMC, 2010) Educational standards. As such, participants referred to "Mentors" during data collection and this language is reflected in the thesis. However, it is acknowledged that current students are educated under the NMC (2018) Standards which utilises different terminology (Practice Supervisors/Assessor).

Chapter Two: Literature Review

2.0: Literature Review Introduction

This chapter explores the existing literature relating to the meaning, origins and scope of compassion in a nursing context and what is known about student nurse socialisation in compassionate nursing practice. The literature review provided a platform to evaluate and summarise existing literature (Aveyard, 2007) to contextualise this study in the existing knowledge (Gibbs, 2008; Creswell, 2012). An inductive research approach was adopted. Guidance from available literature and existing theories were utilised to assist in developing insights into compassion and the experience of socialisation in compassionate nursing practice. This approach facilitated the aim of locating existing knowledge, explanations and concepts from available empirical data (Gill and Johnson, 2010), which guided future phases of the research process.

2.0.1: The aims of the chapter

The aim of this study was to answer three research questions:

- What are the experiences of compassion for student mental health nurses?
- What are the factors in practice placements that influence student mental health nurses in their development as compassionate mental health practitioners?
- How can placement providers facilitate positive socialisation in compassionate mental health nursing practice for mental health nursing students?

In order to develop a foundational understanding of the factors that may influence these areas of interest, it was deemed important to develop insights and understanding about the praxis compassion, and to explore what is already known about student nurse socialisation in compassionate nursing practice. Four chapter aims were therefore developed to assist in developing this fundamental knowledge:

i. To explore what is currently known regarding the origins of compassion

ii. To critically analyse what is currently known about the scope of compassion in contemporary nursing practice
iii. To identify a definition of compassion in nursing for the purpose of this study
iv. To critically analyse what is known about student nurse socialisation in contemporary compassionate practice.

2.0.2: The structure of this chapter

Firstly, the rationale for the use of an inductive approach to the literature review is explained[3]. This is followed by an explanation of the methods utilised in the literature review[4], including the search strategy[5], inclusion/exclusion criteria applied to the search[6], study selection process[7] and details regarding the methods employed to evaluate the selected literature[8]. Key themes identified in the review of literature sourced are presented; the meaning of compassion[9], the origins of compassion[10], the scope of compassion in nursing practice[11] and student socialisation in compassionate nursing practice[12]. Finally, a summary of the pertinent findings of the literature review and the application of this to latter phases of this study are presented in the literature review summary[13].

2.0.3: Rationale of approach

It is acknowledged that literature reviews are appropriate when investigating broad and abstract questions (Baumeister and Leary, 1997; Sinclair et al, 2016) or diverse concepts (Sinclair et al, 2016) such as compassion. However, this research was a constructivist study which utilised a grounded theory approach to analyse data. Engaging in a literature review when utilising a grounded theory approach to data analysis is controversial (Ramialho et al, 2015). Indeed, seminal texts (Glaser and Strauss, 1967) discourage grounded theory researchers from engaging with the literature before data analysis. They argue that it risks

[3] See 2.0.3: Rationale of approach – pg30.
[4] See 2.1: Methods – pg33
[5] See 2.1.1: Search Strategy – pg34
[6] See 2.1.2: Inclusion / Exclusion Criteria – pg35
[7] See 2.1.3: Study Selection – pg36
[8] See 2.1.4: Analysis of the literature – pg38
[9] See 2.2.1: The meaning of compassion – pg40
[10] See 2.2.2: The origins of compassion – pg43
[11] See 2.2.3: The scope of compassion in nursing practice – pg51
[12] See 2.3: Student nurse socialisation in compassionate nursing practice – pg60
[13] See 2.4: Literature Review Summary – pg65.

contaminating data collection and subsequent analysis, which can become constrained and unduly influenced by existing theories (Ramialho et al, 2015) and prevent findings from being truly grounded in, and emergent from, the data (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Glaser, 1992; Walls, Parahoo and Fleming, 2010).

However, in alignment with a constructivist axiology[14], it is recognised that the researcher influences the research through their own life and professional experiences (Charmaz, 2014). Indeed, Charmaz (2014 pg239) states that developed constructivist grounded theory, "*depends on the researchers view; it does not and cannot stand outside of it"*. Knowledge acquired through engaging with literature is considered an extension of the researcher's experience (Charmaz, 2014). From this position it might be argued that engagement with an existing body of literature, rather than negatively impacting the emergence of theory, could have a positive influence and guide the researcher to identify developing theory and potential lines of inquiry (Corbin and Strauss, 2015; Strauss and Corbin, 1990; Hickey, 1997; Ramalho et al, 2015). It was however acknowledged that in order to achieve this, the researcher should maintain *"an attitude of scepticism"* towards the literature (Straus and Corbin, 1990, pg5). Indeed, Charmaz (1990) identifies that the groundedness of the theory generated "*results from the researchers' commitment to analyse what they actually observe in the field or in their data"* (Charmaz, 1990, pg1162). The researcher should prioritise data collected over their own assumptions and previously acquired knowledge through engagement with the literature (Charmaz, 1990; Dunne 2011); but rather than disregard existing knowledge, should aim to maintain a critical approach (Thornberg, 2012). Therefore, it was concluded that conducting a literature review before data collection to assist in guiding potential lines of inquiry was appropriate. The decision to engage in a literature review was also a pragmatic one, as both the De Montfort University and NHS ethics committees required a literature review to demonstrate the rationale and importance of the study.

[14]See 3.3: Paradigm – pg74.

Two main types of traditional literature review are identified in research literature: the systematic literature review and the narrative literature review (Aveyard, 2007). For the purpose of this study, a narrative literature review was selected. Onwuegbuzie and Frels (2016) state that narrative literature review is the most common type of literature review utilised, as the method facilitates the uncovering of a broad overview of the topic under exploration, rather than examining a specific research question for which a systematic literature review would be more appropriately utilised.

Onwuegbuzie and Frels (2016) identify four common types of narrative review:

i. General review – which provides an overview of the most critical aspects of contemporary knowledge regarding the topic
ii. Theoretical review – in which the researcher examines how theory has shaped research
iii. Methodological review – provides a description of research designs and methods utilised in studies
iv. Historical review – in which the researcher examines the historical context of the topic.

As previously stated, the purpose of engaging with a narrative literature review was to develop insights into fundamental existing knowledge relating to the meaning, origins and scope of compassion in contemporary nursing practice and student nurse socialisation in compassion, to guide future phases of the research. As such, a methodological literature review was discounted, as it was deemed that the focus on research designs and methods utilised in studies would not increase knowledge relating to the aims of this literature review. The theoretical literature review was also discounted for the scope of this review; although examination of how theory had shaped research relating to compassion in nursing could have added depth to findings, it would not facilitate an overview of the most critical and contemporary aspects of compassion in nursing and may have constrained analysis of data of subsequent phases. Therefore, the general review (as described above) was utilised to meet the aims of the literature review, in combination with a historical literature review to help uncover useful insights into the origins of compassion.

Narrative literature reviews have received some criticism, as typically no information is provided about how the search was conducted, how studies were selected or the criteria used to ascertain validity and trustworthiness of findings (Greenhalgh, 1997; Ayeyard, 2007; Onwuegbuzie and Frels, 2016). To support transparency and demonstrate trustworthiness of the search conducted for this study, the search methods utilised are described in the following section 2.1: Methods.

2.1: Methods

Question and keyword development tools were utilised to develop literature review questions and the search strategy (Table 2.1 and 2.2 below). Such formats are frequently used in nursing and health research (Bettany-Saltikov, 2012) and assist in the identification of key concepts in the research question and appropriate search terms (Schardt, et al, 2007; Bettany-Saltikov, 2012; Hoogendam, Robbe and Overbeke, 2012). Several tools are available including PICO (Population, Intervention, Comparison, Outcome), which is designed for quantitative research and PEO (Population, Exposure, Outcome) which is designed to assist in the development of qualitative research questions and keywords (Bettany-Saltikov, 2012). Due to the nature of the aims of the chapter, the PEO format was applied. Two questions were developed to guide the literature search. These questions were aligned with the aims of this chapter[15], to support the development of foundational knowledge of the factors that may influence student socialisation in compassionate practice through placement experiences. The research questions are specified below:

i. What is known about the meaning, origins and scope of compassion in contemporary nursing practice?
ii. What is known about student mental health nurse/student nurse socialisation in compassionate practice?

[15]See 2.0.1: The aims of the chapter – pg29.

Table 2.1 – PEO question and keyword development for literature search question 1 – "What is known about the meaning, origins and scope of compassion in contemporary nursing practice?" search:

PEO:	Keywords	Alternatives
Population	Nursing	Nurse Nurses Nurs*
Exposure	Compassion	
Outcome	Concept Analysis	Definition

Table 2.2 – PEO question and keyword development for literature search question 2 – "What is known about student mental health nurse / student nurse socialisation in compassionate practice?" search:

PEO:	Keywords	Alternatives
Population	Mental Health Nurses Student*	Psychiatric / psychiatry (Psychiat*) Nurse / Nursing/ Nurs* Students / Undergraduate
Exposure	Compassion	
Outcome	Socialisation	Socialization Learning Teaching

One of the benefits of using PEO is that the researcher is encouraged to use synonyms or related words (alternative keywords) to increase the search parameters (Bettany-Saltikov, 2012). Alternative keywords were generated through consulting a thesaurus and through existing knowledge through preliminary reading. The keywords 'dignity, empathy, caring, humanity and kindness' were initially included as alternative keywords for compassion, as these concepts are inter-related and in some instances an overlap with the concept of compassion was apparent. However, these terms were later excluded from searches due to generating a large amount of literature which was not relevant to the questions posed.

2.1.1: Search Strategy

Two separate literature searches were conducted: one for each of the search questions previously specified. Bibliographical databases were utilised for each search. Databases contain digital publication of references to published literature including journal articles, books, conference and conference papers (Polit and Beck, 2010). Each search was

conducted on nine electronic databases between January and February 2016 and alerts were set on the identified databases to allow access to any relevant articles published after this time. Therefore, relevant articles published to and including December 2020 were also accessed and where appropriate, included. This ensured that emerging concepts could be integrated into the literature review as the research progressed (Urquhart, 2012). Databases selected for the searches were: Academic Search Premier EBSCO, British Nursing Index (BNI (known as BNI at the time of the search, currently named British Nursing Database (BND)), Cochrane Library, Cumulative Index of Nursing and Allied Health Literature (CINAHL) Plus, MEDLINE (Pubmed), PsycINFO, Science Direct, Scopus, and ZETOC. These databases are all relevant to nursing and health care.

Key terms identified in Table 2.1 and Table 2.2 were utilised in various combinations to source relevant literature for review. Appendix 1: Literature search strategy, demonstrates the keyword combinations utilised for each of the two searches. Key word combinations were utilised in each search to ensure that search parameters were wide enough to encompass all relevant literature, and yet specific to the chosen subject in an attempt to avoid the yield of irrelevant information and support the most relevant research being accessed (Im and Chang, 2012). Boolean operators were included to assist in focusing each search. Boolean operators are identified as being especially beneficial when the research topic contains multiple search terms (Jaffe and Cowell, 2014; Smith and Nobel, 2016), as in the case of the searches conducted. The Boolean operators of “AND” and “OR” were utilised in each search to extend and limit the results in combination with the devised keywords (Jaffe and Cowell 2014; Smith and Nobel, 2016). A truncation tool was implemented in each search as a technique to extend the searches to include various word endings and spellings (Jaffe and Cowell, 2014; Smith and Nobel, 2016). The application of this technique is also demonstrated in Appendix 1.

2.1.2: Inclusion/Exclusion criteria

Advanced search strategies were utilised on each electronic database which supported the application of inclusion/exclusion criteria. These criteria detailed below, were applied to each of the searches conducted. Peer reviewed articles, reviews, literature reviews and

reports were selected for inclusion. Grey literature was also included to ensure that relevant government reports and guidance were also accessed. The full text option was selected in each database to ensure that where available, full text was accessed for each reference generated. Literature written in English was included and literature written in any other language was also included; a translation tool was utilised to translate text into English where necessary. Date restrictions were applied from 1990 until 2016, with alerts set for articles meeting search criteria from February 2016 to December 2020. The decision to widen the search to include literature from 1990 was based upon comments in the public domain that suggested deficits in compassion in nursing were caused by the changes made to nurse education (the transfer to Project 2000) in the early 1990's (RCN, 2012; Darbyshire and McKenna, 2013).

2.1.3: Study selection

Flowcharts in this section demonstrate the study selection process for each of the two literature searches conducted and should be viewed in combination with Appendix 1, which specifies the full literature search parameters for each separate search. Figure 2.1 below details the search results that were obtained following this process for the search question:

> *"What is known about the meaning, origins and scope of compassion in contemporary nursing practice?"*

The literature selected to develop understanding about the definition of compassion are listed in Appendix 2: Sources included in phase one literature review.

Figure 2.1: Study selection flowchart for "What is known about the meaning, origins and scope of compassion in contemporary nursing practice?" search:

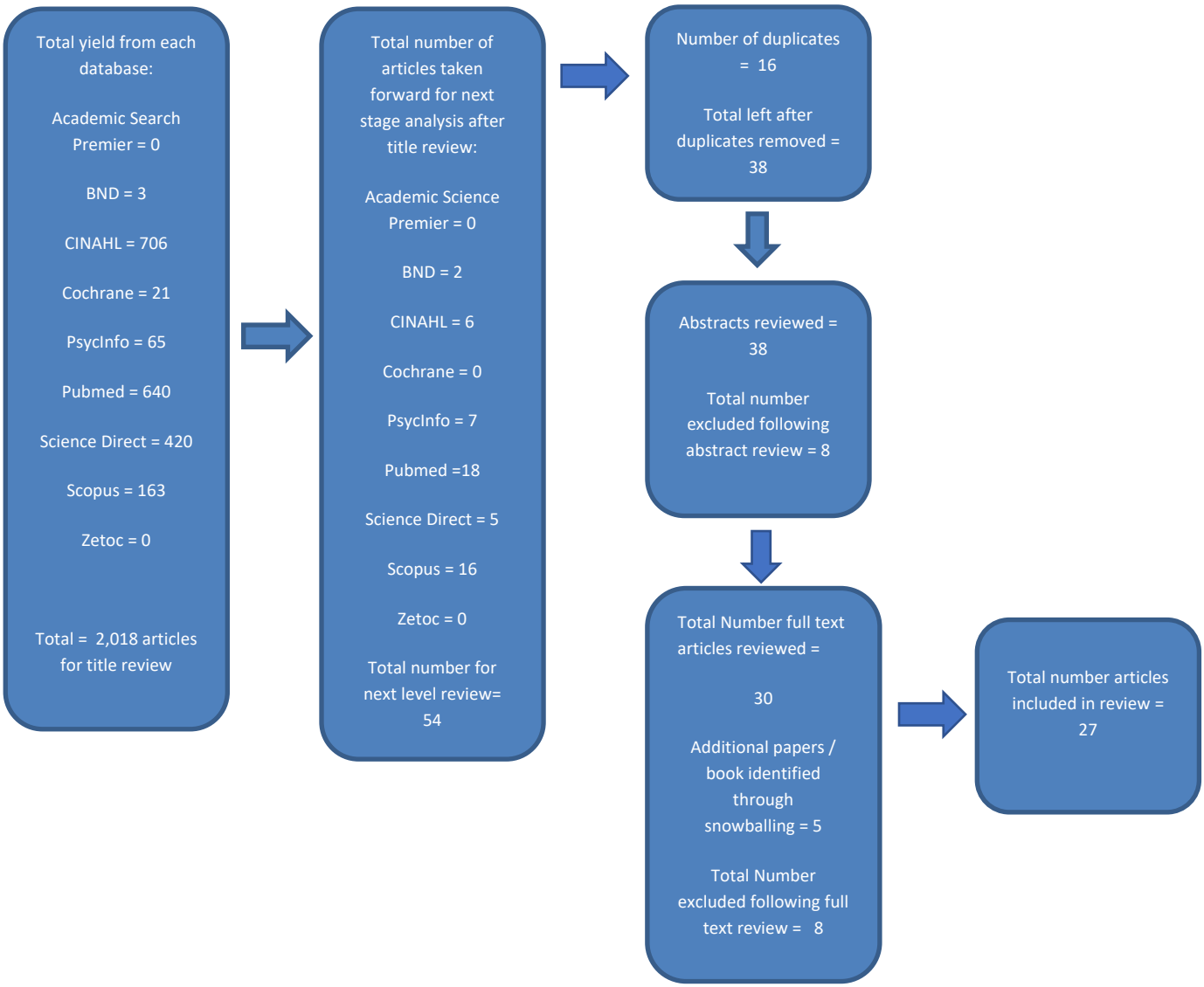
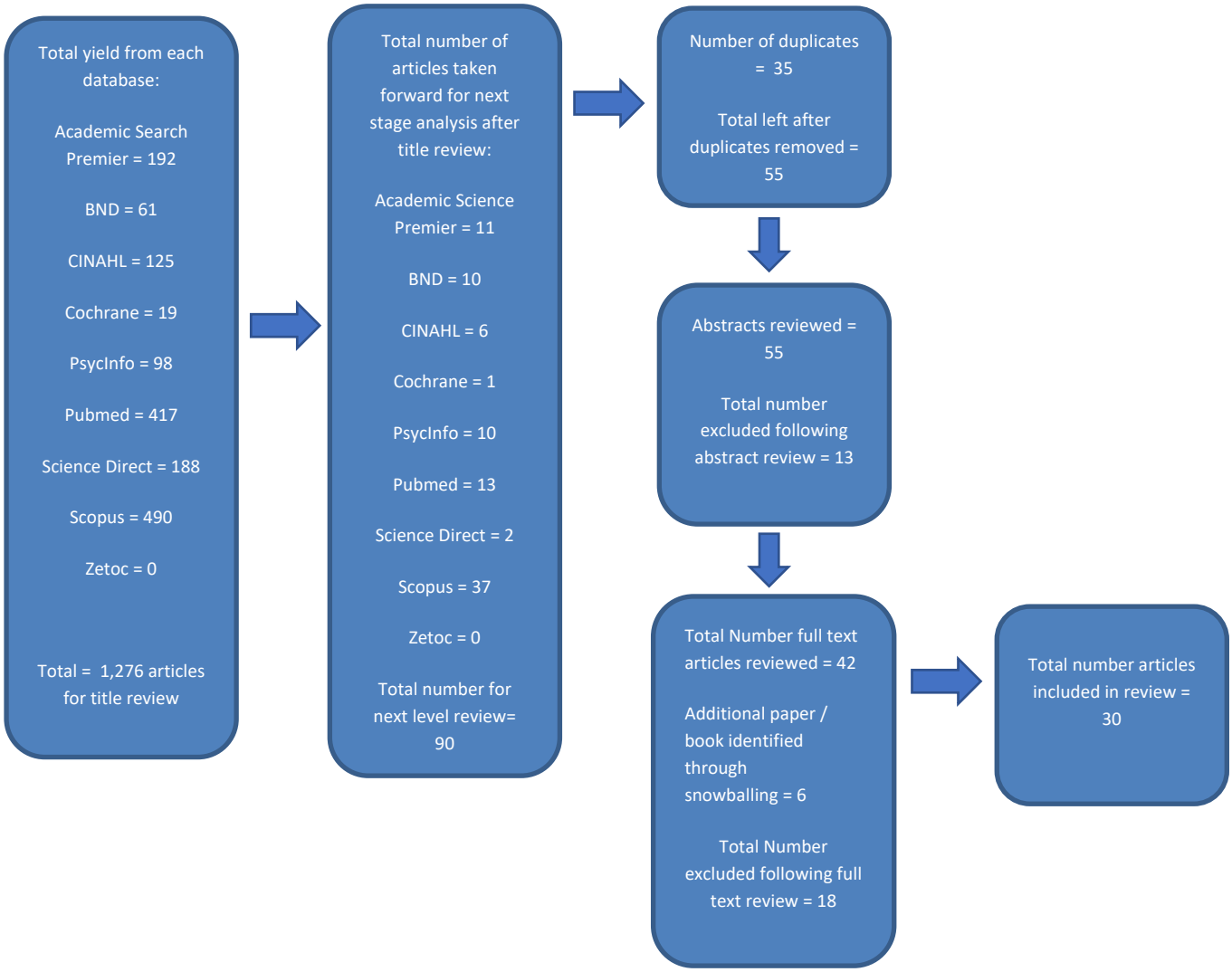


Figure 2.2 below details the search results that were obtained following this process for the search question:

> *"What is known about student mental health nurse/student nurse socialisation in compassionate practice?"*

The articles selected to develop insights into student socialisation in compassion are detailed in Appendix 3: Sources included in phase two literature review.

Figure 2.2: Study selection flowchart for "What is known about student mental health nurse/student nurse socialisation in compassionate practice?" search:



2.1.4: Analysis of the literature

A three-stage iterative approach was taken in the analysis of each piece of literature (source) selected for inclusion in the review. Stage one involved the review of each source and notes made which identified and summarised key themes and debates. These notes were scrutinised in detail to ascertain core dimensions of identified themes and debates in stage two. Finally, comparisons were made between identified themes and debates, and conceptual links and gaps in literature were explored to achieve a level of synthesis.

2.2: Compassion: The meaning, origins and scope in nursing practice

Service users, families, clinicians and policy makers identify compassion as the cornerstone of quality health care (Sinclair et al, 2016). However, it is also recognised that there is tension in the conceptualisation of compassion in health and social care environments, with misconceptions about the definition and delivery of compassionate care evident (Adamson et al, 2011; Dewar, 2011; Dewar et al, 2013; Kneafsey et al, 2015; Bond et al, 2018; Pehlivan and Guner, 2019). Despite a lack of agreed definition of compassion in nursing literature, compassion is cited in many health care policies, reports and recommendations (Schantz, 2007; Durkin, Usher and Jackson, 2018) and there are expectations that nurses should engage in compassionate nursing care (RCN, 2010 in Straughair, 2012b). However, these documents do not assist in the identification of behaviours and values that exemplify compassion. This deficit contributes to the lack of clarity about the scope of compassionate nursing practice at individual, team and health service organisation levels (Dewar et al, 2013). Indeed, it is suggested that a lack of understanding about the meaning, origin and scope of compassion results in confusion, and subsequently a lack of articulation as to what is required to engage in compassionate nursing practice (von Dietz and Orb, 2000; Dewar, 2010 in Dewar, Pullin and Tocheris, 2011, Dewar, 2011). It is further argued that without a shared definition and clarity of meaning and scope of compassion applied to nursing, the concept of compassion will *"remain little more than a rhetorical and political devise which trips easily off the tongue but remains elusive"* (Dewar and Nolan, 2013, pg1248). Moreover, nurses will not be able to fully claim compassion as a fundamental component of professional nursing practice (Olshanksky, 2007, in Straughair, 2012b). As such, a shared definition of compassion applied to nursing is required to provide greater clarity of the scope of compassion in nursing practice (Dewar et al, 2013).

Therefore, the aim of this section of the literature review is to develop greater insight into understanding the meaning, origin/s and scope of compassion in contemporary nursing practice. The original aim of this literature review was to explore definitions specifically in relation to compassionate mental health nursing practice. However, it is of note that out of the 27 sources included in this part of the review, only four (Barron, Deery and Sloan, 2017; Knaak, Mantler and Szeto, 2017; Ring and Lawn, 2019; Gerace, 2020) were specific to

mental health nursing. This demonstrates the paucity of research relating to compassion and mental health nursing. As such, the inclusion criteria were extended to include sources that explored definitions, origins and scope of compassion in all fields of nursing practice.

2.2.1: The meaning of compassion

There is consensus that some of the confusion surrounding the definition of compassion in nursing arises due to overlap with other terms that are implicit with compassion when applied in a nursing context (von Dietz and Orb, 2000; Schantz, 2007; Goetz, Keltner and Simon-Thomas, 2010; Dewar et al 2013; Sinclair et al, 2016, Bond et al, 2018). Such terms, identified below, are often used interchangeably in the literature when discussing compassion which may have created further confusion (Straughair, 2012b). Identified implicit terms include:

- Love (Dewar, 2013; Goetz, Keltner and Simon-Thomas, 2010)
- Empathy (Dewar, 2013; Schantz, 2007; von Dietze and Orb, 2000; Goetz, Keltner and Simon-Thomas, 2010; Straughair, 2012b, Tierney et al, 2017; Bond et al, 2018; Galetz, 2019; Pehlivan and Guner 2019; Gerace, 2020)
- Caring (Schantz, 2007; von Dietze and Orb, 2000; Straughair, 2012b; Galetz, 2019)
- Sympathy (Schantz, 2007; von Dietze and Orb, 2000; Goetz, Keltner and Simon-Thomas, 2010; Straughair, 2012b; Galetz, 2019; Pehlivan and Guner 2019; Gerace, 2020)
- Pity (Goetz, Keltner and Simon-Thomas, 2010)

In addition to the implicit terms identified above, a number of affiliated terms are also recognised:

- Wisdom (Dewar, 2013)
- Humanity (Dewar, 2013)
- Dignity (Dewar, 2013; Bond et al, 2018)
- Commiseration (Schantz, 2007)
- Mercy (Schantz, 2007)
- Clemency (Schantz, 2007)

- Kindness (Goetz, Keltner and Simon-Thomas, 2010)
- Tenderness (Goetz, Keltner and Simon-Thomas, 2010; Schantz, 2007)
- Warmth (Goetz, Keltner and Simon-Thomas, 2010)
- Intelligent kindness (DoH, 2012 cited in Bond et al, 2018)

The interchangeable use of these implicit and affiliated terms may contribute and perpetuate some of the erroneous assumptions that exist relating to the definition of compassion (Schantz, 2007). It can be particularly difficult to distinguish compassion from empathy and sympathy as these concepts, along with pity, are in a *"family of compassion related states"* (Sinclair et al, 201.6, pg2). It is further noted that characteristics of compassion, empathy and sympathy are closely intertwined (Sinclair et al, 2016; Kneafsey et al, 2015) and that compassion is a combination of both empathy (objective understanding of another's situation) and sympathy (subjective responses orientated to the self) (Sinclair et al, 2016). However, there appear to be specific and unique characteristics that separate compassion from other implicit and affiliated terms; namely, the motivations underpinning compassionate actions[16] (Sinclair et al, 2016) and the behaviour generated towards another following the acknowledgement of suffering (Schantz, 2007; Sinclair et al, 2016; Galetz, 2019).

To further understand the unique characteristics of compassion, it may help to consider the etymology of the word compassion. The word compassion originates from the Latin, "compati", meaning "to suffer with" (Schantz, 2007). Acknowledgement of suffering was identified as a key component of compassion in the literature reviewed. Indeed, identification of physical, psychological or social suffering is recognised as a trigger for compassion (Tudor, 2001 in van der Cingel, 2009; Durkin, Usher and Jackson, 2018). Dictionary definitions of compassion (cited by Schantz, 2007; Straughair, 2012b; and McCaffery and McConnell, 2015) all refer to the identification of suffering, coupled with the desire or motivation to relieve the suffering of another. This is further reflected in other definitions given (Chochinov, 2007, cited in Dewar et al, 2013; Goetz, Keltner, Simon-Thomas, 2010; Sinclair et al, 2016; McCaffery and McConnell, 2015; Perez-Bret, Altisent and

[16] See 2.2.2: The origins of compassion – pg43.

Rocafort, 2016; Durkin, Usher and Jackson, 2018; Pehlivan and Guner 2019). Alternative definitions given in the literature are:

- Wanting the best for someone suffering (van der Cingel, 2009)
- Showing love (von Dietz and Orb, 2000)
- Reverence towards another human (von Dietz and Orb, 2000)

None of these definitions identify action as a component of compassion, yet is seems to be the functional component of action that distinguishes compassion from the other associated experiences of empathy and sympathy (von Dietz and Orb, 2000; McCaffery and McConnell, 2015, Galetz, 2019). Some authors state that action in response to compassion results in care that intends to bring comfort to the care recipient (Dewar, 2013).

In addition to an action orientated response to suffering, vulnerability may also be a trigger of compassionate thoughts and actions (Dewar, Pullin and Tocheris, 2011; Snow, 1991 in Dewar et al, 2013). Indeed, Dewar (2013) challenges the perception that compassion is purely a response to witnessing suffering, and suggests that the experience of suffering could be a response to extreme crisis (Dewar, 2013). As such, day to day acts of compassion in a nursing care context in which extreme crisis may not be present are often triggered by the recognition of vulnerability (Dewar, 2013; Dewar et al, 2013). Dewar et al (2013) identify that if compassion is only recognised in response to the identification of suffering, this results in significant interactions that are compassionate being overlooked. Dewar (2013, pg49) states that it is *"more appropriate to view compassion as a response to vulnerability in others as this more accurately reflects compassion in practice".* A definition of compassion which recognises vulnerability is relevant to mental health nursing practice, in which service users may not demonstrate suffering but may experience vulnerability due to their mental health needs. Indeed, based on professional experience, the recognition of vulnerability in those with mental health needs is more often a catalyst for compassionate care than the recognition of suffering. As such a definition of compassion that incorporates the identification of vulnerability is pertinent to this thesis.

Dewar (2011, pg263) provides a definition of compassion in which the identification of vulnerability is key:

> *"the way in which we relate to other human beings when they are **vulnerable**. It has to be nurtured and supported. It involves noticing another person's **vulnerability**, experiencing an emotional reaction to this and acting in some way with the person, in a way that is meaningful for people. It is defined by the people who give and receive it and therefore interpersonal processes that capture what it means to people are an important element of its promotion"*

In addition to the recognition of identified vulnerability being a pre-cursor for compassionate care, Dewar's description emphasises the relational aspect of compassion. This is discussed in greater detail in section 2.2.3: The scope of compassion in contemporary nursing practice. The characteristics identified as being evident in compassionate nurses are also identified in that section.

In summary, compassion is viewed as being a nebulous concept with contrasting definitions and views about what it comprises of. Compassion is seen as the identification of vulnerability or suffering and consequent actions taken to alleviate the vulnerability or suffering witnessed, with the aim of supporting/bringing comfort to those affected. The way/s in which compassion is expressed in contemporary nursing practice is explored in 2.2.3: The scope of compassion in contemporary nursing practice. However, first the origins of compassion are explored to further develop understanding of the praxis of compassion.

2.2.2: The origins of compassion

It is evident in the literature that authors use varying abstract nouns when discussing compassion, with some authors using multiple abstract nouns interchangeably throughout a single piece of work to describe or categorise compassion. This is highlighted in the list below (Table 2.3). Where authors have used multiple abstract nouns to describe compassion, their names have been highlighted in bold.

Table 2.3: Authors use of abstract nouns to describe compassion

Abstract noun:	Author/s that use the abstract noun to describe compassion:
an emotion	• **van der Cingel (2009) (1)** • **von Dietz and Orb (2000) (1)** • Straughair (2012b) • **Kneafsey et al, (2015) (1)**
an emotional response	• **von Dietz and Orb (2000) (2)** • Dewar (2010 speaking at an RCN conference) in Dewar, Pullin and Tocheris (2011)
a virtue	• Mannion (2002) in van der Cingel (2009) • **von Dietz and Orb (2000) (3)** • Durkin, Usher and Jackson (2018) • **Kneafsey et al, (2015) (2)**
a moral virtue	• **von Dietz and Orb (2000) (4)** • Schantz (2007) • Bradshaw (2011) in Straughair (2012a) • Kapelli (2008) in Straughair (2012a) • McCaffrey and McConnell (2015) • Pehlivan and Guner (2019)
a principle	• **von Dietz and Orb, (2000)(5)**
an inherent quality	• **Schantz (2007) (2)** • Bond et al (2018) • **Galetz (2019) (1)**
a concept	• **van der Cingel (2009) (2)** • McCaffrey and McConnell (2015)
a construct	• **van der Cingel (2009) (3)**
an intention	• **van der Cingel (2009) (4)**
a duty	• **van der Cingel, 2009 (5)** • **von Dietz and Orb (2000) (6)** • Perez-Bret, Altisent and Rocafort (2016)
an obligation	• **von Dietz and Orb (2000) (7)**
a value	• **Kneafsey et al, (2015) (3)**
a quality	• **Kneafsey et al, (2015) (4)**
an attitudinal state	• **Galetz (2019) (2)**
a feeling	• **Galetz (2019) (3)**
an affective state	• **Galetz (2019) (4)**

Although compassion could indeed be categorised using multiple abstract nouns (for example, it could be considered as a duty, obligation and intention), the lack of consensus of an abstract noun to define compassion, and the diverse meaning of some of the abstract nouns used (such as emotion, virtue or inherent quality), demonstrates the contrasting understanding and subscription to theories on the origins of the term compassion. The abstract nouns used, appear to reflect the authors belief about the origin of compassion, whether this be underpinned by theology, philosophy or evolutionary theory. Indeed, the origins of compassion are explored in studies considering mortality, theology and evolution, with theoretical claims about compassion reaching contrasting conclusions (Goetz, Keltner and Simon-Thomas, 2010). The origin of compassion as an emotion is explored through the

lens of evolutionary theory in the subsequent section, followed by exploration of the interpretation of compassion through philosophical and theological lenses.

Evolutionary theory and compassion:

The origins of compassion may be instinctive (Taylor, 1999 in van der Cingel, 2009) or primitive (Taylor, 1999 in van der Cingel, 2009; Goetz, Keltner and Simon-Thomas, 2010), with examples of compassionate behaviours seen in primates closely related to humans (Goetz, Keltner and Simon-Thomas, 2010). As such, the phenomenon of compassion has been explored through the lens of evolution since the time of Darwin (Goetz, Keltner and Simon-Thomas, 2010).

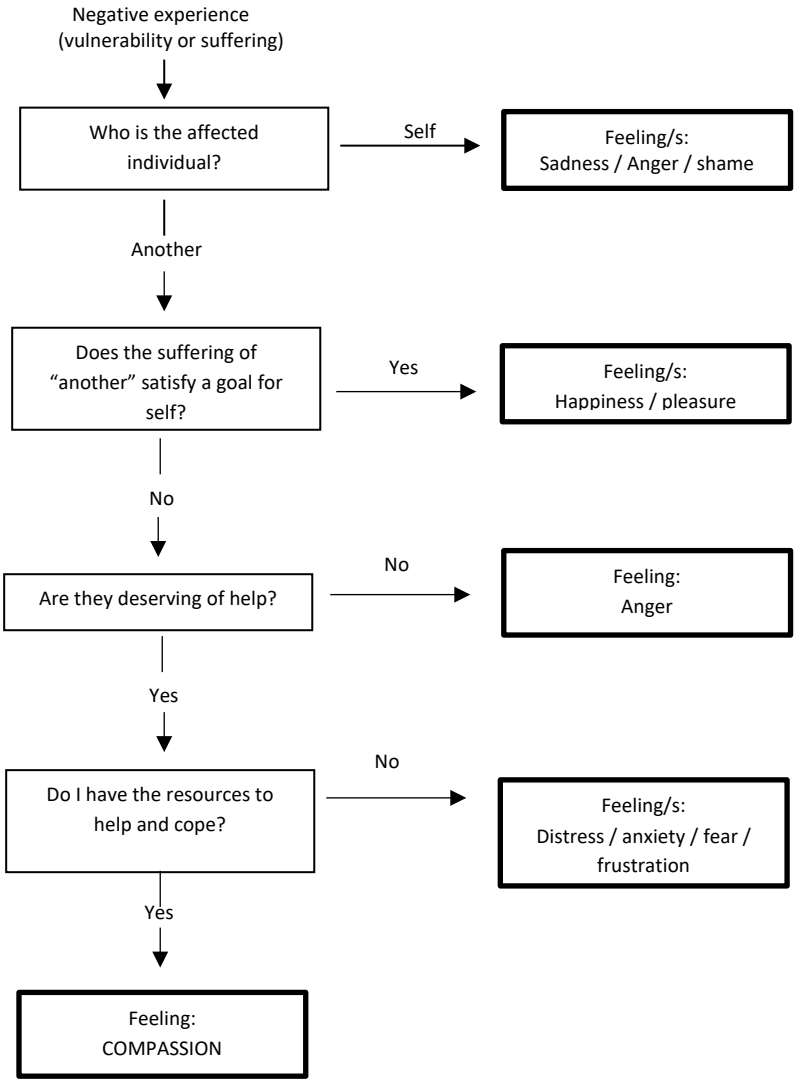
Evolutionary theorists have identified the motivation of compassion in primate monkeys and homo sapiens. Theories suggest that compassion has evolved for three main reasons; as a brief affective state orientated towards meeting the needs of vulnerable offspring to increase chances of survival (de Waal, 1996; Warneken and Tomasello, 2006; in Goetz, Keltner and Simon-Thomas, 2010), as a desirable attribute in mate selection (Neff and Karney, 2009; in Goetz, Keltner and Simon-Thomas, 2010) and to facilitate alliance formation and mutually beneficial, co-operative relationships with non-relations (Goetz, Keltner and Simon-Thomas, 2010).

Although often referred to as an emotion throughout the literature, compassion is not confirmed to be an emotion in its own right. There are three key evolutionary theories relating to the nature of compassion which suggest that compassion could in fact be:

I. **a vicarious emotion**, and an alternative name for empathic distress (Hatfield, Cacioppo and Rapson, 1993 in Goetz, Keltner and Simon-Thomas, 2010)
II. **a combination of sadness and love,** rather than a separate emotion (Post, 2002; Shaver et al, 1987; Fehr and Russell, 1991; Underwood, 2002; in Goetz, Keltner and Simon-Thomas, 2010)
III. **a distinct emotion**, with responses that distinctly differ from responses seen in distress, love and sadness (Goetz, Keltner and Simon-Thomas, 2010).

van der Cingel (2009) suggests that witnessing vulnerability or suffering is not enough to prompt compassion and that compassion is in fact underpinned by distinct thought processes and response behaviours. These thoughts and behaviours differ from those experienced and displayed in other emotions due to the object of the appraisal process being on the experience of the other person (van der Cingel 2009; Goetz, Keltner and Simon-Thomas, 2010). This supports the argument that compassion is a distinct emotion in its own right, and to feel compassion it is essential that the individual is able to identify with the individual, by using imagination to empathise and enable the recognition of vulnerability (van der Cingel, 2009). Alongside the ability to empathise, the witness of distress or vulnerability also engages in an element of appraisal that occurs through structural thinking patterns and is affected by individual value systems and socio-cultural background (van der Cingel, 2009). This influences specific appraisal regarding the other's deservingness of help and also includes consideration of the individual's ability to help reduce the vulnerability or suffering witnessed (Goetz, Keltner and Simon-Thomas, 2010). Compassion is therefore underpinned by the relationship between emotions and distinct thoughts, which provide the motivation for acts of compassion (van Dietz and Orb, 2000). This process is demonstrated in Figure 2.3 below.

Figure 2.3: Appraisal processes underpinning the decision to engage compassionately with another (amended from Goetz, Keltner and Simon-Thomas, 2010, pg356)



People are more likely to demonstrate compassion to those that they can identify with, such as relatives and those with similar personal values, beliefs, preferences, behaviours or physical characteristics (Einsberg and Miller, 1987 in Goetz, Keltner and Simon-Thomas, 2010; van der Cingel, 2009). Furthermore, when deciding if someone is deserving of help, consideration is given to their reputation, trustworthiness and character, in addition to evaluation of whether they are deemed responsible for their own situation (Goetz, Keltner and Simon-Thomas, 2010). Nussbaum (1996, in van der Cingel, 2009) states that compassion can only be experienced when suffering is viewed as being undeserved, and that if it is deemed that the person is experiencing undeserved suffering (or vulnerability), they are

more likely to be treated compassionately. However, if there is any suggestion that the negative experience is self-inflicted or perceived as deserved, individuals are more likely to experience blame and reproach from others (Nussbaum, 1996, 2001 in Goetz, Keltner and Simon-Thomas, 2010). This is evidenced in studies examining compassion and specific diagnoses, with findings indicating high levels of compassion towards those with Alzheimer's disease, cancer and heart disease but low levels of compassion demonstrated towards those with obesity or drug abuse (Goetz, Keltner and Simon-Thomas, 2010). Indeed, lower levels of compassion are demonstrated where an individuals' situation is perceived as self-inflicted and therefore deserved (Goetz, Keltner and Simon-Thomas, 2010).

This is of great relevance to mental health nursing as it is recognised that perception of self-inflicted or deserved situations may create a significant barrier to mental health nurses feeling able to engage in compassionate mental health nursing care (Barron, Deery and Sloan, 2017). Barron, Deery and Sloan (2017) identified that where service users are perceived as "*not helping themselves to recover"* or failing to *"learn from their mistakes",* this created a significant barrier to the nurse being able to engage in compassionate mental health nursing care (Barron, Deery and Sloan, 2017, pg217). Furthermore, some mental health nurses acknowledged that they were less likely to engage in compassionate care when they worked with service users who were deemed to be difficult or manipulative (Barron, Deery and Sloan, 2017; Knaak, Mantler and Szeto, 2017), or when the service user either rejected the nurse or demonstrated dependence on the nurse (Barron, Deery and Sloan, 2017). This indicates associations between the stigma directed towards some mental health conditions (in particular those perceived as self-inflicted) and the resulting vulnerability or suffering being therefore seen as self-inflicted and less deserving of compassion (Barron, Deery and Sloan, 2017; Knaak, Mantler and Szeto, 2017).

The reported characteristics of repeated negative patterns of behaviour, manipulation of others, rejection of staff, dependence on staff/services and difficult or challenging behaviour are often associated with a diagnosis of personality disorder (Barron, Deery and Sloan, 2017; Knaak, Mantler and Szeto, 2017). Personality disorder is a highly complex mental health condition and some mental health nurses described the characteristics or

symptoms listed above as creating barriers to engaging in compassionate care with those with the diagnosis (Barron, Deery and Sloan, 2017; Knaak, Mantler and Szeto, 2017). Indeed, mental health service users (especially those with a diagnosis of personality disorder or those who demonstrate challenging behaviours or complex presentations) reported experiencing stigma within mental health service provision (Barron, Deery and Sloan, 2017; Knaak, Mantler and Szeto, 2017; Ring and Lawn, 2019), which had a negative impact on the delivery of compassionate care (Barron, Deery and Sloan, 2017). Service users reported that when mental health professionals demonstrated stigmatising attitudes and behaviours towards them, they experienced an increase in subtle or overt threats of coercive mental health treatments, increased paternalism and increased therapeutic pessimism (Knaak, Mantler and Szeto, 2017), all of which are the antithesis to compassionate mental health nursing care.

It is suggested that the stigma experienced is driven by mental health nurses feeling ill equipped to manage and support the complex and multiple needs presented in practice (Barron, Deery and Sloan, 2017; Knaak, Mantler and Szeto, 2017; Ring and Lawn, 2019). This therefore highlights the importance of not just beliefs about deservingness, but also the impact of access to resources to be able to engage in compassionate mental health nursing care. It has furthermore been recognised that stigma within mental health services is often underpinned by staff burnout and compassion fatigue (Knaak, Mantler and Szeto, 2017). This therefore highlights that in addition to practical resources, mental health staff require emotional resources to reduce the infiltration of stigma in to their work and increase the opportunity for compassionate practice.

Philosophical and theological lenses of interpretation of compassion:

As identified above, the compassion appraisal process also includes the balancing of the cost of compassion (access to financial, emotional and practical resources) against the potential benefits of helping, and individuals are more likely to engage in compassion when they have access to resources that support coping with the vulnerability or suffering experienced (Goetz, Keltner and Simon-Thomas, 2010). This demonstrates that compassionate appraisals include judgements of fairness or justice (Goetz, Keltner and Simon-Thomas, 2010) and

moral choices to be made (von Dietz and Orb, 2000). Indeed, compassion is examined and debated in virtue and justice theories and has been applied to philosophical, Christian and Buddhist traditions (Sinclair et al, 2016; Straighair, 2012a), as well as theories relating to the ethics of care (van der Cingel, 2009). Compassion is understood to be rooted in Christianity, with Christian scripture advocating followers of the faith to be compassionate in all deeds and actions (Straughair, 2012a):

> *"you should all agree among yourselves and be sympathetic; love thy brothers have compassion and be self-effacing".*

(1 Peter; 3:8 The New Jerusalem Bible, 1990; pg1402).

Prior to the 19th Century, care for the sick in the UK was carried out by religious orders, but as both society and the role of the professional nurse developed, caring for the sick transferred to the responsibility of health care professionals (Dingwall, et al, 1988 in Straughair, 2012a). It is therefore not surprising that Christian beliefs and scripture underpinned the expectations of compassionate nursing care delivery in early nursing practice. Christian scripture advocates engaging in compassionate actions with the sick, through the parable of the good Samaritan (Luke 10, 29-37, New Jerusalem Bible, 1990). The good Samaritan demonstrated unconditional compassion to someone who was considered both culturally and traditionally as an enemy (Luke 10, 29-37, New Jerusalem Bible, 1990). Jesus encouraged his disciples to "*go and do the same yourself"* (Luke 10, 37, New Jerusalem Bible, 1990, pg 1222). Compassion for others is therefore identified as a method of striving to be God like and a requirement to achieve salvation (Kapelli, 2008 in Straughair, 2012a; Galetz, 2019).

Straughair (2012a) states that Christian ideals have further permeated nursing practice due to the influence of Florence Nightingale, who translated and transferred her Christian ideals and values into the characterisation of the modern nurse. Nightingale's translation of Christian values into professional nursing practice have heavily influenced how nurses are viewed today, and the expectations surrounding nursing practice and care (Straughair, 2012a). However, there are tensions for contemporary nurses faced with the challenge of

meeting and balancing these historical expectations, theological ideals (Bingham, 1979 in Straughair, 2012a) and also delivering contemporary technically competent care (Bradshaw, 2011 in Straughair, 2012a).

Further evidence for the religious and philosophical roots of compassion arise from reference to compassion as a virtue (Mannion, 2002; in van der Cingel, 2009; von Dietz and Orb, 2000) or a moral virtue (von Dietz and Orb, 2000; Schantz, 2007; Bradshaw, 2011 in Straughair, 2012a; Kapelli 2008 in Straughair, 2012a; McCaffrey and McConnell, 2015). However, it is argued that nursing discourse needs to move beyond the *"virtue script"* of compassion (Gordon and Nelson, 2005 in Dewar et al, 2013, pg4). It is suggested that the virtue script of compassion results in an understanding of nursing based on characteristics and qualities that are traditionally associated with sentimentalities which fail to highlight the complexity of skills that nurses must develop through professional education and experience, all of which underpin contemporary compassionate practice (Dewar et al, 2013; McCaffery and McConnell, 2015).

It is evident that there are numerous theories and little consensus about the origins of compassion. The theory about the origin/s of compassion is further considered in combination with key points taken from both section 2.2.1: The meaning of compassion and section 2.2.3: The scope of compassion in contemporary nursing practice, in section 2.4: Literature review summary.

2.2.3: The scope of compassion in nursing practice

The lack of clarity surrounding the definition of compassion[17] and the meaning of compassion has contributed to limited understanding of how compassion should translate into health care contexts (Sinclair et al, 2016; Tierney et al, 2017; Bond et al, 2018). This is especially apparent in relation to mental health nursing (Barron, Deery and Sloan, 2017). Furthermore, numerous qualities, characteristics, attributes and skills are identified as being required of the compassionate nurse and this, coupled with the subjective nature of

[17] As explored in 2.2.1: The meaning of compassion – pg40.

compassion (Dewar, 2013), contributes to challenges in articulating the meaning of compassionate nursing care (Durkin, Usher and Jackson, 2018). The complexity of engaging in compassionate nursing practice is acknowledged by Curtis (2015, pg59) who provides a definition of compassion specifically in relation to nursing care:

> *"Compassionate nursing practice is complex, comprising the enactment of personal and professional values through behaviour that demonstrates the emotional dimension of caring about another person and the practical dimension of caring for them in a way to recognise and alleviate their suffering".*

As previously presented and further reiterated in Curtis's (2015) definition above, the nurse must be able to identify vulnerability or suffering and act to relieve the vulnerability or suffering experienced. The review of the literature suggests that for this to occur, certain antecedents must be in place. Sinclair et al (2016) suggest that identification of vulnerability or suffering can be enhanced by the nurse understanding, and exposure to, the meaning of loss. It is further suggested that this understanding allows the nurse to identify with, and relate to, the experience of another (van der Cingel, 2009; Sinclair et al, 2016). The ability to identify with and relate to the patient are considered as essential for compassion (van der Cingel, 2009; Dewar, 2010 in Dewar, Pullin and Tocheris, 2011; Dewar, 2011; Dewar, 2013; Sinclair et al, 2016; Pehlivan and Guner 2019). As previously explored, Dewar's (2011, pg263) definition of compassion[18] highlights the importance of the ability to relate with the vulnerability of others. This is identified as a catalyst for the experience of an emotional connection that results in meaningful action being taken to alleviate the identified vulnerability (Dewar, 2011; Dewar, 2013). This suggests that the quality of the relationship developed between nurse and service user is therefore of upmost importance, and is underpinned by both the ability to engage in emotional connection and interpersonal processes (Dewar, 2011; Dewar, 2013; Dewar et al, 2013). The nurse can enhance their ability to engage in emotional connection by taking time to find out information about the patient, which supports the identification and relational aspects of engaging compassionately (van der Cingel, 2009; Dewar, 2013; Pehlivan and Guner 2019). Taking interest in and accessing information about the patient supports the experience of empathy,

[18] As cited on pg43.

which is viewed as an essential requirement to engage compassionately (van der Cingel, 2009). Imagination is also identified as a requirement for the nurse to be able to empathise, imagine how the patient feels, and recognise their vulnerability (van der Cingel, 2009). All of this must be underpinned by a genuine interest in the patient and their experience of vulnerability or suffering (Sinclair et al, 2016). It is proposed that compassionate nursing care is motivated by virtues including care, honesty, fairness and a sense of justice[19] (von Dietz and Orb, 2000). Qualities of respect, dignity, kindness (von Dietz and Orb, 2000) and preserving integrity in others (Dewar, 2013) are identified as key qualities that underpin compassionate thoughts, which lead to compassionate actions. Therefore, to engage compassionately, nurses need to develop these antecedent characteristics. The literature does not clarify the processes involved in delivering compassionate care (Dewar, 2013). However, studies identify numerous characteristics, skills and actions required of the nurse, such as being caring, genuine and emotionally engaged, which all contribute to the demonstration of compassionate care. Appendix 4: Identified characteristics, skills and actions of a compassionate nurse, lists the characteristics as specified in each source reviewed.

The numerous qualities and skills listed in Appendix 4 highlight that compassionate nursing care involves more than simply experiencing an emotion or motivation driven by religious, philosophical or moral values. Indeed, authors suggest that to be a compassionate nurse, the whole praxis of compassion must be engaged in (Bradshaw, 2009 in McCaffery and McConnell, 2015). However, the compassion praxis is a complex and dynamic process (Dewar, Pullin and Tocheris, 2011; Dewar, 2013). This is heightened by the fact that it is a subjective experience, which requires flexibility on the part of the nurse and willingness to get to know the patients' values, ensuring that responses offered are meaningful for the individual (Dewar, 2010 in Dewar, Pullin and Tocheris, 2011; Dewar, 2011; Dewar, 2013; Pehlivan and Guner, 2019). Like Curtis's (2015) definition[20], Dewar's (2011) definition[21] of compassion recognises the complexity of engaging in compassionate practice, identifying that it is defined by the interpersonal processes engaged in by those who give and receive

[19] As identified in the previous section 2.2.2: The origins of compassion – pg43
[20] As cited on pg52
[21] As cited on pg43.

compassion. The subjective nature of compassion suggests that there cannot be one single formula for engaging in compassionate practice. Indeed, the subjective nature of compassion requires the nurse to make judgements in each compassionate interaction about how to act, based upon what would have meaning for both the giver of compassion and the recipient (Dewar, 2011). As a result, it could be argued that the frame of reference for compassion is ever-changing. This further highlights the complexity and nebulousness of the praxis of compassion, and it could potentially add further confusion to the debate regarding the definition and scope of compassionate nursing in contemporary practice. Moreover, recognition of compassion in nursing practice may be difficult, and could impact on the challenge of articulating the scope of compassion in the practice context (Dewar, 2013; Pehlivan and Guner, 2019). Indeed, examples of compassion in nursing practice are often invisible as they consist of small, profound acts which are *"simple, not clever; basic, not exquisite; peripheral, not central"* (Pearson, 2006, pg22, in Dewar, 2013, pg49). As such, it is suggested that compassion is often more noticeable in its absence rather than action (von Dietz and Orb, 2000; Dewar, 2013). Dewar (2013) suggests that seeing compassion as innate and something that nurses 'just do' has limited the exploration of compassion and the understanding of the complexities associated with compassionate nursing practice.

Effective communication is a key medium for the conveyance and recognition of even small acts of compassionate care (von Dietz and Orb, 2000). Compassion is demonstrated and recognised with verbal and non-verbal communication, through presence, by offering verbal acknowledgement of suffering or vulnerability and taking action that clearly acknowledges vulnerability or suffering experienced (van der Cingel, 2009). Effective communication supports the relational nature of compassion (von Dietz and Orb, 2000; Dewar, 2013; Dewar et al, 2013; Durkin, Usher and Jackson, 2018). Moreover, effective communication skills, and the ability to develop relationships and forge emotional connections, are central in in the interpersonal processes that underpin the delivery of compassionate care (von Dietz and Orb, 2000; Dewar, 2013; Dewar et al, 2013; Kneafsey et al, 2015).

von Dietz and Orb (2000) state that the relational nature of compassion in practice requires the nurse to make efforts to get to know the individual patient and connect with them as a

fellow human who has distinct needs and a unique experience of life. Taking steps to actively identify with the patient is also acknowledged as key in the relational aspect of compassion (von Dietz and Orb, 2000; van der Cingel, 2009; Dewar, 2011; Dewar, 2013; Kneafsey et al, 2015; Perez-Bret, Altisent and Rocafort, 2016). This element of the relational nature of compassion is of interest, as it connects back to the thought appraisal process that is experienced when deciding if someone is deserving of compassion[22]. This is discussed further in section 2.2.4: Compassion: The meaning, origins, and scope in nursing practice summary. Compassionate nurse-patient relationships are marked by meaning, authentic care for the patient and a willingness to provide support and comfort. They are underpinned by patient centredness, respect, liking the patient, acknowledgement of their beliefs/wishes/needs, empathy, acting in their best interest (von Dietz and Orb, 2000) and working in partnership with the patient (Dewar, 2013).

Studies do not clarify exact processes or formulas to support delivery of compassionate nursing care (Dewar, 2013). This is due to the nebulousness of the qualities, characteristics and skills required to deliver compassionate nursing care, as a subjective experience that is dependent upon the quality of relationship and reciprocity (Dewar, 2013). However, key processes have been identified to achieve relationship-centred care (Dewar, 2011; Dewar, 2013), which contributes to the delivery of compassionate nursing care. These processes are underpinned by effective communication, relational and inter-personal skills, and involve engaging in conversations with patients to develop understanding of them, how they feel about their experience of care, and what is important to them. It is suggested that compassionate conversations are underpinned by the 7 C's of communication model (Dewar, Pullin and Tocheris, 2011; Dewar, 2013, Dewar et al, 2013; Dewar and Nolan, 2013), which comprises the following requirements for practitioners:

- to be **courageous** – have the courage to ask questions and hear truthful responses
- to **connect** emotionally – ask patients to communicate how they feel and be willing to share personal feelings
- to be **curious** – ask appropriate questions to demonstrate authentic interest

[22] As discussed in section 2.2.2: The origins of compassion – pg43.

- work **collaboratively** – encouraging participation, collaborative decision making and shared responsibility
- **consider** other perspectives – hear the patient's perspective, recognise that they are the expert in their experience
- to be **compromising** – work together to achieve the best outcome/s for all
- to **celebrate** – notice strengths and what has worked well and use affirming language to offer positive reinforcement

(Dewar, Pullin and Tocheris, 2011).

The use of the 7 C's of communication does not necessarily provide a process for compassionate nursing care, but it does provide a framework which could be useful for all health care professionals engaging in the relational aspect of compassionate nursing care. Indeed the 7 C's framework would enhance meaningful communication and provide the opportunity to understand the patient, resulting in potentially increased identification with the patient, increased understanding of their vulnerability or suffering, and insight into practical and supportive actions that could be engaged in to reduce the vulnerability or suffering experienced. The 7 C's could therefore form an integral part of the framework for compassionate interpersonal relations, as posited by Kneafsey et al (2015), which includes five specific stages:

I. **Stage 1 – Connecting**, is where the clinician uses communication skills to connect with the patient,
II. **Stage 2 – Recognising feelings**, is where the clinician recognises the feelings that are evoked in the patient encounter,
III. **Stage 3 – Becoming motivated**, is where the clinicians uses the feelings identified in stage 2 to develop desire to help the patient,
IV. **Stage 4 – Taking Action to help**, is where the clinician implements a plan of action to help the patient
V. **Stage 5**, relates to the clinician **sustaining their relationship** with the patient by using the skills from Stage 1.

(Kneafsey et al, 2015, pg77).

The relational aspect of compassionate nursing care cannot be denied; however, the provision of compassionate care is more than a purely individual and intrinsic experience for the one responsible for delivering care (Dewar, 2013). Some authors suggest that to deliver compassionate care, staff need to work in compassionate organisational environments (McQueen, 2000; Gallagher, 2004; Finfgeld-Connett, 2008; Firth-Cozens and Cornwell, 2009 in Adamson et al, 2011; Tierney et al, 2017). Indeed, Dewar (2011) identifies that compassion must be both nurtured and supported within the clinical context. As such, extrinsic factors should be considered. Staff are more likely to engage compassionately when working in organisations which embody a culture of staff feeling valued, listened to, supported (Kanov et al, 1994 in Dewar, 2013; Dewar and Nolan, 2013), cared for (Smith, 2008), and in which they are given time to engage in reflection (Barron, Deery and Sloan, 2017). However, many care cultures are impoverished, adopting a model of working which is dominated by ineffective and weak leadership, punitiveness, task orientation (Patterson et al, 2011; Dewar and Nolan, 2013) and increasing organisational demands (Adamson et al, 2011; Barron, Deery and Sloan, 2017). These hierarchical, punitive care environments, have a negative impact on nursing staff ability to engage in compassionate nursing care (Dewar, 2013, Dewar et al, 2013; Dewar and Nolan, 2013). To help overcome this, Youngson (2008, in Dewar, 2013) identifies an action plan for creating compassion enriched organisations:

- *"Declaring compassion as a core value*
- *Rewarding rather than punishing compassionate care*
- *Honing compassionate and relationship skills*
- *Creating a safe place for meaningful conversation in the workplace*
- *Challenging models of professionalism*
- *Defining compassion as a management and leadership skill"*

(Youngson, 2008 in Dewar, 2013, pg54).

Compassion enriched organisations is a topic of relevance for this study in relation to the environments in which students are exposed during their placement experiences. The impact that extrinsic factors have on their socialisation in compassionate mental health nursing practice is discussed further in section 2.4: Literature review summary.

2.2.4: Compassion: The meaning, origins and scope in nursing practice summary

Engaging with the literature to answer the first question: *"What is the definition of compassion in a nursing context?"* has highlighted areas of relevance to this study relating to the meaning, origins and scope of compassion in contemporary mental health nursing practice. It was felt important to develop a clear working definition of compassion prior to engaging in data collection due to the nebulous nature of compassion, to support recognition of examples of compassionate practice in the data collected. Synthesis of the literature resulted in the development of a definition of compassion in nursing practice, presented below:

> *Compassion comprises of the identification of vulnerability or suffering in another. It is complex due to its subjectivity and may be visible through the demonstration of numerous qualities, attributes and values. It is underpinned by the nurses' interpersonal skills and the ability to engage in emotional connection. It is this emotional connection that leads to engagement in meaningful action generated towards the other, aiming to address the observed vulnerability or alleviate the identified suffering.*

This definition incorporates the recognition of vulnerability which as presented previously, resonates with experiences within mental health nursing care[23]. It was reasoned that inclusion of vulnerability in the definition would contribute to the identification of potential interactions in mental health care that exemplify compassionate practice which would otherwise be overlooked if the focus was only in relation to the identification of and acts to reduce suffering, as identified in the literature (Dewar, 2011; Dewar et al, 2013). However, the definition also acknowledges that actions to reduce the experience of suffering may also be a trigger for compassion (Tudor, 2001 in van der Cingel, 2009; Chochinov, 2007, cited in Dewar et al, 2013; Schantz, 2007; Goetz, Keltner, Simon- Thomas, 2010; Straughair, 2012b; McCaffery and McConnell, 2015; Sinclair et al, 2016; Perez-Bret, Altisent and Rocafort, 2016; Durkin, Usher and Jackson, 2018; Pehlivan and Guner 2019). Furthermore, the definition incorporates the importance of meaningful action to attend to identified vulnerability or suffering, as identified as a distinguishing feature of compassion throughout the reviewed

[23] As presented on pgs42, 43 and 52.

literature (von Dietz and Orb, 2000; Schantz, 2002; Dewar, 2013; Curtis, 2015; McCaffery and McConnell, 2015; Sinclair, 2016; Galetz, 2019). The complexity of engaging in compassion due to the nebulous qualities that underpin the subjective nature of compassion is also included (Dewar, 2010 cited in Dewar, Pullin and Tocheris, 2011; Dewar, 2011; Dewar, 2013; Pehlivan and Guner, 2019). The definition also highlights the importance of interpersonal skills and the ability to engage in emotional connection with another (Dewar, 2011; Dewar 2013), which is identified as the cornerstone of compassionate practice and leads to meaningful action that differentiates compassion from empathy and sympathy (von Dietz and Orb, 2000; McCaffery and McConnell, 2015, Galetz, 2019). The definition presented above has drawn together the dimensions of compassion identified within the literature and was used as guide throughout the data collection and analysis stages of this thesis. The definition is re-examined in 6.3: The definition of compassion - revisited[24] and developed based on knowledge developed through analysis of the study findings.

The following section 2.3: Student nurse socialisation in compassionate nursing practice, considers findings from the literature reviewed to answer the second question: *"What is known about student mental health nurse/student nurse socialisation in compassionate practice?"*

2.3: Student nurse socialisation in compassionate nursing practice

This section explores the second literature review question generated "What is known about student mental health nurse/student nurse socialisation in compassionate practice?" It is of note that out of the 30 sources included in the review, only four (Brown et al, 2013; Crawford et al, 2013; Edward, 2005; Warelow and Edward, 2007) were specific to mental health nursing. However, although areas of relevance were identified in each of the four sources, none of them explicitly explore the socialisation of student mental health nurses in compassionate practice. This highlights the dearth of evidence in relation to the socialisation of student mental health nurses in compassionate practice, and further

[24] Please refer to pg278.

supports the importance of this study. Due to the lack of sources that specifically consider student mental health nurse socialisation, the inclusion criteria were extended to incorporate sources that explore socialisation for students and nurses from all fields of nursing practice. The following section explores the impact of both the theoretical and practice components of nurse education and the influence of these experiences on socialisation in compassion. However, first the meaning of professional socialisation is explored, and an overview of reflective strategies identified in the literature that may support positive socialisation in compassionate practice is provided.

2.3.1: Professional socialisation

Socialisation is the way in which skills and knowledge are acquired and applied to behaviour and self-identity in the nursing profession (Cohen, 1981 cited in Curtis, Horton and Smith, 2012). Professional socialisation refers to the process that individuals experience which leads to internalisation of the professional values and attitudes of the sub-culture in which they are exposed (Johnson, Haigh and Yates-Bolton, 2007).

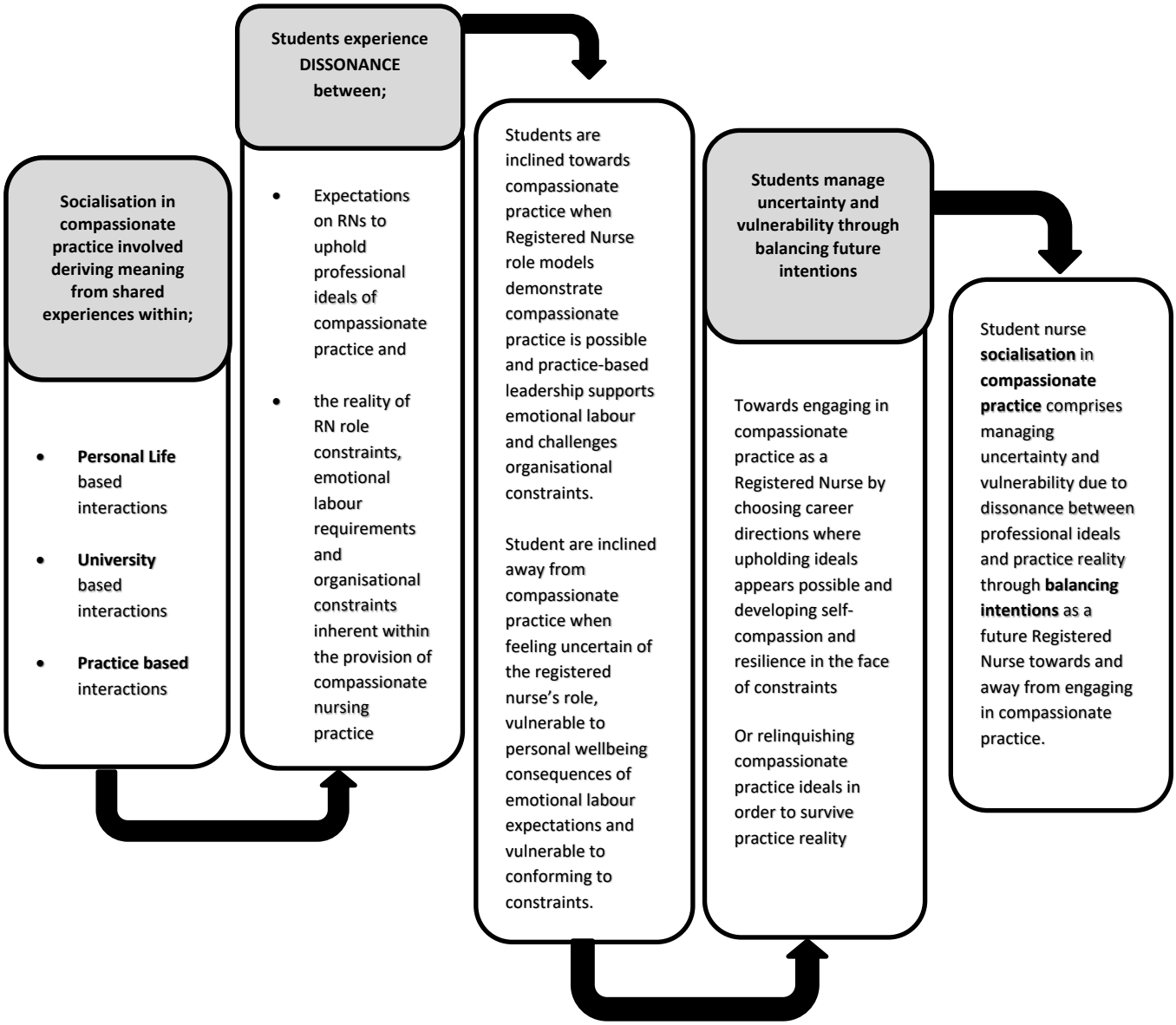
Literature specifically exploring student nurse socialisation in compassionate nursing practice (Curtis, Horton and Smith, 2012; Curtis, 2015) confirms that it is complex and is impacted not only by experiences during the programme of nurse education, but also by personal life experiences. Indeed, nursing students (like other students) have diverse personal backgrounds, personal attributes, life experiences and expectations, which can impact how professional socialisation in compassion is internalised (Curtis, Horton and Smith, 2012; Curtis, 2015; Straughair, 2019). Therefore, even when two student nurses are exposed to the same educational activities or practice placement, their experience and internalisation of socialisation in compassionate practice may differ significantly.

A New Grounded Theory of Student Nurse Socialisation in Compassionate Practice developed by Curtis (2015) is demonstrated in figure 2.4 (below). The theory suggests that students are socialised through a combination of personal life experiences, theoretical experiences and practice experiences during their programme of study. The impact of student vulnerability on socialisation in compassionate practice is highlighted, as is the

impact of dissonance between student professional ideals and expectations of registered nurses to uphold professional ideals and the realities of nursing practice (Curtis, 2015). The dissonance experienced is a consequence of interactions between student personal, practice and university-based educational experiences (Curtis, 2015). Subsequently, it is identified that students need to find balance between competing intentions and compassionate ideals (Curtis, 2015).

The research conducted by Curtis (2015) utilised participants from the adult field of practice nursing programme, however figure 2.4 provides a useful framework for the exploration of factors that may influence the socialisation of student mental health nurses in compassionate mental health practice. The application of this as a guidance framework for data collection and analysis is discussed further in section 2.4: Literature Review Summary, section 3.6.3.4: The initial coding process and section 4.1: Introduction to Focus Group Findings.

Figure 2.4: A New Grounded Theory of Student Nurse Socialisation in Compassionate Practice developed by Curtis, 2015, pg274).



2.3.2: The impact of theoretical nurse education on socialisation in compassionate practice

As stated above, research (Curtis, Horton and Smith, 2012; Curtis, 2015; Straughair, 2019) suggests that student socialisation in compassionate practice is affected by personal experience, as well as theory and practice exposure. However, students experience poor alignment of these diverse experiences throughout their programme of study. Diekelmann (2002; cited in Leffers and Martins, 2002) suggested that the nursing curriculum can become

oppressive and may serve to create dissonance between theory and practice experiences. In response to this, proposals have been put forward that Higher Education institutions should work in collaboration with practice partners, to realign professional ideals with the reality of contemporary practice (O'Driscoll, Allen and Smith, 2010; Adamson et al, 2011; Curtis, Horton and Smith, 2012; Curtis, 2015; Durkin, Gurbutt and Carson, 2019) and provide opportunities for student nurses to enact their professional values and ideals (Maben, Cornwell and Sweeney, 2010; Durkin, Gurbutt and Carson, 2019). Moreover, it is identified that professional education must address the compassionate design of health services but specify that for this to be achieved those responsible for nursing education must consider the way in which compassion is cultivated (Crawford et al, 2013; Bond et al, 2018). In addition, it is argued that education should not be limited to exploring values or communication skills, but rather aim to develop a deeper understanding of other factors in health care which may influence compassion depletion and cultivation (Crawford et al, 2013; Geraghty, Oliver and Lauva, 2016; Bond et al, 2018;). Adamson et al (2011) suggest that relationship centred care (which as previously identified is a cornerstone of compassionate care[25]) should be embedded throughout nursing educational programmes. Richardson, Percy and Hughes (2015) suggest that nursing curriculums should include a module which focuses on how students can develop effective compassionate caring skills. Hall (2015) states that including compassionate leadership training in nurse education could assist in creating a culture of compassion by equipping front line nursing staff to champion compassion.

However, there is debate as to whether compassion can be taught and learned (Richardson, Percy and Hughes, 2015; Geraghty, Oliver and Lauva, 2016; Pettit et al, 2019; Durkin, Gurbutt and Carson, 2019). It could be argued that this debate is underpinned by the lack of understanding about the origin/s of compassion, which in turn has led to confusion about whether it is an emotion, a value, a virtue or something that can indeed be taught or harnessed. Nursing researchers have responded to this debate by developing and evaluating strategies to assess if compassion can indeed be taught, developed, or learnt in nursing

[25] As presented in 2.2.3: The scope of compassion in nursing practice, pg51.

education and care contexts. Eight strategies identified in the literature are presented in Appendix 5: Strategies to develop/teach compassion discovered in the literature.
Each of the eight studies[26] included an exploration of a strategy of reflection, to assist in making compassionate practice more explicit in nurse education. The studies report some benefit in participant recognition of vulnerability or suffering and identification. Personal reflection is recognised as being key in supporting individuals to develop insight into the identification and facilitation of conditions required to engage in compassionate care (Geraghty, Oliver and Lauva, 2016; Pettit et al, 2019). Indeed, all the studies presented in Appendix 5 offer some insight into the positive effects of supporting individual reflection regarding the intrinsic and extrinsic factors that may impact engagement in compassionate nursing practice. However, each study reports short-term outcomes, and as such, further research is required to assess the longitudinal efficacy of these pedagogical methods to enhance reflection and positively affect knowledge, values and attitudes that lead to behaviour change and an increase in engagement in compassionate practice.

The eight studies also all identify the need for explicit learning relating to compassion to be present through the nursing curriculum. Currently in the UK, fifty percent of nursing education occurs within clinical practice settings and fifty percent occurs within the academic setting (Nursing and Midwifery Council, (NMC) 2010; 2018). Both academic and practice learning have been found to have an impact upon student development and socialisation (Melia, 1987) in compassion (Curtis, Horton and Smith, 2012; Curtis, 2015; Bond et al, 2018). As such, the following section explores the impact of practice experiences on student socialisation in compassionate practice.

2.3.3: The impact of practice experiences on student socialisation in compassionate practice

Research suggests that practice experiences can have a negative impact on socialisation in caring behaviours, which have been shown to diminish as students' progress through their nursing programme (Mackintosh, 2006; Murphy et al, 2009; Brown et al, 2008; Johnson,

[26] See Appendix 5: Strategies to develop / teach compassion discovered in the literature – pg344.

Haigh and Yates-Bolton, 2007). Miers, Rackaby and Pollard (2007, in Straughair, 2012a) found that nursing students became much less idealistic about altruistic values than other health care professional groups, due to the experience of the professional values and attitudes that they were exposed to during their programme. This occurs particularly where nursing students experience poor standards of care and negative attitudes towards patients (Brown, et al 2008; Straughair, 2019) in the practice context.

Socialisation in compassion is complex and consists of more than simple exposure to social norms. It requires compassionate attitudes to be fostered through role modelling in the practice context (Adamson et al, 2011; Brown et al, 2013; Kneafsey et al, 2015; Bond et al, 2018; Pettit et al, 2019; Durkin, Gurbutt and Carson, 2019; Straughair, 2019). The role modelling of compassion by those in positions of leadership is recognised as a powerful facilitator of compassionate nursing practice, and compassionate leadership is viewed as vital in cultivating a climate of compassion within the clinical context (Adamson et al, 2011; Pettit et al, 2019; Straughair, 2019). When compassionate leadership is not just role modelled by the team/ward managers but is also emanated from the executive levels of the care organisation, this further supports the development and sustainment of a compassionate care culture (Pettit et al, 2019; Straughair, 2019). This then positively impacts individual staff socialisation in, and maintenance of, compassionate nursing practice. In addition, resilience can be fostered in the workplace by effective role modelling (Edward and Warelow, 2005, in Warelow and Edward, 2007). Personal resilience is identified as essential to help students cope with the pressures of clinical practice (Edward, 2005) and it has been argued can be bolstered by increased levels of self-compassion (Pettit et al, 2018). This is of note as it is identified that resilience can reduce the impact of compassion fatigue and burnout (Edward and Warelow, 2005, in Warelow and Edward, 2007), which can inhibit engagement in compassionate nursing practice (Pettit et al, 2017).

2.3.4: Students nurse socialisation in compassionate nursing practice summary

Looking to answer the question *"What is known about student mental health nurse/student nurse socialisation in compassionate practice?"* involved analysis of the meaning of

socialisation and how this may occur throughout the educational process, including during both the theory and practice elements of contemporary nurse education. The areas of relevance to assist future phases of this study are presented in section 2.4: Literature review summary.

2.4 Literature review summary

This literature review sought to answer two key questions: *"What is known about the meaning, origins and scope of compassion in contemporary nursing practice?"* And *"What is known about student mental health nurse/student nurse socialisation in compassionate practice?"* Answering these questions helped develop insights into the overarching research questions by identifying the factors that influence student nurses in the development of compassionate mental health practice. Furthermore, consideration has been given to how educational providers and practice partners can support positive student nurse socialisation in compassionate nursing practice. Although the majority of the sources selected were not specific to mental health nursing, the knowledge uncovered could be applicable to a mental health nursing care context and provided an important foundation to develop understanding of the processes underpinning student mental health nurse socialisation in compassionate practice.

The exploration of the meaning, scope and praxis of compassion in nursing has highlighted that there is more scope for clarity and consensus relating to the understanding of compassion in healthcare. Despite the ubiquitous use of the word in nursing and health guidance, policy and research, the praxis of compassion is nebulous. The nebulous nature of compassion and need for a unique approach to the demonstration of compassion in individual care contexts and encounters (Dewar, 2013), may well contribute to the confusion about what compassion is and how it should be demonstrated by nurses in the practice context. There is scope for future studies to explore and articulate how compassion applies to every day contemporary nursing practice.

There is currently no definitive agreement as to whether compassion is a distinct emotion, a combination of other emotions or a vicarious emotion (Goetz, Keltner and Simon-Thomas,

2010) but there is agreement that regardless of the origin, compassion is underpinned by specific, structured thought processes and compassionate appraisals, which are influenced by individual values and socio-cultural background (Goetz, Keltner and Simon- Thomas, 2010; van der Cingel, 2009). Key processes of compassionate appraisal include making judgements about deservingness of compassion and evaluating resources available to respond compassionately (Goetz, Keltner and Simon Thomas, 2010; van der Cingel, 2009). This may be of particular relevance to mental health nursing, in which a proportion of service users could be perceived of as perpetuating their own vulnerability or creating their own suffering by engaging in self-harming behaviours, illicit drug taking or repeating patterns of negative behaviours. These points may well be of relevance to future phases of this study and as such, participants in the study were encouraged to discuss their perceptions and experience of deservingness of compassion in the practice context. The relational aspect of compassion also connects to the compassionate appraisal process and results in individuals being more likely to demonstrate compassion towards those that they identify with. Caring conversations which are underpinned by the 7 C's of communication model (Dewar, Pullin and Tocheris, 2011; Dewar, 2013, Dewar et al, 2013; Dewar and Nolan, 2013), provide a framework which could enhance health care professional's engagement in compassionate practice. Caring conversations are underpinned by effective communication, interpersonal skills, willingness to develop a relationship and a desire to develop understanding of the patient, how they feel about their experience of care and what is important to them. Engagement in caring conversations facilitates the development of relationships with service users which could positively influence nurse identification with them, therefore increasing opportunity for compassionate care interactions. Willingness to invest in relationships is an area of significance for the latter stages of this study. In addition, the impact of the consideration of cost of compassion and access to resources to reduce suffering may also be pertinent in mental health services, which are historically and chronically underfunded (Docherty and Thornicroft, 2015).

The demonstration of compassion moves beyond an individual responsibility to that of health service providers who hold a responsibility for creating the environment in which nurses are able to engage compassionately with service users. As such, the concept of

compassion enriched organisations (Youngson, 2008, in Dewar, 2013) is a topic of relevance for this study in relation to the environments in which students are exposed during their placement experiences, and the impact that this has on their socialisation in compassionate mental health nursing practice.

Exploration of what is currently known about student mental health nurse/student nurse socialisation in compassionate practice has highlighted the dearth of evidence available that considers student mental health nurse socialisation in compassionate practice and re-enforces the importance of this research being undertaken. Synthesis of information gathered from the sources utilised in the review has highlighted that student nurse socialisation in compassionate practice is affected by personal, theoretical and practice experiences. Indeed, the New Grounded Theory of Student Nurse Socialisation in Compassionate Practice developed by Curtis (2015) was utilised to generate sensitising concepts to loosely guide data collection, with the aim of developing further insights into the experiences of student mental health nurses that assist in their socialisation in compassionate practice. The application of this is further discussed in Chapter Four: Focus Group findings.

All teaching strategies identified in this literature review utilised different modes of reflection to support students to develop compassion and it is clear that reflection is a key component of compassionate practice. Additionally, the exploration of the impact of factors that influence socialisation in compassionate practice, when in the practice context, has highlighted the importance of positive role modelling of both acts of compassion and of resilience that support acts of compassion.

Engaging in the literature review has assisted in developing understanding relating to the meaning, origin/s and scope of compassion and student socialisation in compassionate nursing practice. Indeed, a working definition of compassion that will be used throughout the remaining thesis has been developed[27]:

[27] As presented on pg58.

> *Compassion comprises of the identification of vulnerability or suffering in another. It is complex due to its subjectivity and may be visible through the demonstration of numerous qualities, attributes and values. It is underpinned by the nurses' interpersonal skills and the ability to engage in emotional connection. It is this emotional connection that leads to engagement in meaningful action generated towards the other, aiming to address the observed vulnerability or alleviate the identified suffering.*

Furthermore, the literature review highlighted a dearth of research focused on student mental health nurse socialisation in compassionate practice, emphasising the importance of this study, which aimed to answer the research questions of:

- What are the experiences of compassion for student mental health nurses?
- What are the factors in practice placements that influence student mental health nurses in their development as compassionate mental health nurse practitioners?

And;

- How can placement providers facilitate positive socialisation in compassionate mental health nursing practice for mental health nursing students?

The review of the literature provided some insight into areas that may be of interest during later phases of the study and provided a useful guide for developing data collection. There was however commitment to being led by data that was actually observed and gathered in the field to ensure that findings were not unduly influenced by engagement in the literature review. This was identified by Charmaz (1990) as vital when engaging in a grounded theory approach to data analysis. The following chapter, Chapter Three – Methodology and Methods, presents the rationale underpinning the methodology selected for this study, and examines the research strategy and operational research methods utilised to gather data that was most suitable for answering the research questions posed.

Chapter Three: Methodology and Methods

3.0: Introduction

This chapter presents the rationale underpinning the chosen methodology and methods. Focus groups were selected to develop in-depth, critical understanding of the factors that foster student mental health nurse socialisation in compassionate practice. The focus group data led to the exploration of factors present in a compassion enriched mental health nursing care practice environment, that sustain a teams' ability to support positive socialisation in compassionate mental health nursing practice. A case study of one environment in which students felt they have experienced compassion for themselves, service users and staff was employed. Observations and individual interviews were used to triangulate data collected from the selected case study site.

The ontological, epistemological and axiological position of the research, which underpins the selected research paradigm of constructivism, is also critically considered and presented. Furthermore, the theory underpinning the selected search strategy of student focus groups and a single site case study, is critically examined. The research settings, participants, data collection methods and data analysis process are also discussed, and the ethical implications of the study are presented. Finally, evidence that the study meets quality assurance standards by critically exploring credibility, dependability and transferability of the study is explored.

As previously stated,[28] an original aim of the study was to develop understanding of the whole praxis of factors that facilitated and supported engagement in compassionate practice, including personal, theoretical and practice exposures. However, as the study progressed, the focus of the research questions, aims and objectives were re-considered due to student participant responses in focus groups, which concentrated on practice experiences. Following the data, the aims of this study were amended to explore the factors

[28] As presented in 1.2: Research aims and objectives – pg22.

in practice placements that influenced student mental health nurse socialisation in compassionate mental health practice, and the influences that contributed to practice placements being able to sustain the factors that support positive socialisation in compassionate practice. As such, the focus of the research process was on developing understanding of the experiences and realities of socialisation experienced by student mental health nurses and the factors that supported practice staff to foster positive socialisation in compassionate practice. This lends itself to a qualitative methodology (Denzin and Lincoln, 2011). The rationale for the selection of a qualitative underpinning to the research is explored in section 3.1 of this Chapter. The justification for all methodological choices and design of methods utilised to gather data is further presented throughout this chapter. Hiles's (1999) model of disciplined enquiry is utilised to support the structure of the chapter into seven distinct sections:

i. **Qualitative or Quantitative?** – exploration of qualitative and quantitative methodologies is presented, and rationale provided for the choice of methodology underpinning this research
ii. **A disciplined research enquiry** – the Hiles (1999) model of disciplined enquiry is introduced and rationale provided for adopting this model to support the facilitation of a disciplined research enquiry throughout the research process
iii. **Paradigm** – ontological, epistemological and axiological position of the research are explored and presented
iv. **Strategy** – methodological underpinning of the research is explored and presented
v. **Methods** – rationale for design of procedures for data collection is presented
vi. **Analysis** – rationale is provided for the decision to utilise a grounded theory approach to analysis of the data collected
vii. **Methodology summary** – a chapter summary is provided, and links are made with Chapters four: Focus Group Findings and Chapter five: Case study findings.

3.1: Qualitative or Quantitative?

This section provides an overview of both quantitative and qualitative research methodologies and justification is provided for the decision to utilise a qualitative methodology for this research.

Research methods tend to be divided into two main types: quantitative and qualitative (Muijs, 2004). Quantitative research is described as an approach to explain *"phenomena by collecting numerical data that is analysed using mathematically based methods (in particular statistics)"* (Aliaga and Gunderson, 2000; cited in Muijs, 2004, pg1). Quantitative methods include the utilisation of questionnaires, surveys or tests (Muijs, 2004) to obtain numerical data.
Particular research questions lend themselves towards a quantitative methodology (Muijs, 2004), including questions that demand a quantitative answer, questions aiming to identify numerical change, questions aiming to identify variables that may affect a certain phenomenon and questions to test hypothesis.

Muijs (2004) further identifies a number of examples of where quantitative methods are not suited, which include; when a problem needs to be explored in depth, when theories or hypothesis need to be developed, if the issues explored are particularly complex and for exploration about the meaning of specific events or experiences.

Therefore, quantitative research methodology was not suitable for exploring the research questions proposed in this study. Indeed, choice of methodology adopted for any research must be influenced by the research question/s being addressed and the problem or phenomenon under scrutiny (Silverman, 2000) and as such, a qualitative approach was considered (Ritchie et al, 2013) and adopted.

Qualitative research is an appropriate methodology to employ when the research is concerned with the *"what, why and how"* of a specific phenomenon (Ritchie et al, 2013). It is described as a naturalistic, interpretative approach which focuses on exploring phenomenon from an interior perspective, thus concentrating on the perspectives and experiences of research participants (Flick, 2009). Qualitative data usually involves words or images rather

than numerical data, and the data can be collected through various methods including interviews, focus groups or observations (Ritchie et al, 2013). The data produced is voluminous, rich and in-depth (Ritchie et al, 2013). Ritchie et al (2013), identify a number of common characteristics of qualitative research. Firstly, it helps to provide an in-depth, interpreted understanding of the social world of study participants by exploring their experiences and perspectives (Ritchie et al, 2013). It is also non-standardised, offers flexible data collection methods, can be utilised to explore emergent issues and provides rich data that is comprehensive and complex (Ritchie et al 2013). Furthermore, analysis ensures that the complexity and uniqueness of participant experience is retained, and it allows the researcher to be open to emergent issues (Ritchie et al 2013). Finally, it supports detailed descriptions of the phenomenon under investigation and provides scope for the researcher to acknowledge their own role and perspective in the research process (Ritchie et al, 2013).

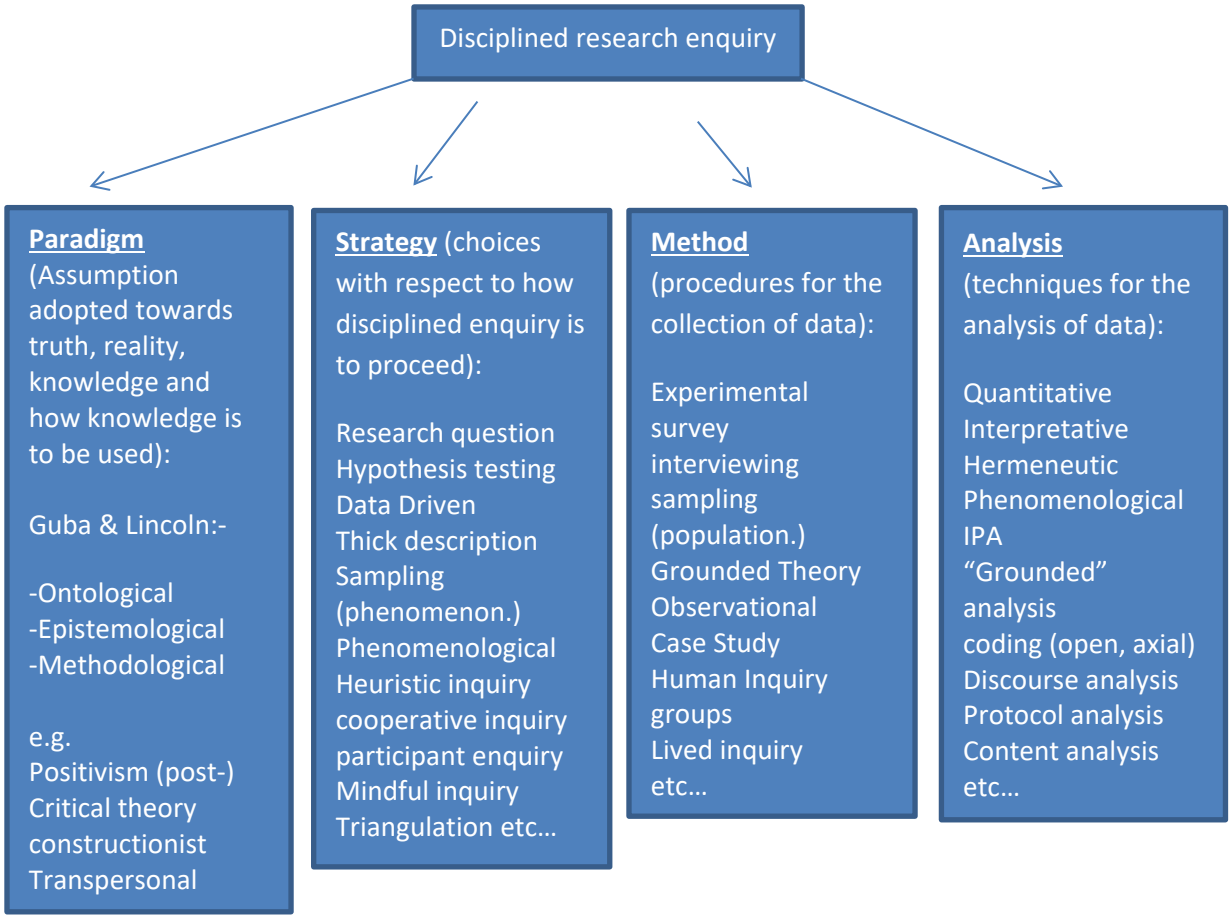
This research aimed to explore the complexity of experiences and student mental health nurse and placement team staff realities of socialisation in compassionate mental health practice in great depth. It was therefore concluded that it was most appropriate to utilise a qualitative framework for this study. However, qualitative research has been criticised due to factors such as lack of transparency in procedures during the progression of the research, and lack of generalisability (Hammersley, 2008). To assist in ensuring transparency in the qualitative research process, Hiles (1999) suggests a model of disciplined research enquiry which provides a systematic approach to developing knowledge (see Figure 3.1). Hiles's (1999) model of disciplined enquiry was adopted during the study design phase to support transparency in the research process. The model is further utilised throughout the remainder of the chapter to provide structure, in addition to being utilised to contribute towards a disciplined approach to the overall study design choices.

3.2: A disciplined qualitative research enquiry

Hiles (1999) makes no distinction between qualitative and quantitative methodologies and justifies this by identifying that too much focus has traditionally been placed on the distinction between the methodologies. It is instead proposed that social research should be

defined by its paradigms rather than by devised methodology (Hiles, 1999). The model, as demonstrated in Figure 3.1 below, clarifies the requirements of a disciplined inquiry.

Figure 3.1: A model of disciplined enquiry (taken from Hiles, 1999, pg 6-7).



3.3: Paradigm

The initial element of a disciplined enquiry as specified by Hiles (1999), is the identification of the research paradigm. Some authors suggest that what defines social science research is not the methodology utilised but rather the paradigm underpinning the research (Giorgi, 1970; Polkinghorne, 1982; Hiles, 1999), therefore the importance of research paradigms should not be underestimated (Hiles, 1999).

A paradigm is a set of as basic beliefs that underpins the research process (Guba and Lincoln, 1994), addresses the underpinning philosophical dimensions of social science

research, and provides fundamental beliefs and assumptions about how the world is perceived (Wahyuni 2012). A paradigm provides a framework that guides the behaviour of the researcher (Jonker and Pennink, 2010) and influences the practice of the research (Wahyuni, 2012), including the choice of research strategy, methods and analysis. Wahyuni (2012) identifies four research paradigms that the social science researcher should consider: positivism (naïve realism), post positivism (critical Realism), constructivism (interpretivism) and pragmatism.

Each of these four paradigms are underpinned by two main distinguishing dimensions; ontology and epistemology (Laughlin, 1995; Kalof, Dan and Dietz, 2008; Saunders, Lewis and Thornhill, 2009; Wahyuni, 2012). Ontology specifically relates to the view of how reality is perceived (Guba, 1990). A subjective ontological theory identifies that reality is socially constructed and assumes that individuals involved in a specific experience contribute to the social phenomenon that occurs (Wahyuni, 2012). However, an objectivist ontological view perceives that reality is external and independent of social actions and interpretations of social experiences (Saunders, Lewis and Thornhill, 2009). Epistemology is philosophically linked to ontology and is concerned with the view of what constitutes acceptable knowledge (Guba, 1990), and the way in which knowledge is generated and conceptualised in an approach that is deemed both acceptable and valid (Wahyuni, 2012).

Wahyuni (2012) developed a model of fundamental beliefs of research paradigms applicable to social sciences. This model is based on previous work of others (Saunders et al, 2009; Guba and Lincoln, 2005; Hallebone and Priest, 2009) and illustrates the assumptions and philosophical standing of four research paradigms that the qualitative researcher could align with. The model is demonstrated in Table 3.1 below.

Table 3.1 Fundamental Beliefs of Research Paradigms in Social Sciences

	Research Paradigms			
Fundamental Beliefs	Positivism (naïve realism)	Post positivism (critical realism)	Interpretivism (Constructivism)	Pragmatism
Ontology: The position on the nature of reality	External, objective and independent of social actors	Objective. Exist independently of human thoughts and beliefs or knowledge of their existence but is interpreted through social conditioning (critical realist)	Socially constructed, subjective, may change, multiple	External, multiple view chosen to best achieve and answer to the research question
Epistemology: the view on what constitutes acceptable knowledge	Only observable phenomena can provide credible data, facts. Focus on causality and law-like generalisations, reducing the phenomena to simplest elements	Only observable phenomena can provide credible data, facts. Focus on explaining within a context of contexts	Subjective meanings and social phenomena. Focus upon details of the situation, the reality behind these details, subjective meanings and motivating actions	Either or both observable phenomena and subjective meanings can provide acceptable knowledge dependent upon research question. Focus on practical applied research integrating different perspectives to help interpret the data
Axiology: the role of values in the research and the researcher's stance	Value-free and etic Research is undertaken in a value-free way, the researcher is independent of the data and maintains an objective stance	Value-laden and etic Research is value laden; the researcher is biased by world views, cultural experiences and upbringing	Value-bond and emic Research is value bond; the researcher is part of what is being researched and cannot be separated and so will be subjective	Value-bond and etic-emic Values play a large role in interpreting the results, the researcher adopting both objective and subjective points of view
Research Methodology: the model behind the research process	Quantitative	Quantitative or qualitative	Qualitative	Quantitative or qualitative (mixed or multi-method design)

(Taken from Wahyuni, 2012, pg70)

Positivism and post positivism share the epistemological stance that *"only observable phenomena can provide credible data and facts"* (Wahyuni, 2012, pg70). As this research was concerned with student mental health nurse experience of compassion, socialisation in compassionate practice, and sought to explore student mental health nurse and practice team staff experience, opinions, thoughts and perceptions, which are not observable, these research paradigms were discounted for this research. Likewise, the pragmatism paradigm was discounted as pragmatist researchers favour the utilisation of both qualitative and quantitative data to increase understanding of social reality (Wayhuni, 2012). Therefore, like positivism and post positivism, the epistemology underpinning pragmatism was not congruent with the intent of this research.

Fundamental beliefs in relation to this research were rooted in constructivism. A constructivist ontology is aligned with a subjective paradigm which recognises that reality is created experientially (Alvesson and Deetz, 2000). Denicolo, Long and Bradley-Cole (2016) identify the strength of a subjective paradigm which allows for richer insights into the research question to be developed by assisting in the elicitation of deep and rich insights into participant personal experiences. Constructivism is also strongly linked to a relativist approach in which reality is viewed uniquely by each individual and therefore the idea of 'truth' is individually defined (Easterby-Smith, Thorpe and Lowe, 2002). Constructivist researchers acknowledge that each individual's sense of reality is socially constructed through innumerable personal life experiences which then influence their perception of events, behaviour and reality (Denicolo, Long and Bradley-Cole, 2016). Constructivism is therefore concerned with developing understanding of participant perspectives and interactions with the world (or participants personal paradigm's) (Denicolo, Long and Bradley-Cole, 2016). As inner experience cannot be directly measured, the researcher indirectly accesses the phenomena experienced by gaining insight into participants' perception and reality (Alvesson and Skoldberg, 2009). This requires the researcher to focus upon the details of the situation being explored, ensuring examination of both subjective meanings and motivating actions behind the phenomenon, to uncover inside perspectives and meanings of social phenomenon from participants (Wahyuni, 2012).

This fundamental aspect of constructivist research could be viewed as a limitation of this philosophical framework, as social phenomena and meaning attached to this can only be viewed by the perception of the individual and cannot be seen as definitive (Bryman, 2001). However, constructivist researchers believe that understanding of individual realities can provide unique insights into issues underpinning cognitions and behaviours (Denicolo, Long and Bradley-Cole, 2016). The constructivist researcher can then identify and explore commonalities by bringing individual perceptions and experiences together, to develop meaningful insights into the phenomenon under investigation (Denicolo, Long and Bradley-Cole, 2016).

In relation to student mental health nurse socialisation in compassionate practice, it is acknowledged that the experience of socialisation is socially constructed (Melia, 1987; Blackstone, 2009). As such it is unique to each participant and may change depending on a multitude of factors (Wahyuni, 2012). By identifying relationships between individual perceptions and experiences, this research contributes to meaningful comprehension of the factors underpinning experiences of socialisation in compassionate mental health nursing practice.

In addition to the research question having influence over the choice of methodology utilised (Silverman, 2000), the selected methodology should also be congruent with the underpinning philosophy of the research (Denicolo, Long and Bradley-Cole, 2016). As this study is underpinned by constructivist epistemology which seeks to understand individual meaning underpinning phenomena (Crotty, 1998), it is consistent with the overarching qualitative methodology (Wahyuni, 2012).

In addition to the two main philosophical dimensions identified above, basic beliefs that influence how the researcher investigates reality (Wahyuni, 2012) must also be considered. Axiology relates to ethics, and beliefs in relation to the value of the topic being investigated (Wahyuni, 2012). As previously identified, constructivist researchers recognise the value of inside perspectives, and therefore focus upon studying reality from the perspectives of the participants (Wahyuni, 2012). However, it is also recognised that the experiences and values of the researcher influences both the collection of data and its subsequent analysis within constructivist research (Wahyuni, 2012). Rodwell (1998) identifies that the researcher is interactive and inseparable from the research participants. It is recognised that the researcher and research participants interact and influence each other (Rodwell, 1998). This interactive engagement with research participants is accepted phenomena in constructivism due to the recognition of dimensions of the knowledge building process, including reactivity, indeterminacy and interaction (Rodwell, 1998). Indeed, personal experience of being a mental health registrant and a former mental health nursing student, albeit over 20 years ago, makes the researchers experience inseparable from that of the participants.

The dimension of reactivity acknowledges that no research design can eliminate observable reactions to the research process and participants, including the researcher, experience change as a result of engaging in the research process (Rodwell, 1998). It is also identified that attempts to control reactivity are deceptive and therefore not conductive with the values of empowerment that underpin constructivism (Rodwell, 1998).

Indeterminacy relates to the recognition that what the researcher observes is not true nature, but rather nature exposed due to methods of questioning (Rodwell, 1998). In essence this means that the researcher learns about what they explicitly ask about and therefore not only disturb the natural research environment but actively shape it (Rodwell, 1998).

Finally, the dimension of interaction acknowledges that the research process is shaped by what is observed, and participants are shaped by their expectations about the research and future use of the data they share (Rodwell, 1998). It is recognised that the interaction between researcher and participant in constructivism creates the data ultimately collected (Rodwell, 1998). Due to this, it is identified that it is not possible to remove interaction from a constructivist enquiry because it is acknowledged that within constructivism:

- *"Theories and facts are not independent", (Rodwell, 1998 pg29)*
- Purposive sampling and emergent design are not possible without interaction,
- Interaction supports moving beyond objectivity,
- *"Research with humans is inherently dialectical", (Rodwell, 1998 pg30)*
- Meaningful research is not possible without understanding of participants,
- Researcher knowledge can be realised through interactivity

(Rodwell, 1998).

Interaction in the research process provides the opportunity for learning and knowledge expansion due to the developed mutuality. Within constructivism if opportunities for interaction are reduced, the opportunity for 'wholeness' of an in-depth inquiry are negatively impacted (Rodwell, 1998).

The ontological, epistemological and axiological positions of constructivism are consistent with the values of mental health nursing, in which developing understanding of individual experience and reality, and consideration of the impact of external social influences, is viewed as paramount in any therapeutic work engaged in (Michie and Abraham, 2004; Clarke and Walsh, 2009). Therapeutic work in mental health nursing is underpinned by human interaction, which provides the nurse opportunity to develop increased opportunity to understand of service users' unique situation (Clarke and Walsh, 2009). This therefore further cemented the choice of utilising a constructivist paradigm to underpin the study.

Following identification and selection of an appropriate paradigm to support a credible and appropriate philosophical stance to the research, the Hiles's (1999) model of disciplined enquiry guides the researcher to develop a robust research strategy. Section 3.4 explores the strategy utilised in this study and provides rationale for the developed strategy design.

3.4: Strategy

Methodology underpins the overall strategy of any research (Silverman, 2000). As previously identified, this research was concerned with exploring student nurse socialisation in compassionate mental health practice and the influences that foster a practice team (placement area) to sustain the factors that support positive socialisation in compassionate practice. This therefore lends itself to a qualitative methodology, which is consistent with the constructivist paradigm (Wahyuni, 2012). There are five specific research strategies that can be used within a qualitative study: ethnography, narrative research and phenomenology, grounded theory and case study (Creswell, 2012). In the following section, an overview is provided of each of these strategies and justification is provided for the ultimate selection of the research strategy developed and adopted.

3.4.1: The selection of a qualitative strategy for data collection

The core components of the five qualitative approaches of ethnography, narrative research, phenomenology, grounded theory and case study are included and a summary of the

justification for inclusion or exclusion for each approach in this study is identified in Table 3.2 (below).

Table 3.2: Core components of five qualitative research strategies

Characteristics	Ethnography	Narrative Research	Phenomenology	Grounded Theory	Case study
Focus	Interpretation of meaning in a culture	Exploring the life of an individual	Understanding the essence of an experience	To develop a theory based upon data available	In-depth description and analysis of case/s
best suited for	Interpretation of meaning in a culture	Telling of individual stories	Describing the essence of a lived experience	Developing a theory based on views of participants	In-depth understanding of case/s
Analysis	Studying a group who share the same culture	Studying one or more individuals	Studying several individuals who have the same experience	Studying a process involving many individuals	Study of an event or activity of more than one individual
data collection	Primarily observations and interviews	Primarily interviews and documents	Primarily interviews with individuals but documents and observations can also be utilised.	Primarily interviews with 20 – 60 individuals	Multiple sources including interviews, observations, documents.
Data analysis strategies	Analysing data through description of the culture sharing group	Analysing stories for retelling	Analysing data for significant themes	Analysing data through coding	Analysing data through description of case themes
Researchers rationale for Inclusion/ Exclusion	Exclusion: Culture is only one aspect of innumerable life experiences that may impact an individual's perception of experience	Exclusion: The aim of the research is to explore individual perceptions behind the essence of experiences, specifically in relation to socialisation in compassionate practice and does not aim to collect descriptions of life experiences	Exclusion: The utilisation of Phenomenology has the potential of limiting the research to description of individual experience. The aims of this research are to consider both individual experience and social contexts in relation to group experiences to develop theory in relation to the phenomenon under investigation. Therefore, this methodology is not appropriate for this research.	Exclusion: Grounded theory is exploratory and suitable when there is little or no work in the field. Furthermore, It is unlikely that the research will be able to access 20-60 participants for interview due to the specific focus of the research. However, although excluded as a sole methodological approach to the research, the strength of data analysis processes is acknowledged and a GT approach to data analysis will be utilised within this research to support academic rigour and robustness and mitigate the criticisms that a case study approach to research has poorly defined data analysis processes.	**Inclusion:** **The utilisation of a case study as a method of data collection will support in-depth exploration of the complex issues underpinning phenomenon under investigation. A case study approach supports multiple data collection sources and methods and will allow access to participants in a "real life" academic / clinical context.**

(Adapted from work by Creswell, 2012).

Ethnography: Denscombe (2004, pg84) identifies that the literal meaning of ethnography is *"a description of peoples or cultures"*. The modern-day ethnographic researcher explores cultural groups that may involve data collection from numerous people who interact over

time (Creswell, 2012). It was concluded that an ethnographic approach for this study was not appropriate as it was recognised that culture is only one of the many factors that may underpin the essence of experience and individual reality of socialisation in compassionate mental health nursing practice. This in combination with issues in relation to researcher immersion in the group under investigation and the time required to spend in the field, resulted in an ethnographic approach being excluded as a strategy for data collection in this research.

Narrative research: Narrative research focuses on stories that are told by individuals (Polkinghorne, 1989). Within narrative research, the researcher gathers data by exploring the "stories" and individual experiences of one or two subjects; putting those experiences in a chronological order and aims to apply meaning to those experiences (Creswell, 2012). The decision to exclude this approach was made as it would not allow examination of the unique meaning underpinning experiences and realities of socialisation in compassionate practice as is promoted within constructivism (Denicolo, Long and Bradley-Cole, 2016).

Phenomenology: A phenomenological approach endeavours to explore individual experiences and perspectives in relation to a phenomenon, with the aim of uncovering the essence of what is important to the individual in their experience of reality (Smith, Flowers and Larkin, 2009). The approach focuses upon participant thoughts, feelings, and perceptions about their reality of the situation and allows analysis of the multiple perspectives experienced (Barker, Pistrang and Elliot, 2002). However, a phenomenological approach was discounted due to concerns that the focus on individual experience would limit the exploration of social constructivism underpinning socialisation (Bryman, 2001).

Grounded Theory: Grounded theory aims to move beyond description and generate theory (Glaser and Strauss, 1967; Charmaz, 2006; Creswell, 2012; Denicolo, Long and Bradley-Cole, 2016). Theory development is generated from the data obtained from many participants who have experienced the process being explored (Strauss and Corbin, 1998), specifically in relation to the actions, interactions and social processes experienced (Creswell, 2012).

However, it is an exploratory method and therefore is suitable when there is little or no known work in the field (Salkind, 2010). As research has previously been conducted by Curtis (2015) regarding student nurse socialisation in compassionate practice, this methodology was excluded.

It is of note that any one of the qualitative methodologies described above, could have been applied to support the in-depth exploration of complex issues using multiple data sources and participants in a real-life context, which was identified as inclusion rationale for the selected methodology of case study. Indeed, of the methodologies described above, both phenomenology and grounded theory methodologies were seriously considered for this study. A phenomenological strategy was originally contemplated for this research as the affiliation between phenomenology and the researchers own ontological and epistemological stance was identified. Furthermore, the strength and rigour of grounded theory data analytical processes (Charmaz, 2000; Strauss, 1987) was acknowledged and resulted in serious consideration of a grounded theory methodology being adopted. However, it was discovered that a grounded theory approach to analysis could be utilised in combination with another qualitative approach to enhance analytical rigour[29]. As such, case study methodology was adopted for this study. It was deemed that case study would support triangulation of a data collection strategy and allow for in-depth exploration of the complex issues underpinning student socialisation in compassionate mental health nursing practice. The choice of case study methodology and a grounded theory approach to data analysis, was ultimately a personal preference, which upon reflection was consistent with the values of mental health nursing and my desire to engage in in-depth understanding of the experiences of others. Additional evidence to support the merging of the two approaches is provided in 3.6.1: The merging of a case study approach for data collection and a grounded theory approach for data analysis. However, first Case study methodology is explored in the following section – 3.4.2: Case study methodology.

[29] See 3.6.1: The merging of a case study approach for data collection and a grounded theory approach for data analysis – pg117.

3.4.2: Case Study methodology

The origins of case study methodology can be traced back to social sciences through the works of sociologist Le Play, in 1855 (Scholz and Tietje, 2002). Case study increased in popularity during the early 20th Century when it was used to support statistical studies (Tight, 2017; Harrison et al, 2017) and was adopted as a quantitative approach to data collection in the fields of anthropology, psychology, history and the social sciences (Harrison et al, 2017). By the 1950's, case study had fallen out of fashion due to concerns about lack of robust analysis and lack of generalisability associated with the methodology (Tight, 2017). However, the late 1960's and early 1970's saw greater importance placed upon, and consequent use of, qualitative methods of research (Tight, 2017). The development and diversification of qualitative methods of research at this time (Tight, 2017; Denzin and Lincoln, 2018), led to reappraisal of the application of case study, which resulted in a resurgence of popularity for the use of case study (Simons, 2009a; 2009b; Tight, 2017) as a qualitative methodology (Tight, 2017). Case study popularity has maintained its status as a valid approach in both quantitative and qualitative studies and is used in diverse research disciplines including (but not limited to) business, psychology, law, anthropology, psychology, health and education (Tight, 2017). Case study is an effective and flexible strategy (Harrison et al, 2017) which allows the researcher to explore a case over a period of time through detailed, in-depth data collection (Creswell, 2012), enabling exploration of complex phenomenon (Yin, 2003) in *"real life contexts"* (Lauckner, Paterson, and Krupa, 2012, pg4; Harrison et al, 2017). Meyer (2001, pg 329) defines a 'case' as *"one or more organisations, or groups within organisations"*. A case study strategy is identified as of particular use to assist in the answering of 'how and why questions' (Leonard-Barton, 1990; Yin, 2003; Meyer, 2001; Lauckner, Paterson, and Krupa, 2012). Bryman (2004) identifies that a case study approach may focus on detailed analysis of a single case, however data can be collected from multiple sources (Creswell, 2012; Lauckner, Paterson, and Krupa, 2012) within the single case site, with the aim of the researcher developing an in-depth, rich understanding of the phenomenon of interest (Anaf, Sheppard and Drummond, 2007; Stake, 2000, 2006; Creswell, 2012; Lauckner, Paterson, and Krupa, 2012). However, the utilisation of a single case study site is criticised as offering a lack of representativeness, which results in the view that single case studies can only be considered as indicative, anecdotal and unscientific (Buchanan, 1999). As such, it is argued that single

case studies have low external validity which cannot be a platform for theoretical claims (Tsoukas, 1989). However, a single case study is identified as a useful strategy for research in which clarity about social structures and contingent factors leading to certain behaviours can be observed (Tsoukas, 1989). It is further identified that single site case study can in fact lead to the uncovering of new theoretical relationships and support the questioning of established theoretical relationships (Dyer and Wilkins, 1991). Indeed, Mitchell (1983) identifies that the validity of a single site case study does not depend on the representativeness of the case under exploration but rather upon the *"cogency of the theoretical reasoning"* (Mitchell, 1983, pg207).

Buchanan (1999) identifies two approaches to generalisation that are relevant when utilising a single site case study strategy. The first is analytical generalisation in which implications of current theory and conceptualisations are explored, and the second is naturalistic generalisation (Stake, 1994). Indeed, Stake (1994) challenges the view that research findings must be transferable or generalisable and instead argues for *"naturalistic generalisation"* (Stake, 1994, pg240). The reader engages in a personal and at times unconscious process of cognisance, in which they reconstruct arguments drawn from findings, to develop personal insights and understanding. This is consistent with the constructivist paradigm in which it is recognised that in addition to the exploration of research participant experiences, the researcher also influences the research process (Rodwell, 1998; Wahyuni, 2012), and further builds upon this by acknowledging the role of the reader in *"reconstructing knowledge in ways that leave it differently connected and more likely to be personally useful"* (Stake, 1994, pg241).

Buchanan (1999) identifies that it is the task of the researcher to select an appropriate case which is not based on representativeness but on opportunity for learning from the case. The selected case could represent either a negative or positive example of the issues under exploration, in which the researcher seeks patterns and provisional generalisations (Buchanan, 1999). The researcher then identifies relationships between conclusions and current theory, before handing over to readers of the research to allow consideration of findings against their personal perspectives and experiences (Buchanan, 1999).

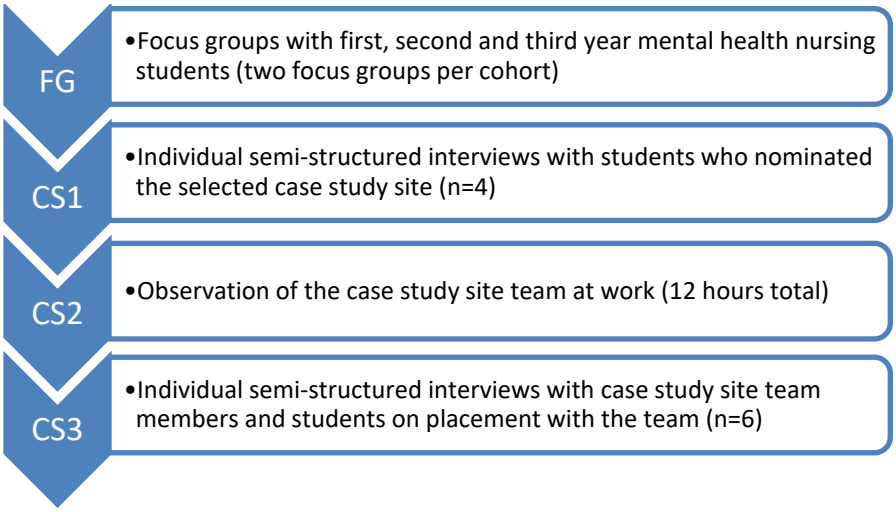
The case study strategy supports triangulation of rich and voluminous data collection from multiple sources and through multiple data collection methods. It was therefore concluded that this would be an appropriate strategy to provide vital insights into the potentially complex factors underpinning student mental health nurse socialisation in compassionate practice. Case study described by Stake (1994, 1995) is well aligned with the constructivist perspective and therefore the utilisation of a case study strategy as described by Stake (1994, 1995) was deemed appropriate to examine the phenomenon of interest (Yin, 2003). The methods devised to gather data to support the case study strategy are explored and described in section 3.5: Methods. However, although identified as the most appropriate strategy to proceed with the enquiry, Meyer (2001) and Yin (2003) identify that the case study strategy has a poorly defined process of data analysis. Fortunately, it is also identified that a case study strategy can be aligned with many analysis methods (Merriam, 1998; Lauckner, Paterson, and Krupa, 2012). Therefore, it was recognised that robust data analysis methods would have to be utilised in combination with the approach. This is further explored in section 3.6: Analysis.

Once the research strategy is decided upon, the Hiles (1999) model guides the researcher to consider the methods to be employed to facilitate data collection procedures within the research. Therefore, as a consequence of decisions made to conduct a qualitative, constructivist case study, methods for triangulation of data collection that align with this approach were considered. The procedures developed and adopted for collecting data for this research are explored and justified in the following section 3.5: Methods.

3.5: Methods

The methods that were utilised in this study are demonstrated in Diagram 3.1 (below). Rationale is provided for the decision to utilise each method, the theory underpinning each method, and detailed descriptions of how each method was applied to the study to facilitate data collection, is provided in this section.

Diagram 3.1: The methods of the study



Denicolo, Long and Bradley-Cole (2016) state that it is not possible to validate constructivist research as constructivist approaches emphasise the identification of patterns and meanings which are constructed through life experiences and are influenced by personal, historical and socio-cultural contexts (Gergen, 2001), rather than attempting to discover the definitive truth (Madill, Jordan and Shirley, 2000). However, it remains important that the researcher aims for constructivist studies to be sound and authoritative (Denicolo, Long and Bradley-Cole, 2016). According to Guba and Lincoln (1989) and Denicolo, Long and Bradley-Cole (2016), this can be achieved by aiming for the overall research design to be:

- **Credible** (robustly appropriate methodology / methods used to uncover the essence of the phenomena and provide credible data)
- **Confirmable** (the degree to which the research can be confirmed or corroborated by others)
- **Dependable** (methodology is trustworthy and carried out with integrity and transparency)
- **Transferable** (the research design is replicable, rather than the results being generalisable) Deniloco, Long and Bradley-Cole (2016) specify that ensuring that research complies with rigorous principles of credibility, confirmability, dependability and transferability provides a robust indication that research is of high quality. Reynolds et al (2011) identify that there are no standardised or structured

procedures to ensure quality in qualitative research. In this study it was determined that by ensuring that the research design met the principles listed above, the research would be able to withstand scrutiny and provide confidence regarding reliability of interpretation of data, which are key indicators of quality qualitative research (Reynolds et al, 2011).

The study evolved to include two phases to support a research strategy that was sound, authoritative, trustworthy, and that adequately addressed the complexity of the research questions (Hiles, 1999). The development of two phases also aimed to meet the principles of credibility, confirmability, dependability and transferability, therefore supporting high quality research. The phases of research are introduced below and then explored in greater depth throughout the following section.

Through preliminary background reading (Chapter Two – Literature Review), it was discovered that socialisation in compassionate practice is influenced by the personal experiences, the theoretical component of the nursing programme and practice experiences (Melia, 1987; Curtis, Horton and Smith, 2012; Curtis, 2015). As such, the decision was made to utilise student participant focus groups in phase one of data collection to facilitate the exploration of factors influencing socialisation in compassionate mental health nursing practice from individual, theory exposure and practice exposure lenses. The data gathered from focus groups with student mental health nurses demonstrated the perceived importance and impact of practice experiences on student socialisation in compassion. Constructivism provides a research framework that supports the emergence of constructs (or themes), which influence the development and evolution of the study (Rodwell, 1998, Charmaz, 2006). Therefore, data collected in the focus groups directly contributed to the decision to utilise the case study approach, as previously described, for phase two of the research. In addition, data obtained from the focus groups was used to provide guidance in relation to specific factors to be alert to during the case study. When it became evident that focus group participants believed the practice environment to be overwhelmingly the greatest influence on their socialisation in compassionate nursing practice, they were asked to identify practice areas that had supported that. The case study site that was chosen was

selected from the nominations made by student participants from the focus groups. The theory underpinning the use of credible focus groups is presented in section 3.5.1.1: Focus Groups – the theory. The recruitment procedure adopted is described in section 3.5.1.2: Phase one – Focus group recruitment. The aims of the focus groups are specified in section 3.5.1.3: Phase One data collection – Focus Groups. The practical implementation for the focus groups is described in 3.5.1.4: Operationalisation of Focus Groups.

As previously discussed, the utilisation of a case study was deemed to be most suitable to facilitate the gathering of data to explore the complex factors that influence student mental health nurses in their development as compassionate mental health nurses. The research also explored how positive socialisation in compassionate mental health nursing practice for mental health nursing students could be supported and facilitated. Indeed, multiple methods of data collection are encouraged in case study research, to facilitate a comprehensive, synergistic and holistic examination of the phenomenon under investigation (Harrison et al, 2017). Therefore, adoption of the case study methodology provided opportunity for multiple methods to be triangulated, to both cross-validate findings and also to uncover differing dimensions of socialisation in compassionate practice. Rodwell (1998) identifies that the utilisation of a case study and associated methods is preferred in constructivist studies as they are less reductionist than other research strategies, support the exploration of multiple realities and also support access to participants in a natural setting. Therefore, the decision was made to conduct a case study within phase two of the study, focusing upon a practice placement area identified by student mental health nurses. The case study aimed to uncover factors that both influenced and sustained positive socialisation in compassionate practice explicitly within the mental health nursing practice context. The methods utilised to collect data and justification for the development of methods utilised within the case study will further be described throughout the rest of the chapter[30]. Ethical considerations in relation to the study will also be described and justified in section 3.5.2.5: Ethical considerations of all phases.

[30] See 3.5.2.1: Phase Two case study selection – pg98; 3.5.2.1.2: Phase Two case study recruitment – pg100; 3.5.2.1.3: Phase Two Case Study Operationalisation – pg103; 3.5.2.2: Semi-structured interview the theory – pg103; 3.5.2.2.1 Semi-structured interview - operationalisation – pg105; 3.5.2.3: Practice observation – the theory – pg106 and 3.5.2.3.1: Practice Observation – Operationalisation - pg110.

This section has provided an overview of the methods selected for data collection and introduced the need for the research design to be credible, confirmable, dependable and transferable (Deniloco, Long and Bradley-Cole, 2016). The following sections explore the theory underpinning the methods selected for data collection in this study, the recruitment process', and descriptions of the application of methods to collect data, with the aim of demonstrating this research was indeed credible, confirmable, dependable and transferable.

3.5.1.1: Focus Groups – the theory

Focus groups are an established data collection method in social science research (Morgan, 1997). 'Group interviews' were first reported in research published in 1926 (Bogardus, 1926, cited in Morgan, 1997). Focus groups have grown in popularity throughout the social sciences and have become particularly popular within nursing research, with a number of nursing research publications detailing their use (Barbour and Kitzinger, 1999; Webb and Kevern, 2001). Focus groups are facilitated, structured groups with a small number of participants, and allow the exploration of individual views and experiences in relation to specific topics through group interaction (Litosseliti, 2003). Krueger (1994, pg6) defines the focus group as "*a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment".* Litosseliti (2003) identifies that focus groups are useful for: generating new information, obtaining differing perspectives on the same phenomenon/issue, obtaining information to assist in understanding participant attitudes, beliefs, opinions and experiences, and examining shared perceptions and understanding of participant and generating ideas.

Understanding of the phenomenon under scrutiny emerges from participants' open ended, flexible responses, providing the researcher with insight into the participants' experience of the world around them (Litosseliti, 2003). A key component of focus groups is that participants share their experiences and perceptions, but they are also able to respond to comments, suggestions, ideas and perceptions of other group participants (Litosseliti, 2003). This facilitates participants building and further developing views expressed within the

group and results in a synergistic approach in which a greater range of experiences, ideas and opinions are expressed, leading to deeper understanding of meaning (Stewart and Shamdasami, 1990). Participants can also learn from each other and may consequently re-evaluate their own understanding, perceptions and experiences (Kitzinger, 1994, 1995). Focus groups replicate a more *"natural environment"* (Litosseliti, 2003, pg2) than an individual interview which supports participants to both influence and be *"influenced by others – just as they are in real life"* (Kruegar, 1994, pg19). The utilisation of focus groups as a data collection method is therefore consistent with the ontological and epistemological beliefs underpinning a constructivist paradigm (Wahyuni, 2012). Additionally, Litosseliti (2003) states that focus groups are a useful medium to combine research flexibility with theoretical grounding and academic rigour. Utilising focus groups can therefore be invaluable for qualitative research projects (Kitzinger, 1994; Gibbs, 1997; Litosseliti, 2003).

It was hoped that with utilisation of focus groups, that participants would have the opportunity to share and re-evaluate their own experiences and enhance their understanding of the factors that influenced their socialisation in compassionate mental health nursing practice. The ultimate aim was to achieve in-depth understanding of participant experiences, feelings and 'truth' about their socialisation in compassionate mental health nursing practice through the co-creation of knowledge between participants and the researcher. It was recognised that good focus group practice and effective facilitation would have to be engaged in to achieve this.

Although multiple benefits of utilising focus groups to assist data collection is evident, there are recognised challenges in focus group utilisation which were considered to support effective facilitation of each focus group. Litosseliti (2003) identified the following issues for consideration by the researcher:

- False consensus – where one or two participants dominate the session and other participants agree with them to avoid conflict
- The facilitator may find it difficult to distinguish between the views of individuals and the group, and individuals who disagree with points may not wish to say so

- Limited participants and therefore representativeness of the sample leads to difficulties making generalisations about data uncovered
- Analysis and interpretation of focus group results can be complex.

However, Litosseliti (2003) goes on to identify that these limitations can be addressed through considered planning and robust focus group facilitation. This includes the researcher ensuring appropriate selection of participants (purposive sampling was employed in this study, by inviting participants who shared the same characteristics of being a student mental health nurse), ensuring clarity about focus group expectations, and the facilitator ensuring that leading questions were avoided (Litosseliti, 2003). It was recognised that the issue of lack of generalisability could be overcome by ensuring focus groups were triangulated with other data collection methods (Litosseliti, 2003) (as evident in phase two of this research) and by acknowledging that focus groups and indeed constructivist research are not generalizable but may be indicative of the phenomenon under investigation (Litosseliti, 2003; Wahyuni, 2012; Denicolo, Long and Bradley-Cole, 2016).

Litosseliti (2003) identifies that different types of focus groups should be used for different types of research (for example, telephone groups may be utilised for marketing focus groups) and suggests the social sciences research projects should utilise full face to face groups. It is identified that groups conducted in person maximise richness of data and helps to facilitate spontaneity from participants, as well as offering the facilitator the opportunity to read for non-verbal communication between participants which can further assist in the development of social constructs (Litosseliti, 2003). It is further suggested that face to face social science focus groups should aim to include between 6 and 10 participants (Litosseliti, 2003) although some authors recommend 6 to 12 participants as appropriate (Barbour and Kitzinger, 1999). It is however agreed that any fewer participants than 6 may not result in the depth of rich data required to fully explore the phenomenon under scrutiny (Barbour and Kitzinger, 1999), due to the limited opportunity for spontaneity, thus having a negative impact upon richness of response (Barbour and Kitzinger, 1999; Litosseliti, 2003). It is further suggested that any more than 10 to 12 participants may result in challenges for the

group facilitator to manage the discussion, which could lead to less detailed discussion and more broad accounts being shared which may not be representative of participant views and experiences (Litosseliti, 2003). Likewise, Litosseliti, (2003) suggests that facilitating too many focus groups may result in repetition of issues discussed and therefore suggests that two focus groups can be useful; the first with the aim of identifying broad issues and a follow up session with the aim of facilitating deeper and comparative exploration of issues addressed.

The theory underpinning the use of focus groups demonstrates that they provide a credible method of collecting data to uncover the essence (Deniloco, Long and Bradley-Cole, 2016) of student mental health nurse socialisation in compassionate practice. Dependability in relation to the use of focus groups in this study is further explored in the following sections, which describe the focus group recruitment process (3.5.1.2: Phase One Recruitment) and the practical implementation of the focus groups in this study (3.5.1.3: Phase One data collection).

3.5.1.2: Phase One - Focus Group Recruitment

To recruit students to phase one focus groups, the programme leader for undergraduate BSc in Nursing (with NMC registration) was asked to email all first, second and third-year mental health nursing students from the January (01) cohorts to invite them to participate in the research. 01 cohort students were first choice for participation due to the phase of their programme being best aligned to the time in which the focus groups were planned, in order to avoid delaying the data collection process. However, had recruitment targets not been met from the 01 cohorts, the backup plan of recruiting from the September (09) cohorts was in place. The invitation email outlined the key aspects of the project. Students were asked to express their interest in participation in the study by emailing the lead researcher and returning a reply slip (Appendix 9). Each student who expressed interest was forwarded a Participant Information Sheet (Appendix 8), which explained the study in detail including issues such as confidentiality. Researcher availability to discuss the information

provided in greater detail and to clarify any questions that individuals may have had about the study and their participation was ensured.

To maximise potential participant inclusion, the researcher also organised to attend suitable student lectures to discuss the project with students and answer any questions that they had. Students were not directly recruited from these lectures but were asked to consider participation and email expressions of interest of participation to the researcher. This method of recruitment increased participation by 100%.

The recruitment methods utilised and described above demonstrate transferability (Deniloco, Long and Bradley-Cole, 2016) as the procedure could be easily replicated by future researchers, contributing to the trustworthiness of the overall research design.

Once student mental health nurse participants were recruited, the focus groups were commenced. The aims of the focus groups are described in the following section and the practical implementation of the focus groups is described in the section 3.5.1.4: Operationalisation of Focus Groups.

3.5.1.3: Phase One data collection – Focus Group Aims

The first aim of the focus groups was to explore the factors that influenced socialisation in compassionate mental health nursing care by gaining a deeper understanding of student mental health nurse experience of compassionate practice. The second aim of the focus groups was for student mental health nurses to provide accounts of their experience and reality of socialisation in compassionate practice from a personal perspective (Denicolo, Long and Bradley-Cole, 2016), and provide opportunity for participants to express their developing views based on responses from other participants (Litosseliti, 2003). The third aim of the focus groups was for information gathered in this phase to support the emergent design of the second phase of data collection (Rodwell, 1998), by identifying mental health student nurse placement experiences that supported appropriate socialisation in compassionate mental health nursing practice. As such, recommendations made by student

participants in this phase of the study led to the selection of case study site in phase two of the study. Selection of the chosen case study site following these recommendations is discussed further in section 3.5.2.2: Phase Two data collection. In addition to this, data collected from the focus groups also facilitated the identification of significant factors for the researcher to be alert to during the case study phase. The researcher was led by the emerging data that was obtained in the focus groups which led to the development of the overall research framework and had a direct impact upon the evolution of the study (Rodwell, 1998; Charmaz, 2006).

3.5.1.4: Operationalisation of Focus Groups

Following recruitment of participants as described above, separate focus groups were facilitated with first, second and third-year undergraduate mental health nurses studying at De Montfort University. The students were invited to take part in two focus groups during the 2016/2017 academic year. The decision to have separate focus groups for each cohort was strategic, as it was identified that students were likely to feel more conformable discussing issues with other students that they knew and shared similarities with (in terms of being student mental health nurses in the same phase of their programme). It also allowed fair representation of students from each cohort as it was identified that there was an increased probability of false consensus of perhaps third-year student dominating sessions, and others agreeing due to the perceived hierarchal status. The aim was to recruit between 6 to 12 participants for each focus group for the reasons outlined previously and it was decided that two focus groups per cohort would be used as per Litosseliti's (2003) recommendation, also previously identified. The first focus groups for each cohort were facilitated at the beginning of their academic year, and the second group towards the end of their academic year. It was hoped that this would highlight any significant points throughout the year that contributed either positively or negatively to student socialisation in compassionate mental health care and allow further insights into student development within the programme. However, the focus groups had to be organised around the student planner and as the third-year students were out in placement towards the end of their year,

their second focus group had to be brought forward by two months to support their attendance and engagement.

Table 3.3 (below) demonstrates the timeline of focus groups completed with each cohort and the number of participants at each focus group.

Table 3.3 – Focus Group breakdown

Mental Health Student Nurse Year of Study	Focus Group 1	Number of participants	Focus Group 2	Number of participants
First Year	April 2016	10	February 2017	6
Second Year	April 2016	2	February 2017	2
Third Year	April 2016	11	November 2016	9

Although the required number of participants were recruited for the first and third-year focus groups (and initial numbers ensured that even with inevitable withdrawal from the study, there would still be an appropriate number of participants in each group), only two participants were recruited for the second-year focus groups. However, it is worth noting that the entire cohort from which these participants volunteered was a small group of eight mental health student nurses. Therefore, the two that did participate equalled 25% of the total group. Although not ideal (for the reasons outlined above), it was rationalised that if skilfully facilitated, useful data could potentially still be generated from the two participants.

Focus groups were held at De Montfort University and were arranged around the student's academic timetables, with the aim of maximising attendance and ensuring that student participants were comfortable in their surroundings to encourage open responses (Litosseliti, 2003). Each focus group lasted approximately one hour each with the aim of avoiding repetitiveness and oversaturation of data (Litosseliti, 2003).

The emphasis of the focus group method was observation to facilitate explorative and interpretative responses from participants (Litosseliti, 2003). However, the importance of preparing a focus group agenda (appendix 6) was recognised, to assist with providing structure to the groups (Litosseliti, 2003) and a list of topic questions (appendix 7) to guide the participants and further help maintain the structure of the sessions (Litosseliti, 2003). The focus group questions were carefully considered, developed and sequenced appropriately in the focus groups to facilitate the generation of in-depth discussion (Litosseliti, 2003). Knowledge developed from engaging in the research and writing of Chapter Two –Literature Review, was used to generate the question guide with the aim of developing understanding of participant perceptions and experience of the issues identified within the literature reviewed. Questions were purposely designed to use an open-ended or neutral questioning stance rather than using closed questions to encourage participant discussion (Litosseliti, 2003). General or broad questions were strategically used before more complex or controversial questions, with the aim of building participant confidence at answering questions as the focus groups developed (Litosseliti, 2003). Participants were also encouraged to reflect upon and develop their ideas, views, opinions and perceptions of experiences within the group context (Litosseliti, 2003) which is consistent with the ontological and epistemological underpinnings of a constructivist approach (Wahyuni, 2012; Denicolo, Long and Bradley-Cole, 2016). Lecturing and classroom management skills were drawn upon to support robust focus group facilitation. Efforts were made to support student participants to feel that they were in a safe space, where they could openly discuss their experiences and share and explore their beliefs and opinions without fear of rebuke or judgement from the facilitator. This in turn role modelled the expectations of non-judgement from other focus groups participants. Previously developed classroom management skills, also resulted in facilitator confidence and ability to provide all participants the opportunity to contribute, rather than discussions being dominated by a few participants only. This was further enhanced by re-enforcement that all student participant contributions were valued and meaningful. Used in combination, all of these factors resulted in rich, voluminous and insightful data being obtained from the focus groups that were facilitated.

Participants who attended the second focus group for each cohort were invited to identify and recommend placement areas which in their opinion had assisted in their positive socialisation in compassionate care practices. These recommendations were then utilised to guide the recruitment of the case study site in the second phase of the study. This will be further explored in the following section, 3.5.2.1: Phase Two case study selection.

3.5.2.1: Phase Two case study selection

As previously stated, Meyer (2001) defines a 'case' as single or multiple organisations or groups within organisations. For the purpose of this research, the 'case' was a single placement area within a local NHS Trust provider that students had accessed as part of their placement experiences throughout their programme of study. Indeed, the in-depth practice case study site (n=1) was chosen from placement areas identified by participants in phase one as described previously. The original research strategy was to access multiple case study sites that were deemed to be representative of areas of practice that students have access to throughout their programme of education. As such, the original research plan proposed the completion of case studies in adult acute services, community services, older person services, treatment and recovery services, forensic services and child and adolescent services. The aim of accessing multiple sites was to develop understanding of how socialisation in compassionate mental health nursing practice may occur within diverse clinical areas (Anaf, Sheppard, and Drummond, 2007; Stake, 2000). However, Stoecker (1991; cited in Lauckner, Paterson, and Krupa, 2012) states that utilising multiple case studies may lead to oversaturation of data which results in the researcher missing important idiosyncrasies of each individual case. To reduce the risk of this, Creswell (1998) suggests that a maximum of four cases be examined to allow adequate exploration of each case. Furthermore, participants from phase one did not recommend any forensic or child and adolescent services for case study investigation, which automatically excluded these services from case study selection.

However, after drawing on the work from Stake (1994, 1995) regarding the effective use of single site case study, as explored in section 3.4.1: The Selection of a qualitative strategy for

data collection, and due to time pressures of the study and lack of resources (single researcher conducting the study with no funding), it was concluded that accessing a single case study site would be appropriate if voluminous data could be collected. This could be achieved by using multiple data collection methods within the overall case study strategy (Creswell, 2012; Lauchner, Paterson and Krupa, 2012). Therefore, the decision was made to focus upon a singular case study site for this research, but to utilise multiple methods of data collection to enhance access to rich data. It is however acknowledged that utilising a singular case study site could be viewed as a limitation to this research, and it is recommended that any future studies consider the use of multiple case study sites to support exploration of comparisons (Anaf, Sheppard and Drummond, 2007; Stake, 2000) of student nurse socialisation in compassionate mental health nursing care. Table 3.4 (below) demonstrates the breakdown of services recommended by participants in phase one.

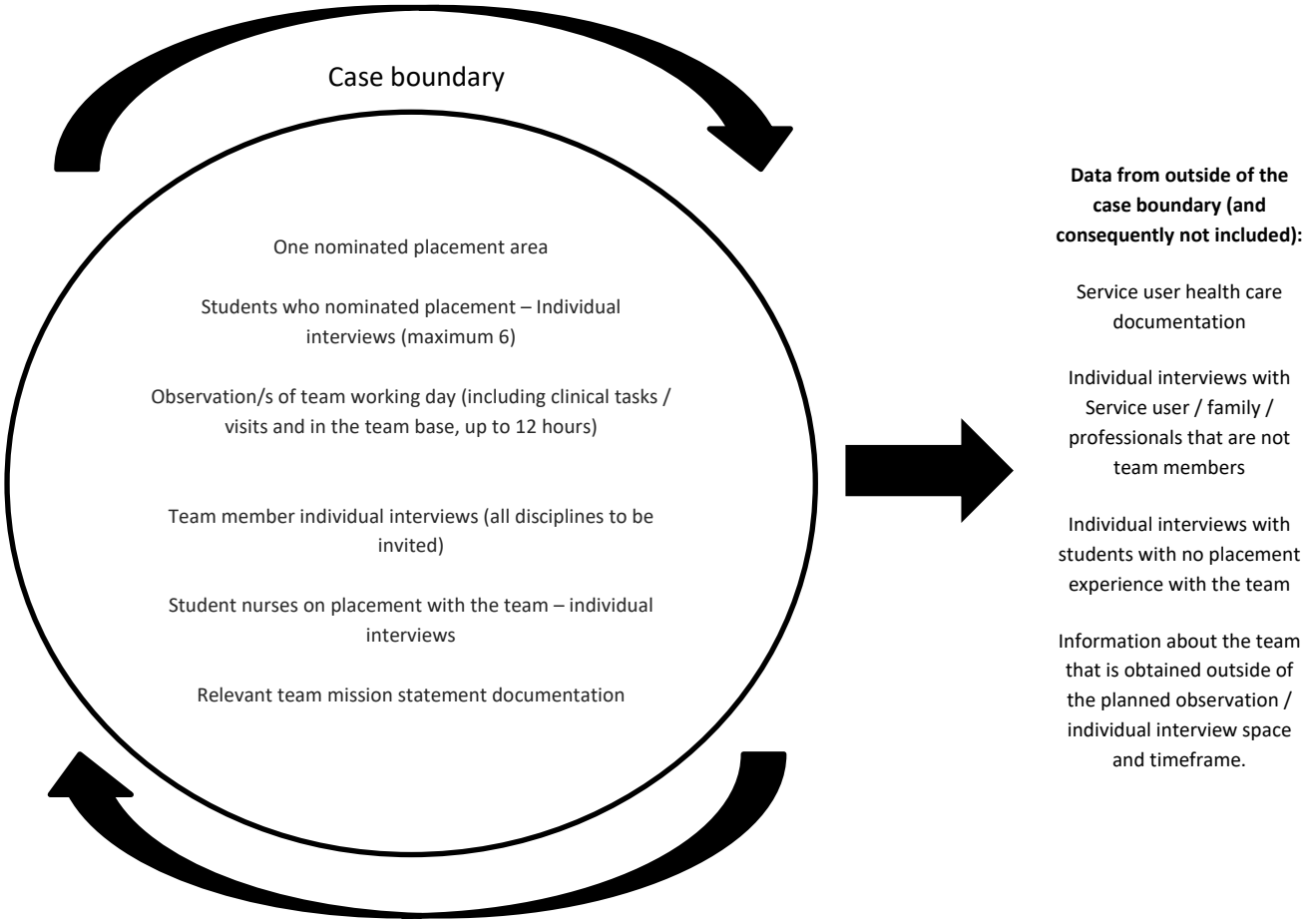
Table 3.4: Placements recommended by participants in phase one

Team Specialism:	Number of Nominations:	Highest number of nominations for one team from the specialist subgroup:
Adult In-patient	10	2
Community	16	6
Older Adult In-patient	3	2
Recovery and Treatment	10	2

The ultimate selection for the case study was based upon the frequency in which all student participants recommended specific areas in the focus groups completed in phase one. The selected case study site was recommended by n=6 student participants in total.

An important aspect of case study methodology is the boundaries that are applied to clearly set out the scope of the case study (Merriam, 1998; Harrison et al, 2017). Indeed, case boundaries define what is and is not included in the study (Harrison et al, 2017). Merriam (1998) states that if boundaries are not applied to a study, it cannot qualify as a case study. The boundaries applied to this study are demonstrated in figure 3.2 (below).

Figure 3.2: Applied case study boundaries



Once the case had been identified by participants and selected, and the case study boundaries had been established, the placement area was invited to participate in the case study phase of the research. The recruitment process for the case study is described in the following section, 3.5.2.1: Phase Two case study recruitment.

3.5.2.1.2: Phase Two case study recruitment

To facilitate team recruitment to the study, a letter was sent to the team manager of the nominated placement area (appendix 10). Examples of a participant information sheet (appendix 11) were also included as well as a reply slip (appendix 12) for the team manager to return if interested in participating. Once the completed reply slip was returned, indicating interest in the study, contact was made with the team manager to facilitate a visit

to the team to introduce the research. Prior to the planned meeting, the team manager was asked to discuss the study with the team and distribute participant information sheets and individual invitations (appendix 13) for team staff to participate in clinical observations and individual interviews, therefore reducing the potential for staff/the team as a whole to feel pressurised to volunteer to participate.

Following this, presentation of the research was arranged at a weekly team meeting. This also provided opportunity for any questions that team staff had to be answered. Team members were given time to consider the research and decide if they wished to be involved following the meeting. The manager then contacted the researcher the following day to confirm that the team had discussed the research and had agreed to participate. Once consent was given by the team manager, a suitable time for observation to take place was agreed and it was decided that the researcher could observe team staff in their daily work. This included observation of team staff visiting service users in care home environments and engaging in work tasks at the team base. The manager also invited the researcher to observe the whole team in their weekly team meeting.

Posters (appendix 14) were designed for the practice area explaining the researcher's background and the purpose of the research. The intention of these was for them to be used in the practice area so any service users, carers or staff accessing the area were aware that an observation was occurring. Team staff were given the opportunity to 'opt out' (appendix 15) of the observation if they wished to. However, fortunately no staff members opted out of participation of the observation.

Service users and their carers receiving care from the team and who were visited during the occurrence of observations of team staff were informed of the researcher's role and the study by the team member under observation. No information about service users was included in data collection and no service user details were recorded. However, service users were also provided with the opportunity to 'opt out' (appendix 16) of the observation if they so wished. As all service users visited had a diagnosis of varying stages of dementia, and therefore their capacity to consent could have been impaired, permission was sought

from care home managers/staff in which team staff under observation visited service users, to allow the researcher to observe team member interactions and work in the care home environment.

After the observation period, the individual semi-structured interviews with staff members at the team base were organised. All team staff who agreed to be observed and did not chose to opt out of the observation process where be invited to participate. The individual interviews (appendix 17) explored personal beliefs, attitudes and experiences of compassionate practice, as well as student socialisation in compassionate practice, in greater depth and lasted approximately 20 - 30 minutes per participant. All interviews were carried out in a booked private room within the teams' base area and were digitally recorded. Glaser (1965) states that recording and transcribing data can be counter-productive when a grounded theory approach to data analysis is utilised, and instead recommends utilising field notes of interviews as an alternative to facilitate an acceptable pace to support theory generation. However, Charmaz (2006) argues that recording and transcription of data obtained in individual interviews supports the coding and re-coding that is integral to a grounded theory data analysis approach. This is therefore why digital recording equipment was utilised in the study.

Finally, consent (appendix 19) was obtained from each team member participant before each individual semi-structured interview occurred. Staff were made aware that they could agree to be observed without also agreeing to participate in an individual interview. It was also explicitly explained to staff participants that they could choose to withdraw from the study at any time, but that data collected up until their point of withdrawal would continue to be utilised in the study.

Once appropriate recruitment of participants occurred, methods utilised to gather data from participants were utilised. The following section 3.5.2.1.3: Phase Two Case Study Operationalisation, details the methods utilised within the case study to support the collection of data, to facilitate analysis of the factors underpinning student mental health nurse socialisation in compassionate practice.

3.5.2.1.3: Phase Two Case Study Operationalisation

To enhance credibility and collection of data to facilitate in-depth exploration of the factors that underpinned and influenced socialisation in compassionate mental health nursing practice, the case study evolved to incorporate triangulation of three specific data collection methods:

i. Individual semi-structured interviews with student participants who had recommended the placement area in phase one – focus groups
ii. Practice observations of the daily work of staff employed at the case study site
iii. Individual semi-structured interviews with staff employed at the case study site.

Justification for utilisation of each of these methods of data collection to form the case study, is provided in the following sections of this chapter.

3.5.2.2: Semi-Structured Interview – The theory

Interviews are a widely used method of data collection in social research (Denzin and Lincoln, 2018) and allow a verbal exchange between the researcher and participant, in which the researcher aims to elicit information, opinions or beliefs from the participant (Maccoby and Maccoby, 1954; cited in Denzin and Lincoln, 2018). In modern research there are different modes of interview, including telephone interviews and online interviews (Denzin and Lincoln, 2018). Indeed, these types of interviews may prove very useful for marketing research (Denzin and Lincoln, 2018). However, the importance of face-to-face interviews in which the researcher could be engaged and present, due to the impact that interpersonal skills can have on eliciting required data, and the potentially sensitive content of the interviews (Denzin and Lincoln, 2018) was acknowledged for this study.

Three types of face-to-face interview are described in the literature (Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015), these are structured interviews, unstructured interviews and semi-structured interviews.

Structured interviews are most commonly utilised in surveys and use the same logic as questionnaires (Denzin and Lincoln, 2018). Researchers administering the interview should read the questions developed precisely to each participant and do not provide any other information to that of the scripted interview (Conrad and Schober, 2008; cited in Denzin and Lincoln, 2018). Although structured interviews can be useful in some contexts, the decision was made to exclude this method of interviewing from the study as structured interviews do not support the interaction between the researcher and participant that would maximise participant engagement and develop the in-depth knowledge (Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015) of socialisation in compassionate mental health nursing practice that was required in this study. The approach is also inconsistent with the axiology of the constructivist paradigm in which the researcher is viewed as being an integral part of the phenomenon under investigation (Wahyuni, 2012).

Unstructured interviews are a contrast to structured interviews and the researcher spends considerable time with the participant to understand and explore their experiences, views and opinions (Denzin and Lincoln, 2018). The interviewer cannot prepare questions for the interview and instead, allows the participant free narrative (Denzin and Lincoln, 2018). The role of the interviewer is to attentively listen, refrain from interrupting and ask only occasional questions for clarification purposes (Denzin and Lincoln, 2018). The use of unstructured interviews was discounted due to resource and time restraints, and because the aim of the interviews was to collect data about the chosen case study area. As such, it was important that the interview have some structure to provide topic guidance for participants to support focus.

Semi-structured interviews provide a median between structured and unstructured interviews (Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015). They are often utilised as a method of qualitative interviewing (Warren, 2002; cited in Denzin and Lincoln, 2018) and are popular within human and social research (Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015). Semi-structured interviews provide additional flexibility to that of the structured interview, and it is acknowledged that dialogue between the interviewer and

participant can lead to rich, in-depth data collection (Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015). As such the use of semi-structured interviews supports interaction between the researcher and participants, which is fundamental in the knowledge building process of constructivism (Rodwell, 1998) as previously described. The flexibility of the semi-structured interview also allows the interviewer to pursue any important thoughts expressed by the participant and the researcher can be visible in the consequent knowledge production (Denzin and Lincoln, 2018), therefore the utilisation of semi-structured interviews is consistent with the constructivist paradigm axiology (Wahyuni, 2012). In comparison to unstructured interviews, the interviewer can focus the interview on issues deemed most relevant to the phenomenon under investigation (Denzin and Lincoln, 2018). Indeed, Brinkmann and Kvale (2015, pg6; cited in Denzin and Lincoln, 2018, pg580) state that the semi-structured interview *"is defined as an interview with the purpose of obtaining descriptions of the world life of the interviewee in order to interpret the meaning of the described phenomena"*. Therefore, the decision was made to utilise semi-structured interviews to gather data within the case study.

3.5.2.2.1: Semi Structured interviews - operationalisation

Semi-structured interviews were completed with n=4 of the student participants who recommended the clinical area for case study in phase one – focus groups, prior to access of the case study site. The aim of this was to elicit information in relation to the reasons they had nominated the area and to provide some guidance in relation to the completion of the observations and development of semi-structured interviews within the practice area. This therefore directly contributed to the emergent research process, which is consistent with constructivism (Rodwell, 1998). The decision was also made to include semi-structured interviews with staff working in the selected case study site and student mental health nurses on placement with the case study site after team observations were completed. The aim of this was to provide opportunity to find out additional information from team staff and students to clarify points of interest and pertinence identified in the observation process. There was also opportunity to explore personal experiences of the realities of

compassionate practice and student socialisation in compassionate practice in greater depth within the practice environment.

Table 3.5 (below), demonstrates the number of semi-structured interviews completed during phase two and the disciplinary background of those who participated:

Table 3.5: Participants in individual semi-structured interviews

Pre / during clinical site access:	Discipline / Background:
Pre-site access	Student Mental Health Nurse (3rd Year)
Pre-site access	Student Mental Health Nurse (3rd Year)
Pre-site access	Student Mental Health Nurse (2nd Year)
Pre-site access	Student Mental Health Nurse (2nd Year)
During site access	Team Manager (Mental Health Nurse)
During site access	Community Mental Health Nurse – Band 6
During site access	Community Mental Health Nurse – Band 6
During site access	Community Mental Health Nurse – Band 6
During site access	Clinical Psychologist
During site access	Student Mental Health Nurse (2nd Year)

After semi-structured interviews were completed with student mental health nurses who recommended the area for case study, practice observations were engaged in. The theory justifying the inclusion of practice observation in the case study research design is provided in section 3.5.2.3: Practice Observation – The theory, below. The reality of how observation was engaged in within this study is explained in section 3.5.2.3.1: Practice Observation - Operationalisation.

3.5.2.3: Practice Observation – The theory

The utilisation of observation in research is well established, indeed Angrosino and Rosenberg (2011; cited in Denzin and Lincoln, 2018) highlight that observation is a foundation of research methodology. Observation is commonly utilised in case study research (Stake, 2000) and utilising observation in constructivist case study research is appropriate when the research focuses on *"what people do, how they behave or actions they take in specific circumstances*" (Denicolo, Long and Bradley-Cole, 2016, pg18). Stake (1995) identifies that utilising observation in case study research allows the researcher to develop greater understanding of the intricacies of the case under exploration. Observation facilitates the exploration of unique relationships which the researcher may be otherwise

unexposed to, and this allows unique description and understanding of the case study site to be developed (Stake, 1995). Observation is also consistent with constructivist research as it facilitates the investigation of the social interpretations which may influence the phenomenon under investigation (Stake, 1995). It allows the researcher first-hand insight into participants experiences (Gerrish and Lathlean, 2015) rather than relying on individual interviews, which may be unreliable as a singular method due to participants potentially responding with what they assume the research wants to hear rather than an accurate account of their experiences (Denicolo, Long and Bradley-Cole, 2016). The cross validation facilitated by triangulation of multiple methods of data collection therefore provides rationale for the use of semi-structured interviews and observations in combination, in order to obtain the data required to explore the research question for this study (Gerrish and Lathlean, 2015).

Gerrish and Lathlean (2015) identify that observation methods may range from unstructured to highly structured in design. McLeod (2015) identifies three types of observation commonly used in social and psychological research: controlled observation, naturalistic observation, and participant observation.

Neither controlled (appropriate for quantitative observation studies) or naturalistic observation (commonly utilised by zoologists and naturalists to explore the natural world) (McLeod, 2015) were deemed appropriate for this study. Participant observation is commonly used in nursing and social research and is strongly associated with qualitative methodology (Gerrish and Lathlean, 2015). Participant observation allows the observer to explore and understand experiences from the perspective of the participant, by observing participants in their normal environment (Gerrish and Lathlean, 2015).

Within observation, the role of the observer is on a continuum from full participant to complete observer (Gold, 1969; cited in Gerrish and Lathlean, 2015). The role of full participant, in which the observer is completely embedded in the research area and fully participates in activities of those under observation, is often utilised in ethnography studies

(Gerrish and Lathlean, 2015). The observation may be carried out covertly, as participants are not aware that they are being observed (Gerrish and Lathlean, 2015) and as such there are ethical implications to consider when conducting covert observations (observation without consent) (Gerrish and Lathlean, 2015). The decision was made to exclude the utilisation of complete participant observation within this study due to the amount of time required to become an established member of the team, and because this level of immersion as an observer is consistent with ethnography which was discounted as an approach for this study.

According to Gerrish and Lathlean (2015), the role of complete observer is most commonly used within quantitative studies, and as the term suggests, the researcher is a complete observer with no interaction with the environment and participants under observation. As planned observations were conducted within the practice environment and it was acknowledged that observer presence would have an impact, the decision was made to engage in the observation as an observer-as-participant. This allowed participants to discuss the work of the team and reflect on their actions (Gold, 1969; cited in Gerrish and Lathlean, 2015) throughout all periods of observation. This is consistent with fundamental principles of constructivism, as previously discussed, in which the importance of researcher – participant interaction is acknowledged and encouraged (Rodwell, 1998). It is further acknowledged that as the primary researcher is a mental health nurse by background, participants may have viewed the researcher/observer as an 'insider' who could be trusted to understand the context of care delivery, and be less judgemental about care activities engaged in. This could have supported participants to feel comfortable, leading to a reduction in modified behaviour, which can occur when observations are utilised (Oswald, Sherratt and Smith, 2014). Consequently, it was hoped that this would positively impact interaction, resulting in more trustworthy data collection. However, it was also recognised that professional background of the researcher could also be a disadvantage, as the researcher could hold professional bias which may influence the interpretation of actions observed. This was taken into consideration during the data collection and analysis stage

and steps were taken to reduce the potential impact of this, in relation to recording of field notes which is described below.

In addition to the potential disadvantages in relation to the researcher's primary profession, other potential limitations of the utilisation of participant observation in case study research were considered. Such limitations include the influence of the Hawthorne effect in which participants, being aware of the observation being undertaken, may modify their behaviour (Oswald, Sherratt and Smith, 2014). The Hawthorne effect is known as the 'Achilles heel' of observation research (Coombs and Smith, 2003; cited in Oswald, Sherratt and Smith, 2014). Therefore, it is essential for the researcher engaging in participant observation to consider approaches to reduce the potential impact of the Hawthorne effect and potential contamination of data gathered and consequent results (Oswald, Sherratt, Smith, 2014). One strategy is using multiple data collection approaches to enhance reliability of findings and reduce the potential impact of the Hawthorne effect (Bryman, 2003; Oswald, Sherratt and Smith, 2014), which provides additional rationale for the incorporation of semi-structured interviews within the case study. Oswald, Sherratt and Smith (2014) describe the importance of the observer building a relationship with participants through conversation and suggest a six-phase protocol to mitigate the impact of the Hawthorne effect. The six stages of the protocol are:

I. Gauge the person
II. Non-threatening perception
III. Introduction
IV. Establishing rapport
V. Relaxed signal
VI. Link conversation to area of interest

Based on previous experience, this approach was consistent with the skills utilised in mental health nursing practice and therefore was easily adopted in the observation phase of the study. Each stage of the protocol is described below and details of how the protocol was

applied to this research are provided in the following section 3.5.2.3.1: Practice Observation – Operationalisation.

3.5.2.3.1: Practice Observation - Operationalisation

The purpose of engaging in practice observation was to allow focus on the staff at the case study site and to develop insights into the ways in which they supported and sustained student mental health nurse socialisation in compassionate mental health practice. In total, 12 hours were spent in the practice area selected to allow for holistic observation to take place. The holistic observation focused upon the quality of student mentorship (supervision/support/guidance/engagement/assessment) and staff engagement in compassionate activities with service users, each other and aimed towards students. Furthermore, relationships between:

- members of the practice team
- practice staff and students
- practice staff and other non-team staff involved in service user care
- practice staff and service users

was also focused on during the 12 hours of holistic observation that was undertaken.

'Shadowing' of the clinical team during daily work, supported this and allowed the first-hand observation of any relevant details in terms of culture or events of interest (Denscombe, 2004) that may have had an impact upon student mental health nurse socialisation in compassionate practice.

Three separate periods of observation were conducted which are detailed in Table 3.6 below.

Table 3.6: Observation breakdown

Observation date	Observation Length	Observation details	Participants:
October 2017	4 hours	Initial assessment of a service user in a care home environment with a Band 6 nurse	One Community Mental Health Nurse – Band 6
November 2017	4 hours	Care home visits to see several service users with a band 6 nurse and student mental health nurse	One community Mental Health Nurse – Band 6 and one student mental health nurse – 2nd year
December 2017	4 hours	Weekly team meeting	One team manager (nurse background), Two medics, One psychologist, One occupational therapist, One support worker, One student mental health nurse – 2nd year, Two administrators, Five Community Mental Health nurses (both band 5 and 6).

As identified previously, consideration was given to minimising the potential for the Hawthorne effect throughout each observation period and the six-phase protocol developed by Oswald, Sherratt and Smith (2014) was utilised. The protocol is described below and details of how it was applied in this study are also provided.

3.5.2.4.: Reducing the potential for the Hawthorne effect

The first stage of the Oswald, Sherratt and Smith (2014) protocol involves the researcher gauging both the setting and the participants. The semi-structured interviews completed with student participants prior to accessing the practice site facilitated this phase of the protocol and supported the gauging of the environment and potential participants through information received in the student participant interviews. The next phase of the protocol was for the researcher to create a non-threatening perception (Oswald, Sherratt and Smith, 2014). As part of the recruitment strategy for the case study site, the researcher arranged to attend a team meeting to discuss the study and provide participant information face-to-face to team members. In preparation for this, personal presentation was considered in an attempt to maximise engagement, with the researcher making a conscious decision to dress in a smart – casual outfit, as the team members would be required to do for their daily work. Appropriate body language and eye contact were demonstrated throughout the meeting to avoid presenting as either too distant or intimidating (Shea, 1998). Efforts were

made to respond to team humour appropriately, thus demonstrating flexibility and spontaneity in communication which assists in building relationships (Shea, 1998). General 'small talk' was also engaged in with team members, again with the aim of reducing any potential perceived threat held by team members (McCosker, Barnard and Gerber, 2001). Attending the team meeting also provided appropriate opportunity for full introduction to be offered. Oswald, Sherratt and Smith (2014) identify that appropriate introductions are fundamental to a successful observation process and highlight introductions as the third stage of the six-stage protocol. When participants are observed by an observer who has not introduced themselves, they can find this extremely stressful. Participants are then likely to question why the researcher is observing them and also question their own abilities and skills, resulting in a potential increase of mistakes or errors being made (Oswald, Sherratt and Smith 2014). Therefore, a full introduction was offered at the recruitment meeting and introductions were also offered at each subsequent observation visit. Stage four of the protocol involves the researcher establishing a rapport with observation participants. The previous stages had laid the foundations for establishing rapport with team member participants, and further efforts were made to establish rapport at each subsequent observation visit by utilising effective communication skills. This included ensuring open body language, appropriate eye contact and demonstrating active listening (Webb, 2011). Further effective communication skills used were demonstrating responsive, spontaneous and consistent humour (Shea, 1998), ensuring that first names were used early on and throughout conversations, and being complimentary (Oswald, Sherratt and Smith, 2014) where appropriate, while demonstrating genuineness (Shea, 1998). Similarities of the researcher being a registered mental health nurse and having worked within community mental health environments was also utilised to establish rapport (Oswald, Sherratt and Smith, 2014). Stage five is the recognition of signals that participants are relaxed (Oswald, Sherratt and Smith, 2014). This is identified as being one of the most important stages to reach within the protocol, as once participants demonstrate that they feel relaxed around the observer, they are more likely to share honest expressions, thoughts and perceptions (Oswald, Sherratt and Smith, 2014). The biggest indicator that this stage has been met is when participants engage in light humour around the observer (Oswald, Sherratt and Smith 2014). This was established relatively early on due to engaging in the previous steps of the

protocol and identified humour both in the initial recruitment meeting and in all subsequent observational visits. The final stage of the protocol is when the observer is able to engage the participant in conversation about the phenomenon under investigation. This was initially achieved by discussing issues in relation to compassion at various care homes the team service user group resided in with staff participants, which led to discussions and individual reflections of care.

The Oswald, Sherratt and Smith (2014) protocol for reducing the impact of the Hawthorne effect was a useful model to subscribe to. It reduced the impact of the Hawthorne effect on data collection and allowed the participants to feel comfortable enough to demonstrate behaviour and thoughts that may have not otherwise been observed. The implementation of the protocol was easy to incorporate, as it is very similar to communication approaches that the researcher has previously utilised to maximise service user engagement when in clinical practice.

3.5.2.4.1: The importance of recording robust observation field notes

In addition to taking proactive steps to minimise the potential impact of the Hawthorne effect, consideration also had to be given to the way in which data was recorded from the observations. It is identified that field notes may take a variety of forms such as handwritten notes, audiotaped notes or electronic files (Yin, 2014). Field notes may be informal 'jottings' that the researcher keeps throughout the observation process and should be converted into formal field notes as soon as possible after the observation process (Yin, 2014). It is recognised that recorded field notes are a construction of the researcher's experience within the field, which reflects their perspective and conscious and subconscious choices about pertinent issues identified during the observation process (Sunstein and Chiseri-Strater, 2007). Therefore, detailed field notes relating to people observed, behaviours, actions, activities and the environment were taken throughout the observation (Schwandt, 2015), to provide both sequential and consequential scenes from the observation process for later analysis (Charmaz, 2006). The field notes taken included both descriptive information in relation to the factors observed, reflective information which

served as a record of the researcher's own thoughts, and notes for lines of further inquiry in semi-structured interviews with practice staff (Schwandt, 2015). This level of detail in field notes supported line-by-line coding which is used within grounded theory data analysis (Charmaz, 2006). Generalised observations were however not included in field notes as it is identified by Charmaz (2006) that such generalisations provide the researcher with little substance on which to engage in the coding process in data analysis.

This section has explored the justification for choices underpinning selected methods utilised to gather data to support the exploration of factors contributing to the socialisation of student mental health nurses in compassionate mental health practice. Section 3.5.2.5; Ethical considerations of all phases, describes the ethical considerations of the developed research strategy and methods utilised to collect data, to support appropriate ethical safeguards being implemented throughout the research process, thereby enhancing dependability of the research in relation to integrity of the processes engaged in (Deniloco, Long and Bradley-Walsh, 2016).

3.5.2.5: Ethical Considerations of all phases

Prior to commencement of this research, ethical approval was obtained from:

- De Montfort University Research Ethics Committee (Appendix 20)
- Leicestershire Partnership NHS Trust Research and Development Department (Appendix 21)
- NHS Research Ethics Committee via Integrated Research Application System (IRAS) (Appendix 22)

It was recognised that it was possible that some participants in all phases of the study (Phase One Student Focus groups and Phase Two Case study) might have found talking about their experiences of compassion and nursing care somewhat distressing or uncomfortable. It was not anticipated that any harm would be caused to participants, but it was made explicit that if a participant felt that their involvement in focus groups, semi-

structured interviews or observations was either distressing or uncomfortable, they could leave the research activity at any time. Fortunately, this did not occur, but had it occurred, appropriate signposting of participants to student support services at De Montfort University and staff support services within Leicestershire Partnership Trust had been prepared.

As stated in section 3.5.2.1.2: Phase Two recruitment, all participants were made aware that they could withdraw from the study at any time. However, due to complexity of removing data from the focus group and the case study methods, although participants had the right to withdraw at any time, the consent forms (appendix 19, 23, 24 and 25) specified that any data collected prior to the point of withdrawal would be utilised within the study.

All data gathered was anonymised using a serial coding system for representation in the data, to ensure compliance with the Data Protection Act 1998 and then latterly the Data Protection Act 2018. A hard copy of data obtained was kept in a locked, fireproof filing cabinet when not in use. Electronic information was stored on a laptop used only for research purposes. The laptop had relevant security passwords in place to ensure that electronic data could not be accessed by anyone other than the primary researcher.

It was acknowledged that ethical considerations had to be implemented to avoid research bias potentially associated with the researcher's role as a senior lecturer at the university where student participants were recruited from. To avoid any potential ethical implications, it was ensured that students were aware that their responses would be anonymous and would not impact their progression on the course. In addition to this, a third party (the programme leader at the time) was used to initially invite students to participate in the research so as students did not feel pressured to participate.

As a registered mental health nurse and nursing lecturer, it was acknowledged that the researcher had a professional requirement to report any concerns about practice that might be identified. It was made explicit that should students disclose or demonstrate unsafe practice throughout the research process, information would be discussed with researcher

supervisors in the first instance and then forwarded to the School of Nursing Safeguarding Lead if necessary. Likewise, it was also made explicit that if practice staff disclosed or demonstrated any unsafe practice, the manager of the practice area would be informed, and the Lead Nurse for Leicestershire Partnership Trust (the NHS Trust responsible for the team's service delivery) would also be notified. It was further agreed that the supervisory team would be informed of any practice concerns to ensure that correct reporting protocol was adhered to if necessary.

As the study included observations of practice areas, it was acknowledged that there would be some contact with mental health service users, as observations would be conducted in the care environment where service users were in receipt of mental health nursing care. However, no data was collected from service users within the practice area. It was agreed prior to commencement of the observation process that should a service user approach the researcher within the practice area and disclose any risk (to self or others), that this information would be immediately passed on to qualified nursing staff working within the practice environment. Again, the duty as a registrant to ensure the safety of any service users at all times was acknowledged and adhered to. Although this plan was in place, no service users approached the researcher to disclose risk and nor did the researcher identify any risk issues that required escalation, therefore this plan did not have to be engaged in.

In addition to the above, the study complied with the standards set by:

- Getting the Evidence: Using research in policy making (2003)
- The Mental Capacity Act (2005)
- Nursing and Midwifery Council (NMC) Code of Professional Standards of practice and behaviour for nurses and midwives (2015)
- Nursing and Midwifery Council (NMC) Code of Professional Standards of practice and behaviour for nurses, midwives and nursing associates (2018)
- Caldicott Principles (2013).

Compliance with these standards, resulted in appropriate ethical safeguards being implemented throughout the research process.

This section has provided rationale for methods selected to gather data, the recruitment process for both phases of the research and the ethical considerations engaged in by the researcher. The aim of this was to enhance credibility, confirmability, dependability and transferability of the research (Denicolo, Long and Bradley-Cole, 2016). The following section 3.6: Analysis, provides rationale for data analysis choices and describes the data analysis processes utilised within this research.

3.6: Analysis

The aim of this section is to provide rationale for the application of a grounded theory approach to data analysis in this study. The data management process utilised within the study is described. The data analysis process, including tools used to support analysis, leading to identification of major theoretical categories and theoretical conceptualisation of data is also rationalised and presented. The section is concluded with a summary of the data analysis process applied to support robust analysis of data collected.

3.6.1: The merging of a case study approach for data collection and a grounded theory approach for data analysis

Although a case study approach was identified as being an appropriate approach to select for this research, criticisms of case study strategies in relation to lacking robust data analysis (Yin, 2003) were recognised as a potential concern in relation to academic rigour. However, the strength of grounded theory in relation to facilitating the development of theory, and in relation to robust data analysis, was acknowledged. In addition to this, Rodwell (1998) identifies that grounded theory analysis is preferred by constructivist researchers, as this ensures that *"findings are grounded in the context of the inquiry"* (Rodwell, 1998, pg58). Rodwell (1998, pg58) further states that grounded theory analysis supports emerging research design processes, in addition to facilitating the exposure of *"values, beliefs, attitudes, prejudices and biases of all participants*". As such, the application of a grounded theory approach to data analysis in combination with the utilisation of a case study strategy

was decided upon. This supported in-depth exploration of the experience and realities of student mental health nurse socialisation in compassionate mental health practice. Strauss (1987) supports the integration of these research strategies and successful integration of these approaches is described by Lauckner, Paterson, and Krupa (2012). However, to ensure that this decision was philosophically, and methodologically sound, methodological congruence of the strategies was considered, to confirm that both could be aligned with the constructivist paradigm. Through this exploration, it became evident that both case study and grounded theory approaches could sit within multiple paradigms (Lauckner, Paterson, and Krupa, 2012). For example, Yin's (2003) approach to case study is rooted in ontological beliefs consistent with a positivist /post-positivist paradigm (Lauckner, Paterson, and Krupa, 2012). However, Stake (1995; 2000; 2005; 2006) described a method of case study which is consistent with the constructivist paradigm, in which perspectives of participants are gathered and agreed upon collectively, therefore providing a strong correlation with the ontological belief that reality is locally constructed (Lincoln and Guba, 2000).

Charmaz (2006) identifies a constructivist grounded theory approach to data analysis which acknowledges the researcher's stance in relation to constructing theory based upon their *"past and present involvements and interactions with people, perspective and the research practices"* (Charmaz, 2006, pg10). Therefore, to enhance methodological congruence through the study, the decision was made to draw from the work of Stake (1995, 2006) and Charmaz (2000, 2006, 2014), as identified above, which both recognise the researcher's role in constructing interpretations of the data gathered (Lauckner, Paterson, and Krupa, 2012). It was concluded that this combination of case study data collection strategy and grounded theory data analysis approach would be best placed to support an in-depth exploration of the research questions posed. The combination approach supported both robust data collection and data analysis. The aim for this was to overcome criticisms relating to poor data analysis procedures associated with the case study strategy (Yin, 2003), as previously identified. The grounded theory data analysis approach utilised in this study will be discussed and described in the remainder of this chapter.

3.6.2: The data analysis process

As previously identified, constructivist research recognises that the researcher is part of what is being researched, influencing both the collection of data and the consequent analysis of data (Charmaz, 2000, 2006, 2014; Wahyuni, 2012). This is consistent with the requirement for qualitative research to utilise an interpretative and intuitive approach to data analysis (Denzin and Lincoln, 1994; Creswell, 2007; Denzin and Lincoln, 2008). Grounded theory analysis facilitates engagement in an interpretative and intuitive approach (Charmaz, 2003; Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015). It requires the researcher to be both iterative (the researcher moves back and forth between the data, often returning to previous data and issues explored) and interactive (Charmaz, 2003; Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015). Furthermore, the researcher uses their worldview, personal standpoints and situations that arise at research sites; developing a relationship between personal beliefs and views and the emerging data to interpret and make sense of data collected (Charmaz, 2014). Engaging with data iteratively was required throughout the research, as simultaneous data collection and analysis was required to develop and construct lines of inquiry throughout the research process. Indeed, the utilisation of an iterative process of collection and analysis allowed interactive exploration of emerging questions, themes and concepts, which guided further data collection and analysis.

3.6.3.1: The Data Management Process

The aim of grounded theory analysis is to produce categories which are integrated into a theory which emerges from and is 'grounded' in the data collected (Glaser, 1978; Glaser, 1992, Charmaz, 2006). This process requires the construction, deconstruction and reconstruction of data, through the constant comparison of categories and themes (Glaser, 1978; Rodwell, 1998; Charmaz, 2014). Effective data management was crucial to support appropriate and robust data analysis (Bazeley and Jackson 2013). To facilitate this, all focus groups and interviews were digitally recorded and transcribed verbatim by the researcher within 48 hours, and field notes from observations were typed up within 24 hours. Although time consuming, the process supported the development of detailed knowledge and

'getting to know' the content of each focus group, interview and observation. It also facilitated the 'reliving' of each data collection event. This 'reliving' enabled the recall of non-verbal communications made by each participant, which were documented in memos and compared against the recordings. Recordings were revisited to support comparative analysis, and this enabled the researcher to actively listen to and consider not only the content of dialogue but also the tone of participants, reoccurring themes in dialogue, and identification of issues actively avoided in discussion. Including all of these factors in analysis assisted in the interpretation of the data but resulted in vast volumes of data that required effective management. NVIVO-11 was therefore utilised as a data management tool (Bazeley and Jackson, 2013).

NVIVO is computer software that is commonly used to assist in data storage, management and analysis in qualitative research (Bazeley, 2013; Bazeley and Jackson, 2013). All focus group and interview transcripts and observation field notes were uploaded and stored on NVIVO to support systematic analysis of data collected. In addition to storage of primary transcripts, NVIVO also provides the facility to store researcher memos. As specified previously, memos relating to the 'reliving' and contextualisation of dialogue of focus groups, interviews and observations were documented and stored on NVIVO. In addition to this, memos were also stored which documented the researcher's thoughts and emergent interpretation of the data. NVIVO provided the ability to use 'nodes', which were used to organise memos and link memo content to key issues and points within the transcripts. The use of 'nodes' facilitated the constant comparison of data and supported the identification of emerging themes. The NVIVO text-searching tool was used to cross check themes across all data, which resulted in the discovery of core themes in the data and the identification of emerging theory (Charmaz, 2014).

Bazeley and Jackson (2013, pg3) identify that although the application of NVIVO can indeed support the storage of a complete data and methodical analysis of the data, it cannot *"turn sloppy work into sound interpretations".* An iterative approach was therefore vital in the data analysis process to support analytical rigour (Charmaz, 2003; Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015). Emerging themes, patterns and connections were also

discussed in regular supervisory sessions, which supported the refinement of insights into the emerging theory.

Gerrish and Lathlean (2015, pg198) identify that rigorous grounded theory data analysis is characterised by six procedures:

i. *"Constant comparison,*
ii. *Coding the data,*
iii. *Reducing codes and developing categories,*
iv. *Linking the categories and finding patterns,*
v. *Discovering the core category,*
vi. *Discovering or building the theory".*

NVIVO software supported each of these procedures which are discussed in further detail below.

3.6.3.2: Constant comparison

As previously identified, the procedure of constant comparison requires the researcher to engage in iterative analysis in which sections of data are compared (Charmaz, 2003; Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015). To achieve this, data collected from each focus group in phase one (focus groups with student participants), was compared against data from each of the other focus groups. In addition to this, focus group data was also compared with data collected in phase two (semi-structured interviews with student participants pre-access to the practice site, with observations and semi-structured interviews completed during access to the practice site), as well as data obtained within phase two being compared against all other data obtained in phase two. The adoption of this 'compare and contrast' method facilitated the reconsideration of provisional ideas and conclusions that had previously emerged. It also supported enhancement of the overall exploration of the factors underpinning and influencing student socialisation in compassionate mental health nursing practice (Gerrish and Lathlean, 2015), thereby working towards the creation of theory (Glaser, 1978; Rodwell, 1998; Charmaz, 2014).

3.6.3.3: Coding the data

In order to facilitate the comparative analysis throughout the data, the first task in the grounded theory analysis process is to code data and ask analytical questions of the data that has been gathered (Charmaz, 2014). This assists in furthering understanding of the data (Charmaz, 2014) and the identification of emerging themes, categories and sub-categories, thereby facilitating the uncovering of potential relationships between categories identified (Guba and Lincoln, 1994). This process therefore supports direction of subsequent data gathering relating to issues identified (Charmaz, 2014). There are two phases of coding within grounded theory data analysis: initial and focused (Charmaz, 2014). Both of these phases of coding were engaged in during data analysis within this study and the application is described below in 3.6.3.4: The initial coding process and 3.6.3.5: The focused coding process.

3.6.3.4: The initial coding process

Initial (or open) coding is the beginning coding stage to support the identification of key concepts (Charmaz, 2003; Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015).
The aim of initial coding is to generate codes through engaging in line-by-line coding (Charmaz, 2006). Line-by-line coding is a time-consuming process in which the researcher names each line of written data (Glaser, 1978). Although a time-consuming process, Charmaz (2006) identifies that line-by-line coding is a useful analysis method when engaging in analysis of interviews and observations, as it provides valuable insights into participant implicit concerns in addition to their explicit verbalisations and their experience of the social world around them. It provides a mechanism that supports interpretation of data and highlights relationships between implicit processes and visible structures (Charmaz, 2006). An additional benefit of using line-by-line data analysis is that it supports the development of insights into potential gaps in data, which can guide the researcher in their next lines of enquiry (Charmaz, 2006).

In addition to transcribing focus groups and interviews verbatim within 48 hours, initial memos captured first impressions and thoughts about data collected. Digital recordings and

transcripts were listened to and re-read numerous times during the initial coding process to support 'getting to know' and immersion in the data. Transcripts were read and re-read line by line and specific words, sentences and paragraphs were highlighted to support inductive analysis of all datasets (Charmaz, 2006). A mind map tool was used to identify repeated words to support the recognition of themes emerging from each transcript which further supported this process. Reducing data to small components and making comparisons across the datasets supported the initial development of descriptive codes and categories and contributed to developing insights from participant perspectives and understanding of the meaning underpinning dialogue (Glaser, 1978, 1992).

The process was repeated to examine data for each focus group, interview and observation, and enabled the data to be broken down into meaningful codes and themes. This supported the constant comparison of key words, potential meanings, and themes across the datasets and the progression of codes, themes and ideas to tentative analytical categories. Data analysis of each data collection event informed data collection in subsequent focus groups, interviews and observations across all phases of the study.

The New Grounded Theory of Student Nurse Socialisation in Compassionate Practice framework (Curtis, 2015)[31] was identified as a sensitizing concept to guide the initial iterative process of data collection and analysis (Rodwell, 1998) of phase one, focus group data. However, although used to guide analysis of data collected during each phase, steps were taken to ensure that analysis was not constrained by the framework and that the researcher remained open to all possibilities (McMillan and Schmacher, 1993; Denscombe, 2004).

Table 3.7 below is an excerpt taken from analysis of focus groups in phase one, using line-by-line coding and mapped against the New Grounded Theory of Student Nurse Socialisation in Compassionate Practice (Curtis, 2015).

[31] As introduced in Chapter Two: Literature Review, section 2.3.1: Professional Socialisation – pg60.

Table 3.7 Line by line coding – Focus groups mapped to the Socialisation in compassionate practice framework

Examples of line by line coding taken from Focus group	Mapping to the Socialisation in Compassionate practice framework
"for me personally, it has been my upbringing and the challenges that I have faced growing up that have made me the way I am today.	Personal Exposure
"They are respectful and compassionate and demonstrate it by just who they are…they (mental health academic staff) focus on thoughts and feelings".	Theory Exposure
"She (the nurse) was such a role model to me, I try to be like her and consider what the patient wants, not just have knee jerk reaction out of fear of risk".	Practice Exposure
"staff said to me, we don't spend time with her because it just feeds into it (the service users' behaviour), that was something that I really struggled with on that placement, I felt really torn"	Dissonance between professional ideals and the realities of practice
"there should be more than one, there should be a couple every year and we should meet with service users each time".	Education to improve socialisation

Charmaz (2014) identifies that using in vivo coding, in which participant exact words and sentences are utilised, can facilitate deeper understanding of meaning. As stated previously, initial codes were continually reviewed to support the iterative approach to data that is required in grounded theory analysis. The review of the initial codes facilitated the identification of the emergence of themes and categories as data was conceptualised. This process continued throughout all analysis (Charmaz, 2014). As a result of utilising this approach, analytical categories that were developed could be continually compared with other categories, which assisted in the identification of emerging relationships in the data. Table 3.8 below, demonstrates one of the core categories that emerged due to this process; *"Giving of time"*[32].

[32] As explored in the finding chapters (Chapters 4 and 5) of this thesis.

Table 3.8: Example of *"Giving of time"* analytical category

Excerpts from data which illuminate "giving of time" as a category	Analytical Category
"in mental health, we have the time factored in to spend time with the patients and find out what's going on. We have the time to be compassionate".	Giving of time to patients
"I make sure I stop and take time to understand the persons' experience, not just get caught up tasks"	Giving of time to patients
"we've got the benefit of being a smaller team and we spend quite a lot of one to one time with them (student nurses)… we embrace people (students) coming in and we like to work with them and we have the time to work with them, and that's really important"	Clinical staff giving of time to students
"We'd sit down and she'd explain why things are being done, she never rushed. She gave me time… it made be feel much more confident, it was just really compassionate support"	Impact of making time for students
"it's like people haven't sat down with them (students) before and invested that time to give them the support they need so they can develop and learn and with that little bit of time and support, you can really see them shine"	Impact of making time for students
"Time pressure is a big one. We are always under pressure to do more with less and that impacts on people being able to be compassionate because we're always trying to prepare for what could come next instead of having the energy to be person-centred"	Time as a barrier to compassion

Once these initial stages of coding had been conducted, the coding process progressed to focused coding, which is explored in the following section 3.6.3.5: The focused coding process.

3.6.3.5: The focused coding process

Once initial analysis had taken place, the second major phase of coding, focused coding (Charmaz, 2003; Charmaz, 2006; Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015), was engaged in. Codes generated in focused coding are identified as more "*directed, selective and conceptual*" than the coding that occurs in the initial coding process (Charmaz, 2004,

pg57) and the process supports the synthesis and analysis of larger segments of data. Constant comparison and cross checking of data provided a systematic approach to the identification of significant and recurrent codes developed and allowed decisions to be made about which initial codes were most analytically appropriate to support the robust categorisation of data (Charmaz, 2006). The process was enhanced by allowing time for reflection on initial codes and emerging categories. What participants were trying to convey, how the data contributed to the study and how the data fit with the emerging themes and categories (Heifetz, Grashow and Linsky, 2009) were also considered.

The iterative approach of comparing data from participants across each phase of the study supported the interpretation of participant meaning (Charmaz, 2003; Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015), with some statements analysed making explicit points about issues that had been implicitly raised previously. This provided prompts to return to analysed data and re-explore topics that had been too implicitly discussed to discern previously (Charmaz, 2004). As a result of this, new threads of analysis became evident and ideas that were previously unidentified emerged from the data (Charmaz, 2014).

3.6.3.6: The discovery of categories

Categories which aimed to explain and make sense of the data, specifically what participants were saying, began to emerge and gradually became clearer through the process of continual coding and recoding. This was a complex process which was supported through regular reflective discussions with the supervisory team, and through the use of reflective memos which were attached to data in NVIVO. In addition to this, reflecting with participants at the end of each focus group, each individual interview and with the case study team after initial data analysis had occurred, enabled participants to contribute to the process of discovery of core categories.

As stated previously, Curtis's (2015) New Grounded Theory of Student Nurse Socialisation in Compassionate Practice was utilised to shape the analysis of phase one. As this progressed it became apparent that understanding the experience of student mental health nurse

socialisation in compassionate practice could not be fully understood without in-depth consideration of the practice environments that they are exposed to throughout their programme of study. The category of an enriched practice learning environment therefore remained relevant throughout the study and an example of how this supported ongoing analysis is demonstrated in Table 3.9 below.

Table 3.9: Emerging categories that support socialisation in compassion

Emerging categories that contribute to positive socialisation	Feeling safe	Feeling part of the team	Continuity	Feeling valued and significant	Compassionate purpose	Positive impact on achievement	Permission to be compassionate
Positive mentorship experiences	✓	✓	✓	✓		✓	✓
Recognition of student vulnerability	✓			✓		✓	✓
Positive role modelling	✓		✓			✓	✓
Effective team leadership	✓	✓	✓		✓	✓	✓
Team cohesiveness	✓	✓		✓	✓		✓
Shared working ethos			✓		✓	✓	✓

In addition to this, memo writing, free writing and diagramming also aided the complex process of analysis. Each of these methods and their application in this study are discussed below.

Memo writing:

As previously stated, memos were used throughout and were pivotal in the data analysis process. The memo writing assisted in creating and identifying the emerging theory (Charmaz, 2004; 2014) by prompting the analysis and re-analysis of data and codes generated earlier on in the analysis process (Charmaz, 2006).

The use of memos supported the comparing of ideas and connections being made between data sets. Memos were particularly useful in supporting links being made between explicit points which had only been implicitly discussed previously. This therefore prompted the re-

exploration of topics that had been previously implicitly discussed and supported the discernment of meaning and relevance. It is recognised that memo writing supports the researcher to pause and reflect upon codes generated and content of data in alternative ways (Glaser, 1998) and that it assists the researcher to capture their thoughts of the moment and formulate new questions and directions to pursue (Charmaz, 2004). A memo excerpt is provided below as an example of memos stored:

> "*This links in with CSSI3- Line 37-63, where part. explicitly discussed the impact of student vulnerability and pleasing mentors to get signed off. Parts discuss authenticity of clinical staff but don't seem to recognise that they are equally as inauthentic in this situation where admissions are being made that they will abandon compassionate ideals in order to succeed. What else is going on here though? How do they end up in this position? What is missing/occurring – specifically, explicitly – that results in this inauthenticity? (For cstaff and studs?) What am I not yet seeing? Need to compare further against CSS11, CSS12 and CSCS's when they occur for explicit details and further implicit issues relating to this. Are there variations in the others or other similarities? * NOTE: Could ask an explicit question about this in CSCS's".* (Excerpt taken from memo 20/06/2018).

Free-writing / narrative- discourse writings:

Frequent episodes of 'free writing' proved to be extremely useful in the development of analytical themes. Free writing is recognised as a valuable method in which the researcher can liberate their thoughts and feelings about the data under analysis and increase awareness of, and receptivity to, emerging themes (Charmaz, 2004). The use of free writing further supported constant comparisons being made and challenging and questioning of data and the researcher's thoughts. Spontaneous free writing memos were used to document thoughts, feelings and questions for follow-up throughout the data. Although similar to the memos documented as described previously, free writing focused more on analytical complexities and impromptu ideas for further consideration. As such, the use of free writing supported the development of new insights and questions to guide the analysis process.

In addition to the free writing of memos described above, a free writing approach was also utilised to develop a narrative-discourse overview of the data. Bazeley (2013) advocates the use of combining coding and narrative techniques to aid analysis, identifying that the

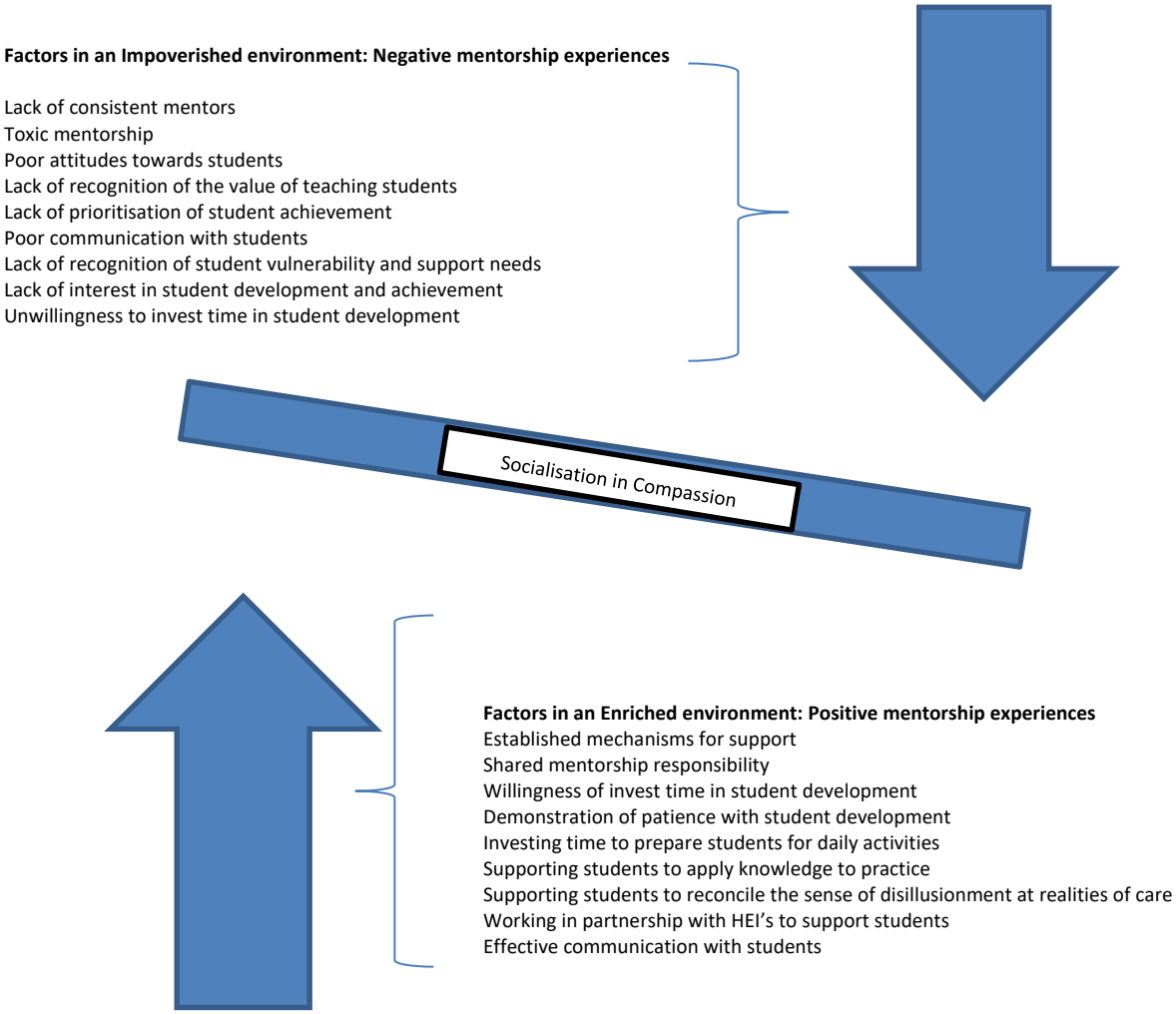
combination is beneficial when analysing substantive data and stories embedded in the data (Bazeley, 2013; Riessman, 2008). The narrative-discourse was also coded and analysed, and was found to be extremely beneficial, as the vast amount of data under analysis and adding of memos proved to be somewhat overwhelming at times. Engaging in the free writing narrative–discourse process supported psychological immersion in and cognisance of the vast amounts of data, and also assisted in the sense of achieving progress. It supported sustainment of focus by facilitating the development of new insights into data, clarifying outstanding questions about data and guiding the remaining analysis process (Heifetz, Gradshow and Linsky, 2009). The technique also assisted the development of both contextual and theoretical understanding of the data (Polkinghorne, 1988).

The use of diagrams and tables:

Diagrams and tables were also used throughout the analysis process to visually identify links and comparisons, and support movement from description of data towards abstract conceptualisation. Using diagrams and tables provided valuable visual prompts which assisted in providing clarity and increased understanding of the meaning of data (Charmaz, 2014).

Diagram 3.2 is an example of a diagram that was developed. It illustrates the factors identified as present in enriched practice environments that supported socialisation in compassionate mental health nursing practice, compared against the factors identified as being present in impoverished environments that did not support socialisation in compassionate mental health nursing practice, with explicit consideration of the role of the mentor.

Diagram 3.2: The socialisation seesaw



The utilisation of both diagrams and tables to support management and analysis of data proved to be extremely useful in restructuring and affirming thinking and developing understanding and conceptualisation of the emerging categories (Corbin and Strauss, 2014). It also assisted in the recognition of saturation of data which will be discussed in the section below.

3.6.3.7: Saturation of theoretical categories

Glaser (2001) and Charmaz (2004) identify that many qualitative researchers confuse saturation with repetition in data; theoretical saturation differs from the repetition of

describe events, situations, experiences or statements, and rather relates to the conceptualisation of comparisons, until such a point that no new patterns, properties, meaning/s or further insights emerge within identified theoretical categories (Dey, 1999; Charmaz, 2006).

Utilising a theoretical saturation approach supported the researcher to remain open to all possibilities within the data throughout the iterative analysis process, by not excluding data based on repetition. When assessing each category for theoretical saturation, the following considerations were made as advised by Charmaz (2006; 2014):

- Which comparisons had been made between data within and between categories?
- What sense could be made of these connections?
- Where did this lead the research?
- How did the comparisons illuminate the theoretical categories?
- In what direction did this lead the research?
- Were new conceptual relationships identified?

Through engaging in this process, connections between categories emerged and became clear which led to new insights and understanding in relation to the original research questions (Corbin and Strauss, 2014). The process also directly contributed to the theorising of data, which was identified and could only commence once key categories and emergent understanding of relationships between categories were apparent (Morse, 1994; Rodwell, 1998).

Saturation and subsequent theorisation were further discussed in detail during the supervisory process to provide quality assurance (Glaser, 1978; Charmaz, 2014) and support the identification that true theoretical saturation had been achieved.

3.6.3.8: Conceptualisation

When utilising a grounded theory approach to data analysis, it is through the discovery of central categories and core concepts that theory is generated (Gerrish and Lathlean, 2015). It is identified that for the constructivist researcher, conceptualisation of theory provides an

interpretive framework that supports the development of abstract understanding of relationships in the data (Charmaz, 2014). As identified throughout this section, the utilisation of the iterative approach to data analysis, and constant comparison of codes and themes, led to the discovery of the central categories. The use of memo-writing, free-writing, narrative and discord free-writing and diagramming supported comparison of categories, which resulted in conceptualisation and the development of theory. As stated previously the New Grounded Theory of Student Nurse Socialisation in Compassionate Practice (Curtis, 2015) was utilised to guide analysis and provide a constructivist-interpretative analytical framework (Schwandt, 1998).

Numerous categories emerged and were developed through the analysis process and decisions had to be made about which categories should be raised to theoretical concepts (Charmaz, 2014). Categories that contained meaningful data which supported analysis moving forward and demonstrated relationships with other categories were selected for additional analytical refinement. The relational properties between other key categories identified (Charmaz, 2014) were also analysed. Both major and minor categories emerged through data analysis, but those categories that contained the properties for the development of theoretical concepts subsumed the minor categories, and further illuminated those categories that should be raised to a theoretical concept (Charmaz, 2014). The complex process of conceptualisation and the development and emergence of core categories is described in detail in Chapter Four: Focus Group Findings and Chapter Five: Case Study Findings.

Rodwell (1998) identified that co-construction is fundamental to constructivist research as it provides opportunity for exploration of data, which can provide alternative understanding and interpretation which could otherwise be missed by the researcher. Gerrish and Lathlean (2015) identify that the theory developed should be recognised by people working in the field. As such, and to enhance continual consistency with the constructivist paradigm (Wahyuni, 2012), the theoretical concepts generated from analysis were discussed and debated with participants. This enabled the researcher to ascertain if interpretation of the data resonated with the experience of the participants to support accuracy and validity, and

also to build upon researcher understanding. Participants in each phase were given the opportunity to discuss any other issues that they felt were pertinent or had been missed in analysis, and the process also provided the opportunity for participants to develop on issues previously discussed, by comparing ideas and themes that had emerged.

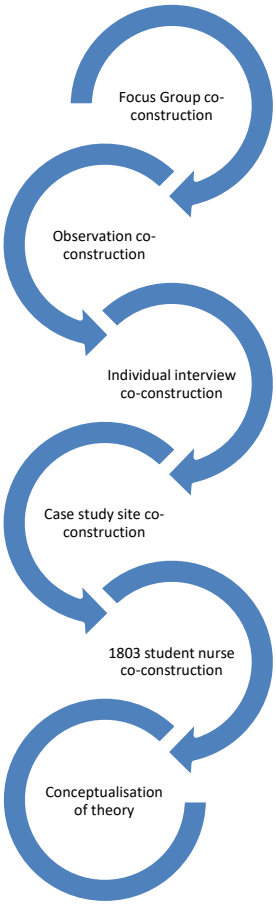
This model of co-construction was applied throughout each phase of data collection, and co-construction of data from each phase was also fed into the next phase of the study to constructively build meaning and understanding. Diagram 3.3 demonstrates the overall co-construction process.

Findings were also presented to all team members at the case study site. The researcher returned to the case study site and discussed the theoretical concepts generated from the analysis to ascertain if there was any resonance with the experience of the participants. This took place with the team in July 2019. Those present at the meeting included the team manager, two band 6 community mental health nurses, two medics and two health care support workers. Team members were given the opportunity to discuss any other issues that they felt were pertinent or had been missed in the analysis. Those in attendance agreed that the categories, core concepts and theoretical concepts that had been generated through data analysis resonated with their experiences within the team[33].

In addition to co-construction with team members from the case study site, findings were also presented to a cohort (n=25) of second year student mental health nurses. This allowed the researcher to ascertain if overall findings resonated with their experiences of socialisation in compassionate mental health nursing practice through their placement experiences. Discussion generated through this also supported the development of key concepts[34].

[33] See 5.4 Resonance of study findings – pg242
[34] See 5.4 Resonance of study findings – pg242.

Diagram 3.3 – Co-construction throughout the study



The impact of reflexivity on conceptualisation:

As previously identified[35], constructivist research acknowledges the influence of researcher experiences and values on data analysis and conceptualisation (Rodwell, 1998; Wayhuni, 2012). The process of reflexivity encourages the researcher to recognise and acknowledge their role as an integral part of the phenomenon under investigation (Holland, 1999; Saltzman, 2002; Gerrish and Lacy, 2006; Dodgson, 2019) and therefore arguably forms a fundamental component of constructivist research. Indeed, Dodgson (2019) identifies that the researcher has an impact upon and makes a difference to the findings in their study. As such, objectivity cannot be present in qualitative studies (Dodgson, 2019). Consequently, the researcher needs to take responsibility for the impact of their own characteristics, pre-dispositions and interests within the research and be cognisant of the impact that these may

[35] See 1.1: Impetus of the study, pg19 and 3.3: Paradigm, pg74.

have on the research setting, participants, questions asked, data collected, data interpretation and themes presented (Holland, 1999; Berger, 2015; Dodgson, 2019). Reflexivity requires the researcher to engage in continuous in-depth self-examination and have in-depth awareness of personal characteristics such as their:

- emotional responses to research participants
- immigration status
- language traditions and patterns
- personal preferences
- political and professional beliefs
- sexual orientation
- social positioning
- theoretical orientation

(Berger, 2015; Teh and Lek, 2018; Dodgson, 2019).

However, reflexivity is more than engaging in personal reflection (Dodgson, 2019). The researcher needs to be aware of similarities and differences between themselves and participants, and the potential impact that this may have on the research process (Dodgson, 2019). It requires the application of sociological self-analysis which results in identification of researcher personal constructs (Holland, 1999) and unconscious bias (Dodgson, 2019). Furthermore, reflexivity requires awareness of how these personal factors may impact conceptualisation and acknowledgement of how interpretation/conceptualisation aligns with the researchers existing beliefs (Dodgson, 2019).

Authors (Holland, 1999; Berger, 2015; Teh and Lek, 2018; Dodgson, 2019) recognise the importance of reflexivity in the research process, stating that it enhances research rigour and quality (Teh and Lek, 2018) and increases credibility of findings (Berger, 2015) and research trust-worthiness (Teh and Lek, (2018). Engagement in reflexivity may also contribute to a deeper understanding of the study for the researcher and reader alike (Berger, 2015). McCabe and Holmes (2009, pg1519) identify that reflexivity also encourages "emancipation" in the research, in which the researcher and participants co-collaborate to develop new understanding about situations during data collection and the data analysis

process. As presented above, this process of reflexivity was adopted within this study and is evidenced through the case study site co-construction and student co-construction described in Chapters Four[36] and Five[37].

Table 3.10: Commitment to reflexivity throughout the study (below) identifies how the concept of reflexivity was engaged in and made transparent throughout the research process.

Table 3.10: Commitment to reflexivity throughout the study

Chapter / Section reference:	Evidence of engagement in reflexivity:
Chapter 1 – 1:1 Impetus of the student	Personal and professional experiences, beliefs and positionality presented.
Chapter 3 – 3.2.1: The section of a qualitative strategy for data collection	Identified that the ultimate choice of research strategy (case study and grounded theory approach to analysis) was based upon personal preference
Chapter 3 – 3.5.1.4: Operationalisation of Focus Groups	Identified that professional skills and pre-existing knowledge were used to enhance the running of the focus groups, to facilitate participant engagement
	Specified that a core aim of the focus groups was the co-creation of knowledge between participants and researcher
Chapter 3 – 3.5.12: Phase One Focus group recruitment	Acknowledgement of impact of professional role on potential sense of coercion for students to participate and steps taken to reduce risk associated with this
Chapter 3 – 3.5.2.3: Practice Observations – The theory	Impact of professional experience on perceptions and engagement of participants recognised and acknowledged
	Consideration of my role (my impact) in possibly contributing to the Hawthorne effect
Chapter 3 – 3.5.2.4: Reducing the potential for the Hawthorne Effect	Further consideration of my role (my impact) in possibly contributing to the Hawthorne effect and steps identified and implemented to reduce the impact
Chapter 4 – 4.5: Student participant reflection on focus groups	Co-creation with student participants to develop greater clarity and insights into the focus group data
Chapter 5 – 5.4: Resonance of study findings	Co-creation with student and staff participants to develop greater insights into interpretation of data
Chapter 5 – Strengths and Limitations of the study	Confirmation that focus groups participants were given the opportunity to comment and reflect upon findings from their initial focus groups with me
	Interpretations and constructions for all phases fed back, discussed and reflected upon with 2nd year mental health nursing students, to support co-creation of knowledge and understanding
	Personal and professional views, opinions and experiences shared with focus group participants regarding constraints in practice resulting in enhanced student and researcher awareness of issues present in practice
	Presentation of preliminary findings to the team. Interpretations of data considered and discussed between team members and myself
	Potential influence of unequal power dynamic between myself as research and student participants recognised (Personal tutor and latterly programme leader for some students)
	Clarity about plans for dissemination of findings and using professional role as programme leader to influence and make changes to student nurse educational provision
Chapter Seven – 7.3: Personal reflection of the research process	Identification of the personal learning that occurred, consideration of the impact of myself on the research but also the impact of the research upon me.

[36] Please see 4.5: Student participant reflection on focus groups – pg195.
[37] Please see 5.4: Resonance of study findings – pg242.

Several strategies are identified as enhancing reflexivity including numerous reflective writing strategies, experiential learning activities, classroom-based activities and engagement in continual education activities (Landy et al, 2016). A reflective journal (Landy et al, 2016; Brunger and Duke, 2012; Hayward and Charrette, 2012; Mkandawire-Valhmu and Doering, 2012), which included personal reflections on the research process, progress, data, and considerations about the impact of self on the research, was utilised to enhance reflexivity in this study. Utilisation of the reflective journal assisted with in-depth consideration of my impact on all aspects of the study, including choice of methodology, methods and strategies but also in the interpretation and conceptualisation of the findings. As identified in 1:1 – Impetus of the study and in this section, I recognised the importance of considering how my personal and professional background, experiences, beliefs and values could impact the research process. For example, the except below from the reflective journal demonstrates reflection on focus group data:

> *"I'm struggling to move on from what they were saying about feeling blamed by academic staff (for not engaging in compassionate care). I think I've probably been a bit guilty of this myself maybe? There is that bit of me that thinks that you should always challenge non-compassionate practice but I'm forgetting the vulnerable position that they are in and the complexities associated with that. I've been thinking back to my experience as a newly qualified and thinking about that incident where I raised concerns about a member of staff and being told not to make waves and was pushed to retract my complaint. I remember how much courage that took and my fears about being professionally black-listed. I need to not lose sight of that. It's easy for me to say now that we should always challenge poor practice but I am in a position of experience, power, knowledge and confidence which means that it is achievable for me. As a 21-year old, newly qualified, ambitious female, who was complaining about a male member of staff to a male manager, I was not in that position. I felt so disempowered and afraid of the consequences. How can I judge our students when I so nearly did the same as a registrant? I need to be more conscious of this throughout the next focus groups and discuss the sense of blame that they experience in more detail to really try to understand it. I can share my experience so*

they feel less judged and hopefully they'll feel able to take freely about this" (Reflective Journal – 20/11/2016).

I made efforts to engage in the reflective journal throughout the research process. My reflections were discussed at supervisory meetings and supervisors asked further probing questions to aid self-analysis. I also shared an overview of my reflections of each focus group at the next focus group/end of the second focus groups for each cohort and in a presentation to the case study team in July 2019 and with second year mental health nursing students, as described in 5.4: Resonance of study findings. This supported reflexivity through mutual collaboration, where participants are involved in discussions about analysis and evaluation of the data (Finlay and Gough, 2003).

3.6.3.9: Data Analysis Summary

A grounded theory approach to data analysis (as previously described) was selected for this study as it was identified that the integration of a grounded theory approach would provide a robust data analysis strategy (Laucker, Paterson and Krupa, 2012). It was further rationalised that this approach would offset criticisms that case study strategies lack robust data analysis (Yin, 2003), while facilitating the in-depth exploration and analysis of how student mental health nurses are socialised in compassionate practice. An iterative approach was taken to consistently compare and contrast data, emerging themes and categories (Charmaz, 2003; Denzin and Lincoln, 2018; Gerrish and Lathlean, 2015). Constructions were developed which then informed subsequent data collection methods and lines of enquiry (Charmaz, 2004). Participants actively contributed to the data analysis during all phases of the study and engaged in mutual collaboration of themes and categories through discussions. These discussions enabled in-depth exploration of themes, categories and emerging theory grounded within the data (Rodwell, 1998). Appendix 26: Summary of data analysis process utilised in this study, illustrates a summary of the key steps taken during the analysis process.

3.7: Methodology summary:

This chapter has explored the rationale for the qualitative methodology utilised within this study, drawing upon the Hiles (2009) model of disciplined enquiry to strengthen the study design and provide structure to the chapter.

The selected research paradigm of interpretivist constructivism has been explored. Rationale has been provided for the selection of the specific paradigm presented that is consistent with the ontological, epistemological and axiological position of both the paradigm and the researchers own research stance. The basis for the utilisation of a case study strategy and data collection methods utilised (focus groups, semi-structured individual interviews and practice observation) have been explored and described and ethical considerations have also been described. Finally, the utilisation of the combination approach of using case study strategy and a grounded theory approach to data analysis has been rationalised, and details of the analysis process provided. Appendix 27: Summary of research design choices, provides a summary of the research design choices that were utilised in this study.

Throughout the research process specific consideration was given to ensuring that the study was credible, confirmable, dependable and transferable (Guba and Lincoln, 1989; Deniloco, Long and Bradley-Cole, 2016)[38], in order to evidence research quality assurance. These domains known as parallel criteria (Guba and Lincoln, 1989) have been explored both explicitly and implicitly throughout the chapter, and Appendix 28: Summary of how the study meets parallel criteria – quality assurance, provides a summary of how each of these criteria is met through the study design, with specific reference made to sections in this chapter that evidence meeting each element.

Findings that emerged from the data collection and consequent analysis are presented and explored in Chapter Four – Focus Group Findings and Chapter Five – Case study findings. Key areas for discussion from all findings are discussed in-depth in Chapter Six – Discussion.

[38] Refer to section 3.5 Methods – pg86.

Chapter Four: Focus Group Findings

4.1: Introduction to Focus Group Findings

This chapter presents the findings from student participation focus groups as described in section 3.5: Methods. The aim of the focus groups was to develop an understanding of the experiences, opinions and perceptions of student mental health nurses, to begin to answer the research questions of:

- "What are the experiences of compassion for student mental health nurses?"

And

- "What are the factors in practice placements that influence student mental health nurses in their development as compassionate mental health nurse practitioners?"[39]

As described previously[40] the New Grounded Theory of Student Nurse Socialisation in Compassionate Practice developed by Curtis (2015) was selected, to generate sensitising concepts and provide a loose guide for data collection and initial analysis of student perceptions of the factors that influenced their socialisation into compassionate practice. Participant experiences of personal, theoretical and practice exposures that were perceived as either assisting or limiting their socialisation in compassionate mental health nursing practice were sought. However, it was evident that participants experienced some difficulty in articulating how theoretical experiences influenced their socialisation in compassionate mental health care. A lack of impact of the theoretical component of the nursing programme was articulated and the majority of participants felt that they gained the most of their learning, knowledge and understanding of compassionate practice from the practice context:

> *"I haven't learnt anything about being compassionate from lessons. Don't go trying to teach us models of compassion, it won't work... I've learnt it through my placements. You just can't teach us how to do it in a classroom. We've got to see it and experience it, not imagine it…" (*FG1: 3rd year Student 1).

[39] As specified in 1.2: Research aims and objectives – pg22
[40] As discussed in 2.4: Literature review summary – pg65 and 3.6.3.4: The initial coding process– pg122..

Student lack of recognition of the importance and relevance of theoretical education on their socialisation in compassionate practice will be further discussed in Chapter Six: Discussion.

Participants appeared to experience less difficulty in discussing the impact of practice experiences and exposures on their socialisation in compassionate practice. Being led by the data, the focus of the research questions posed was reviewed. Rather than exploring the whole praxis of socialisation in compassion, including personal, theoretical and practice exposures, the second research question was amended to focus on the impact of practice experiences on student mental health nurse socialisation in compassionate practice:

> *"What are the factors in practice placements that influence student mental health nurses in their development as compassionate mental health nurse practitioners?"*

The third research question was also amended from exploration of how nurse educationalists/approved educational institutions for nurse education could cultivate student mental health nurse socialisation in compassionate practice, to the question below:

> *"How can placement providers facilitate positive socialisation in compassionate mental health nursing practice for mental health nursing students?"*

In order to begin answering these research questions, the aims of this chapter were to:

- develop in-depth understanding of the ways in which student nurses are socialised in compassionate mental health practice during their practice experiences

- develop in-depth understanding of the ways in which student socialisation in compassionate practice is inhibited during their practice experiences

Furthermore, the impact of the New Grounded Theory of Student Nurse Socialisation in Compassionate Practice (Curtis, 2015) on student mental health nurse socialisation in compassionate mental health nursing practice is explored and articulated.

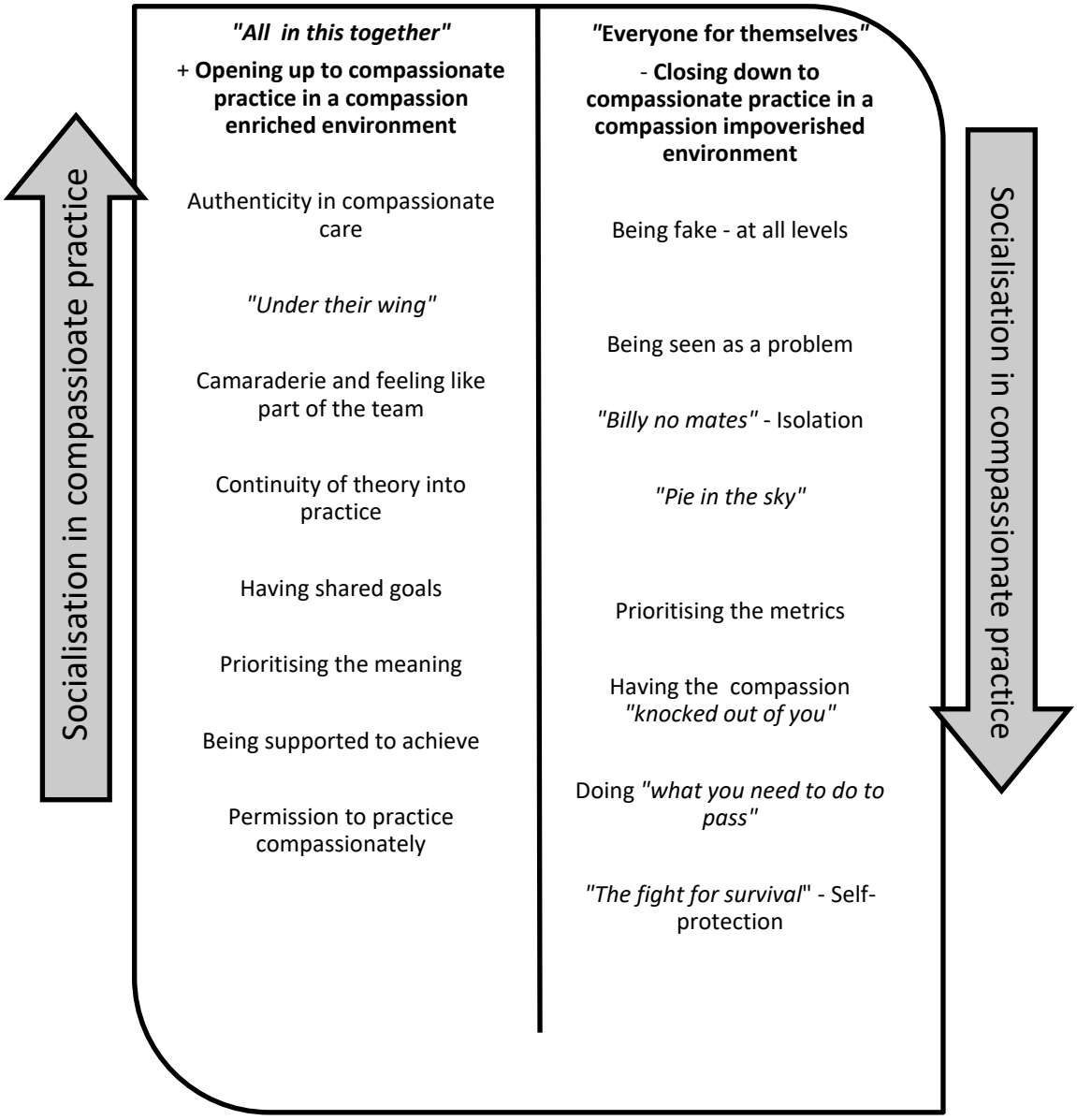
The analysis of focus group findings resulted in the identification of two overarching themes present in the focus group data:

- *"All in it together"*
- *"*Everyone for themselves*".*

These themes were an antithesis of each other and are demonstrated in Figure 4.1: The factors underpinning student mental health nurse socialisation in compassionate practice (below).

The themes of *"All in it together"* and *"*Everyone for themselves*"* are explored throughout the rest of the chapter, and theme headings (as in Figure 4.1) are used to structure the findings.

Figure 4.1: The factors underpinning student mental health nurse socialisation in compassionate practice:



The experiences under the theme of *"All in it together"* in an incremental combination, resulted in students being able to internalise the value of engagement in compassionate mental health nursing practice. A journey of socialisation through experience of recipient of compassion through to the giver of compassion was identified. This socialisation journey was supported by the experience of having permission to engage compassionately,

including implicit and explicit permission obtained within the practice environment but also through the student providing themselves with permission to engage in compassionate mental health nursing practice. Indeed, when exposed to practice areas, where the themes of *"All in it together"* were present, students experienced an opening up to compassion. This journey is demonstrated in figure 4.2: The Ladder of Socialisation in Compassionate Mental Health Nursing Practice (below).

Experiences identified under the category of *"*Everyone for themselves*"* were an antithesis to the themes in *"All in it together".* The factors identified in this theme resulted in students experiencing a closing down to compassion, both in terms of desire and scope of engaging in compassionate mental health nursing practice. The meaning that students derived from these experiences was that they were vulnerable, unsafe, insignificant and had to engage in self-protection to progress through their placement experiences. This resulted in students becoming introspective and re-focusing their care priorities to their own needs, often at the detriment of supporting the needs of service users by engaging in compassionate mental health nursing practice. Consequently, student ideals and sense of compassionate purpose and intent were affected, as was their socialisation in compassionate practice.

The journey through those placement experiences lacking in compassion and the consequent impact on the inhibition on socialisation in compassionate practice is illustrated in figure 4.3: The Retrogress Ladder of Socialisation in Compassionate Mental Health Nursing Practice.

Figure 4.2: The Ladder of Socialisation in Compassionate Mental Health Nursing Practice

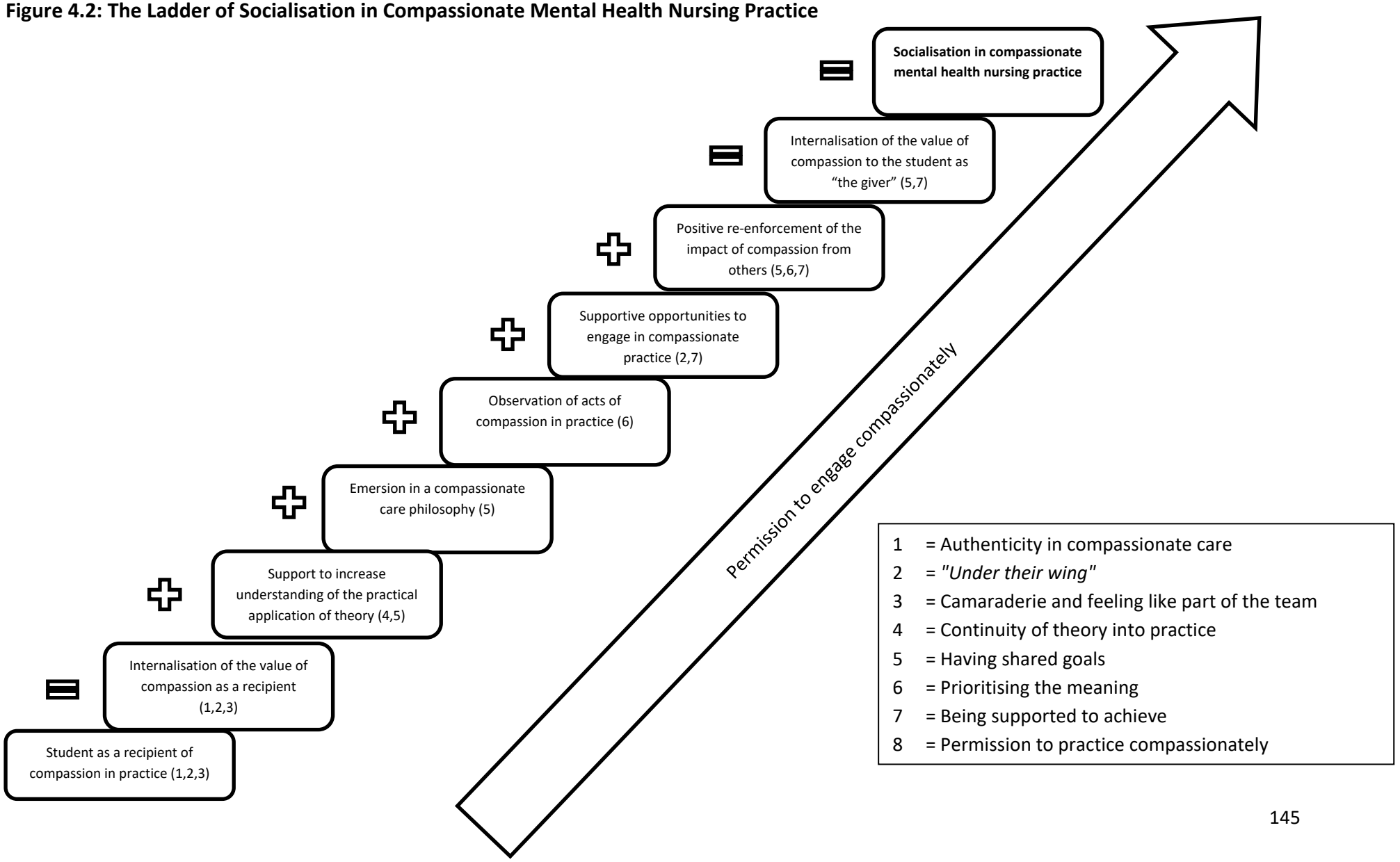
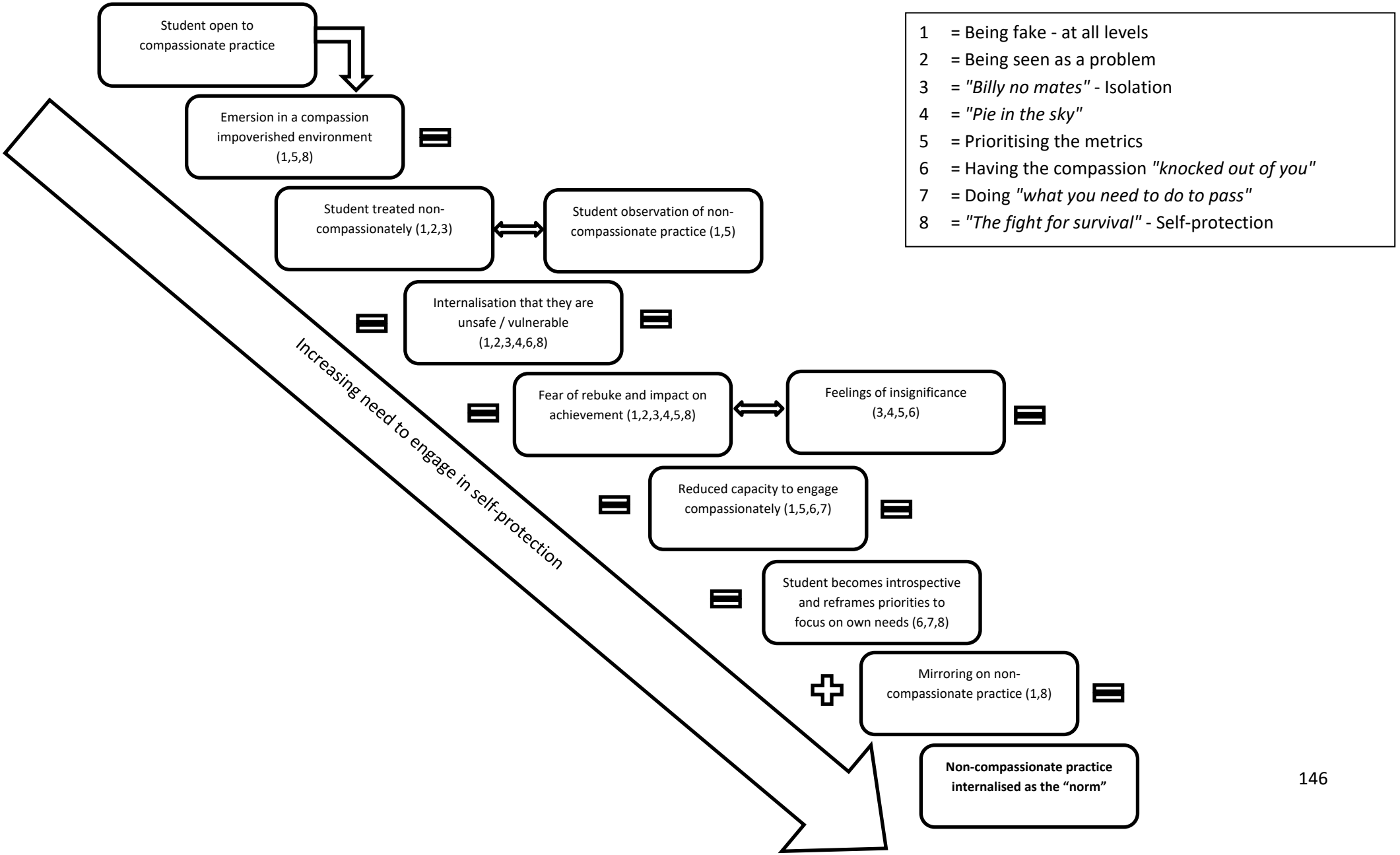


Figure 4.3: The Retrogress Ladder of Socialisation in Compassionate Mental Health Nursing Practice.



4.2: "All in it together"

Eight themes[41] were identified under the aegis of *"All in it together"* which related to student experience of practice environments, in which they were exposed to factors that had a positive impact upon their socialisation in compassionate mental health nursing practice.

Like compassion, relational aspects underpinned environments that facilitated positive socialisation in compassionate practice. The data collated from the focus groups demonstrated that students derived meaning from their practice experiences, largely based on these relationships, interactions and the process of engagement enacted between individuals in the environment.

The myriad of factors underpinning the eight themes of *"All in it together"* are explored throughout the rest of this section to develop in-depth understanding of the ways in which student nurses are socialised in compassionate mental health practice.

Authenticity in compassionate care:

Authenticity in compassionate care refers to a perceived genuineness in compassionate interactions from staff directed towards students, service users and others. Exposure to authenticity of practice staff during placement was identified as an important facilitator of student socialisation in compassionate mental health nursing practice. Participants identified that it supported feelings of safety in the practice environment, and it was viewed as an indicator of high levels of compassion in the team by some students. Although one might expect that staff authenticity in compassionate care would be common practice, unfortunately, participants reported that this was not the case and that it was only present in some placement experiences.

Students felt that they experienced direct demonstrations of authenticity when practice staff took a genuine interest in them, both personally and in terms of professional development:

[41] As identified in Figure 4.1 – pg143.

> *"…she (practice mentor) was really spontaneous when she spoke to me… we had personal conversations, not just generic ones. She made me feel like a person. She remembered things about me, you know, what I like doing and my preferences. It felt like she was invested in me and that made me feel like I really mattered…"* (FG2: 1st year student 3).

This personal interest in the individual resulted in students feeling that staff members were invested in them and increased their feelings of shared humanity, equality in the relationship, value, and enhanced feelings of significance as a student within the care environment.

Practice staff who worked in this way, were seen as taking a genuine interest in student wellbeing. This served to further bolster student feelings of significance and demonstrated genuine care for them as both current and future members of the mental health workforce:

> *"…they (practice staff) always reminded us to be kind to ourselves and made sure we took our breaks. It's easy to get caught up and forget to look after yourself and they had to sort of say it to me before I even realised. I just felt like they really cared for me, not just on my placement but for my future as well. They were trying to help me protect myself…"* (FG1: 3rd year student 4).

The recognition of the importance of the wellbeing of staff and students and active encouragement to support them in acts of self-care also re-enforced student perceptions of being in a positive care culture. In this culture, compassion for self, exercised by staff made space for compassion for service users and students:

> *"in their (practice) team meetings, they did mindfulness and their idea was you can't be compassionate to other people if you can't be compassionate to yourself. It wasn't always focused on the patient's things all of the time, it was, actually, lets focus upon our needs as well and see if we can look after ourselves. You just knew that if they were compassionate to themselves and us (students) that they were going to be the same with patients as well"* (FG1: 2nd year student 1).

Participants identified that they were more likely to experience feelings of psychological and emotional safety in those placements where staff engaged in authentic positive interactions with students. A genuine positive attitude towards students, and the characteristics of being friendly, approachable, patient and non-intimidating, all contributed to these feelings of safety. The exposure to positive practice staff attitudes towards students and associated characteristics led some participants to develop two key assumptions about the trajectory

of their placement experience. The first assumption was that the team embodied a genuine non-judgemental approach, which led to students feeling that they could ask questions freely and actively engage in opportunities to develop compassionate practice without fear of rebuke:

> *"…when they're (practice staff) genuinely friendly, you don't feel as if you're going to be judged if you have a question or if you are compassionate to a patient, you know that you're safe to do it without them criticising you or telling you off"* (FG2:1st year Student 2).

In addition to demonstrating the impact of authentic support for students, the quote above also highlights the importance of students experiencing the feeling of safety, resulting in the sense that students were supported to act compassionately in the practice context. This is further explored in the theme – Permission to practice compassionately.

The second assumption that participants made was that evidence of these genuine positive attitudes was an indicator of high levels of compassion within the team. Indeed, participants also identified a positive association between the compassion demonstrated directly to them as students and compassion demonstrated to others. This included fellow team members and service users, again leading to the belief that compassionate practice would be supported and encouraged and providing the permission that students sought to engage in compassionate practice:

> *"you know if they are compassionate to you (the student), then they are much more likely to be compassionate to each other and even the patients. So you know from the beginning that they are going to support you and encourage you to be compassionate with patients"* (FG2: 3rd year student 2).

In addition to bolstering student experience of authenticity in the practice context, students also identified that positive staff attitudes communicated that staff were actively engaged in compassionate efforts to reduce fear and anxiety experienced by students:

> *"…when they're (practice staff) really positive like that, you just feel like they're being really compassionate coz (sic) they're obviously trying to make sure we don't feel scared, coz it can be scary sometimes, and they want to make sure we're not overcome by anxiety and whatnot. It just seems really compassionate to me…"* (FG1: 3rd year student 4).

This created the sense that students would be *"looked after"* on the placement. The importance of students feeling *"looked after"* is explored in the theme that follows, *"Under their wing"*.

"Under their wing":

"Under their wing" was a quote that came directly from a student in a focus group who described how it made them feel *"looked after"* while on placement. Feelings of psychological, emotional and physical safety in student relationships with practice staff also came under the aegis of *"Under their wing".* The importance of feeling safe and secure during placement experiences was both explicitly and implicitly discussed by all cohort focus groups. However, it became apparent through the analysis of the data that students experienced a journey throughout their programme of study, in which their safety needs changed as their journey progressed. First year student participants spoke about their need to feel *"looked after"*, with heavy emphasis on the identification of their vulnerability in the role of the new student who required compassionate support in the practice context:

> *"I think it's really important that they (practice staff) look after us while we're on placement. They need to recognise that we're just starting out and got a lot to learn and that we need that extra guidance, especially when we're going into areas (care specialties) where we've never had any experience before. They shouldn't just leave us to it, they need to be compassionate to us, as well as the patients…."* (FG2: 1st Year student 3).

Second year students identified their needs of continuing to feel *"looked after"* through more indirect supervision, which was facilitated by practice staff supporting the student to work more autonomously than in their first year but providing permission for students to access staff support if required:

> *"I don't think we need to be looked after in the same way that we needed in year one. Now it's more like I want to be given a bit of freedom and be able to do things on my own a bit more but I also want to know that I can go and ask for help if I need it or if they (practice staff) see me getting into a pickle, they'll ask if I need help, you know?"* (FG2: 2nd year student 2).

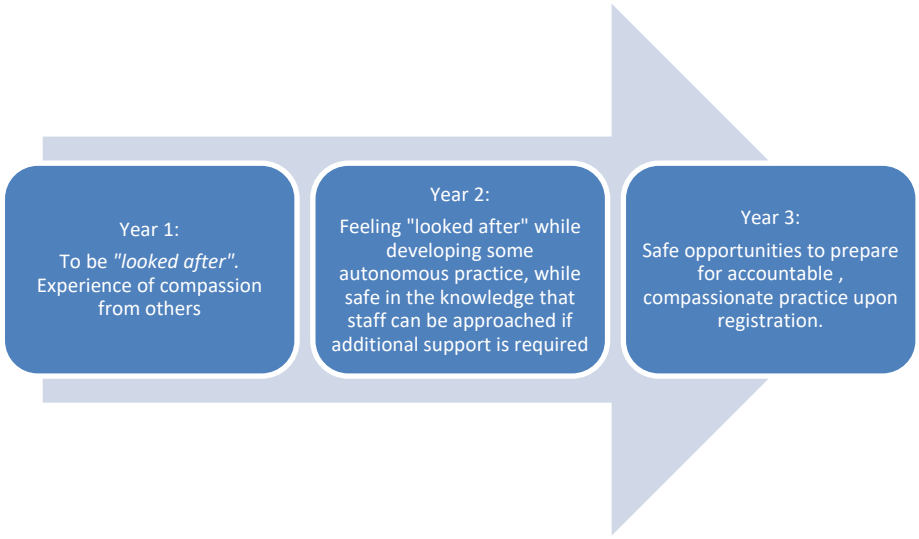
Final-year students discussed the importance of experiencing feelings of safety provided by their mentor in relation to their development as accountable practitioners and their preparation for registration. However, it was important for them that practice staff

continued to recognise them as a student and that they were provided with the opportunity to engage in enriching learning experiences:

> *"… I think now we're 3rd years our learning needs have changed quite a bit. I don't need my hand holding like when I first started…They (practice staff) need to prepare us for the transition from student to qualified, I don't necessarily mean just leaving us to it and using us as an extra pair of hands though, we still need support and to be treated like a student and be allowed to do things that help our learning…"* (FG2: 3rd year student 6).

The journey from needing to feel *"looked after"* in year one of the programme to the need for safe opportunities to prepare for registration is illustrated in figure 4.4 below:

Figure 4.4: The student journey through the experience of 'safety' needs:



The notion that socialisation in compassionate mental health nursing practice would be negatively affected if students did not experience each of these phases of the journey in order was discussed with the third-year participants. It was concluded by these participants that each phase of the journey had to be experienced chronologically for successful socialisation in compassionate practice to occur, and that socialisation was prevented if these building blocks were not in place.

In addition to contributing to feelings of being safely supported to practice, participant experience of being *"looked after"* also enhanced their feelings of significance. This was reflected in student participant responses during the focus groups, with feelings of being

accepted, worthy and valued by the team recognised as bolstering students' sense that they *"mattered".* Furthermore, it was apparent in the data that the feelings of acceptance and inclusion within the team heightened the feeling of being cared for and *"looked after"* or *"looked out for",* which further enhanced some students' feelings of personal value and increased feelings of significance:

> *"when they (practice staff) make you feel a part of it, and they look out for you. I guess you just realise that you are important and that, I dunno (sic), like you deserve to be there…"* (FG1: 3rd year student 5).

To enhance the feeling of being *"looked after"* and cared for while on placement, participants reported that they would often actively look for a member of staff who was willing to take them '*under their wing*' in each placement. This was something that occurred in both placements that were viewed as being a compassionate enriched and those considered as compassion impoverished. However, in compassion enriched environments, students felt that they had more access to staff members that were willing to take on the role of looking after them:

> *"…when the whole team is compassionate, they all look out for you and that's great coz (sic) if your mentor isn't available or perhaps you just don't click with them or whatever, there is always someone else that you can turn to for that support but (in those placements) where there isn't much compassion, you tend to just identify the one person who probably seems like they've got the most compassion or at least are the most open to students, and they're who you latch on to, just so you've got someone looking out for you I suppose…"* (FG2: 3rd year student 9).

This indicates that even in those practice environments that were deemed to be compassion enriched, other factors including rapport with mentor impacted feelings of safety experienced, resulting in students attempting to enhance feelings of safety through relationships with other staff. It also suggests that even when placement areas were considered to be compassionate overall, that there were 'areas of grey' in which the sense of compassion was diminished[42].

First choice for taking on the role of *"protector"* in the practice context was most often the allocated student mentor. However, students reported instances in which they would look to other staff members to take on the role, as demonstrated in the quote above. They

[42]Explored in 4.4: The "many shades of grey" – pg193.

looked for someone with whom they felt they had a positive relationship and demonstrated the qualities of kindness, friendliness, approachability, supportiveness, authentic concern for student experience and could advocate for the student:

> *"…it's what I look for in every placement, someone I can go to, that I get on with and who'll support me and show me the ropes or give me opportunities to try things out. It's better if it's your mentor because they're signing you off but it's not always and sometimes you have to find someone else that you get on with, who'll stand up for you a bit, so you can feel supported and safe I suppose, it's having that protector…"* (FG2: 2nd year student 2).

Students felt that there were many more *"protectors"* in compassion enriched environments but also identified that these people could exist in those areas largely perceived as lacking in compassion. This offered a sense of protection against the negative culture:

> *"…there is usually one (member of staff that can take the student under their wing) but not always. I wonder how they manage to stay compassionate when everyone around them is so, like negative, but yeah, they can just give you that buffer so you can get through. Otherwise, it's a bit horrendous really…"* (FG2: 3rd year student 7).

The experience of having staff members take them "*under their wing"* increased student feelings of being both cared for and valued within the team, further enhancing student feelings of acceptance, inclusion and personal and professional significance. These feelings were however increased when a number of staff members demonstrated willingness to take on that role, highlighting the importance of a shared team approach to working with and supporting students on placement:

> *"when they (practice staff) all look out for you, it's better because you just think it's more genuine, you know? Like they all think you're worthwhile so that makes you feel really good but if only one or two of them (practice staff) take any interest, you sort of wonder and can feel a bit out of it really…"* (FG2: 1st year student 6).

Participants considered themselves as the recipients of compassion when they experienced being taken "*under the wing"* by practice staff. Students suggested that where practice staff did this, they recognised student vulnerability and the act of taking them "*under their wing"* was an explicit compassionate response:

> *"when they (practice staff) look out for you like that, it's like they acknowledge the power dynamic issue and that we're a bit vulnerable really… and I suppose when they*

see that and then do something about it by you know, looking out for us, that's really compassionate. I think so anyway…" (FG1: 2nd year student 2).

Students suggested that this had a profound impact upon socialisation in compassionate practice. For some, experiencing the benefits of compassionate engagement first-hand made them feel more able to recognise the potential benefits of compassion towards others:

"…my mentor was so compassionate to me, like really, really good and it just made me realise how important it is to be compassionate to other people, because it made such a difference to me and I don't think I'd ever really understood it (the benefit of compassion) before she'd been like it with me…" (FG2: 1st year student 3).

It also demonstrated to students that they could engage compassionately with each other and other members of the team, as well as service users:

"… I'd never considered it before I'd actually experienced it (compassion from practice staff). I guess I could like recognise the power of it and get a better idea of the impact it can have….and the other thing that struck me was that it's not just about patients. We have to be compassionate to each other as well. They really looked after me and I suppose it made me more inclined to want to look after my colleagues as well as the patients" (FG1: 3rd year student 2).

In addition to seeking support from practice staff, participants also valued informal support provided by other student nurses. They reported looking to fellow students who were either older or perceived as more mature, or who were closer to completion of their programme and therefore perceived as more experienced, for additional support:

There is this camaraderie you get from placements and you often get students showing you around the place as part of the induction, especially if they are a 3rd year, it's sort of part of their unspoken role, to look after you a bit. It makes it seem like we are encouraged to look after each other as well as being looked after by others (practice staff) and there's this acknowledgement that we're all in it together. So they're encouraging us to be compassionate to each other so you are more likely to be compassionate with other students who look up to you" (FG1: 2nd year student 1).

This provided additional opportunity for them to be taken under someone's wing. Although considered 'senior', it was identified that third-year students were less judgemental than some qualified staff, as they shared the experience of vulnerability due to their student status:

> *"it's always good when there's another student on the placement with you, especially if it's a third year. They can show you the ropes and whatever and because they're still a student as well, I dunno (sic), they're just not as judgey (sic) as some of the qualified's (sic) because they know what it's like. Some of the qualified staff forget too quickly…"* (FG2: 2nd year student 1).

This was recognised as providing an additional layer of psychological and emotional safety in the placement area.

The camaraderie experienced between students was discussed at some length and the importance of experiencing camaraderie is explored in the following theme.

"Camaraderie" and feeling like part of the team:

The feeling of camaraderie relates to students feeling accepted and included, encompassing feelings of being wanted, welcome and a part of the practice team. However, participants from the first and second-year student cohort explicitly spoke of the impact it has on their feelings of psychological and emotional safety:

> *"…I guess when you have that (sense of camaraderie), you just feel like there is a bit of a safety net, you know there is someone you can talk to about how it makes you feel and it helps you contain it (emotions) a bit better and I suppose it's like a bit of a psychological protection, does that make sense?"* (FG2: 1st year student 3*).*

Feelings of safety were heightened for some, when other students (including those considered as senior, equal and junior) were on placement. They acted as *'comrades'* and added an additional layer of support, reducing the experience of isolation lone students experienced and providing a sense of *'safety in numbers'*. The type of support that students offered each other included supporting and encouraging learning opportunities and assisting in making expectations of students on a particular placement explicit. This support led students to recognise both the boundaries of their role in the practice area and how they could engage compassionately:

> *"One of the most important things is when students look out for each other. So they might say; "I've already had a go at that, ECT for example, why don't you give it a go today and when you do, this is what you do… and you'll be going with Mr X, who gets really worried about it, so say this and do this and that will really help him". It shows thoughtfulness between students and means that you can be compassionate to Mr X because you know what to expect and how to respond"* (FG1: 2nd year student 1).

Camaraderie was also experienced by students from practice staff team members. Participants reported that they were more likely to experience camaraderie in placement areas where practice staff made efforts to make them feel welcome from the start. Students who were made to feel welcome by practice staff felt both accepted and wanted and, as a consequence felt able to settle into the placement quickly.

> *"my mentor took me round, showed me round the ward and introduced me to some of the patients and she took me to the office and introduced me to everyone on shift, so I knew who they were and what they did and who I could go to for help and stuff. It just made me feel really welcome. I wasn't all billy-no-mates, like I have been in other placements… I really felt like they were inviting me to be part of the team, like they accepted me as one of them and I was able to just get on with it much quicker coz (sic) I wasn't trying to navigate myself through it all…"* (FG1: 3rd year student 10).

Orientation to the practice environment, including being shown around the physical environment and being introduced to both service users and other staff members by name and role, was identified as pivotal in enhancing the feeling of being welcome. Indeed, willingness to invest time in student orientation to the placement area led to students experiencing the feeling that they were acknowledged, valued and viewed as a new team member, therefore re-enforcing student feelings of acceptance and significance.
Taking the time to learn the students' name was identified by participants as a simple way of enhancing the sense of welcome and belonging. This was of particular importance to students who did not have traditional English first names. They valued staff members who made efforts to both learn and pronounce their names correctly. However, it was also applicable to students of all name origins, and it was identified that when staff referred to them as "*the student"*, this led to the perception that staff considered them as *'other'* and were not willing to invest energy into learning names as they viewed the student as transient and inconsequential:

> *"For me, one of the best things they can do is learn my name, remember it firstly and make efforts to pronounce it. I feel more valued when they do that. I hate it when they refer to you as 'the student'. It tells me that I'm not important because they can't even be bothered to learn my name. It just makes you feel really unwelcome and you feel separate and isolated…"* (FG2: 1st year student 6).

Participants recognised that being made to feel welcome on placement had a direct impact upon the feeling of acceptance experienced while on placement. The feeling of being wanted was enhanced by staff demonstrating willingness to engage in a relationship with

students away from the primary care giving environment, by inviting them to go on breaks and including them in other social activities, such as team nights out. This enhanced feelings of camaraderie and of student acceptance as another member of the team:

> *"They (practice staff) were so good. They took me to lunch with them, I went on breaks with them… they proper included me and made me feel like I was part of the team. They had a night out for one of the nurses' birthdays and like even invited me on that. It just said to me that they actually liked me, were interested in me and wanted me with them. I wasn't just another pain in the arse student, getting in the way…"* (FG2: 3rd year student 5).

Student participants reflected that being encouraged to participate in social activities with team members was *"the icing on the cake",* and *"an added bonus".* The feeling of being wanted was also fostered when engaging in work related activities. Seemingly simple interactions with students, such as inviting them to accompany and assist staff during specific care tasks, resulted in students feeling wanted and professionally useful and valued by the team which further bolstered feelings of significance.

The heterogeneity of mental health nursing care placement experiences resulted in the challenge of students adapting to a new culture and set of expectations during every placement experience. This was identified as particularly challenging for first year students who experienced three placements, each lasting a number of weeks (one six-week placement and two seven-week placements). These relatively short placements made it more difficult for students to develop feelings of acceptance and inclusion. Participants reported that as they began to develop the feeling of being part of the team, their placements came to an end. However, second and third-year participants experienced two longer placements (10 and 12 week and 12 and 15 weeks respectively). The duration of these placements provided the opportunity for students to build relationships with team members and feel like a member of the team. In addition, these students reported that they had greater clarity about their role as a student nurse in the practice context, in comparison to first year student counterparts, and this also assisted them to embed themselves within the culture of the team more effectively:

> *"In first year, it was really hard. You just start to settle in and feel accepted and then your placement is done. It's been much better this year. You spend so much time with them (in practice) that you become one of them. Plus, I know what I'm doing a bit*

> *more now, so can just crack on and work with them, so it's easier to fit in"* (FG1: 2nd year student 2).

Participants viewed practice staff that made attempts to enhance student feelings of being welcome, wanted and part of the team as role models of compassionate ideals. It was felt that they recognised student vulnerability and that the acts that they engaged in to increase student feelings of acceptance in the team fostered feelings of safety, inclusion and significance. Participants identified that they wished to emulate these practice staff by acting compassionately towards others, and that they were more likely to engage in compassionate nursing when exposed to such role modelling.

Student experiences that came under the aegis of authenticity in compassionate care, *"under their wing"* and camaraderie and feeling like part of the team, assisted in the creation of the feelings of safety, acceptance, inclusion and significance in the practice context. A common thread in all three themes was the importance of practice staff both recognising student feelings of vulnerability and actively attempting to minimise student feelings of vulnerability. The events identified under these themes therefore contributed to students experiencing compassion first-hand and feeling the psychological and emotional impact and benefits of compassion in action. This assisted them to derive understanding and meaning of the impact of compassionate interactions on others and as a result, they began to recognise ways in which they could engage in compassion in the practice context.

While students saw less value in the theoretical study of compassion in the classroom, first-hand experience of compassion resulted in an increased understanding of the theoretical elements of their programme:

> *"…I don't think I'd really recognised it before, coz (sic) I hadn't really experienced it but because they (practice staff) were so compassionate to me, it sort of helped stuff click into place. You know, the stuff you (academics) tell us in the classroom about support and empowerment and whatnot. I suddenly got it and realised what it's about…"* (FG1: 3rd year student 7).

This helped to reduce the recognised impact of dissonance between theory and practice on student socialisation in compassionate nursing practice, and supported continuity between theory and practice, which is explored next.

Continuity of theory into practice:

The New Grounded Theory of Student Nurse Socialisation in Compassionate Practice (Curtis, 2015) used as an initial framework for analysis in this study, recognised the impact of dissonance between student professional ideals and expectations of registered nurses to uphold their professional ideals and the realities of nursing practice (Curtis, 2015). It is argued that supporting students to find a balance between competing ideals and the reality of contemporary practice is vital to support positive socialisation in compassionate nursing practice. Participants in this study spoke extensively about the apparent gap between theory and practice experienced and the impact that this had on their socialisation in compassionate practice.

Participants recognised that experiencing consistent relationships in the practice context supported continuity between the theory component of the programme and practice. Indeed, consistent and supportive relationships resulted in students feeling able to ask questions that could assist them in reducing the theory-practice gap, without fear of rebuke or ridicule:

> *"I think it's easier to ask questions when you are with someone (practice staff) that you've got to know a bit and who's proper supportive of you, like you know they won't judge or take the mick or think you're daft. It feels ok to ask questions and that, for me, is when I can start to understand it all a bit better I suppose…"* (FG2: 1st year student 5).

Experience of compassion in practice resulted in students being supported to apply the theoretical content of their programme to the practice context. Classroom experiences seemed more relevant, and students felt that they could apply concepts learnt in the classroom to improve service user care:

> *"so like, that lecture on breaking bad news… I mean, it was a bit of a dry one and like, I could understand why it was important but it wasn't until I was on placement and my mentor had to talk to a patient about them being diagnosed with schizophrenia that it really made sense and I could draw upon that to help in the situation and try and comfort them, so yeah, the two together (theory and practice) helped me be compassionate I suppose"* (FG1: 3rd year student 1).

One example of the positive benefit of enhanced continuity between theory and practice was that students felt that they were able to '*see the bigger picture*':

> *"I remember the workshop we had about psychosis and ***** (a member of academic staff) really challenged us and it sort of normalised it a bit. Before, I'd have been like, whoa, we need to medicate but after that I remember really taking away that what we see as a problem, might not be a problem for the patient and we need to be guided by them. So when I was at my last placement and I did an assessment, I didn't get caught up in the symptoms and medication like I would have before, I could think about the bigger picture and try to understand what was bothering the patient the most…"* (FG1: 2nd year student 1).

The theoretical knowledge also resulted in greater understanding of antecedents of service user presentations in the practice context. This in turn resulted in students feeling that they were able to engage in truly compassionate person-centred care, and focus on service users' unique needs and priorities, rather than make assumptions about needs based on a purely medical model understanding:

> *"I don't think lectures have made me more compassionate but I think they've helped me to understand some of the other things that might be going on and have an impact on someone and I think when you are open to that, you can be more compassionate because you're looking at the bigger picture rather than jumping to conclusions…"* (FG1: 3rd Year student 2).

Indeed, some participants across all cohort focus groups believed that compassion could not be taught through theory alone, but as evidenced in the quote above, they acknowledged the value of theoretical education in helping them see the bigger picture. Education supported the development of understanding the holistic root triggers for service user distress, rather than attributing all distress to symptom profiles. This resulted in an increased experience of empathy towards service users and consequently students felt more inclined to engage in compassionate practice.

Continuity between theory and practice was further fostered in the classroom setting by academic staff utilising practice examples to illustrate the application of theoretical concepts to their practice experiences:

> *"sessions with ***** (a member of academic staff) are brilliant. She always uses examples to show us how she applied it in practice, so you know that it isn't just theory, it can actually be achieved, so you're more likely to try it out in practice yourself"* (FG2: 3rd year student 4).

This was of particular benefit when academic staff had current experience in mental health nursing care and could use contemporary examples to illustrate the application of theory into the practice context. Additionally, students valued academic staff acknowledging the challenges of implementing theory into practice:

> *"…she's (a member of academic staff) realistic. She knows that it's not always straight forward to do what we're taught in the classroom (in the practice context) because of the challenges, but she'll talk about it and get us to think about what we can do, despite those challenges, so we can provide that evidence-based care"* (FG2: 3rd year student 8).

In addition to academic staff providing illustrative examples of how theory could be translated into the practice context, practice staff engagement in evidence-based care in their daily work was also identified as being a vital factor in fostering continuity. Students reported that witnessing practice staff do this helped to *'put the meat on the bones'* of the theoretical concepts covered in the classroom environment. This resulted in increased student understanding of the relevance of theory and the application within the practice context. This was further bolstered by practice staff investing time to discuss and reflect upon care activities with students:

> *"…She (the practice mentor) sat with me afterwards and we discussed why she hadn't increased his (a service user) meds (sic). She said that although he still had voices, he wasn't bothered by them so he didn't need it (medicine) increased, because the side effects (caused by an increase) could be worse than the voices. She had that compassion to say 'yes, you've got an illness but if it's not bothering you, and you can cope we don't need to give you more medication and risk those side effects'. We've been taught this at uni (sic) but I'd never seen it before and thought it was all rubbish. She made me realise that it could be done, like we've been taught"* (FG2: 2nd year student 1).

These reflective discussions were beneficial as they promoted continuity between theory and practice, increased understanding of rationale underpinning care activities, and provided recognition of some of the ways in which staff may engage compassionately.

Continuity was also experienced by students when they were exposed to consistent compassionate care that was rooted in a shared team ethos and purpose. This was reflected in the data obtained from all cohort focus groups and is explored in the following theme – Having shared goals.

Having shared goals:

As previously identified, continuity between theory and practice experiences was enhanced through exposure to a shared team ethos of compassion focused practice and shared compassionate care goals, which were communicated to students both explicitly and implicitly by practice staff. Indeed, participants felt that exposure to shared team goals of compassionate care assisted in bridging the gap between theory and practice. For some, it reduced the dissonance between theory and practice so commonly experienced by student nurses:

> *"you lot (academics) talk about it (compassionate practice) with us in class but honestly, it's not what we see in practice – not a lot anyways (sic), so it's hard to understand how we can do it but when I had my placement with ***** (placement name), all of them just oozed compassion. They all aimed for it, all the time and it started to make sense. You (academics) were saying it and then they were saying it and doing it, that made a massive difference for me"* (FG2: 3rd year student 3).

Participants reported that when practice team staff shared the same compassionate care goals, this permeated all aspects of the care environment, including student beliefs and opinions about the importance of compassionate care and their care practices. Indeed, participants acknowledged that when they were exposed to teams that embraced a whole team philosophy that prioritised compassionate care, they became immersed in the spirit of the environment. Initially, students reported replicating the compassionate philosophy, goals and actions of staff to improve their sense of acceptance and fitting in within the team:

> *"you can be compassionate when everyone is doing the same thing and everyone is aware of how important is it. You go with the flow and do what they do and become part of it, one of the team, all with the same goal"* (FG1: 3rd year student 3).

Students also recognised that continual exposure to shared team philosophy of compassionate purpose reiterated the significance of compassionate engagement. This further supported student internalisation of the importance of compassionate mental health nursing care and had the power to facilitate transformational understanding of the impact of compassion:

> *"they all (the practice team) believed it (the importance of compassionate engagement) and you could see it in everything they did. It was like a cult of compassion and you were brainwashed into it, in a good way of course, but even if you didn't believe it, you couldn't help but get swept away in the passion of it all and*

start to believe it yourself. It changed me and I've carried those values with me ever since…" (FG2: 3rd year student 4).

In addition to re-enforcing and cementing the importance of engagement in compassionate care for students, shared team goals in compassionate practice also assisted team members to maintain and reinvigorate their compassionate purpose:

> *"if one of them (practice staff) was having a rough day and started to lose sight of the bigger picture because of stress or whatever, the rest of the team would remind them of what they were doing and why they were doing it and it seemed to give them a bit of va va voom so they could keep going and carry on (being compassionate). I guess it helped refocus them…"* (FG2: 3rd year student 7).

The shared team philosophy was not necessarily written into policy but was rather described as a lived philosophy and set of goals that all team members embraced. These philosophies and goals were enhanced in some areas by regular team supervision, in which staff had opportunity to discuss care challenges and reflect on issues affecting their ability to engage compassionately:

> *"…they (the practice team) had supervision with a psychologist every two weeks. It helped them to reconnect with their values and talk about their challenges and they can figure out how to work with the patient and how to be compassionate with the patient in the situation. They support each other and are all in it together"* (FG2: 3rd year student 6).

When a team had shared compassionate care philosophy and goals, it facilitated the explicit and implicit recognition of the significance of compassionate care activities. This in turn bolstered student desire to prioritise compassionate care in the practice context. This is explored in the following theme – Prioritising the meaning.

Prioritising the meaning:

The experience of compassionate purpose was discussed in all focus groups both implicitly and explicitly, as was the prioritisation of compassionate mental health nursing care during placement experiences. Prioritisation of compassion included team recognition of the importance of compassionate practice, coupled with active attempts to engage in it despite barriers to compassion that were present in practice (such as time constraints), aiming to provide compassionate care at all times:

> *"she (the mentor) had a case load of like 50 patients, so she was always pushed for time to fit everyone in, let alone to all the rest of it, like the paperwork and stuff but she still made time for all of them (service users) and when she was with them, even though she had a million other things to be thinking about, the focus was on the patient 100%. I was like she was really driven to give that compassionate care, so didn't let the other stuff get in the way if she could help it…"* (FG1: 2nd year student 2).

In practice contexts where compassionate care was prioritised by practice staff, student participants felt that they could genuinely make a difference by engaging compassionately and that their contributions were valuable and of benefit to service users. This in turn served to re-enforce beliefs relating to the benefits of compassionate practice, which further strengthened student compassionate purpose:

> *"when your placement is compassionate, you get the chance to be compassionate too and I guess you get that feedback from patients and you can see the impact it has and how beneficial it so, so you are more likely to be compassionate again or to the next person…"* (FG2: 1st year student 6).

The focus group data demonstrated that students were more inclined towards engaging in compassionate practice when they experienced role modelling of compassionate practice by practice staff. These exposures allowed students to experience and witness the impact of compassionate care and led to the recognition for some that they could make a difference to the lives of the service users with whom they worked, inspiring them to replicate the compassion driven engagement that they had been exposed to. Participants reflected fondly on those mentors that they viewed as compassionate, and aspired to *"be like"* them in their future careers:

> *"she (the mentor) was so kind, so compassionate and genuine with the patients. That's exactly what I want to be like when I'm qualified"* (FG2: 2nd year student 1).

Indeed, positive role models were identified as integral in assisting students to identify, prioritise and maintain compassionate purpose. One characteristic of compassionate role models identified by participants was the willingness to enter patient-centred, therapeutic relationships. Practice staff who aimed to develop relationships underpinned by the sense of shared humanity left a lasting impression on students:

> *"she (the mentor) worked really hard to build a relationship and get to know the person, not just the diagnosis and symptoms. She tried to stop the power imbalance and told them bits about herself because she didn't want their relationship to be all*

> *one sided and she saw them as a fellow human being, not just a patient. I thought that was so compassionate. That's what I'm going to be like, she was really impressive…"* (FG2: 3rd year student 5).

Students recognised the relational aspect of compassion and especially valued the role modelling of authentic relationships; in which practice staff would willingly both give time to service users and make time for them. The giving and making of time, although viewed as a small act of compassion, was recognised as having potentially significant positive consequences. Engagement in other small acts of compassion and demonstration of willingness to go the extra mile were viewed as role modelling of the prioritisation of compassion, and highlighted to students that compassionate nursing care did not always require equipment and resources:

> *"She (the service user) hadn't seen her family for ages and they were coming in, so one of the staff did her hair and nails, so she looked really nice and she was absolutely thrilled and it was good for her kids to see her looking well. They didn't have to do it, but they did. That kind of made me realise that you don't have to do anything extraordinary to make a difference. You just have to be willing to spend the time to do it…"* (FG2: 1st year student 4).

The realisation that acts of compassion were often not demonstrated through grand gestures that required resources and equipment, but rather through small, creative and person-centred interactions and acts, highlighted that compassion was both possible and achievable. This realisation increased the likelihood of some students making attempts to engage in compassionate nursing care:

> *"he (the service user) hadn't eaten anything while there because he was paranoid that it'd all be tampered with but she (member of practice staff) asked him what he usually liked and the next day, she bought in a pot noodle and he was absolutely delighted… and he wolfed it down and it just made me think that it was a really small thing but it made such a difference and it changed my perspective a bit and I started thinking about the little ways I could be compassionate like that and I really think it's helped me to see more opportunities to be compassionate so yeah, I would say it's made me more likely to act compassionately now…"* (FG1: 2nd year student 1).

Placements in areas where compassion was prioritised and encouraged, served as a reminder for some students about why they had made the decision to commence a career in mental health nursing:

> *"…when you have those placements where you can be compassionate and they're (the practice team) compassionate and support it, it reminds you why you're doing it, you know? Why you came into it in the first place and that's such a powerful feeling. It's like, yes! I'm doing it, I'm achieving what I set out to do…"* (FG2: 3rd year student 3).

Environments in which compassionate care was prioritised and encouraged therefore supported student feelings of personal and professional achievement, and feelings of purpose. Feelings of achievement experienced through prioritising compassionate mental health nursing care activities were further recognised as re-enforcing and creating a cycle of compassionate purpose:

> *"…it's a good feeling when you've done something compassionate and you can see the benefit of it, you really feel like, I dunno (sic), I guess like you've achieved something and because it makes you feel good about yourself and what you've done, you're more likely to do it again because we all want to feel good and that we're doing some good… and the more you do it, the more you keep doing it."* (FG2: 2nd year student 2).

It was identified that feelings of achievement resulted in reinforcement of compassionate purpose, which motivated and inspired students to engage in more compassionate care activities. The impact of being supported to achieve in a practice context and the positive influence that this had on socialisation in compassionate mental health care practice is explored in the following theme – Being supported to achieve.

Being supported to achieve:

Participants spoke of two predominant ways in which they felt they had achieved. Firstly, achievement obtained through engaging in compassionate care:

> *"…it felt like such an achievement, this poor man (a service user) hadn't washed or looked after himself for weeks, probably months and all it took was a bit of compassion from the team to coax him and support him in a non-judgemental way. He was really resistant to start with, but it was the compassionate approach that made the difference, without that, we'd still be at square one…"* (FG2: 1st year student 2).

Some participants identified that they experienced greater feelings of achievement when they knew that their acts of compassion had directly contributed to service user's recovery journey:

> *"He started wearing his suits again, and you know, putting effort in, looking proper dapper. It felt like such a turning point in his recovery journey, and I felt so proud that we'd helped him get to that. It's stuff like that, that makes it all worthwhile…"* (FG2: 1st year student 2).

The sense of achievement in relation to engaging in compassionate care was often re-enforced by service user or carer feedback about the impact of the compassionate care interaction:

> *"sometimes you don't even realise the impact that your compassion has on someone until they tell you, you know? Until they actually say – thank you, that made a difference and then you realise that yeah, I did that. I helped make that difference for them and that's a really good feeling"* (FG2: 1st year student 6).

The feeling of making a difference to the lives of service users and receiving positive feedback about compassionate interactions was a catalyst for increased student motivation to engage in compassionate care activities:

> *"when you see the difference you can make by being compassionate with people, I guess it gives you a little boost and you're more likely to carry on being compassionate because of it. It's the same when you get that positive feedback about the difference you've made, you know from your mentor or the patient or whatever – you are more likely to be compassionate again because it makes you feel good. You feel good for doing it and also to some extent for being recognised for doing it…"* (FG2: 3rd year student 4).

Passing practice assessment/s and the impact of this upon engaging compassionately, and upon ultimate socialisation in compassionate mental health nursing practice, was the second element of achievement that participants reported. A factor that fostered both feelings of practice achievement and achievement in assessment was working with a team in which students felt safe and supported. Where this occurred, participants felt both supported and encouraged to achieve across the different domains:

> *"…they (practice staff) made sure I could meet all of my objectives and went out of their way to help me, so I didn't have that fear hanging over my head about failing the placement. They were just so supportive and really had my back, and I actually felt like one of the team…they encouraged me to be with patients and be compassionate to them rather than worry about my books (placement assessment documentation)"* (FG2: 3rd year student 4).

The support and encouragement to achieve provided students with the sense that they

were given '*permission'* to engage compassionately. The sense of needing permission to engage in compassionate mental health nursing practice was re-iterated across all focus groups and is explored in the following theme - Permission to practice compassionately.

Permission to practice compassionately:

The idea that students required permission to engage in compassionate mental health nursing care, in some cases even before they had experienced a placement, was discussed by participants in all focus groups, and underpinned many of the themes presented previously in this chapter:

> *"I'm worried that I'll go into my first placement and I'll want to be compassionate, but I won't see other people doing it and finding it's the norm in that place and that they think it's fine, to be like that and it's just the norm of that culture. I like to think I could still be compassionate but I'm worried that they might not let me, and I might not be brave enough to stand up to it…"* (FG1: 1st year student 4).

The sense of needing permission to act compassionately was perpetuated throughout the rest of the programme, and students reported seeking permission both implicitly and explicitly from service users, practice staff and the wider organisation, to engage in compassion in each placement experience throughout all years of the programme. Implicit permission to engage compassionately was, as discussed above, present through experiences of practice staff role modelling compassionate interactions and actions with students, other staff and service users. Where students were exposed to this, they recognised compassionate care as an expectation and '*the norm'* within the area, and perceived that their engagement in compassionate mental health care would therefore be supported. Students spoke of mirroring the actions of compassionate role models within the practice context to build confidence in engaging compassionately, and also recognised that the act of mirroring provided a safe platform to develop their compassionate care skills:

> *"I just copied what she (the mentor) did and how she interacted. It let me practice different ways of being compassionate with the patients and because I was basically copying everything she did, I knew it was ok and I wouldn't be told off or criticised because it was what she was doing…"* (FG1: 3rd year student 5).

Students also found implicit permission to engage compassionately when team leaders, managers and senior staff in the wider organisation demonstrated commitment to compassionate values through acts of compassion directed towards staff:

> *"the manager organised fortnightly supervision with a psychologist for the team to reflect and off-load and re-evaluate and whatever. I thought it said something about the manager and the wider organisation, you know, that they were willing to invest time and money to do that to support staff and I guess it made me feel safe to be compassionate because it was coming from the top – down. It wasn't just lip-service, they actually role modelled what they were asking the team to do…"* (FG2: 3rd year student 7).

The demonstration of compassion by senior members of the wider organisation supported the sense of a compassionate care environment in which consistent permission to engage compassionately was given. This was also re-enforced in teams that embraced a shared philosophy of compassionate purpose. Participants recognised the importance of consistent permission and stated that lack of consistent permission to engage compassionately had a profoundly negative impact upon their socialisation in compassionate practice:

> *"when they're all compassionate (practice staff), you can stay compassionate and it becomes second nature, but it's much harder when you're working in a team where some of them are compassionate and others aren't, because you have to change how you interact and what you do, because the staff that aren't compassionate disapprove and criticise and might have a go at you. So, you don't really know where you stand and puts you off and all the chopping and changing from being able to be compassionate to not being able to be, is knackering… in the end, it's easier to just give up and go with the herd and then you risk losing it completely"* (FG1: 3rd year student 7).

Students recognised that engaging in compassion where the shared team compassionate purpose was lacking required them to be courageous. Unfortunately, a reality of the sense of vulnerability that students reported experiencing, perceived lack of power and authority, coupled with reliance on practice staff to sign-off placement achievements, often resulted in participants weighing up their compassionate ideals against their desire to achieve a pass for the placement[43]. However, some participants recalled practice experiences in which it was made explicit by mentors that they expected students to demonstrate compassionate values and ideals, and engage in acts of compassion with service users, which bolstered the sense of being given permission to engage compassionately:

> *"she (the mentor) made it really clear from the outset. She actually wrote it in my initial interview, that she expected me to be compassionate. So, I aimed for it from the beginning really. I mean, you can't get any clearer than that!"* (FG1: 2nd year student 1).

[43] As explored in "Doing what I need to do to pass" – pg189.

Students also experienced explicit permission to engage compassionately when they were given direct guidance about compassionate ways to engage in care activities from all members of staff or senior students. This was further supported through reflective discussions facilitated by practice staff, and was underpinned by compassionate philosophy:

> *"we (student and mentor) used to have these reflective talks and she always focused on compassion – you know, what had we done that was compassionate and how we could approach things (compassionately) going forward. They really helped me understand what she expected from me and it helped me understand what I could and needed to do."* (FG1: 3rd year student 8).

In addition, positive feedback received from service users and practice staff members[44] about compassionate care actions also served to explicitly provide permission for engaging in future acts of compassion in the care context:

> "*when you get that positive feedback, like someone saying – you did this and it was really compassionate and look at the difference it's made, well done, keep it up, sort of thing, it re-enforces that you should be doing it and that you're supported to do it, so you're more likely to keep doing it"* (FG1: 3rd year student 3).

Explicit permission to engage compassionately with individual service users was also sought from the service users themselves. When participants perceived that permission was denied by service users, this had a negative impact upon their engagement in compassionate mental health nursing care:

> *"It can be hard to show compassion. I think a lot of the time, patients don't want compassion. That's what I've found on some of the wards…"* (FG1:3rd year student 2).

Numerous factors were identified that could impact a service users' desire to be treated compassionately including acuity of illness, lack of insight, unequal power balance between service users and staff, age, gender, and ethnic and cultural background of the service user and staff member. It was suggested by several participants in the third-year cohort focus group that it is easier to demonstrate compassion with older adults with organic mental illness, in comparison to adults or younger people with functional mental illness:

> *"I find I use compassion a lot more in my elderly placements. The patients want it, they seek it out, not like in acute (adult acute inpatient care)"* (FG1: 3rd year student 7).

[44] As explored in "Being supported to achieve" – pg166.

A lack of permission (implicitly or explicitly) to engage in compassionate mental health nursing practices made students feel limited and restricted in their use of compassion. In addition to seeking permission within the practice context, it was acknowledged that the student had to provide themselves with permission to engage compassionately. The giving of self-permission was easier when students felt safe, supported and encouraged to engage in compassion. However, other factors influenced self-permission, including the students' physical, emotional and psychological capacity to engage in compassion:

> *"it's easier when you're feeling tip-top and everything is tickedey-boo but sometimes, you stop yourself and tell yourself – "no" because, I don't know, you're stressed or tired or whatever and giving that extra bit will be the straw that breaks the camel's back and you just can't give any more. But if you feel like you've got the energy to do it, then it's all steam ahead, like "yes – I will be compassionate". Ultimately, whatever happens, you have to be the one that lets yourself do it"* (FG1: 2nd year student 1).

The sense of having permission, including implicit, explicit and permission to self, within the practice area, permeated all aspects of the student's placement experiences. Indeed, it was acknowledged as underpinning all opportunities to engage in compassionate acts and ultimately student socialisation in compassionate mental health nursing practice. However, the opposite was true in practice environments that had a negative impact upon student socialisation in compassionate practice, where the sense of permission to engage compassionately was inhibited or absent. In addition to the positive experiences identified, students also drew upon many negative placement experiences that were deemed to have an adverse impact upon their socialisation in compassionate practice. Students from all focus groups provided negative examples of socialisation, suggesting these experiences were commonplace. The impact these compassion impoverished environments had on student socialisation in compassionate mental health nursing practice is explored in the following section – "Everyone for themselves".

4.3: "Everyone for themselves"

The theme heading of *"*Everyone for themselves*"* was amended from a student participant quote in which the phrase *"Everyman for himself"* (pg193) was used to describe their feelings of isolation within the compassion impoverished mental health care environments. It is acknowledged that use of the phrase *"Everyman for himself"* could be construed as

contributing to negative gender-related stereotypes for male student nurses and nurses. As such the phase was altered from the original quote to *"*Everyone for themselves*",* as it was felt that this would continue to convey the sense of isolation described by participants, while avoiding negative connotations aimed at a minority group within nursing.

As with *"All in it together",* eight themes (as identified in Figure 4.2) were identified under the aegis of *"*Everyone for themselves*",* which relate to student experience of practice environments where they were exposed to factors that had a negative impact upon their socialisation in compassionate mental health nursing practice. These experiences were the antithesis of those described in the previous section *"All in it together".* Indeed, the factors identified in *"*Everyone for themselves*"* resulted in students experiencing a closing down to compassionate practice. The eight themes of *"*Everyone for themselves*"* are:

- Being fake – at all levels
- Being seen as a problem
- *"Billy no mates"* - Isolation
- *"Pie in the sky"*
- Prioritising the metrics
- Having the compassion *"knocked out of you"*
- Doing *"what you need to do to pass"*
- *"The fight for survival"* - Self-protection

The data collated from the focus groups demonstrated that students were negatively affected by placement experiences they deemed were lacking in compassion. Their understanding of and ability to engage in compassionate mental health nursing practice was affected in the short-term while working in these areas:

> *"sometimes it's just easier to go along with the herd. Keep your head down, keep the end goal in sight and hope this is a one off and that you can be compassionate in the next placement instead"* (FG2: 2nd year student 1).

Additionally, participants also reported longer-term negative effects of working in these areas due to their socialisation in pervasive negative practices, which had an impact upon student longer-term sense of compassionate purpose:

> *"I had this placement, and it was terrible. The staff were just horrible. There was no compassion, they all behaved like the patients were just a massive inconvenience who they couldn't be bothered with and they'd just sit in the office and avoid them as much as they could and I'm ashamed to say, I did the same. It was just easier to go along with them…and it followed me in to the next one (placement) and the next one. I'd gone from trying to be compassionate to hiding in the office and busying myself with paperwork because I'd become blinded to why I was doing it. It took quite a while and a really brilliant mentor at my last placement to help me turn it back around… Looking back, that placement was really toxic. It's like it polluted me with its poison"* (FG2: 3rd year student 4).

It is of note that participants had more difficulty in articulating concrete examples of how they were socialised in compassionate nursing practice in comparison to articulating the negative factors that inhibited socialisation. Indeed, participants were able to offer concrete examples of where compassionate practice was lacking and the impact this had on their development of compassionate care with much greater ease. This is reflective of the suggestion that compassion is often more noticeable in its absence than by its presence (von Dietz and Orb, 2000; Dewar, 2013).

A myriad of factors were identified as having a negative impact upon students' ability to engage in compassionate practice in the short and long term. These factors are explored through the eight themes of *"Everyone for themselves"* to develop in-depth understanding of the ways in which student nurse socialisation in compassionate mental health practice was inhibited during placement experiences.

Being fake - at all levels:

The theme of Being fake at all levels is the antithesis of the theme of Authenticity in compassionate care in 4.2: "*All in it together*". Inauthenticity or being 'fake' was identified as having a negative impact upon socialisation in compassionate practice. Layers of inauthenticity were identified, including inauthenticity in individual practice staff and placement teams, in the wider health care system and in policy makers. All layers of authenticity are explored through this theme.

Students identified that individual practice staff inauthenticity was visible through perceived disingenuous interactions with others (co-workers, students and service users) and through a demonstration of a lack of compassionate intentions. Multiple examples of staff demonstrating a lack of authenticity were given and included reports of staff appearing to engage compassionately with others but then talking negatively about affected individual when in the confines of the nursing office:

> *"some of them (practice staff) are just so two-faced. They're all nicey- nicey (sic) to your face or to someone else but when they get behind closed doors, it's like a massive bitch-fest and they take the piss. It just makes you feel really on your guard, like you've got to really watch yourself coz (sic) you know, that they could be bitching about you an' all (sic)…"* (FG1: 3rd Year student 3).

It was identified that it could only take "*one bad apple"* to have a negative impact upon student sense of safety within the placement. However, the impact of individual negative staff members could be mitigated when surrounded by staff who were viewed as genuinely supportive:

> *"sometimes all it takes is one bad apple to make you feel like that (unsafe). You can't trust them and really have to watch it with them coz they'll be all nice and pally but will try to stab you in the back. It's not so bad if the rest of them (the team) are alright and really want to support you but it still makes it difficult…"* (FG1: 3rd Year student 5).

Students reported two ways in which they would attempt to deal with 'bad apples'. The first was to try to avoid them and gravitate to other staff who were perceived as being compassionate and supportive of students. The second was to try to forge a relationship with the 'bad apple' in the hope that they would support the student. It was however recognised that this was a risky strategy and one that students would resort to when the individual was perceived to be in a position of power, such as being their mentor:

> *"if you've got any sense, you just avoid them and stay out of their way but sometimes it's harder to do, like if it's your mentor. You have to try and get on with them somehow because they're signing you off, so when this happens you have to put some effort in to trying to get them on your side… I wouldn't risk it if it was just another random team member but when it's your mentor, you need to play the game a bit to get through…"* (FG1: 3rd year student 2).

Where this was the case, some students reported feeling the need to mirror the inauthenticity when with the individual, and pretend to be someone or something different from their true self to try and impress the individual staff member and as a way of ingratiating themselves to them:

> *"if it's your mentor, you just make sure they see you do what they do. Become a mini-them when you're with them because then how can they criticise you if you are doing exactly what they are and I think it feeds into their ego and they like that they've been able to mould you into them, so they tend to chill out with you a bit…"* (FG1: 2nd year student 2).

It was recognised that experiences with 'fake' individual staff members had less of a lasting impact than exposure to a wider team culture of inauthenticity:

> "*when it's just one (disingenuous member of staff), you can put it to one side and it doesn't have the same lasting effect that it does when they're (practice staff) all like that, even if it's the mentor, once you're away from that placement, you can move on but when they're all like that on one placement, it stays with you…."* (FG2: 2nd year student 2).

In addition to presenting an inauthentic version of the self when working with disingenuous individual members of staff, students also reported feeling the need to do this consistently when working in teams in which the majority of staff were viewed as being inauthentic. Students reported feeling that they had to moderate their true selves in these situations, and at the furthest extreme mirror team inauthenticity and pretend to be like the majority of team members in order to survive the experience:

> "*…when you realise that the whole team are just really fake or at least most of them, you know you've got to watch your back all the time and I guess what I've done is I pretend to be someone I'm not and more like them, so I'll copy them and present a fake version of myself so they can't hurt me, and I'll do that with them all for the whole placement. It's not who I want to be but it's about self-preservation"* (FG1: 2nd year student 2).

When students were exposed to a placement where they perceived the majority of staff being inauthentic, this had a significant impact on trust in student-staff relationships, both during the affected placement experience and in future placements:

> *"in those situations, you just know you can't trust any of 'um (sic) and because you've got your guard up, it stops you from really developing a relationship with them, not that you particularly want to… and it makes you really wary on your other placements too and it takes time to build up that trust in other people when you've been so surrounded by that negativity…"* (FG1: 3rd year student 10).

Indeed, students reported the feelings of insecurity remaining with them and creating long lasting feelings of fear during later placements. Some students attempted to avoid trying to "*stand out"* in future placements, and attempted to keep their "*head down"*, due to the experience affecting their ability to *"trust"* practice staff as a whole:

> *"when you're surrounded by people who are fake, it affects you there and then, you're on your guard and worried about poking your head above the parapet in case it's shot at, so you try not to stand out. So, you might not be compassionate, you wouldn't be cruel, you just wouldn't do anything to make you stand out… and if you're not careful, you take that with you. It instils a fear that you've always got to watch your back and that you can't trust anyone, you become a bit paranoid, even in new placements…head down, crack on, don't make waves, just so you can feel safe"* (FG2: 2nd year student 1).

Third year participants also identified that perceived inauthentic guidance from the wider health care organisation and health policy also resulted in feelings of uncertainty, which had a negative impact upon their feelings of safety and socialisation in compassionate practice:

> *"…you've got the Trust with their guiding visions and values that tell you - you should be compassionate, and it's all over national mental health policy that we have to be compassionate but if something goes wrong, you know, you take some positive risks in working with a patient, which we're told we should do to empower them and whatever but it all goes tits-up, people are hauled over the coals. They (the organisation) don't support us, they blame you and you realise it's all bollocks, it's just fake. You know, they say we should be compassionate but there is no compassion to us, so you get to the point where you think – why bother!"* (FG1: 3rd year student 3).

Third year students also spoke of perceived lack of authenticity underpinning national guidance relating to nursing, specifically in relation to the implementation of the Six C's (Cummings and Bennett, 2012) and government investment:

> *"…it's like the Six C's, honestly, I'd love to be compassionate but it's often not a reality because of the limitations placed on us by the organisation. It's frustrating because it becomes an individual issue rather than compassion being the responsibility of the whole organisation. In fact, it should be even wider than that. The government needs to take responsibility too, how can we be compassionate when we are so underfunded and scrabbling (sic) around for basic resources, where is their compassion for us? It just smacks of a do what we say, not what we do approach which makes you think it's all just bullshit"* (FG2: 3rd year student 7).

It was suggested by some participants that individual negative staff members perhaps began their careers wanting to make a difference, but that their exposure to tokenistic investment in compassionate care resulted in diminished capacity to experience and demonstrate compassion for others:

> *"it's a bit worrying really, they (practice staff) probably didn't start out like that. They were probably like us, all idealistic and wanting to make a difference but maybe over time, it's what the job and the lack of support to actually be compassionate and the lack of investment has turned them in to. It makes me worry that the same will happen to me…"* (FG1: 3rd year student 6).

It is of note that no students identified the wider organisation as having an impact upon their experience of positive socialisation in compassionate practice. However, third year students were able to look beyond both their own experiences of being treated compassionately, and compassionate care directed towards service users, and recognised the impact of inauthentic organisations on practice staff ability and willingness to engage in compassionate practice:

> *"I feel sorry for some of them (practice staff). If they're not treated well by the employer, it becomes really stressful and how can they be expected to be compassionate to other people…"* (FG2: 3rd year student 2).

Students suggested that a lack of compassion demonstrated by the organisation contributed to staff feeling unsupported and pressured in the workplace, which resulted in reduced staff capacity to positively engage with students on placement:

> *"there is so much pressure from the organisation and although they tell the rest of us that we need to be compassionate, it doesn't trickle down from the top, so they (practice staff) end up being really stressed and they're so focused on themselves (because of the stress) that they just can't deal with us as well"* (FG1: 3rd year student 9).

This was seen as directly contributing to some practice staff viewing teaching students as additional work that they did not have the time or capacity to support. This resulted in the perception that students were a problem in the practice context. This is explored further in the following theme - Being seen as a problem.

Being seen as a problem:

Unfortunately, participants in all cohort focus groups reported experiencing the feeling that they were often perceived as an inconvenience by practice staff when on placement, which made students feel both unwelcome and unwanted:

> *"sometimes it's obvious that they just think you're a massive inconvenience. It's like they think we're an added extra to their workload and that we just get in the way, that makes you feel pretty unwanted to be honest…"* (FG1 2nd year student 2).

This apparent lack of empathy towards students in the placement area did not have to be demonstrated by the whole team and could be a result of the attitudes of one or two members of the team only. However, students were particularly affected when this attitude was exhibited by their placement mentor. It was in these instances that students reported finding another member of staff to work with who would 'take them under their wing', to reduce the frequency of contact with the mentor harbouring the negative attitude. The feeling of being viewed as 'a problem' resulted in students feeling isolated, embarrassed, useless and afraid to engage compassionately with service users:

> *"I'd been talking to this patient and she'd got a little bit weepy talking about her children, so I sat with her… My mentor came up and asked, in front of the patient – I was mortified –what had I done to her? He said that I'm not there to make people cry and said he'd have to sort out the mess I'd made…I was so embarrassed. After that, I was scared to talk to anyone in case he started at me again…* (FG2: 1st year student 4).

Participants also reported instances where they were accused of causing problems by doing something perceived as simple, such as spending time with a service user. Accusations from practice staff included that they were creating unrealistic expectations of the contact time that regular staff could have with service users when students were not at the placement area:

> *"I was told I had to stop spending time with this patient because they said she'd rely too much on staff and it'd make more work for them once I'd gone…"* (FG2: 1st year student 2).

Such examples reinforced to students that their presence was problematic and lacked value within the practice context. This increased the sense of isolation experienced and led to the inhibition of feelings of safety, acceptance and significance.

Negative criticism had a profound effect on student willingness to engage compassionately with service users. This was especially apparent when they were directly criticised for demonstrating acts of compassion. Receiving negative criticism resulted in concerns that placement outcomes would be negatively impacted, that they would receive a poor performance report at the end of the placement experience, or that the final placement assessment would be failed. This highlighted the feeling of vulnerability that students often experienced. The feeling of vulnerability experienced resulted in some students moderating their compassionate ideals and actions and again, mirroring staff attitudes and actions in an attempt to 'fit in', and so be viewed as less problematic and increase their chances of achievement in terms of their placement assessment:

> *"I thought I was being really compassionate but I was criticised for it and honestly, it did stop me from being compassionate. I didn't want to fail so I copied what they (practice staff) did and tried to become one of them… I didn't feel comfortable with it, but I did what I need to do so I could pass"* (FG2 3rd year student 2).

In addition to enhancing chances of achievement, participants also reported instances where they failed to challenge poor practices in an attempt to appear like 'less of a problem' and improve their chances of fitting in with the team:

> *"…honestly, I've seen some really – let's say, not gold standard practice and I've just kept my trap shut. Don't get me wrong, if someone was being abused or neglected or there was a safeguarding issue, I'd tell the manager or my personal tutor, I couldn't ignore it, but I've seen some right dodgy practice and I've not challenged it, I've let it go because I don't want them to think of me as the annoying bloody pain in the arse student… you do what you can to fit in and I guess it's been those times that compassion has become secondary, I suppose it's become an unachievable ideal"* (FG1: 3rd year student 1).

Participants reported experiencing a sense of isolation when on placement in areas lacking compassion, which were often underpinned by staff attitudes that they were problematic. The impact of isolation on socialisation in compassionate mental health nursing practice is explored in the following theme, *"Billy no mates"* – Isolation.

***"Billy no mates"* – Isolation:**

Environments in which student experienced a feeling of isolation, separation and alienation from the host team in which they were placed resulted in a diminished sense of acceptance. This led to participants feeling that their socialisation in compassion was hampered. Indeed,

students stated that lacking feelings of acceptance and inclusion resulted in an overall feeling of being unsafe in the practice context, and consequently ensued students presenting an inauthentic version of themselves[45]:

> *"sometimes you feel like a right billy no mates and it makes you feel like a real outsider. You try to fit in the best you can, so, I just keep my head down, do what I need to do and follow their (practice staff) lead and sometimes, that means that I'm not always as compassionate as I should be or as I'd actually want to be…"* (FG2 2nd year student 1).

Unsurprisingly, the factors identified as inhibiting socialisation in "*Billy no mates"* – Isolation are a mirror image of the factors identified in Camaraderie and feeling like part of the team. Indeed, negative staff attitudes and lack of camaraderie resulted in students experiencing heightened feelings of isolation, lack of support and fear of criticism and rebuke:

> *"we've all had those placements that are just horrible, you know, the staff are rude and disinterested in you and the patients and there is no one that you can turn to coz (sic) they're all as bad as each other… You end up feeling really alone and down and actually quite scared…" (*FG1 3rd year student 9).

First-year student participants experienced an increased sense of isolation due to their feelings that they were negatively perceived and under-valued as first-year learners within the practice context:

> *"… the moment you mention you're a first-year that's how they look at you, they really devalue your knowledge and as soon as you say you're a second-year, they value you more. They respect you and are more compassionate towards you. Whereas first years, they don't expect you to know much and they just, it's like you're not properly valued, so you just end up feeling like a real outsider of it all* (FG2: 1st year student 5).

Second-year participants reported experiencing extremes of practice staff both making assumptions of lack of knowledge, and having unrealistic expectations about their knowledge and skills for their phase of programme, which exacerbated their sense of isolation:

> *"…there are certain things that they (practice staff) expect you to know and do but you're thinking, I'm a student, I'm here to learn, you need to show me but they expect you to know what you're doing. But I've also found that sometimes they assumed that we didn't know anything as well, either way, it leaves you feeling a bit stupid and sometimes, I don't know, I felt quite belittled…"* (FG2: 2nd year student 1).

[45] As also described in "Being fake" at all levels – pg173.

The lack of realistic expectations and value of students appeared to be underpinned by negative assumptions and attitude towards students. This included a lack of genuine interest in students as individual learners with unique experiences and learning needs:

> *"Like everybody thinks we're inexperienced but they don't bother to find out about us, about what we did before and don't value the other experiences that we had before becoming a student that might be able to help with a situation. And if you do draw on something from your old job say, they look down at you and don't pay any attention because you weren't a nurse when you did it…"* (FG1 1st year student 6).

Participants spoke of experiencing a feeling of inadequacy in these situations. These feelings were further compounded for participants by a perceived dissonance between mental health nursing as taught and as experienced in some placements. In turn this resulted in intensification of the feeling of isolation that students experienced:

> *"…do you know what makes it (feelings of inadequacy) worse? When you lot (academic staff) stand there telling us, that there is no excuse and that we should always strive to be compassionate no matter what but that's just not the reality of it. We can't always do it but you (academics) saying that, makes you (the student) think it's your problem, that you're not good enough, you're not compassionate enough and then as well as feeling alienated in practice, you feel alienated in the classroom as well because like, I just can't meet your expectations. I can never be what you want me to be. Not when you're faced with all the shit we have in practice… and rather than inspire you to do better, you get so overwhelmed that you just give up because it feels so impossible"* (FG2 3rd year student 1).

This powerful quote highlights not only the impact of dissonance between theory and practice but suggests that the way in which some educationalists deliver theoretical content may create the feeling of unrealistic expectations being placed on students, in relation to their ability to engage in compassionate mental health nursing practice. The experience of dissonance between theory and practice on student socialisation in compassionate mental health nursing practice is further explored in the following theme *"Pie in the sky".*

"Pie in the sky":

Although participants were able to recall positive examples of continuity between theory and practice in their placement experiences, they recounted many more examples of the negative impact of dissonance. The challenges experienced by students of striking a balance

between the gold standard taught in the classroom context, and the realities of contemporary mental health nursing practice, often left them feeling bewildered and unsure of their role and how to respond in specific situations. This resulted in replication of poor standards of care and accepting that such practices were the reality of getting the job done. This is in turn led to reduced engagement in compassionate patient-centred care and increased risk aversion, leading to engagement in coercive and paternalistic mental health care practices.

A lack of illustrative examples used in the classroom to explain how theory could be applied to practice, coupled with a lack of role modelling of evidence-based care in the practice context, and discussions about rationale of engaging in specific care actions resulted in students feeling engagement in compassionate care was unrealistic:

> *"sometimes it all feels just very theoretical, especially when we're told to be compassionate but then no one tells us like how to be compassionate. It just starts to feel like it's blue sky thinking but not actually something that can be achieved…"* (FG1: 2nd year student 2).

Participants also reported occasions when they had attempted to apply theoretical learning to their practice experiences but received criticism from practice staff:

> *"I was made to feel like a goody two shoes for wanting to do things right (as taught in the theory component). They (practice staff) really looked down on me and this nurse said to me, you study in books but that's not reality, you're in the real world now love and you've got no idea…it just made me think that all that stuff that we'd covered in the classroom was nothing more than pie in the sky…"* (FG2: 1st year student 5).

In addition to this, some students reported being led to believe that their programme of education was substandard compared with historical nursing training. This had a significant impact upon the inhibition of student confidence, esteem and feelings of worth. As a result of this, students identified that they were less likely to challenge that status quo by attempting to implement contemporary theory into practice:

> *"they (practice staff) don't seem to have much of an idea about the course. Although they say really disparaging things like 'they (academics) don't know what they're teaching, they're out of date and you can't learn if you're supernumerary' and stuff like that. It gives you the sense that you'll never be a good nurse, that you'll never be as good as them, so you can't change the way things are done…"* (FG1 2nd year student 1).

Even when students were able to make links between theory and practice, disconnection occurred due to numerous challenges identified. Students reported an appreciation for why practice staff members may engage in coercive or paternalistic care rather than the evidence-based approaches that students were introduced to in the classroom. The challenges identified required a pragmatic approach to enhance feelings of personal safety and job security, rather than engaging in theoretical considerations which were perceived as potentially increasing workload or putting feelings of safety at risk:

> *"They've (practice staff) got to weigh it up. It's a cost-benefit analysis. Do I do the gold standard and give myself more work in the long run or risk something (adverse) happening to a patient, or do I keep the patient sedated on meds (sic) for example, because it will keep them safe and by extension, my job is safe? It's about striking a balance and sometimes the reality of what we are working in has to take precedence over what we should be doing…"* (FG2: 2nd year student 1).

The pressures within mental health care services and organisations led to participants questioning the role and purpose of the mental health nurse when faced with challenges of practice, which limited or prevented engagement in evidence-based mental health nursing care.

Dissonance between the theory of managing risk as taught in the classroom and the practical realities of managing risk in the practice context was discussed at some length by the third-year student participants, who were beginning to consider their accountability as future registrants. A lack of feelings of safety were identified as a direct consequence of the inconsistency created by working in risk averse organisations, in which students recognised that staff felt unable to engage in positive risk taking due to fear of blame and rebuke should untoward incidents occur:

> *"even if they wanted to take positive risk, they can't because the set up of the service doesn't support it, not when it's the individual nurse that ends up getting the blame if something goes wrong. They're scared they'll end up dragged to coroners…"* (FG1: 3rd year student 2)

Students recognised that as a consequence, clinician and service needs were prioritised over the needs of the service user, therefore limiting the scope for engagement in compassionate approaches to care:

> *"they (practice staff) become so concerned that they'll get the blame if something adverse does happen, that they don't even try to do things that could be viewed as compassionate, you know, like reducing someone's meds if they've got side effects or whatever. It's also less resource intensive for the nurse and the team if you just leave them drugged up to the eyeballs I suppose. It doesn't sit right with me but sometimes the needs of the patient are the last thing to be truly considered…"* (FG2: 2nd Year student 2).

The impact of student exposure to the prioritisation of clinician and service needs over service user needs on socialisation in compassionate mental health nursing practice is further explored in the following theme – Prioritising the metrics.

Prioritising the metrics:

The perception that mental health care organisations prioritised targets and metrics over the provision of compassionate mental health care was held by participants in all cohort focus groups. The task orientated nature of some care environments was identified as posing a particular barrier, especially when such tasks reduced staff contact with service users:

> *"It's hard to be compassionate when there is so much paperwork to do and reviews right left and centre and concerns from families… you have to prioritise things and you prioritise what the managers say has to be done. They push for the paperwork rather than you actually nursing and being with the patients"* (FG2: 1st year student 6).

Even tasks that included service user contact were negatively affected by focus on the task being done rather than the way in which the activity was carried out:

> *"…there are certain tasks that have to be completed, like blood pressures. A compassionate thing would be to let the patients finish their breakfast and then take their blood pressure, but you've got to get it done and the mangers are breathing down your neck, so you interrupt their breakfast. The targets get in the way, getting it done becomes the priority rather than how it is done"* (FG2: 1st year student 3).

Heavy workload, lack of staff and lack of resources were also identified as having a significant negative impact upon the time that practice staff had to realise compassionate purpose:

> *"it's like involving patients in care plans, I think that's compassionate and I want to do it but a lot of placements don't do it because of time restrictions and staffing. Time is a massive barrier, it's a big factor, you have to get other jobs done, so when*

being compassionate takes time that you haven't got, even if you want to be compassionate, it goes out the window" (FG1 3rd year student 8).

Fear of the consequences of not completing tasks set by managers or the wider organisation was palpable, resulting in practice staff and students prioritising tasks at the detriment of engaging compassionately, due to concerns of rebuke, job security and potential litigation:

"...You end up sat in the office all day, just doing bloody paperwork and I get that some of it is really important but some of it's paperwork for the sake of paperwork. It's like some bloody jobsworth who's never set foot on a ward has come up with it because they don't think you're working hard enough, and if staff don't do it, they get a bollocking or disciplined or whatever but actually, it takes them away from being able to be compassionate with the patients, you can't do it all. It's too much..." (FG2: 3rd year student 4).

As stated in the theme Being fake - at all levels, participants recognised a disconnect between the guiding vision and values of mental health care organisations and the reality of prioritisation of care tasks in at the practice context:

"… it talks about us being compassionate in the visions and values stuff but it's not often that it's role modelled by management. There's no positive re-enforcement that you're doing a good job if you are compassionate, but if you do something wrong, even if you were trying to be compassionate, they soon come down on you. It's like do as we say, not as we do…" (FG2 2nd year student 1).

A consequence of the prioritisation of metrics by front line mental health staff, due to pressure from the wider organisation, societal infrastructure and Government, resulted in some staff making decisions about the deservingness of compassion to provide justification for reduced levels of compassionate care engaged in:

"…it gives them a get out of jail free card – he doesn't deserve compassion because he's violent or he takes drugs and brought it all on himself or whatever, so they don't have to invest that time in the patient and can focus on locking themselves away to get the paperwork done instead…" (FG1: 3rd year student 3).

Students also reported that service users who demonstrated challenging behaviour were often viewed as being problematic and having a negative impact upon meeting organisational key performance indicators. This was due to demonstrating behaviours which took staff away from paperwork requirements and creating additional work (for example, increased critical incident reporting requirements). As such, service users with specific

mental health diagnoses were viewed by some practice staff as being less deserving of compassion. Student participants from all cohort focus groups reported that service users with a diagnosis of Emotionally Unstable Personality Disorder (EUPD)/ Borderline Personality Disorder (BPD) were often highly stigmatised by practice staff, due to engaging in behaviours that were challenging to manage in the practice context and resulted in increased documentation:

> *"it's awful really they're (service users with EUPD/BPD) treated really badly on the whole and it's like they're a massive inconvenience because of the work that they create with dealing with self-harm and then all of the paperwork. Plus, they stop teams from meeting targets, like self-harm reduction targets so staff just end up feeling really resentful because then they're getting it from the managers, so they lose any compassion they might have had for them in the first place…"* (FG1: 2nd year student 1).

The belief that personality disorder is not a true mental illness or that service users are *"attention seeking"* was reported to pervade some practice areas and led to the opinion that these service users were less deserving that those with other diagnoses:

> *"There is a lot less compassion to those with personality disorder. They think it's all attention seeking and that they are being manipulative or self-destructive, so why should they have help. They're (practice staff) a lot less compassionate to them than they would be to someone with first episode psychosis. It's (personality disorder diagnosis) viewed very negatively (within mental health services) and it doesn't help that they (service users with this diagnosis) often do challenging behaviours like self-harm or absconding, because that creates more work and staff just end up getting worn out with it all…"* (FG1: 3rd year student 8).

The challenge of maintaining a compassionate purpose when required to prioritise the metrics was acknowledged:

> *"How can you be compassionate when you haven't got the time to do it coz (sic) you're stuck in the office writing the risk assessment rather than actually doing anything practical to reduce the risk, it's ridiculous…"* (FG1: 2nd year student 2).

The re-direction of staff purpose, from prioritising compassionate care interactions to prioritising metrics, resulted in participants experiencing a diminished sense of compassionate purpose. Reduced compassionate purpose resulted in reduced motivation and attempts to engage in compassionate care activities:

> *"… when you got all the paperwork to do and audits and all the rest of it that take you away from being with the patients, it's like you're pissing in the wind. It's hard,*

> *it's messy and in the end, you just think why do I bother… You lose sight of actual compassionate care because of all the red tape and it's so bloody time consuming, you give up even trying to spend time with them (service users), to be quite frank, you end up not really wanting to and even if you did, what difference would it make really? "* (FG1: 3rd year student 5).

The reduced sense of significance caused by prioritisation of the metrics, in combination with the poor role modelling of compassion towards front line mental health care workers from the employing organisation, had a profoundly negative impact upon personal capacity to engage in compassionate care. This resulted in the sense that students had compassion *"knocked out"* of them. This is explored in the following theme – Having the compassion *"knocked out of you".*

Having the compassion "*knocked out of you*":

The experiences uncovered in the previous "Everyone for themselves" themes all contributed to students either experiencing diminished levels of compassion or inhibition of the ability to demonstrate compassion to service users in their care. Participants reported that their compassionate ideals and ability to engage compassionately had been gradually *"worn down"* through placement experiences where compassion was lacking:

> *" …you don't start out not wanting to be compassionate. When I started (the programme), I thought I could change the world and was determined that I'd always treat people compassionately but over time, I feel like I've just become so worn down by it all (experiences in compassion impoverished placements). I haven't got the energy to change it…"* (FG1: 3rd year student 1).

Participants reported numerous implicit examples of practice staff projection of negative feelings which resulted in both compassionate purpose and student feelings of safety being eroded over a period of time:

> *"it's not just the obvious stuff though, like them telling you the horror stories, it's more subtle than that. Like when you have staff who just sit in the office and don't bother to engage and they're just generally negative and you know that they just don't want to be there. They just seem really unhappy. It makes you think, blimey – this is what the job does to you and you don't want to end up like them and over time it's chip, chip, chipped away bit by bit…"* (FG1: 3rd year student 6).

These feelings were exacerbated through practice staff explicitly projecting their self-dissatisfaction and fatigue on to students:

> *"I had one nurse say to me, 'you'll soon have that (compassion) knocked out of you'. She filled me with horror stories about people getting sued for trying to comfort someone by putting their arm around them. I think she'd had someone complain about her or something. It was like she'd just given up, but it made me feel like she wanted me to give up too…, I felt quite burnt out because of her, so when a patient came to me with a problem, I couldn't deal with it"* (FG1: 3rd year student 3).

Participants also reported experiencing compassion fatigue and burnout themselves due to exposure to challenging behaviours within the mental health care context. These experiences had a negative impact upon student feelings of physical and psychological safety, and it was recognised that students re-directed their compassionate purpose from the service user to the self. In these instances, students reported prioritising their own deservingness as an attempt to improve their own feelings of safety within the care context:

> *"…and when you get a patient who is constantly ligaturing, you get to the point when you're scared to walk into a room, because of what you might see. You become traumatised. Or if you've got a patient who is constantly trying to hit everyone and people get injured, you lose compassion for them (service users) because you don't feel safe and you start to think that they don't deserve it"* (FG2: 3rd year student 2).

Consequently, participant experience of compassionate purpose was negatively impacted and this in turn led to students experiencing guilt and at the furthest extreme, feelings of self-contempt and depersonalisation. This was particularly evident in the data collected from third-year cohort participants, who appeared acutely aware of the risk of burnout and compassion fatigue in the practice context, and some demonstrated signs of beginning to experience the phenomena themselves. This in turn had a profound impact upon students' personal feelings of significance. In this respect, compassionate purpose and significance were intertwined, with reduced compassionate purpose created by burnout or compassion fatigue, resulting in students questioning their significance, worth and ability to create change and support service user recovery:

> *"you can't do it all the time. It's knackering and you just get to the point where you can't be compassionate and you just do your duty and then you start thinking, well what's the point. Why am I doing this. I'm not helping anyone" (FG1: 3rd year student 7).*

The idea that compassion is finite, and the paradox that to prevent burnout students had to de-sensitise themselves from service user distress and therefore not act compassionately, was a strongly held view within the third-year cohort group:

> *"you can't be compassionate constantly, it's exhausting. You have to become de-sensitised, (to service user distress) to protect yourself, otherwise it's not sustainable"* (FG1: 3rd year student 9).

The view had developed as a result of both personal experience within the practice context and the implicit and explicit teachings of practice staff:

> *"you figure it out pretty quickly (needing to become de-sensitised) because you end up feeling just knackered but it's I guess it's re-enforced by seeing how staff are affected when they don't de-sensitise. You can see them get burnt out. I had a mentor who said to me, 'do yourself a favour and don't end up like me, start putting your barriers up now'. I think that was one of the best bits of advice I've been given actually…"* (FG1: 3rd year student 4).

A consequence of students feeling that compassion had been *"knocked out"* of them was a re-direction of priorities from prioritisation of compassionate care interactions with service users, to prioritisation of the self and self-achievement. This is explored further in the following theme – Doing *"what I need to do to pass".*

Doing *"what I need to do to pass":*

When participant feelings of achievement in relation to engagement in compassionate mental health nursing care were diminished, they experienced demotivation and confusion about their identity as a future nurse:

> *"…I've questioned if nursing really is for me. I wanted, and I still want to be able to be compassionate, but it just feels so unachievable coz of everything, I suppose. I dunno (sic) I just feel like I'm floundering coz of the powerlessness of it and I'm not sure that will change when I'm qualified…"* (FG2: 3rd year student 1).

Initially, participants identified that both clinical achievements and practice assessment achievements were viewed as equally important in their overall experience of achievement. However, it soon became apparent that students experienced a sense of idealism about the importance of clinical achievement and that in reality, achievement in terms of passing practice assessments often became a main priority. This was especially apparent when participants felt unable to engage compassionately due to the numerous factors identified previously. Self-achievement particularly became a priority when participants felt that they had to *"please"* mentors[46] to ensure that they passed their placement experience:

[46] As explored in Being Fake at all levels – pg173.

> *"sometimes you can't demonstrate your compassion to the patient because you're pre-occupied with trying to please your mentor so you can pass because it all comes down to what they think of you doesn't it? And what they say about you matters the most, so you can be persuaded to please them rather than be compassionate to the patient"* (FG2 1st year student 4).

Students reported that feelings of achievement in the practice context and making a difference to the lives of service users therefore became secondary to the personal achievement to ensure progression through the programme. However, some participants justified this by minimising the significance of their compassionate engagement with service users and therefore giving themselves permission to put their own achievement of progression first:

> *"…I don't think it really matters in the grand scheme of things. We're only there for a few weeks anyway so we don't really have much impact on the patients, not really. But if I can pass and qualify and get a permanent job, I can be compassionate then and it will mean more because I'll be there all the while, not in and out like we are now"* (FG1: 3rd year student 1).

The justification of 'putting it off' and placing it as a future aspiration limited the scope for students to action compassionate practice in the present. This is reflective of practice staff justifying lack of engagement in compassion and prioritisation of metrics through compassion appraisal of deservingness, as explored in the previous theme of Prioritising the metrics. This demonstrates the power of negative role modelling upon inhibited socialisation in compassionate mental health nursing practice:

> *"I'm just thinking, and I never realised it before but I've done exactly what they (practice staff) do. I've justified not being compassionate to myself so I don't feel bad about it, which is what they do. I never realised how much their actions rubbed off on me, but thinking about it, they definitely have"* (FG2 3rd year student 5).

Students reported that they routinely went "*through the motions"* in order to pass their placement assessment/s. This at times resulted in some of them not engaging in authentic compassionate practice, due to the perceived lack of value by practice staff:

> *"it's tricky, you want to be compassionate but if they don't value it (compassionate practice) and see it as important, you turn a blind eye to it to. You play the game and go through the motions to do what you need to do to pass, it's as simple as that…"* (FG2: 2nd year student 2).

The underlying theme of self-preservation and protection was identified throughout data collected relating to Doing *"what I need to do to pass"* and also throughout all of the other

themes of *"*Everyone for themselves*"*. This is explored in the final theme of *"*Everyone for themselves*"*, *"The fight for survival"* - Self Protection, below.

***"The fight for survival"* - Self-protection:**

As previously presented, participants experienced the sense that they were given permission to engage compassionately in practice areas that embraced and aimed for compassionate practice. This is in direct contrast to their experiences in environments lacking in compassion, in which both the sense of permission to engage in compassionate care was inhibited, and the sense of having to protect oneself from the potential threats within the environment was heightened.

The data across the themes of *"*Everyone for themselves*"* demonstrated that feeling fearful and physically, psychologically and emotionally under threat when in these practice environments was a common experience for students. In addition to findings already presented, participants also reported feeling fearful of staff who did not demonstrate kindness and compassion to service users:

> *"when they (practice staff) aren't good with the patients, even if they're ok with you, it freaks me out because you still get the sense that you've got to watch your back a bit coz (sic) if they can be so unkind to the patients, what's to stop them being like that with you?"* (FG2: 1st year student 4).

Students provided several examples of practice staff lacking compassion in their interactions with service users but making attempts to include students and make them feel like 'one of the team'. Although students recognised the importance of being made to feel both accepted and included[47], the impact was limited when staff demonstrated inconsistency in compassionate approach between service users, co-workers and students. Furthermore, students felt pressured in to mirroring a lack of compassion directed towards others in order continue to be accepted as one of the team:

> *"it's not all it's cracked up to be, sometimes they'll embrace you into to team and see you as one of them, but it feels like there is this unspoken rule of you can be one of us, but only if you do what we do and only what we do and I don't necessarily want to do what they do but I end up doing it... But the trust isn't really there coz (sic) if you put one foot out of line, you'll be ousted from the group. Plus, it's hard to see*

[47] As explored in "Under their wing" – pg150.

yourself turning into something you don't want to be, just so you can get along, so you just feel really unsettled in yourself I suppose…" (FG2: 3rd year student 5).

Participants also spoke of feeling unsafe when practice staff members demonstrated signs of insecurity. Indeed, it was perceived that if staff demonstrated signs of insecurity themselves, then the practice environment was not safe, which had a direct negative impact upon student engagement in compassionate mental health nursing practice:

"if they (practice staff) don't feel safe, we catch the feeling, and it makes you feel even more unsafe. Quite frankly, it's scary and you just focus on getting through the day rather than thinking – oh yes, I have to be really compassionate or whatnot, with the patients" (FG1: 3rd year student 7).

The feeling of fear of potential physical and emotional threat in practice was evident in all cohort focus groups. Participants reported feeling increased levels of fear when faced with challenging situations in which they felt unprepared and unsupported by practice staff, such as exposure to challenging behaviours, episodes of violence and aggression, and witnessing episodes of self-harming behaviours or attempted suicides:

"…we had this one patient who was constantly kicking off and he'd injured one member of staff and kept going at the rest of us. It got to the point where I'd feel sick thinking about going into placement because I was so worried that I'd end up getting hit and I spoke to my mentor about it but he was so unsupportive, he basically said 'suck it up buttercup' and that this is mental health for you and that you can't call yourself a real mental health nurse until you've been hit. I felt so unsupported and isolated and that just made me think that no-one had my back and I literally hid away all day, in the clinic, in the office, in the sluice, wherever I could to try and keep myself out of the way…" (FG2: 3rd year student 5).

The lack of feelings of safety leading to student self-protection was exacerbated in practice environments in which there was a poor leadership presence. These feelings were further intensified in organisations with an established and pervasive 'blame culture':

"I had this placement where if anything went wrong, they'd look for the scape goat to blame and it was all of them, the top managers would blame the team manager, and the team manager would try and deflect the blame by blaming staff and everyone was scared that they'd be the one to blame next. It just felt like it was only a matter of time before they started blaming me for something, so I spent loads of time trying to cover my own back – you know, just in case, and it took me away from actually spending time with the patients. But the really worrying thing for me, is that – that wasn't just a one off. There are loads of places where you have to do that…" (FG2: 3rd year student 2).

When students experienced the feeling of insecurity it resulted in some of them becoming introspective and entering a survival mode, in which they focused on developing their own sense of personal self-protection and feelings of safety by exclusively focusing upon and attending to their own needs. This resulted in limiting both their desire and capacity to engage in compassionate mental health nursing care to meet the needs of service users:

> *"when you feel so on your own, you have to focus on yourself. No one else is looking out for you, and because you're so focused on yourself, you stop being able to see other people's needs or you see them, but you just can't deal with them. It's like it makes you selfish. I've been in those situations and you know, I'm not proud but sometimes you have to prioritise yourself and that's at the detriment of being able to be compassionate to other people…it becomes an everyman for himself type situation and you do what you need to do to survive"* (FG2: 3rd year student 6).

It was the sense of needing to enter a self-protection mode during these negative placement experiences that underpinned the journey through The Retrogress Ladder of Socialisation in Compassionate Mental Health Nursing Practice as demonstrated in figure 4.3.

Students provided examples of either positive or negative practice experiences which impacted socialisation in compassionate nursing practice. The themes presented in both *"All in this together"* and *"*Everyone for themselves*"* were in this way very *"black and white".* However, it is of note that not all experiences were one or the other. In fact, students spoke of experiencing both a mix of positive and negative placement experiences throughout their programme and also positive and negative experiences within the same placement. This is explored in the following section, 4.4: The many shades of grey.

4.4: The "many shades of grey"

As stated above, students reported experiencing a mix of placement experiences that they felt had a positive impact upon their socialisation in compassionate mental health nursing practice, and placements lacking in compassion where their socialisation was inhibited throughout their programme of study:

> *"…I've had both really good placements where they've (practice staff) been really compassionate and terrible ones where there has been absolutely no compassion, it's just luck of the draw I suppose…"* (FG1: 3rd Year student 6).

This lack of consistency across placement experiences resulted in students often feeling bewildered and unsure of whether they had permission to engage compassionately in following placement experiences:

> *"…it can be really hard, like, you come from a placement where they've (practice staff) been really compassionate, to one where they're not at all, and you don't know what to do with yourself…"* (FG1: 3rd Year student 2).

Students also reported that the transition between placements perceived as lacking in compassion and those perceived as compassion enriched placements could be difficult:

> *"…Or it's the other way round, you go from one (a placement experience) that's not compassionate and you've just gone along with it to pass the placement, to one where they are compassionate but you carry on doing what you'd done at the last placement, because that's what you know, so they think you're not compassionate and it can be like starting all over again every time…"* (FG1: 3rd Year student 5).

Additionally, students reported that placement experiences were not always *"clear cut"* and many reported experiences that predominantly supported their positive socialisation in compassionate practice, but where threats to compassion were still apparent. Where this occurred students still reported positive socialisation in compassionate practice overall:

> *"I've had placements where on the whole, I think they've been really compassionate and have helped me be compassionate but it's not always clear cut and even in those situations some of the not so good things still occur but the good outweighs the bad, so the bad stuff isn't such a block…"* (FG2: 2nd year student 1).

Similarly, students also reported experiencing placements that were lacking in compassionate practice but where they experienced glimpses of compassionate care. However, it was perceived by some that in these situations, the factors that inhibited compassion outweighed those that enhanced compassion and therefore exposure to compassionate practice in these contexts had a limited impact:

> *"…and some of the bad ones, they're not all bad. I had a placement that was terrible, but there was this one really good nurse who tried her best to be compassionate and she really tried to support and encourage students as well but I became so affected by all the horrible stuff that I couldn't really appreciate what she was trying to do and to be honest, I started thinking that she was a bit of a fool and that she'd end up wearing herself out with it all…"* (FG2: 2nd year student 2).

Although many *"black and white"* examples of experiences were given by students to illustrate their experiences, it became apparent that few placement experiences were all

good or all bad. This suggested a continuum of compassionate practice environments in which few placements were rooted firmly at either end of the continuum. Indeed, students recognised that in the majority of placements, both factors that facilitated socialisation in compassionate practice and those that inhibited socialisation in compassionate practice co-existed:

> *"It's not all black and white though, there are many shades of grey. You can have a great placement which on the whole supports you to be compassionate but there might be one or two little niggles with it that you're wary of or you could be on an absolutely crap placement but there might be little twinkles of compassion that shine through now and again. In my experience, there tends to be a good mix of the two. Like I said, it's rarely one or the other…"* (FG2: 3rd year student 1).

However, where students experienced this inconsistency either between placements or on the same placement, it was felt that the placement balance had to tip in favour of predominantly compassion enriching experiences for student socialisation in compassionate practice to be sustained:

> *"you just have to hope that you get more good (compassionate placement experiences) ones than bad and that the bad aren't too bad, otherwise you're just learning to be like them (non-compassionate practice staff) and not how you can be compassionate. I think whatever you're exposed to most, is what sticks…"* (FG2 3rd year student 3).

This highlights the complexity of factors that influenced student socialisation in compassionate practice, and that placements that supported student socialisation in compassionate practice and those that inhibited socialisation in compassionate practice both had the potential to have a lasting impact on future practice.

4.5: Student participant reflection on the focus groups

As explored in Chapter Three, it is accepted that within constructivist research that participants and the researcher interact and influence each other throughout the knowledge building process (Rodwell, 1998). This is also consistent with reflexivity, in which mutual between researcher and participants is recognised as facilitating the development of new understanding of situations that arise during data collection and analysis (McCabe and Holmes, 2009). To support this approach within the research, student reflective time was built in to the end of each focus group and at the beginning of each of the second cohort focus groups held. The aim of this was to provide participants with the opportunity to

reflect upon the content of each focus group and to verbalise these reflections to further enhance understanding of their developing thoughts and ideas about their socialisation in compassionate mental health nursing practice.

To encourage student reflection on the content of the focus groups and their socialisation in compassionate practice, general open-ended questions were asked including:

- *"Was there anything that has really resonated with you from this session/the previous session?"*
- *"Has your understanding of your socialisation in compassionate practice changed by attending the group and if so, how?"*

In addition, focused open ended questions were also put to students based on the content of the focus group discussion. Such focused questions included:

- *"Student A (pseudonym) just said that it's made her feel a bit sorry for some of the mentors that she thought we just not very nice before, does anyone else feel like that?"*

Student participants were able to identify a number of ways that their understanding and recognition of socialisation in compassionate practice were enhanced by engaging in the focus groups. These are presented below.

Some participants reflected that they developed greater conscious awareness of their experiences of positive socialisation in compassionate practice as a result of participation. Furthermore, some students were able to acknowledge some of the factors that contributed to negative socialisation in compassionate practice. Moreover, although they did not necessarily condone the negative behaviour and attitudes that they had been exposed to in practice contexts, some students demonstrated empathy for staff members and the challenges faced in practice. As a result of this, it was suggested that the focus groups themselves provided a vehicle to support socialisation in compassionate practice:

> *"…I'd never really thought about it like that before, but actually now I've been able to think about it, it's made we think of some of the problems that they (practice staff) face and I suppose I can understand why they might not always be very compassionate. I don't think it's an excuse mind you but it's an explanation maybe…*

> *And like, taking that step back has helped me see it (the bigger picture) a bit clearer and I feel like I've developed that empathy for them so I try to remember that when I'm on placement next and maybe I'll be a bit more compassionate towards them…"* (FG2: 2nd year student, Student 2).

Focus group participants indicated that they found the cathartic and reflective nature of the focus groups beneficial. A number of participants stated that they valued the sense of shared experience. This was especially apparent when discussing negative experiences of socialisation in compassionate mental health practice. Participants stated that they felt reassured that it was not just them that had been exposed to negative experiences.

> *"I don't know about everyone else, but for me this has been like, Thank God it's not just me. I thought it was something I'd done wrong before. I know it's not good that other people have had some of these bad experiences, but I'm just a bit relieved that it isn't just me…"* (FG2: 1st year student, Student 5).

The benefit of the focus groups in helping students to develop understanding of their own experiences and the experiences of others was emphasised by some focus group participants. It was suggested that similar placement de-briefing sessions facilitated by academics could be useful as an established part of their programme of education going forward:

> *"I've really enjoyed these sessions, it's almost been like having group therapy! I know we said before that you can't teach us compassion in the classroom, but actually I think these (focus group sessions) have been really good and I feel like I understand so much more now. I wish you'd do these after every placement for us all, I just think it would be like really valuable to discuss some of the positives and the challenges (of compassion in practice) much more regularly."* (FG2: 3rd Year student, Student 3).

These student reflections are further considered in 6.1: Strengths and Limitations of the study but now this chapter finishes with a summary of finding presented.

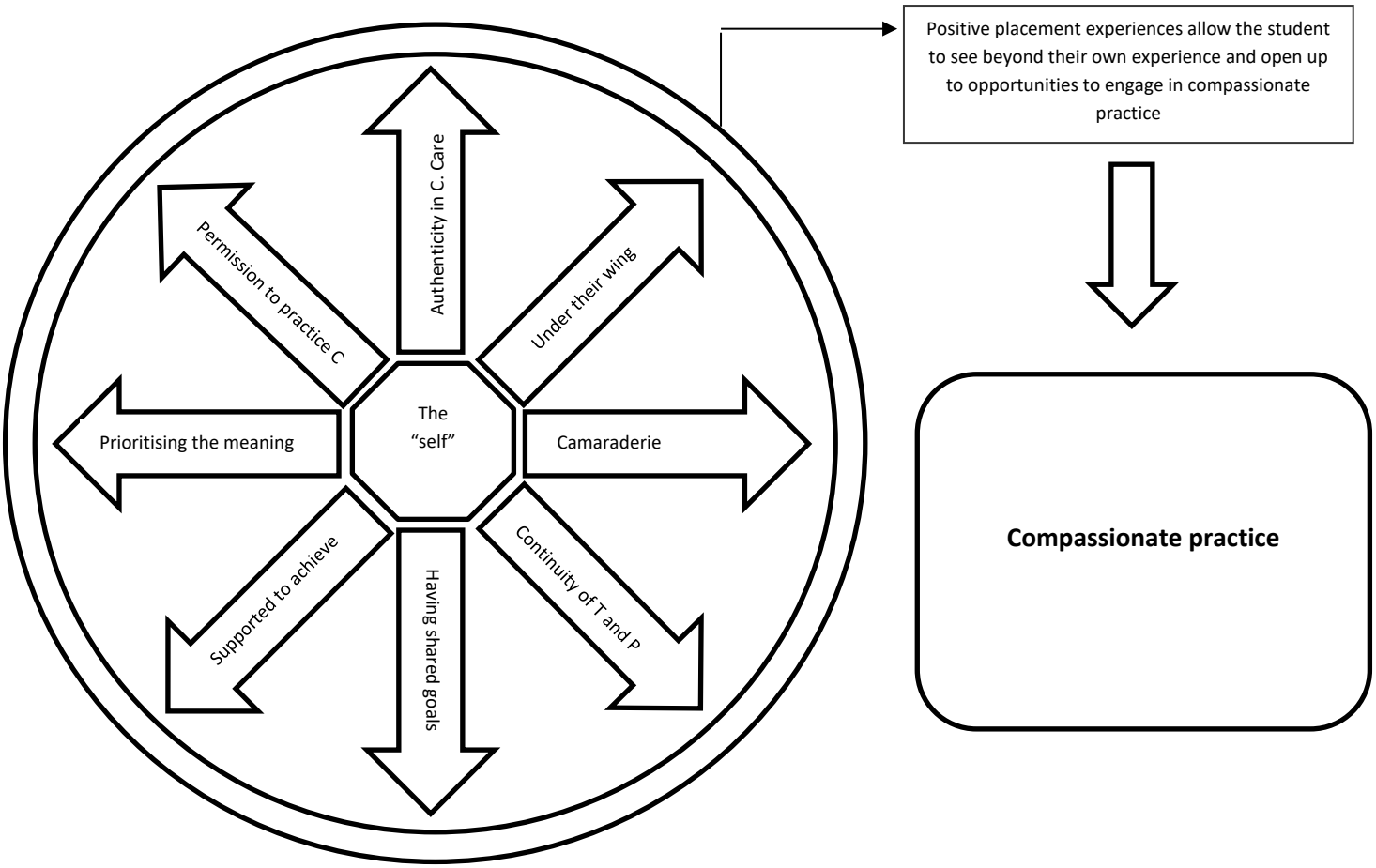
4.6: Focus group findings summary:

In this chapter, the findings from student mental health nurse focus groups were examined to identify factors experienced by students that influence their socialisation in compassionate mental health nursing practice. Two overarching themes were presented – *"All in this together"* and "Everyone for themselves*".*

Student participants identified that each of the themes of *"All in it together"* were experienced in practice placements that were deemed to support socialisation in compassionate practice. Student experiences explored under the themes of Authenticity in compassionate care, *"Under their wing"* and Camaraderie and feeling like part of the team, strengthened student experiences of feelings of safety, acceptance, inclusion and significance in the practice context. Students derived meaning from these experiences, resulting in internalisation of the value of compassion as a recipient. Experiences explored under the theme of Continuity of theory into practice resulted in students increased understanding of the practical application of theory and was underpinned by students being able to make links between the theoretical component of their programme and their practice experiences. Having shared goals supported emersion in a compassionate care philosophy and further bolstered the experience of continuity, as well as feelings of compassionate purpose and achievement. Experiences associated with the theme Prioritising the meaning supported exposure to the role modelling of acts of compassion in practice, which was underpinned by experiences of continuity, compassionate purpose and student feelings of significance. Opportunities to engage in compassionate mental health nursing practice were also underpinned by students developing compassionate purpose and feelings of significance. All of these experiences, in an incremental combination, resulted in students being able to internalise the value of engagement in compassionate mental health nursing practice as the 'giver of compassion'. This therefore demonstrated a journey of socialisation through experience of recipient of compassion, through to the giver. This socialisation journey was supported by the experience of having permission to engage compassionately, including implicit and explicit permission obtained within the practice environment, but also the student providing themselves with permission to engage in compassionate mental health nursing practice. The journey of positive socialisation in compassionate practice in these compassion enriched care environments is demonstrated in figure 4.2: The Ladder of Socialisation in Compassionate Mental Health Nursing Practice. These experiences also supported students to experience a transformational journey of 'opening up' to opportunities to engage in compassionate practice and flourish in their ability to engage compassionately. Through the positive experiences encountered on the journey of socialisation in compassionate practice students were able to consider the bigger picture, demonstrating the ability to see beyond their own needs and be open to the needs

of others. They also became open to compassionate solutions and were able to identify and harness opportunities to engage in compassionate mental health nursing practice. The opening up experience is illustrated in figure 4.5: The 'opening up' to compassionate practice, below.

Figure 4.5: The 'opening up' to compassionate practice



A summary of the factors that enhance positive socialisation in compassionate practice and the consequent meaning of those experiences created by students is provided in Appendix 29: *"All in this together"* – Theme factors that support student socialisation in compassionate practice.

The themes uncovered under *"*Everyone for themselves*"* were an antithesis of the themes uncovered in *"All in this together"* and were experienced in placements where compassionate practice was inhibited or lacking. Participants identified that each of the

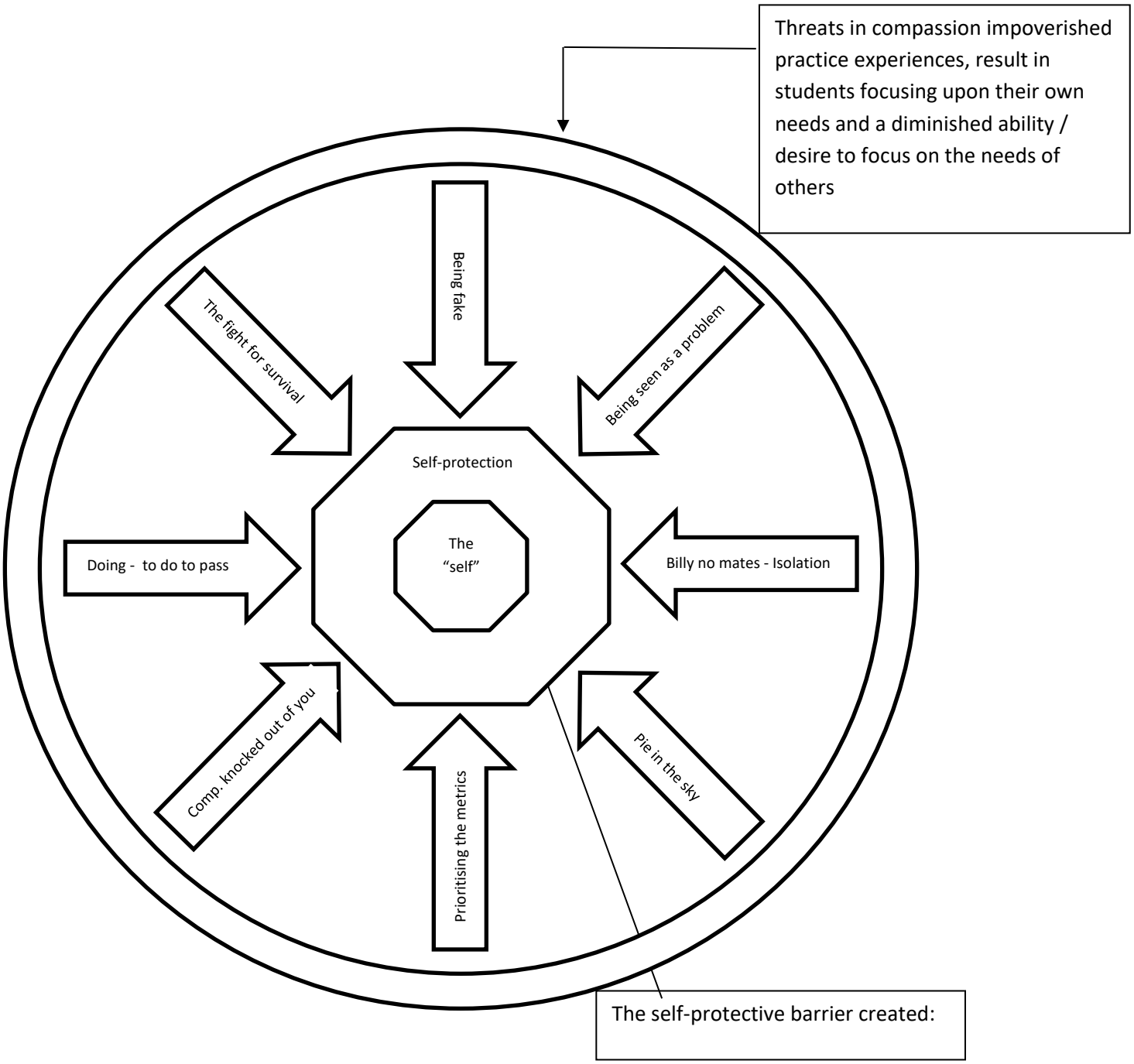
themes of *"*Everyone for themselves*"* were either all or partially present in each of these areas.

Experiences explored under *"*Everyone for themselves*"* were all underpinned by students experiencing feelings of being vulnerable, unsafe and insignificant. This resulted in students engaging in self-protection to progress through their placement experiences. As a result, students become introspective and justified the abandonment of compassionate care priorities to focus upon their own needs, often at the detriment of supporting the needs of service users and engaging in compassionate mental health nursing practice. The student journey through these compassion impoverished placement experiences is presented in figure 4.3: The Retrogress Ladder of Socialisation in Compassionate Mental Health Nursing Practice.

Although the factors in *"All in it together"* created the sense of students 'opening up' to compassion, the factors identified in *"*Everyone for themselves*",* resulted in students experiencing a 'closing down' to compassion. A lack of opportunity and desire to engage in compassionate mental health nursing practice resulted in student compassionate purpose and compassionate intent being severely negatively affected. Indeed, students were unable to consider the bigger picture due to feeling under threat and focusing almost entirely on their own needs to survive the experience. This therefore resulted in them becoming closed off to compassionate care solutions and opportunities to engage in compassionate mental health nursing practice. The closing down experience is illustrated in figure 4.6: The closing down to compassionate practice, below.

The "Everyone for themselves" theme factors that inhibited student socialisation in compassionate practice are presented in Appendix 30: "Everyone for themselves"– theme factors that inhibited student socialisation in compassionate practice. The appendix provides a summary of the factors that inhibited positive socialisation in compassionate practice and the consequent meaning of those experiences created by students.

Figure 4.6: The closing down to compassionate practice



Findings of this chapter are consistent with Curtis' (2015) New Grounded Theory of Student Nurse Socialisation in Compassionate Practice, which was adopted as a sensitising concept to guide analysis of data in this phase. This will be discussed in Chapter Six - Discussion. Findings have corroborated that student socialisation in compassionate practice was influenced by role modelling, leadership and consistency or dissonance between professional ideals and the realities of practice. Furthermore, it was inhibited when students experienced enhanced feelings of vulnerability and uncertainty, which resulted in some students abandoning their compassionate ideals in favour of self-protection and self-preservation to 'survive' the placement experience. The following chapter, Chapter Five – Case study findings, identifies the characteristics of the compassionate practice environment, with specific focus on the factors present in the placement environment that supported the sustainment of the placements' positive impact on student socialisation in compassionate mental health nursing practice.

Chapter Five – Case Study Findings:

5.0: Introduction to case study findings

The previous chapter presented findings from phase one focus groups. The chapter provided an in-depth account of student participant experiences of the factors that impacted socialisation in compassionate mental health nursing practice. The findings within the previous chapter resonated with Curtis's (2015) New Grounded Theory of Student Nurse Socialisation in Compassionate Practice, in relation to the impact of student placement experiences. However, Curtis's (2015) study does not explore the factors that contribute to the development and sustainment of practice environments that support positive socialisation in compassionate practice. Thus, as consistent with an emergent research process and the constructivist methodology (Rodwell, 1998), the direction of this phase of the research was altered and the overall aims of phase two were to:

- develop deeper understanding of the ways in which student nurses are positively socialised in compassionate mental health practice in compassion enriched practice placements
- develop in-depth understanding of the factors that support the development and sustainment of practice areas as compassion enriched learning environments.

The case study approach allowed access not only to individual participants but also to a wider participant group, to support in-depth exploration of the complex issues underpinning socialisation in compassionate mental health nursing practice[48].

The characteristics of the selected case are first presented to provide the reader with background and context of the team. This is followed by exploration of findings that are presented under two overarching themes, *"That's what makes it such an amazing placement"* which explores the specific factors that underpinned student socialisation in compassionate practice at the case study site and *"It makes us what we are"*,

[48] Refer to 3.5: Methods for details of the selected methods to access data in this phase – pg86.

which investigates the factors present in the case study site that sustained the teams' ability to support positive socialisation in compassionate mental health nursing practice.

5.1: Characteristics of the case

The case study site selected was an Older Adults (65 years +) Organic (Dementia) community mental health in-reach team. The team utilised a multi-disciplinary approach for the comprehensive assessment of service users with an established diagnosis of dementia but who were experiencing difficulties due to the symptoms of their diagnosis, and who lived in care homes. The team were also responsible for the provision of specialist support and advice for their service users, families and care home staff across the City and County of the geographical region.

The team operational hours were Monday – Friday, 9am – 5pm (excluding bank holidays) and they offered placement opportunities for 2nd and 3rd year mental health student nurses and occupational therapy students, accommodating a maximum of two students at any one time.

Both the team profile and the physical environment in which the team operated are described in the following sections, and the impact that these factors had on student socialisation in compassionate practice are also explored.

The team profile:

The team consisted of staff members from various multi-disciplinary backgrounds and was fully staffed with no vacancies. Table 5.1 provides an overview of team breakdown.

Table 5.1: Profile of team staff by role and number

Staff role:	Professional Background:	Full time equivalency:
Band 7 – Team Manager	Registered Mental Health Nurse	1.0
Band 6 – Case Manager	Registered Mental Health Nurse	4.0
Band 6 – Case Manager	Occupational Therapist	1.0
Band 5 – Case Manager	Occupational Therapist	1.0
Consultant Psychiatrist	Medic	2.0
Band 3 – Support Worker	Health Care Support worker	1.8
Clinical Psychologist	Psychologist	0.2
Band 6 – Speech and Language Therapist	Speech and Language Therapist	0.2
Band 3 – Administrator	Administrator	0.5
Band 4 – Administrator	Administrator	1.0

Gender breakdown of the team was 86% female and 14% male. All team members were of Caucasian descent and described themselves as British. All nurse participants at the site were experienced and the mean time in which they had been employed in the team was 3.2 years (range from 2 years to 4 years) with mean time as a nursing registrant at 25.2 years (range from 6 years to 40 years). This resulted in the sense of the team being stable due to being made up of mature and experienced staff.

Student participants reflected upon core characteristics of team members and acknowledged the impact upon the perception that team members were compassionate towards students, other team members, service users, relatives and care home staff. The age, experience and gender of nursing team members (who acted as student mentors and therefore main points of contact throughout the placement experience) particularly influenced student perception of them as compassionate individuals:

> *"…they were all so lovely, ***** (staff name) is just one of my favourite people ever. She was so kind and funny, and she genuinely looked out for me, like quite mothering towards me, you know, so I felt quite safe in her hands. I put it down to her being a bit older but they (other nurses in the team) all were really (mothering towards the student). They're all really experienced and it just shines through and I think that's what makes them all so compassionate really…"* (C1 Student Interview: Student Participant 2).

The experience of being 'mothered' was reflective of the positive feelings that students experienced when taken *"under the wing"* of staff as explored in Chapter Four (4.2: "*All in it Together").* Indeed, the experience of being 'mothered' enhanced student feelings of safety within the placement environment. It is of note however that first-year students reported wanting to feel *"looked after"* on placement in *"All in this together"*, whereas second and

third-year students sought incremental supported autonomy. This is of interest as the case study team only accommodated 2nd and 3rd year students on placement, therefore suggesting that 2nd and 3rd year students appreciated still being *"looked after"* in the later phases of the programme.

The physical environment:

The team base was located in a purpose-built satellite building on the outskirts of the grounds of a general hospital site. Unlike the parking facilities across the rest of the hospital, parking directly outside of the building was free and plentiful for service users, staff, students, and visitors.

Upon entering the building, the environment appeared clean and well looked after with no obvious signs of wear and tear to the building, décor or furniture. Staff members and students were required to sign-in to log their presence in the building and any visitors were required to report to reception, where they were greeted by a receptionist who would phone the relevant team or staff member. Visitors were invited to take a seat in the reception area while they waited for the relevant staff member to commence their appointment. The reception area contained numerous posters and leaflets containing information about dementia and service user advocacy, and a poster which clearly specified the Vision and Values of the Health care Trust (Table 5.2 below):

Table 5.2: Trust Vision and Values

Trust Vision:	Trust Values:
"Creating high quality compassionate care and wellbeing for all"	Compassion Integrity Trust Respect

The open display of the Trust visions and values within the reception area potentially served to both highlight and re-enforce the idea that compassionate care was an expected norm within the care culture for staff, students, service users and visitors:

> *"Reception clean and tidy. Receptionist v (sic) friendly. Big poster with Trust V&V (sic) clearly on display. Students would see it on their first day of placement and maybe each time they walk through reception area. Re-enforce the expectation for all that*

> *students and staff will be compassionate to Service Users…"* (Field note C2: Observation 1 6-11)

Team offices and meeting rooms were accessed through a digitally coded security door. The building was shared with other Older Adults community mental health teams, and clinical and meeting rooms were shared with these other teams. However, the team did have dedicated office space for clinicians, administrators and the team manager. Team staff shared office space through a 'hot desk' system. There were some Personal Computers (PC's) in each office area for staff and students to access but staff had also each been allocated a work laptop to further support the 'hot desk' system. Staff demonstrated preference for specific 'hot desking' locations but acknowledged that as other staff also used desks, that there was a need to keep all shared areas clean and tidy and staff did not leave personal belongings in office areas, 'out of respect for each other'. In addition to being clean and tidy, the physical environment appeared calm and relaxed:

> *"well looked after and comfortable offices, staff demonstrate respect for the environment and each other by keeping it clean and tidy – tidying up after themselves. They (staff) appear calm and relaxed, overall a nice feel to the area"* (Field notes C2: Observation 2 32-34).

Staff did not wear uniform, but all dressed in smart-casual work attire as per the team uniform policy. All staff adhered to the uniform policy, therefore contributing to a sense of professionalism, but the non-uniform policy also created a sense of equality between all in the care environment.

Due to the nature of the clinical focus of the team as a community in-reach team that worked with service users with diagnosis of dementia living in care home provision, team members and students on placement with the team spent a significant amount of time working away from the team base. Indeed, all service user contact occurred in various care homes across the geographical catchment area. Care homes in which service users resided and the team visited varied from private facilities to social care funded facilities. As such, students were exposed to diverse care environments in which the physical environment, philosophy of care and standards of care differed greatly.

Throughout the observations, three separate care homes were visited with team staff and students. Home 1 (H1) was a socially funded care home, situated in a predominantly working-class rural area. The physical environment of the home appeared worn but clean and tidy and the guest foyer contained six pictures with affirming messages about kindness which were framed and mounted on the wall (see table 5.3 below):

Table 5.3: Affirming messages of kindness

Picture Number:	Affirming message:
1.	"Kindness is a force for good"
2.	"Kindness makes everyone feel at home"
3.	"Kindness creates a sense of belonging"
4.	"Kindness feels amazing"
5.	"Kindness makes every moment count"
6.	"Kindness builds genuine relationships"

In addition to the affirming pictures, there was a "kindness award" nomination box, in which service users, friends, family and visitors could nominate staff and other residents for kind actions. This therefore provided insight into the way in which residents were valued within the care home environment.

The display of affirmations of kindness, and the kindness award system, conveyed a philosophy of care that was consistent with the delivery of compassionate care, reiterating to staff and students that compassionate interactions with residents was encouraged. Indeed, the team member commented that the kindness affirmations were reflective of her dealings with the home and that they did indeed value kindness, with evident compassionate purpose in their interactions with service users:

> *"…they're a great little care home. The staff have all been there for a while and are a really committed bunch. They always do their best and with the upmost integrity. I've never had any concerns about the care here, not like some places. There's definitely compassion here, no doubt and that make it a lot easier to work with them…"* (C2: Observation 1- Team Member 1).

Home 2 (H2) was visited during observation 2 and was a privately funded, purpose-built care home. H2 was situated in an affluent suburb on the outskirts of the city. As a newly built facility (in operation for the previous 12 months), the environment had minimal wear and

tear and was clean and tidy. Maintenance workers and cleaners were present during the observation period, demonstrating care for the upkeep of the physical environment and the overall first impression was that it was a very impressive facility:

> *"…like a hotel, massive lobby, pastries and other refreshments available constantly for Service Users (SUs). Seemed to be a really high ratio of staff to SUs (sic). Massive brand-new state of the art TV and entertainment systems in various day rooms. Sign for the hairdressers and the activity room. All very impressive - sign me up!"* (Field notes. C2: Observation 2, 94-101).

However, during a reflective discussion between the team member and student in the car directly after the visit, the team member disclosed to the student that H2 had experienced some "*teething problems"* and that the focus of the owner was on an impressive environment at the detriment of care of the residents:

> *"…I was a bit worried about it to begin with. Underneath all the flashiness, the care just wasn't there, they didn't have reliable staff. It's changed now because they've got a new manager and she's really good. I've worked with her before but it's just a reminder that sometimes if you look under the surface, things aren't always as they seem" (C2: Observation 2 – Team Member 4).*

Home 3 (H3) was also visited during observation 2. In contrast to H1 and H2, this was a social care funded care home in a deprived area of the inner city. The physical environment of H3 was one of neglect, with worn and damaged internal decoration and furnishing and general physical untidiness evident. The atmosphere appeared chaotic, and it was difficult to locate a staff member to discuss the resident at the centre of the visit. When members of staff were visible, they appeared stressed, moved slowly and stopped to gossip with other workers, therefore giving the air of a lack of sense of purpose. In addition, when the manager of H3 was asked for an update on the resident being visited, she first discussed her personal stress levels rather than the needs of the residents:

> *"stark contrast to the others (care homes visited). Unpleasant environment. Staff seemed disinterested and didn't want to be there. The manager = negative and whinged about the stress they were under with staffing issues etc but also not a problem solver. Overall, a grey, unwelcoming and unpleasant experience…"* (Field notes C2: Observation 2, 317-322).

The heterogeneity of the care homes visited throughout the course of the team's working day was evident. However, the team member made this a point of discussion with the student in the car journey back to the team base. During the conversation she engaged the

student in a reflective discussion about the differences of each care environment, inviting the student to identify her opinion and perceptions of the care environments before encouraging consideration of the challenges faced in each environment. The team member demonstrated compassion towards service users, reiterating that their care was her top priority, but also towards care home staff. Acknowledging that many of the staff were trying to do their best without adequate funding, resources, support or training, she made it explicit to the student that part of the role of the team was to support and educate care home staff to ensure that service users were receiving quality care.

The requirement for team members and students to travel to service user locations together was acknowledged as a part of the daily work of the team, and provided opportunity for one-to-one time and reflective discussions which did not add to existing workload but was rather accepted as *"time well spent"* in supporting and socialising students by team members:

> *"I like to use the time (travel time) proactively. It seems much more relaxed than sitting in a room and having the same discussion, so it takes the pressure off the students a bit. You can just chat, get to know the student and assess their understanding you know, and get them to think about things in a bit of a different way, so it's time well spent… and it's that opportunity for one to one so they feel included. You couldn't do that on the ward, you just don't have time but it's part of the working day in this job so isn't anything extra"* (C3 Staff interview: Team Member 5).

In addition to the opportunity for one-to-one reflective time throughout the working day, all team members were required to attend a weekly team meeting in which they would discuss all service users open to the team. This provided an additional space for team reflection relating to service user care. Students also attended these meetings and in addition to listening and processing the reflective discussions during the meeting, they were also encouraged to be active participants in the discussions:

> *"the team meetings are great, they (the team) discuss everything that's going on and they're so supportive of each other you know, talking things through… and everyone has a voice, even me, like, they asked for my opinion and it felt like they really listened, and that my thoughts about it all mattered"* (C1 Student interview: Student 3).

The weekly team meetings were identified as essential due to the transient working nature of the team, in which they were often *"in and out"* of the team base at different times from other team members:

> *"…because we're in and out quite a bit, sometimes you don't get to see people (other team members) that much, it's a real God send because we can all see each other and problem solve together, so you always feel supported and not so alone in some of the decisions we have to make…"* (C3 Staff interview: Team Member 3).

Students were therefore exposed to a culture of team support in addition to the autonomous work of individual team members.

Student participants identified other factors that supported their socialisation in compassionate mental health nursing practice in the team. These will be explored under the following theme of *"That's what makes it such an amazing placement".*

5.2: *"That's what makes it such an amazing placement"*

Some of the students who had recommended the case study site and participated in the pre-site interviews, and the student on placement and interviewed during site access, were asked to articulate the characteristics of the team that promoted compassion. Many of the characteristics had been identified in the phase one focus groups. However, participants identified some characteristics that were specific to their experiences with this team. These themes are explored throughout this section:

- *"The gift of time"*
- *"Teamwork makes the dream work"*
- *"They put in a marathon"*
- Compassionate purpose - from implicit to explicit.

"The gift of time":

The mentorship that occurred in the team was viewed as being of exceptionally high quality. Each student participant in phase two reported that they had the best and most supportive experience of mentorship during their placement experience with this team. This in turn was perceived as having had a profound impact on their personal learning, discovery and achievements when on the placement:

> *"my mentor there was by far the best mentor I've had. She was just brilliant and I can safely say that I learnt more from her than anyone (other mentors) else on placement. She really gave me the chance to grow and not just like as a nurse but personally as well. I dunno (sic) I just feel like I achieved so much there…"* (C1 Student interview: Student 1).

The hallmark of the positive mentor (in addition to the characteristics previously identified in Chapter Four) was identified as an individual who supported student development by giving them time. The investment of time in supporting students resulted in students feeling prepared to encounter the daily challenges experienced within the working day, and re-enforced that students were viewed as valuable as well as bolstering student confidence, feelings of acceptance and shared humanity:

> *"I had a fantastic mentor, she's the best I've had. She was really good. We'd sit down and she'd explain what was happening and why things were done, she never rushed. She gave me the gift of time… it made me feel so much prepared to face the challenges of the day and the fact that she really invested that time, just made me feel like a mattered. It was just really compassionate"* (C1 Student interview: Student 4).

Students with additional learning needs particularly benefitted from the investment of time in their development. These students reported negative experiences at other placements, where they felt rushed, unsupported and belittled by staff when they requested additional time and support to achieve certain tasks. In contrast, mentors and other staff in the case study team demonstrated patience resulting in these students feeling supported, accepted and worthy:

> *"I was worried because I'm a slow worker. I have to use special software and they were so good, they just had so much patience for me. My mentor supported me to write a care plan and she went through it with me and told me what was good and what I could do to make it better… she never rushed or told me off… she gave me time to develop"* (C1 Student interview: Student 4).

The impact of recognising specific student vulnerabilities and investing time to support development provided opportunity for students to acknowledge their difficulties and seek support, without heightening feelings of inadequacy. This led to the student developing confidence to engage in further developmental opportunities and bolstered their feelings of achievement during their placement experience.

It was recognised that achievement was further enhanced by practice staff investing time to support students to go beyond their comfort zone to develop their skills and knowledge. Student participants reflected on other placement experiences in which they reported being pushed out of their comfort zone but without time being invested in support from practice staff. This resulted in the raising of student anxieties and decreased feelings of psychological and physical safety within the practice setting. However, student participants valued being pushed out of their comfort zone when they felt supported to do so and felt that they could ask for help if so required. The investment of time in student development by practice staff enhanced feelings of safety and support experienced by students when engaging in such challenging activities, and resulted in students further experiencing feelings of achievement:

> *"she (the mentor) knew that I hated making phone calls, so she supported me in doing them every day, so I could improve and get used to them. It pushed me out of my comfort-zone, but I did it with her support and now phone calls don't faze me in the slightest. I'm quite proud of that little development and because I've felt so good about overcoming that, I guess it's made me more willing to try other stuff that I thought was a bit beyond me really…" (C3 Student interview: Student 1).*

In addition to supporting the development of fundamental skills (as the example above), students also reported investment of time from staff to assist their development and achievement of advanced mental health nursing skills. This had a positive impact on student confidence and motivation to engage in advanced learning opportunities:

> *"She (the mentor) let me lead an assessment. It was really nerve wracking, but she prepared me and told me what to ask and supported me through the whole thing. Afterwards, she told me that I'd done really well and that the only thing holding me back was my self-belief coz (sic) I was actually doing it right. That gave me the confidence to present the assessment to the team and to do more assessments during the placement"* (C2 Student interview: Student 4).

The quote above also demonstrates the whole team commitment to developing students and offering support. The impact of the wider team on student development and socialisation in compassionate practice is explored in the later theme of "*Teamwork makes the dream work".*

Students also valued opportunities in which they could engage in self-directed development. However, it was identified that there was a significant difference between students being *"left to it",* resulting in feelings of being unsupported, compared to students

feeling empowered to enhance their own learning while being supported at a distance from practice staff. The latter approach resulted in students having the feeling of a safety net being in place:

> *"I've had placements, where I've just been left to it. No guidance, no support, just told to crack on when I asked for help, it wasn't very forthcoming. I felt quite on my own and really unsupported then. But when I was on placement with the team (case study team) they let me find ways to enhance my own learning but really supported me. Like I wasn't always spoon-fed, you know? They let me decide what I needed to do and I liked having the opportunities laid out and then I could plan with my mentor how to meet them but she also gave me free reign to explore my own strengths and weaknesses, so that was quite empowering and when I was able to overcome one of those weaknesses, I felt like I'd really achieved something but I also knew that if worse came to worse (sic) that I could always ask them for help and they'd be there in a heartbeat and would always give me time to help me out, so I was sort of left to it but wasn't left to it too much…"* (C1 Student interview: Student 3).

Third year student participants particularly valued the opportunity to 'spread their wings' while being supported from a distance. This was viewed as a demonstration of staff value of the student as an individual learner, and as a way in which team members role modelled compassion towards students. Furthermore, it demonstrated team member ability to assess the support needs of individual students and offer a range of support from 'mothering'[49], to the student being able to undertake assessments and lone working.

The role modelling of time invested in staff-student relationships supported student internalisation of the importance of the investment of time in developing compassionate therapeutic relationships with service users:

> *"… it (the role modelling of investment of time) made me realise how important it is to actually spend time with someone and get to know them. In fact, I'd go as far to say that it made me realise that it's one of the most powerful things you can do…"* (C1 Student Interview: Student 2).

The impact of the investment of time on the delivery of compassionate mental health nursing care was further role modelled by practice staff who demonstrated willingness to invest time with service users, families and the wider inter-disciplinary team. This provided increased opportunity for the development of collaborative care partnerships in which staff

[49] As identified in 5.1 Characteristics of the case – pg204.

and students were more likely to experience positive feedback. This served to re-enforce the value of investing time in others, while bolstering feelings of clinical achievement by reiterating that staff and students could make a positive difference to the lives of service users:

> *"they'd spend time with them (the service users) and with the family and recognised that they family might be grieving their relative because they'd lost who they'd known through the illness. I remember my mentor discussing this with the patient's wife, in that instance it all came together, and I observed all the six C's in that interaction. Afterwards it felt like a real achievement. She'd (the wife) got really benefit from it…"* (C1 Student interview: Student 1).

> *"Reason for referral - Care home (CH) staff having difficulty managing patient (pt) (sic) aggression. ***** (team member) spent time with the pt (sic). Willing to spend time with him, didn't rush him or seem frustrated with delayed responses etc. No aggression (sic) during the meeting. Pt said he's enjoyed the visit and happy to see team again… ***** (team member) spent 30 minutes discussing concerns with CH staff. Very skilled communicator. Encouraged them to express their concerns and supported them to problem solve. Also praised them for some good practice and asking for support. CH v. (sic) grateful and said they felt more focused and able to continue with support with plan in place"* (C2: Observation 1, 112-118/130-137).

Investing time in service user care increased opportunities for students to engage in acts of advocacy which was further recognised as a compassionate care action. Students felt that having the time to engage in acts of advocacy provided enhanced continuity between theory and practice, as well as providing opportunity to engage in perceived acts of compassion. This resulted in students feeling that they were able to make a difference to the lives of service users:

> *"they'd advocate for patients and their families…I haven't seen that done everywhere (other placement opportunities). I've been to some areas where the staff just advocate for the consultant and seem to forget to do it for the patient. Seeing them (the team) advocate like that, reminded me why I'm in it and the difference I can make but also it was like something clicked between what you lot tell us at uni (sic) about advocacy and actually getting to do it. All of a sudden, it all made sense and I felt like I'd really developed because of that…"* (C1 Student interview: Student 1).

The value of investment in time was also noted as key in creating a safe space for all staff to work in, supporting a team culture in which staff members were both treated compassionately by colleagues and were supported to engage compassionately with others:

> *"they're really compassionate with each other, there is this lack of blame culture, if something doesn't work, it was nobody's fault, they'd take time to discuss the problems together in a non-judgemental way, and I really think that helps them to be compassionate with other people"* (C2 Student interview: Student 1).

Indeed, team cohesiveness and support were identified as factors that further supported student socialisation in compassionate mental health nursing practice, and this is explored in the following theme of *"Teamwork makes the dream work".*

***"Teamwork makes the dream work"*:**

All student participants recognised the cohesiveness of the team as something that was distinctive to the team, and as a factor that had a positive influence upon their socialisation in compassionate mental health nursing practice:

> *"I've never experienced anything quite like it. In other placements, the teams' function, on the whole but they're (the case study team) on another level. They all support each other, and not just with actual work, like they all actually get on with each other on a personal level…and they're all singing from the same hymn sheet and they're all compassionate to each other, which I think helps them to be compassionate with the patients. Seriously, it all comes together, like teamwork makes the dream work, so to speak…"* (C1 Student Interview: Student 2).

Indeed, calm and supportive interactions between team members and the shared team ethos of peer support role modelled the importance of team cohesiveness and stability for students, and increased student experience of the feeling of safety during their placement time:

> *"they (team members) worked together really well. The never came across as stressed or flustered with any of the challenges they faced…it was a really calm and supportive environent. There was no bickering, no power clique, they just helped each other out. It felt a lot safer than other placements I'd been on, mainly because of this…"* (C1 Student interview: Student 1).

One of the specific unusual aspects of the teams' inner workings was the provision of opportunities for students to work with all team members, regardless of professional discipline. Students especially valued situations where neither the student nor mentor approached the other members of staff, but rather team members made spontaneous offers to work with students. This demonstrated to students that the whole team were willing to invest time in student development and re-enforced the feeling that they were wanted by the whole team which enhanced feelings of integration:

> *"I had the opportunity to work alongside everyone, not just my mentor. I worked with the OT and even the consultants took me out on visits. That's what's best about the team. They want you to work alongside everyone and it didn't matter if you were a HCA, a doctor or a student – you were respected and I didn't have to go round begging them to take me out, they'd approach me and offer it so I didn't feel like a burden. It really made me feel like one of them, like I was valued, and they all cared. I thought that was really compassionate"* (C1 Student interview: Student 4).

Students valued the support offered by other team members. Whole team support resulted in increased student confidence. When this occurred, students felt encouraged and motivated to push their own limits and work outside of their comfort zone to achieve:

> *"it wasn't just my mentor valued my contribution; they all did. They'd all ask my opinion and views about discharges and when my mentor went on holiday, they trusted me to cover some work for her and it made me feel really valued. It's one thing when your mentor values you but it's another when the whole team does as well. It almost becomes more real… I'd never have had the confidence to do that work before but they believed in me and trusted me and it made me believe in myself more and I knew that any of them would support me if I needed it, so I knew it would be ok…"* (C1 Student interview: Student 4).

Indeed, support from and integration within the team helped enhance feelings of value and importance within the team. These were further bolstered by the provision of equipment and resources for student use to assist them in participating fully in teamwork and clinical duties from commencement of their placement. All participants recognised the investment in and provision of student specific equipment as being distinctive to the team:

> *"There was a computer in the office that they said was just for me to use as a student and they made sure my software was uploaded to help me with writing so I could do the work from the beginning. It's not been like that in other placements. Everywhere else, the staff are always given priority, but this team, I felt like I was being treated like one of them, more an equal than anywhere else I've been…"* (C1 Student interview: Student 4).

The distinctiveness of the provision of equipment re-enforced a sense of authentic value for students:

> *"the fact that they had the computer, it's like they're putting their money where their mouth is. In other places it quite tokenistic like 'oh yeah, we like having students, blah blah blah' but it's all pretty empty. They say the right things but there's no follow through and I guess it makes you think that they perhaps don't really mean it. I didn't feel like that with them (the case study team). I felt like they really meant it and the computer is a great example of how they proved it…" (C1 Student interview: Student 2).*

The provision of student equipment and space within the team environment re-enforced feelings of belonging in the team. Students also felt that it demonstrated that team members genuinely wanted to enhance opportunities for achievement:

> *"oh yeah, the computer was a real bonus… it made me feel like I was really one of them and it meant that I could write up the notes and assessments and I didn't feel rushed because someone else was waiting to use the computer, I could take my time to make sure I got everything right. I wrote up more assessments with the team than I've done anywhere else. I feel like I'm so on it with assessments now because of that…"* (C1 Student interview: Student 1).

Students were able to fully engage in tasks undertaken by team members, providing the opportunity for them to 'try out' being a registrant in a safe and supported environment, further enhancing the sense of personal and professional development:

> *"…I could actually do what they were doing, and it sounds silly, but I actually started to feel like I was a nurse, not an annoying student that's constantly looking over my mentors' shoulder to see what they're doing the whole time... I did notes and care plans, everything, I mean, someone always checked what I wrote to make sure it had all the information, and they gave me some great tips to improve but like, I felt that I'd developed more there than any other placement and it's because I could do all the bits of the job…"* (C1: Student interview. Student 2).

Students also reported feeling that they and individual team members were more inclined to engage in compassionate practice due to feeling supported by the whole team:

> *"it was because of the support from the team that we (the student and their mentor) weren't scared to challenge some poor practice that we saw in one of the homes…we knew we'd be supported by the team and that allowed my mentor to speak out and be compassionate and courageous"* (C1 Student interview: Student 3).

The factors that helped to create and sustain positive team working are explored in 5.3: *"It makes us what we are"*. Before this, the impact of team members – both individually and as a whole team – going the extra mile on student socialisation in compassionate mental health practice is explored in the following theme, *"They put in a marathon*".

***"They put in a marathon"*:**

As identified in phase one focus groups, 4.2: *"All in it together",* participants referred to practice staff involving them in team social activities as *"icing on the cake".* This notion was repeated by participants in phase two case study but was commonly referred to as

demonstration of staff *"going the extra mile"* and related to practice staff willingness and active attempts to form relationships with students. However, students stated that team members went above and beyond even the *"extra mile"* which further heightened the perceptions of feeling valued, accepted and cared for by the team:

> *"They didn't just go the extra mile, they put in a marathon! Like I'd go on a visit with someone, and they'd buy me lunch. They didn't have to do that, but it made me think that they really cared, and they did it with each other, so it made me feel like one of them. They even bought me a gift at the end of my placement and made me feel like I was one of them, leaving for a new job. I've never been made to feel so, I'd don't know. I've never fit in anywhere else like I did there"* (C1 Student interview: Student 3).

All examples of practice staff going the extra mile demonstrated that they did so as personal cost to themselves; financially (as demonstrated in the quote above), emotionally through investing in relationships, or practically through the investment of additional time dedicated to the student and their development.

Students reported that team members also went the extra mile in taking active steps to support their psychological preparation in instances where the gold standard as taught in the classroom was not present in the practice context. Students benefited from engaging in reflective discussions with their mentor or other team members, in which the challenges of practice, rationale for care actions and problem solving to improve future care provision were discussed. Students acknowledged that these reflective discussions supported transformative understanding of ways they could reconcile the challenges of providing 'gold standard' care in contemporary mental health care:

> *"we'd (student and mentor) reflect on what we'd just done in the drive between every visit (to see service users). She really helped me understand that things aren't always black or white and that we have to work in the grey a lot and make the most out of every situation for the patients. I used to get quite disillusioned before because I didn't really understand why it wasn't happening like you'd (academic staff) taught us, but she put so much effort in to help me understand how I could find ways to do my best in every situation and that I could still really help…"* (C1 Student interview: Student 1).

Some of these reflective discussions occurred as formal debrief sessions in which students were encouraged to reflect on specific situations as evidence for meeting placement assessment objectives. However, it was of note that students reported gaining the most

value from informal reflective discussions during periods of travel[50]. Utilising travel time to engage in reflection appeared to be a good psychological technique to support student engagement in reflection. Students felt less pressure in these situations and able to discuss their perceptions openly, without feeling that the attention was purely on them or that they had been 'put on the spot':

> *"…she (the mentor) always tried to encourage me to reflect but the best for me was when we were in the car and it felt like a really informal chat and that was one of the most valuable things we did. I dunno (sic) I think because it was so relaxed and she was focused on the road as well, it felt less intimidating and not as formal, you know, like I was being marked on it or something, so it was like I could be more open and say what was on my mind easier and I think I learnt more because of that because it meant she could help me think about my actual thoughts about a situation…"* (C1 Student interview Student 1).

It was of note that all student participants had accessed other community placements in which they travelled with staff members, therefore having opportunity for this additional reflective time. However, participants reported that this time was utilised differently in by other teams:

> *"when I was on placement with ******* (another community team)… when we were in the car we'd either talk about, I dunno (sic) the weather or other like superficial things or my mentor would tell me his experience and his thoughts but he never asked about my thoughts about the patients and he sort of told me what I should think rather than try to help me to understand why I might think a certain way about a situation… and sometimes a short journey would feel like forever because it felt really forced and hard work but when I was in the car with ******** (mentor from the case study site team), like the time really flew by because she really tried to involve me, and I learnt loads from those journey's, so there was a ma-hoosive (sic) difference…"* (C1 Student interview: Student 2).

The utilisation of travel time as an additional opportunity to engage students in reflective learning was therefore somewhat distinct to the case study team. Students viewed travel-reflection as "*going the extra mile"* to support them in bridging the gap between theory and practice.

Staff utilisation of opportunities for reflection supported student recognition and understanding of both implicit and explicit examples of compassionate purpose. Other ways

[50] As presented in 5.1: Characteristics of the case – pg204.

in which the team supported student identification of compassionate purpose are explored in the following theme, Compassionate purpose – from implicit to explicit.

Compassionate purpose – from implicit to explicit:

Students provided a myriad of examples of the ways in which compassionate purpose was demonstrated implicitly in their time on placement with the team. Recognition and understanding of these implicit examples had the power to support student socialisation in compassionate practice by assisting them to internalise the importance of compassion:

> *"…it's the little things that they (team members) do, I dunno, like the way they interact with the patients or they say they'll do something and they make sure they do it, even if it's seems irrelevant and you realise that it might seem irrelevant to you but to them (the service user) it's really important, and it's those little acts of compassion that they (team members) are always doing so sometimes you don't even realise it's particularly compassionate until you stop and think about it… but you see the difference it makes and how important it is to be compassionate, I suppose…"* (C1 Student interview: Student 3).

However, this depended on students having the ability to recognise subtleties and to 'read between the lines' of care activities and communications. Student participants were also able to provide examples of occasions where implicit compassionate purpose had been made explicit during reflective discussions with team members:

> *"sometimes the compassion is so low key that you don't recognise it as being compassionate until you have that conversation about it and then it's like, oh yeah, that was really compassionate. Sometimes it's just so simple or it seems so natural when they do it that it doesn't even register, you know?"* (C1 Student interview: Student 2).

Making the implicit – explicit was of benefit to students who required additional support to identify the implicit examples of the demonstration of compassionate purpose, and also enhanced the recognition of implicit demonstration for students who already had the ability. It further re-iterated to students that compassion was not necessarily demonstrated through great gestures but could be recognised in small acts of care or support.

Compassionate purpose was made explicit to students by engagement in pre and post care contact discussions in which service user background and history was discussed, including pre-morbid history, family and social background and presenting symptoms. Additionally, students benefited from team members explaining rationale for contacts and care activities.

This provided the identification of key points for the student to be mindful of and assisted in the recognition of purpose of the care interaction from the team members' perspective. Student participants reported that these discussions were not something that they had been exposed to in previous placements, and that they had often not understood the purpose of their role and interactions with service users and others due to lack of explicit direction. This resulted in students feeling bewildered and unsure of their purpose, and the purpose of the nurse in the practice context:

> *"she explained everything to me, so before we went on a visit to see a patient, she'd go through their background and tell me what our role was and what we were doing for them. In other placements, I've been left to it. They didn't explain what my role was or theirs and it was like they expected me to be a mind reader and figure it out for myself. It was brilliant (with the case study team) because she actually made me realise what her role was and what my role was and what I could actually do to help people"* (C1 Student interview: Student 4).

This section has explored the factors experienced by students during placement experiences with the case study team that had a direct impact upon their socialisation in compassionate mental health nursing practice. The following section *"It makes us what we are"* explores the factors present that assisted the team to create and sustain the team as an environment that supported socialisation in compassionate mental health nursing practice. Appendix 31: *"That's what makes it such an amazing placement"* theme factors that support student socialisation in compassionate practice, provides a summary of the factors that enhanced positive socialisation in compassionate practice at the case study site and the consequent meaning of those experiences created by students.

5.3: *"It makes us what we are"*

The previous section explored factors identified by student participants that were present in the case study team. These factors resulted in students considering the team as a compassion enriched practice environment. This section explores the factors that contributed to the team's ability to create and sustain the elements present that supported student mental health nurse socialisation in compassionate practice.

Each of the themes in 4.2 *"All in it together"* and 5.2 *"That's what makes it such an amazing placement"* were presented to case study site team members who participated in individual

semi-structured interviews. Participants were asked to identify the factors underpinning each theme that both created and sustained the positive experience for students during their placement with the team. As a result, four themes were identified in the data obtained. The themes are listed below and are used as headings throughout the remainder of this section:

- Composition of the team
- *"We're all on the same page"*
- Established mentorship management
- *"The flavour of the team is set from the top".*

Composition of the team:

As presented in table 5.1: Profile of team staff by role and number, the team consisted of 15 members of staff. Team participants recognised that the small size of the team resulted in enhanced team working processes and high levels of communication between team members. This facilitated the development of a sense of team cohesion and stability, identified as important in the theme *"Teamwork makes the dream work":*

> *"I think a big part of it (being able to support positive socialisation in compassionate practice) is the fact that we're quite a small team and that makes teamwork easier, probably because it's easier to communicate in a smaller team. I suppose we have to all get on and support each other because they're aren't loads of other people that you can get support from like in bigger teams you can't hide away like in a bigger team, so you have make more of an effort to get along with everyone…" (C2 Team interview: Team member 4).*

The sense of stability was further strengthened by the perceived maturity of the team and professional experience of the team members, all of whom had worked in the team for several years, with a number working in the team since its conception:

> *"…I've been here for two years now but ****** and ******* (other team members) started when the team was brand new, so they know it inside out and the rest of us are all really experienced so that helps (to create the sense of team stability). Maybe the fact that we're all a bit more mature helps as well, we've all got life experience and there isn't that drama in the team that you can get in other teams when the staff are mostly young or a bit inexperienced…"* (C2 Team interview: Team member 4).

It was suggested that mature, experienced staff were attracted to working in the team due to the stability offered through a regular working pattern and the pace of the work

environment, which team members seemed to appreciate during the latter stages of their career. It was also felt that the maturity of the team was a contributor to team members aiming to sustain team stability:

> *"I worked in inpatients for years. I've enjoyed every job I've had but I was definitely ready for a better working routine. I think the irregular shifts can really have an impact on your wellbeing over time, so for me, it was time for more stability I suppose and I was just at a point where I felt a bit too long in the tooth to tolerate the drama of the wards, I suppose it was just that point in my career and I think we're all like that really, we're all really keen to keep it nice and calm really…"* (C2 Team interview: Team member 3).

The cohesion of the team was further strengthened by joint working across the different professional disciplines and the development of clearly defined roles of each team member. This resulted in team members embracing each other's strengths and expertise:

> *"I think we genuinely appreciate each other and because we're a small team, perhaps more aware of each other's specific roles, and we all bring something to the table, which is unique, so we embrace that…"* (C2 Team interview: Team member 2).

It was also perceived that cohesion and stability created by the established team supported the sustainment of the feeling of staff safety. In turn this resulted in team members feeling able to engage in and role model compassionate practice:

> *"we're really close knit but we embrace students into the team too. We've got each other's backs and it just makes you know that everything will be alright so you can put yourself out there and you be a (compassionate) role model to the students, and they can see the different ways that you can be compassionate I suppose… and they see you doing it, so they know that they can do it (C2 Team interview: Team member 3).*

It was suggested that exposure to staff feelings of safety in the care environment was something that also supported students to feel safe within the environment. This in turn resulted in student engagement in opportunities to develop compassionate practices:

> *"…and I think the students see that we've got each-others backs and that we've got their backs as well, so maybe they are more likely to put themselves out there and do things that they wouldn't try in other placements, you know, give that bit extra which can be the difference between being compassionate or not really…" (C2 Team interview: Team member 4).*

Indeed, student participants acknowledged that due to the support received within the team and positive team working practices, they experienced a feeling of safety. A result of this was that students engaged in activities that pushed them out of their comfort zone[51]. The composition of the team was also perceived to have had a direct impact upon team members developing and sustaining a shared care philosophy and ultimately, a team shared sense of compassionate purpose:

> *"…the other thing (that sustains the team's ability to socialisation students in compassionate practice) is because we're a small team, we have more of an opportunity to talk about team goals and agree them together, with everyone involved, so we're all singing from the same hymn sheet and I just don't think that's something that happens in bigger teams, because it's easier to form little cliques and if there is just one person that for whatever reason wants to be negative, it's easier for them to team split and cause fraction. We just don't get that here, there aren't any cliques and if someone tried to team split, it'd be obvious and they'd get caught out, so people like that either have to fall in line and change their outlook or they move on and go somewhere where they can get away with all the negativity…."* (C3 Team interview: Team member 3).

The fragile nature of the composition of the team was acknowledged and it was recognised that any changes to the composition of the team could have a profoundly negative impact upon the factors that support student socialisation in compassionate practice:

> *"the problem is, you never know when things might change, ****** (staff name) is due to retire next year and ****** (staff name) the year after, so that might really change things. Or someone else could leave or become sick or whatever and I think that could really cause a shift in dynamic…* (C3 Team interview: Team member 3).

It was identified that individual values were assessed in the recruitment process, thereby ensuring that staff recruited to the team shared the ethos of compassionate purpose prior to commencement of work with the team. Furthermore, it was perceived that the high levels of compassionate purpose demonstrated by the shared ethos had an impact on the socialisation of new staff into compassionate practices:

> *"…it could be that like attracts like, so perhaps people come to work with us because they can see the potential for being able to be compassionate or maybe they just go along with the majority and become compassionate and quickly develop the values of the team to fit in…"* (C3 Team interview: Team member 2).

[51] As explored under the theme of "The gift of time" – pg211.

Potential barriers to new staff socialisation in team working practices were however identified. The precarious position of the team in relation to upcoming staff retirements meant that the team would need to recruit a number of new staff across a short period of time, which could have an impact upon new staff socialisation:

> *" We've got the two retirements coming up and all it take is for someone to go off sick or move to another job or whatever at the same time and we might get all these new staff in at once and I think it could be much harder in that situation to, I suppose bring them in to our ways of working, and that could cause problems…" (C3 Team interview: Team member 2).*

The composition of the team was identified as a key factor in the sustainment of the team shared philosophy and sense of purpose. However, the shared sense of purpose held by the team was also identified as a factor that helped to sustain the teams' ability to socialise students in compassionate practice, in its' own right. Findings relating to the impact of the teams' shared purpose are explored in the following theme – *"We're all on the same page".*

"We're all on the same page":

All team member participants discussed the values held by individual staff members as having a positive impact upon the socialisation of students in compassionate mental health nursing practice. In addition to the perception that each team member commenced employment with the team with clear compassionate purpose,[52] it was identified that this early compassionate purpose was sustained throughout each individual's employment period. This was something that had not been experienced in other teams previously worked in:

> *"…everyone in the team has come in with wanting to be compassionate, they're all, we're all, naturally compassionate people but I've worked in teams before where people start off trying to be compassionate and end up being not being very compassionate at all, I think because of the stress of the job and other issues but we all want to be compassionate and try to always aim for it …"* (C3 Team interview: Team member 2).

Furthermore, it was identified that the whole team sense of compassionate purpose made it easier for individuals to retain focus on compassionate philosophy and care:

> *"… every single person in the team embodies compassion here. I've worked in other teams where that hasn't been the case and you've felt like you're battling to be*

[52] As identified in Composition of the team – pg223.

compassionate on your own but we're all on the same page here and because everyone aims to be compassionate, it makes is easier to keep going…" (C3 Team interview: Team member 4).

Two key foci of compassionate purpose of team members were uncovered in the data and will be explored throughout the rest of this theme:

- compassionate purpose in care activities
- compassionate purpose demonstrated between staff members and towards students

The team had a shared sense of compassionate purpose relating to the care speciality of older adults with a diagnosis of dementia. All team member participants spoke with passion about their care specialty and the impact that it had on their sense of compassionate purpose:

"I always wanted to work with older people and am so passionate about working with dementia and being able to make a real difference to people's lives… my job is to make sure that they are well cared so they can have some sort of quality of life, that's what drives me and keeps me focused…" (C3 Team interview: Team member 2).

The fact that the team had a specialty focus was viewed as further sustaining team member sense of purpose:

"…we've all come to the team to work with older people with dementia, so it's what we are all passionate about and want to do, it's not like other teams that have that generic focus and you end up having to become a jack of all trades, you know like in the adult community teams, where you might be dealing with loads of different diagnoses, you know, you might be passionate about working with depression, let's say but you end up working with some patients with depression but loads of others with schizophrenia or personality disorder or whatever and it's not what interests you so you lose a bit of focus and don't get the satisfaction out of it that you would if you were just working with depression. I mean, that's just an example but we all get to focus on working a specific age group and a specific diagnosis that we are all really passionate about making a difference to, so that really helps…" (C3 Team interview: Team member 4).

Indeed, a key sustaining factor that underpinned all compassionate purpose relating to care activities was the significance that team members placed on older adults with a diagnosis of dementia. This maintained their drive to ensure that they engaged with compassionate purpose:

> "*I've had the privilege of working with people from all walks of life who have done amazing things with their lives…and when they get diagnosed, people forget about their achievements and the wonderful things they've done. I just think it's really sad and these people deserve the best care possible, dementia's not nice. So yeah, it just makes me want to do all I can for them, to help them and make sure that the true person isn't forgotten…"* (C3 Team interview: Team member 2).

The significance placed upon the service user group had a positive impact upon the time that team members were willing to invest in and spend with service users. It also had a direct positive impact upon team members being willing to *"go the extra mile"* in the care activities engaged in[53]:

> *"It's because we're all so passionate and dedicated to making things better for our patients, because we actually really do value them and care for them, that we're willing to go that extra mile and do extra things to help them and spend time with them, and I think students see that and that probably makes them think that we're quite compassionate and they start thinking of all of the extra little bits that they can do to be compassionate too…"* (C3 Team interview: Team member 3).

In addition to compassionate purpose relating to the direct care of service users, team members also demonstrated compassionate purpose in their work with care home staff. Student participants identified that team members recognised the challenges faced by care home staff and rather than dismiss their experiences, acknowledged the importance of their role in caring for the service user and therefore their value, as well as the team's role in meeting care objectives:

> *"we went into this one home and my initial thoughts were 'oh my lord, this is terrible' the staff seemed harassed, and it just didn't feel very nice, but my mentor said that they were trying to do the best that they could with what they had and rather than judge them, it was our job to educate them and help improve their practices and role model care and compassion to them. Don't get me wrong, if the care was unsafe my mentor would have escalated it, but it actually wasn't. She made me realise that the care home staff were trying really hard and that we need to be compassionate towards them too"* (C1 student interview: student 3).

The importance of demonstrating value of care home staff was reiterated in team member data. The development of non-judgemental, supportive and compassionate working

[53] As discussed in "The gift of time" – pg211 and "They put in a Marathon" – pg218.

relationships with care home staff provided acknowledgement of their value and role in caring for service users:

> *"we work with a huge number of different homes and a number of different personalities, abilities and training and it's really important that we do our job, which we can't do unless we work alongside those care home staff. Sometimes it's harder than others but most often we are called in because staff are asking for some help, so we can't go in wagging our fingers or imposing anything or to say that we know better than them. We are there to share our expertise and support them and hopefully enable them to do what they need to do and let them know that we value that…"* (C3 Staff interview: Team member 5).

Compassionate purpose directed towards service users and care home staff was further supported and sustained during the team weekly meeting. All staff were required to attend the meeting which provided the opportunity to discuss service user challenges and needs, and to develop plans of care in collaboration with each other:

> *"******* (staff member) raised issues with SU (sic) that she wasn't sure where to go with. Rest of team all chipped in, asking questions and making suggestions for what she could do and made suggestions based on previous contact with the home and how best to work with staff and support them too. ****** (another staff member) offered to visit with her to assess and help identify any other factors at play. Really supportive interactions - keeps staff focused on care activities and objectives"* (Field notes C2: O2 402-406).

The supportive nature of the weekly team meeting not only contributed to the sustainment of compassionate purpose relating to care activities but was also one of the factors present in the team that provided opportunity for demonstration of compassionate purpose between team members (including students). Other ways in which this was supported and sustained within the team are explored in the remainder of this section.

The peer and leadership support available in the team resulted in team member participants experiencing enhanced personal feelings of physical, psychological and emotional safety within the workplace:

> *"…because it's such a supportive team to work in, you just have this feeling of, I don't really know how to describe it, of feeling quite safe I suppose because you know that everyone looks out for each other and you'll be supported, no matter how difficult something could be. It's like having a safety net and if you fall the rest of the team are there to stop you falling firstly but if you do fall, they'll do their best to catch you…"* (C3 Staff interview: Team member 4).

This was also demonstrated by the team during the team observations:

> *"…discussed situation where SU (sic) made sexualised comments that made staff uncomfortable. Other team members made a joke about the situation, affected staff member laughed and the humour seemed to help diffuse tension and concerns. Staff member who made the joke also offered to do joint visits going forward to help her feel 'a bit safer'. Demonstrates good emotional and physical support between team…"* (Field notes C2: O2 381-384).

The ability to engage in open dialogue demonstrated that team members felt able to be transparent due to the absence of rebuke and censure from other team members:

> *"we really support each other and I'm not just saying that. I've never experienced anything like it in other places that I've worked. There is usually at least one other staff member that you have to watch out for but here, we really do support each other and if one of us makes a mistake, we all rally round and do what we can to help or just be there for each other. In my last job, I was constantly on tenterhooks that if anything went wrong, I'd be the scape goat, so I ended up making mistakes because I couldn't think straight with it, but here…If you make a mistake, you're not blamed... it makes such a big difference"* (C3 Staff interview: Team member 4).

The team ethos of support and clear sense of compassionate purpose for each other was recognised by students and resulted in them experiencing a secondary sense of physical and emotional safety and support:

> *"you see how supportive they are with each other, and there is none of that bitching that you get in other teams, so you just know that it's a really supportive environment and that they are more likely to support you as well"* (C1 Student interview: Student 3).

The support and compassionate purpose demonstrated between team members further strengthened student perceptions of authentic compassionate practice, which had a positive impact on student socialisation in compassionate mental health care:

> *"I think because they are so compassionate to each other, it just re-enforces that it's not all lip service and that they are all really genuinely and that they really mean the compassionate stuff that they do with the patients …"* (C1 Student interview: Student 2).

In addition, supportive and compassionate interactions did not just occur between team members but was also extended to students on placement with the team. A team approach[54] was taken to supporting students, who were actively encouraged to work with

[54] As explored in "Teamwork makes the dream work" – pg216.

team members from other disciplines. Team member participants were asked to identify the factors underpinning the team approach to student support, and it was suggested that team stability provided a platform for the whole team to embrace students. The cohesive nature of team working that occurred resulted in team members experiencing enhanced feelings of safety and security within the workplace, which in turn resulted in staff members having greater capacity to make attempts to integrate students[55]:

> *"we all get on and are quite stable as a unit so because of that, we can bring students into the fold - so to speak. It might be different if there was upheaval. I guess we'd be distracted by that, so might not be able to prioritise students in the way that we do now"* (C3 Staff interview: Team member 3).

The whole team approach to student support was reflective of the team shared approach to service user care and care of each other:

> *"student being taken out on visits by OT this morning and medic this PM – true team approach to student support. A real sense of shared responsibility among the team – like the student being 'raised by the village'. Same shared responsibility they have for SU's (sic) and each other".* (Field notes C2:O2 563-569).

This whole team approach to student support helped to diffuse the impact of having a student on placement with a small team:

> *"Everyone chips in with students and it's great because they get to learn from other people and understand everyone's roles but, and this is going to sound bit selfish but it's not how I mean it, it also gives you a bit of a break as well. And I don't mean that I don't want to work with students, I do, but sometimes you just need to crack on with stuff and when you have a student, even a really good one, there is that pressure to take time to include them. So, when other people offer to take them for a bit, it's great because they feel wanted and it just gives us that bit of a breather so we can catch up with ourselves as well…"* (C3 Staff interview: Team member 4).

Team member participants identified that they experienced clear purpose as role models for students, acknowledging that their attitudes, behaviours and actions impacted students experience with the team:

> *"…they (students) learn from our example, so if they see that we are supportive of each other as well as compassionate to the patients, they're more likely to be the same. That's why I'm always really careful with what I say in front of students, I'd never talk about one of my colleagues in a derogatory way because I wouldn't want them (the student) affected by the negativity of it all…"* (C3 Staff interview: Team member 5).

[55] As explored in "Under their wing" – pg150 and "Camaraderie - feeling like part of the team" - pg155.

This demonstrated team member awareness of the wider impact of their actions, and also demonstrated an ability to see beyond themselves and the immediate impact of having to mentor a student as part of their workload.

The awareness of the impact of role modelling positive working behaviours was demonstrated by multiple team members:

> *"Student went out to collect lunch – other team members (4x Nurses, 2 x OT and 1 x HCA) started talking about issues they were having with a particular member of staff in the ******* team. Frustration and annoyance ++. When student returned, conversation very tactfully changed. No more negative comments about the individual staff member but included the student in the conversation - said "I was just saying we had some challenges with the referral for **********". Student then involved in conversation about methods to overcome specific challenges but not any derogatory or negative content about the specific staff member…"* (Field notes C2: O3 512-530).

The quote above also demonstrates that the despite student idealism about their experience with the team, challenges to compassion for all were present. This is reflective of the discussion in Chapter Four – 4.4: The many shades of grey.

Awareness of staff member impact as role models, coupled with the support and compassion demonstrated between team members, supported a clear sense of purpose in relation to working with students. This served to sustain the positive role modelling within the team:

> *"we're all (team members) role models so if we want students to be compassionate, first and foremost, we have to be compassionate to each other and that's what makes the difference. The support gives you the strength to carry on so you can always aim to be that role model…"* (C3 Staff interview: Team member 2).

Team member sense of purpose was also demonstrated by ensuring that students felt supported while on placement. Recognition of student vulnerability led to staff members taking positive steps to reduce their experience of vulnerability during the placement period, which again demonstrated team member ability to see beyond themselves to engage in empathic relationships with students:

> *"they're (students) under a lot of pressure and can feel quite overwhelmed. It's really important that we recognise that and support them so they can get the most out of their time with us"* (C3 Staff interview: Team member 5).

The recognition of student vulnerability and pro-active steps taken to support students to overcome vulnerabilities was viewed as being an example of the way in which the team (individually and collectively), engaged in compassion towards others[56]. This further re-enforced student perception of genuine compassion demonstrated by the team:

> *"…they knew it was a bit of a struggle for me and they did what they could to help me succeed. I've felt like other placements just gave up on me, but they didn't, they really tried to help me, and it made me realise that they actually are truly compassionate, it wasn't just a show for patients or managers, it was real…"* (C1 Student interview: Student 5).

Team members recognised that student aims and needs often varied due to unique vulnerabilities, prior experience and phase of programme. As such the need to adopt a flexible approach, taking in to account unique student needs and phase of development, to support achievement was recognised:

> *"…in some students you have to bring it (compassion) out of them because it can be difficult for some students. They might be shy or lacking confidence and need a bit more support to achieve it. So, I try to provide positive encouragement and talk things through and encourage them to reflect and put it into practice really"* (C3 Staff interview: Team member 4).

In order to support student achievement, there were times when team members were required to engage in difficult conversations with students to highlight areas for development. Team members reported being more likely to engage in these conversations with confidence when their experience within the team was underpinned by experiencing feelings of being supported in their role as a practice educator, and when they had clear purpose in supporting student development:

> *"those conversations are always hard and never pleasant but it's easier when you know that you've got the back-up of the team, it really helps with confidence and I think it helps that we are all quite experienced, not just as mentors but in general, so that helps with confidence too because you just feel more sure about what you need to do and I always just remind myself what I'm doing it for. You're doing it to help them improve so they can be a good nurse but also for the patients because if you don't nip things in the bud early on, it's the patients that will suffer for it…"* (C3 Staff interview: Team member 3).

Team member roles in supporting consistency and making active attempts to reduce dissonance often experienced between theory and practice was also recognised as key in

[56] As explored in "The gift of time" – pg211.

supporting students to develop their compassionate practice. Team members demonstrated awareness that students may be shocked or confused by some of the realities of contemporary practice and acknowledged inconsistencies between taught content and practice experienced. However, efforts were made to ensure that this acknowledgement was not communicated to students through disparaging comments about the quality of their educational programme, but rather through a balanced appreciation of the challenges faced in both education and practice and understanding of the aim for developing gold standard practice:

> *"it's our (practice staff) job to help them (students) understand and work in the reality of the job and supporting them to do the best they can with what we've got. You teach them what we should do, and we teach them how to apply it. We're all trying to achieve the same thing, the best care possible"* (C3 Staff interview: Team member 5).

This was a stark contrast against student experiences[57] in other placements and demonstrated that team members had a clear sense of purpose related to their role of assisting students to apply theory into practice. The extension of reach of compassion to include nurse academics/educators also bolstered both the sense that students themselves were valued, and that their classroom educators were valuable. This is turn supported student 'opening up' to compassion[58]:

> *"she helped me to understand how I could apply the classroom stuff at placement, and I didn't feel silly when I suggested things that we've been told to do or aim for in class. In fact, she said, 'yes, they're (academics) right, we do need to do that' and I suppose it made me realise how much we can learn in the classroom and what you lot (academics) are doing to really try and help us to be the best we can be…"* (C1 Student Interview: Student 2).

Additionally, team members recognised the importance of both formal and informal reflection. The potential for transformative learning for students when they are engaged in psychological reflection within the practice context was recognised by team members; they were willing to invest time to develop the skills required to facilitate meaningful reflective discussions with students. All of the nursing team members had accessed additional continual professional development to advance in their roles as student mentors:

[57] As reported in "Pie in the sky" – pg181
[58] As explored throughout Chapter Four – pg140.

> *"we're all (the nurses in the team) mentors so we've all done the mentorship training. I really enjoyed it to be honest and thought it was really useful because it made me consider what it's like for students and what I need to do to help them to really understand and rationalise some of the things they experience on placement. They (the mentorship programme staff) were really big on encouraging reflective discussions, which I think has been one of the most useful things I took from it…"* (C3 Staff interview: Team member 4).

The quote above further demonstrates team member ability to look beyond themselves and in this instance consider the ways in which they could support students to 'open up' to compassion.

In addition to recognising the importance of engaging students in psychological reflection, staff also engaged in their own reflection. Examples were given of team members reflecting on their own experiences as students, as well as their own personal experiences of negative mentorship, to motivate themselves to engage in high quality, positive and supportive mentorship:

> *"when I was a student I had mentors that really didn't want to spend any time with me and made me feel really unwelcome. I'll never be like that. We, all of us, embrace students here and we like to work with them and make time to work with them and that's really important"* (C3 Staff interview: Team member 4).

The mentors in the team harboured positive attitudes to students. Each team member participant reported enjoying their role in supporting students and recognised the value of reciprocity in mentoring students in relation to their own continual development:

> *"I like being a mentor because it helps keep my skills up. I learn as much from them as they do from me"* (C3 Staff interview: Team member 2).

The team had a well-established mentorship management process. This underpinned team member attitudes and experiences of mentoring students on placement with the team. The impact of this on sustaining the conditions required to support the socialisation of students in mental health nursing practice is presented in the following theme - Established mentorship management.

Established mentorship management:

It was recognised that a number of team norms of working had become established over a period of time. Some of these norms were identified as emerging through conscious planning, while others were identified to have developed and become established within the team as part of the natural team development process. One such developmental process identified was established mentorship management:

> *"because we've all worked together for quite a while, we've got in to certain ways of working (as a team) that I suppose have become the norm for us, like the associate mentor, we didn't always have that but someone went off sick and the student needed another mentor and actually we realised that it is better for the student if they have a main mentor and an associate because they've always got someone they can go to then, so it became something that we just do all the time…"* (C3 Staff interview: Team member 4).

The developed mentorship approach in which students were allocated a lead mentor and an associate mentor further enhanced the sense of shared responsibility of student experience within the team. The approach was recognised as having a positive impact on students by providing additional points of support during their placement experience, and it reinforced staff feeling supported in their role as practice mentor:

> *"it seems to work better when they've (students) got a mentor and an associate mentor. It's better for them because if one person isn't here, they've got someone else to turn to and it's better for us because we support each other and the shared responsibility lifts some of the weight off your shoulders"* (C3 Staff interview: Team member 3).

Students were also allocated to mentors on a rotational basis. This ensured that all mentors in the team had regular student mentorship contact to maintain mentorship skills, but they also had recuperative breaks from mentorship responsibilities:

> *"we take it in turns really which is great because we all keep our hand in but you also get a break sometimes which sometimes you just need, and it's not even about a break from the students, I'll still take them out on visits with me, I haven't got a problem with that, it's a break from the extra paper work you end up doing (as the mentor) but having that bit of a break just means that we don't constantly feel overloaded so you actually look forward to having a student with you again… (C3 Staff interview: Team member 5).*

Regular breaks from the mentorship role were particularly important following occasions when mentors had worked with a challenging student which could result in team members feeling fatigued and disillusioned:

> *"I had a really challenging student who just, really made me question everything. To cut a long story short, she failed the placement and she obviously had lot of personal issues going on and I'd invested so much time in her, but she said some really horrible things and tried to cause a bit of trouble, it was just all really unpleasant… and I felt quite burnt out afterwards. I think if I'd have been expected to take on another student straight away, I might have tarred them with her brush, so to speak… I got in to this mind-set of them (students) all just being trouble makers… but because I didn't have to take on another student straight away, I could stand back a bit, and not get involved and give myself a bit of time to recover and I realised that she was a one off and that the vast majority of students are actually really good and don't deserve to be tarred with her brush…" (C3 Staff interview: Team member 4).*

The break from mentorship ensured that practice staff had time to reflect and limit the impact of their negative experience of mentorship on future engagement with students, by refreshing staff sense of purpose regarding mentorship. All team members who participated in individual interviews stated that a positive placement experience created by effective mentorship was high on the teams' unwritten agenda and was something re-enforced by the team manager through specific acts of leadership. The impact of leadership on the creation and sustainment of conditions to support effective student socialisation in compassionate mental health nursing practice is explored in the following theme - *"The flavour of the team is set from the top".*

***"The flavour of the team is set from the top"*:**

Participants recognised that effective and supportive team management and leadership was a root facilitator, underpinning both the creation and sustainment of the factors identified by students as supporting their socialisation in compassionate mental health nursing practice.

Participants perceived that team management and leadership played a crucial role in the teams' capacity to engage compassionately. It was recognised as a facilitator of the team's

overall sense of emotional, psychological and physical safety and employment security. This further contributed to the sense of internal team support:

> *"…I think the leadership in the team is really important, ******* (the team manger) is really supportive, she's obviously got her job to do and makes sure we meet targets and whatever but she's really good and I think genuinely cares for us, so you feel a bit safer knowing that and I think because we have that compassion shown to us by someone in authority, it makes it easier for us to be compassionate then as well…"* (C3 Staff interview: Team member 3).

This was further reflected by the team manager, who recognised the potential emotional impact of the work that the team engaged in. The manager's role in facilitating a supportive culture within the team to reduce the impact of potential emotional strain was also identified:

> *"the job can be really hard in an emotional sense and with managing the workload, I appreciate that, so it's important that they (team members) are supported properly, not just by me but by each other. I really try to promote that in the team, because when they feel supported, they can achieve so much more…" (C3 Staff interview: Team member 1).*

Indeed, all observed interactions between the manager and team members were based in professional support in which team members were encouraged to voice their concerns and opinions, and all staff contributions appeared to be given equal value:

> *"Manager facilitated the meeting – made sure everyone had the opportunity to contribute and all staff encouraged to discuss difficulties and help each other problem solve. All staff contributions considered and appeared respected and valued"* (Field notes C2:O2 411-412).

This contributed to staff feeling that their contributions, opinions and experiences were genuinely considered as significant:

> *"We're all given a chance (in the team meeting) to discuss issues and chip in to help problem solving. It's not just let to the doctors and the manager to decide, all of our opinions matter, regardless of our background and we're always made to feel that our input and experience is really valued, and I suppose it makes you feel important and yeah, valued…"* (C3 Staff interview: Team member 2).

The team manger not only facilitated team meetings but also actively contributed as an experienced clinician, assisting the team to make safe care decisions, thereby enhancing feelings of team member safety when making complex care decisions:

> *"…it's reassuring that she's (the manager) really experienced and her background is older people as well, so she really knows what we face, and she lets us all contribute and try to problem solve together but we know that when it comes to it, she'll give some direction about what we need to do to make sure that we're doing what we need to and so that makes you feel much more confident and supported as well…"* (C3 Staff interview: Team member 5).

Team member participants respected the manager's knowledge and experience. This coupled with the team manager's active demonstration of compassionate purpose in reflective discussions, and when giving team members advice relating to care, resulted in an increase in staff socialisation in compassionate practice through increased opportunities to engage compassionately:

> "*It helps that she (the manager) knows her stuff and is compassionate to us as a team as well as the patients we care for. She's really big on the six C's and I think still views nursing as a vocation. So, we see her being compassionate and we follow suit. She makes it easier for us to be compassionate because she leads by example and it's an example that we all want to follow"* (C3 Staff interview: Team member 3).

The team manager had a clear sense of purpose relating to the role of manager and was acutely aware of the importance of compassionate team leadership in setting the tone of team ethos and a compassionate culture:

> *"I feel strongly that the flavour of the team is set from the top…if you haven't got that compassionate leadership, then it doesn't spread down and it makes it really hard for people who are working on the shop floor to be affirmed in what they do" (C3 Staff interview: Team member 1).*

Although it was felt that the tone of the culture of the team should be set by management, the ceiling for this appeared to be the team manager and did not extend to higher management in the organisation. Rather, participants recognised the potential negative impact of the wider organisation on staff and student feelings of safety and did not identify any positive impact of the wider organisation on the team's ability to socialise students in compassionate mental health nursing practice. It was suggested that the wider organisation in which the team was a part of had a profound impact upon working experience and potential fatigue and burnout:

> *"…sometimes they (the organisation) impose things on us and there is no consultation, no real notice of the changes and they don't always give us a lot of information, so it feels like there is no rhyme or reason behind what we're supposed to do, so you're left feeling a bit out on a limb and resentful because you don't understand why your workload has had to increase and that can leave you feeling*

exhausted and that's when you're most at risk of burnout I think…" (C3 Staff interview: Team member 2).

It was however recognised that supportive management and leadership in the team provided a buffer between staff and organisational pressures from senior managers, which limited perceived organisational threats. It also helped to sustain staff and student experience of a secure working environment in which they could engage in compassionate mental health nursing care:

> "*it must be hard to protect the team from some of the pressures that come down from higher managers at times but she (the team manager) acts as a bit of a buffer between them and us, so we feel quite protected in that way and know that we continue to be compassionate and make sure students are compassionate, without worrying about the barriers that might come from the Trust…"* (C3 Staff interview: Team member 3).

This buffer provided staff with the emotional and practical space required to be able to continue to invest time in care activities and each other (including students). It also enabled them to feel that they could invest more into their care giving activities without experiencing burnout from workload:

> *"…. that protection means that we're not overloaded with extra and unnecessary red tape work, so we can focus on spending time wisely and doing that bit extra because we're don't feel burnt out…"* (C3 Staff interview: Team member 3).

The sense of protection and buffer provided by the team manager also resulted in staff having the emotional capacity to maintain focus on compassionate purpose towards students:

> *"…and it (the sense of protection) means we've got the emotional strength to really carry on and make sure that we can think compassionately and then act compassionately to everyone, not just the patients but to each other and to the students"* (C3 Staff interview: Team member 3).

The team managers acknowledgment of the value of students having placements within the team was identified as a further factor that supported the sustainment of the feelings of student significance within the team. It was the manager's recognition of student significance and the desire to support their achievement that resulted in equipment and resources being accessed and made available for student use:

> *"they (students) play such an important role, they're our nurses of the future and we need to mould them into compassionate nurses if we want that for the future, so it's*

> *important that we invest in them now. So, when it was identified that they couldn't be fully engaged because they couldn't access the system (computer equipment and online Trust system), I thought it was important that we facilitate that, so they could really get stuck in and be a part of it. It took a bit of effort to procure it (computer equipment specifically for student use) but it was well worth it and now they can take part in writing notes and care plans so they're developing more…"* (C3 Staff interview: Team member 1).

The first sentence of the quote above also demonstrates the team manager's willingness and ability to see the bigger picture in relation to beliefs about student significance. The recognition of student significance was further re-enforced by the team manager's acknowledgement of the importance of staff accessing developmental opportunities in their roles of working with students. Indeed, all nurses in the team had completed mentorship training and were supported by the team manager to attend yearly mentorship updates. These opportunities for development were prioritised and this served to re-enforce the feelings of managerial value placed on students and staff roles as mentors:

> *"…we're all (nurses in the team) mentors and we do the yearly updates too which ****** (team manager) makes sure that we all attend and prioritise. So, we know that she values students and that she wants us to be supported and up to date with our mentorship and she makes sure that we get that time out to do it, so that makes us feel valued in our role as mentors too"* (C3 Staff interview: Team member 4).

The encouragement and support of staff attending mentorship updates and training also had a positive impact on the reduction of dissonance between theory and practice, and enhanced continuity between the two elements of the nursing programme:

> *"…because she (the team manager) makes sure we prioritise the mentor updates, we can stay abreast of developments and that really helps the students on placement with us because we know what they are being taught and how we can help to consolidate that learning for them…"* (C3 Staff interview: Team member 4).

It was also recognised that the team manager role modelled the value of students to team members, which in turn had a positive impact upon staff recognition and acknowledgement of student value and significance:

> *"I think because she (the team manager) prioritises the student experience and tries to support them and support us, supporting them, it re-enforces that she genuinely sees students as important and that what we do is important, so she I suppose she role models the importance of students and making sure that they have a good experience with us and if you see it's important to someone in authority, it becomes*

more important to you too and you're more likely to follow suit…" (C3 Staff interview: Team member 2).

5.4: Resonance of study findings

To adhere to the constructivist paradigm underpinning this study, findings from the case study and researcher reflections on data interpretation and conceptualisation were presented to both the team that the case study was conducted in, and also to student mental health nurses (n=25) in separate presentations.

The presentation of preliminary findings and researcher reflections were presented to the practice team in July 2019 and took place in a weekly team meeting. Unfortunately, some team members were unable to attend the presentation. However, findings were discussed with the team manager, two consultant psychiatrists, two band 6 community mental health nurses and two health care support workers. Feedback from the team indicated that they were able to resonate with the findings and reflections presented:

> *"I think what's interesting is that some of it is so obvious, no offence at that but, some of it, is just like yeah, of course we do that but there are other elements there too that now you've said it, yeah, I can really see the impact. It makes me feel a little bit proud of us all because I don't think we always do it consciously, you know, we just do it…"* (C4 Sharing Findings: Team member 6).

Team members did not have anything to add to findings, reflections and feedback given during the presentation indicated that they felt that the interpretation and conceptualisation of findings represented an accurate portrayal of the factors underpinning student socialisation in compassionate care that occurred within the team.

Preliminary findings from both focus groups and the case study and researcher reflections were also presented to a cohort of student mental health nurses from De Montfort University. Unfortunately, these could not be presented to those students who had identified the practice area for case study, as they had all completed their programme of study. However, they were presented to (n=25) second year student mental health nurses to ascertain if conclusions were consistent with their experiences in practice. Student participants identified that the factors uncovered in the case study and the focus groups had

also been present in other practice areas that they perceived as having either supported of inhibited their socialisation in compassionate practice:

> *"what you just said about that team (the case study team), yeah, I'd say they are the sort of things that I really value in a placement and I think help you be more compassionate and yeah I suppose it has been a bit of a journey of development. I think the stuff about permission is good as well, because that's what we're all looking for, but I don't think we are necessarily really conscious of that all the time…* (C5 Sharing Findings Student 14).

> *"I think the bits that stuck out to me most were about the bad experiences. I just had a really difficult placement. I felt all that – that you said, made complete sense. I definitely closed down. I couldn't even think about being compassionate to the patient's coz (sic) I had to think about myself so much. It's making so much sense now you've said but I've been feeling really bad about it, like it was my fault or something…"* (C5 Sharing Findings Student 3).

Students also agreed that in their experience, placements experiences did not often sit at extreme ends of the compassion continuum, but rather that placements were considered as *"mostly compassionate"* or *"mostly non-compassionate*[59]*"*:

> *I've never experienced it all at once like that (as in the case study) but I've had bits of it in good placements, so yeah, I think you're right about it not always being clear cut and that nowhere is 100% compassionate or 100% terrible, I think you tend to get, well in my experience anyway, mostly compassionate or mostly non-compassionate placements… well, give or take…"* (C5 Sharing Findings: Student 14).

5.5: Case Study findings summary

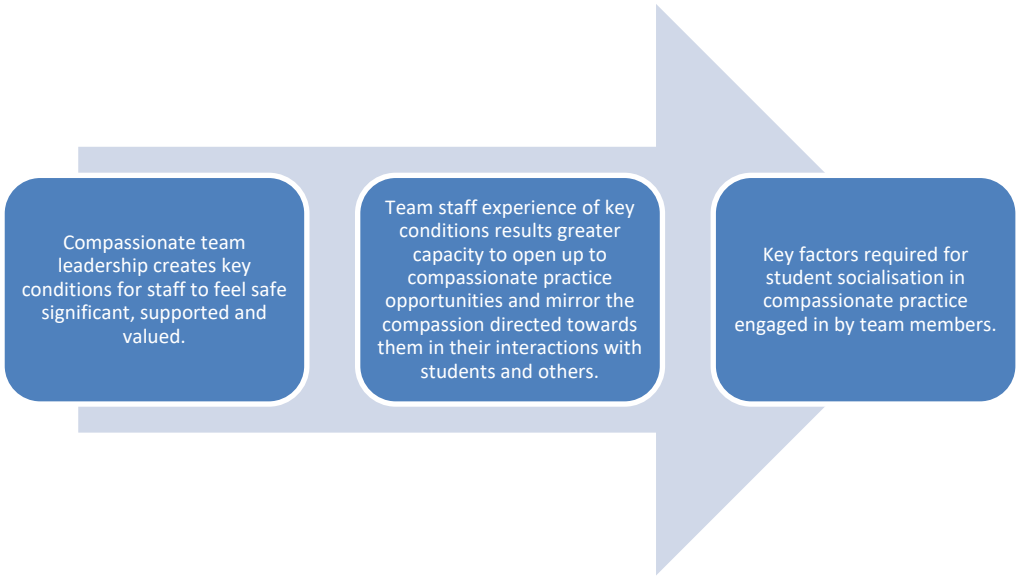
The findings suggest that practice environments that support positive student socialisation in compassionate mental health practice are created and sustained by a myriad of factors which are interconnected and re-enforce each other. A summary of these factors is demonstrated in Appendix 32: The factors that sustained the teams' ability to socialise students in compassionate mental health nursing practice.

Furthermore, the factors that support the sustainment of the teams' ability to support socialisation in compassionate mental health practice are reflective of the factors that students reported as supporting their socialisation. For example, team staff identified the

[59] As discussed in 4.4: The many shades of grey – pg193.

importance of feeling safe, secure and supported in their employment to allow the capacity for them to engage compassionately with service users, students and with each other. This mirrors student recognition that feeling emotionally, psychologically and physically safe in the practice environment supports their capacity to engage compassionately. This is therefore suggestive that the key conditions required for student socialisation in compassionate practice also need to be present for staff members within the environment. This is demonstrated figure 5.1: The impact of leadership on team ability to socialise students in compassionate practice, below.

Figure 5.1: The impact of leadership on team ability to socialise students in compassionate practice



However, it also became apparent that the team environment was potentially fragile, and if one component of the team structure were to be altered, this could have a detrimental impact upon the teams' continued sustainment of factors that support socialisation of students in compassionate mental health nursing practice. This is demonstrated in figures 5.2 and 5.3 below. Figure 5.2 demonstrates that where the combination of factors that sustain a teams' ability to socialise students in compassionate practice exist, these act as a buffer which deflects threats to the teams' ability to socialise students in compassionate practice. Figure 5.3 demonstrates that where these factors are inhibited or removed, these threats erode the teams' ability to positively socialise students in compassionate mental health nursing practice.

Figure 5.2: Factors that facilitate a teams' ability to support socialisation in compassionate practice

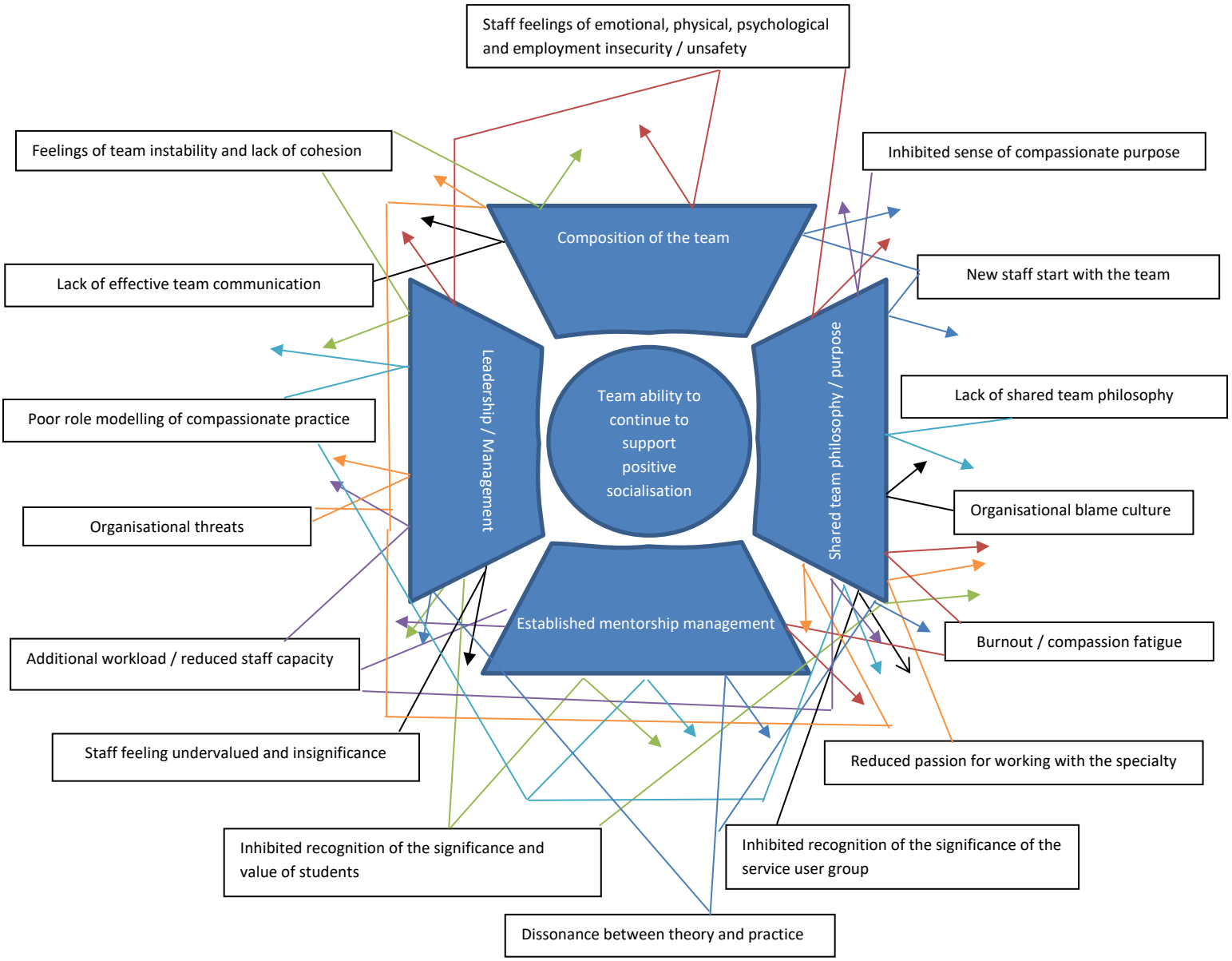
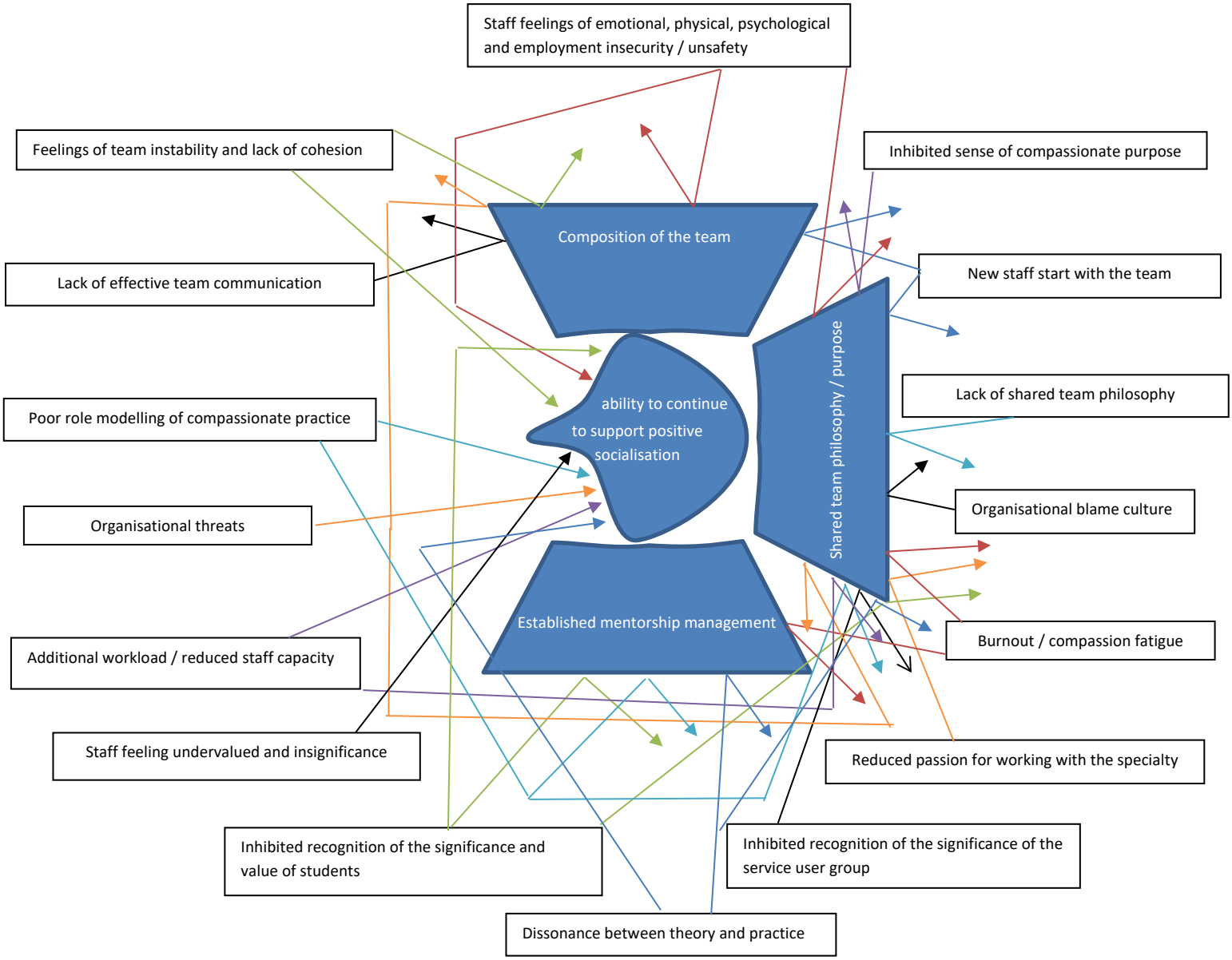


Figure 5.3: Infiltration of threats to socialisation in compassionate practice, when sustaining factors are removed



As the empirical components of the study and strengths and limitations of the study have now been presented, Chapter Six: Discussion, will explore the extent to which the study aims have been addressed, and the contribution the study makes to enhance understanding of the factors that influence student mental health nurse socialisation in compassionate mental health nursing practice.

Chapter Six: Discussion

6.0: Introduction to the discussion

As stated in Chapter One, the impetus for this study was based upon personal experiences throughout a 20-year mental health nursing career, in which there was exposure to what is now recognised as compassion enriched and compassion impoverished mental health nursing care. The importance of developing, nurturing and cultivating mental health care contexts in which compassionate interactions and interventions could be engaged in was also acknowledged as a driver for the study in Chapter One. A dearth of evidence relating to how student nurses are socialised in compassionate mental health nursing practice was also highlighted. A key motivation was to uncover the elements that support socialisation in compassionate mental health nursing practice. The intention was that this could support student mental health nurses, as nurse registrants of the future, to develop the capacity and ability to engage in compassionate mental health nursing care provision. As such, the following research questions were developed:

- What are the experiences of compassion for student mental health nurses?
- What are the factors in practice placements that influence student mental health nurses in their development as compassionate mental health nurse practitioners?

And;

- How can placement providers facilitate positive socialisation in compassionate mental health nursing practice for mental health nursing students?

To address these research questions, the study utilised a multi-phased, multi-methods approach. A literature review was conducted (Chapter Two) to facilitate the discovery of existing knowledge of the meaning, origins and definition of compassion. Knowledge of student socialisation in compassionate practice was also explored. The literature review provided a solid foundation for the two empirical phases of the research that followed. The first phase (Chapter Four) comprised of focus groups (n=6) conducted with 1st, (n=2) 2nd (n=2) and 3rd (n=2) year student mental health nurses. The purpose of these focus groups was to develop insights into the opinions and perceptions of student mental health nurses regarding their experiences of compassion, and the factors that they felt influenced their

socialisation in compassionate mental health nursing practice. The focus groups also allowed the development of in-depth understanding of the ways in which student mental health nurses were socialised in compassionate mental health practice. In addition, they facilitated in-depth understanding of the way in which socialisation in compassionate practice was inhibited. The focus group data therefore contributed towards answering the first and second research questions.

Phase two of the study (Chapter Five) comprised of a single case study of a placement area nominated by student participants during focus groups as one that had supported their positive socialisation in compassionate mental health nursing practice. The case study comprised three data collection methods; individual semi-structured interviews with students who originally nominated the placement; observations of the nominated team in their daily work and individual semi-structured interviews with team members and students on placement with the team at the time of case study data collection. The case study further supported the development of deeper understanding of the ways in which students were positively socialised in compassionate mental health nursing practice. Furthermore, it facilitated the exploration and in-depth understanding of factors that supported the development and sustainment of a compassion enriched learning environment. This environment in turn effectively supported student socialisation in compassionate mental health nursing practice.

The research strategy was emergent, as consistent with the constructivist paradigm (Chapter Three). The original research questions and aims included exploration of the personal experiences of students, practice exposures and theoretical influences, as taught in the classroom. However, the research foci were amended following student focus groups in which students identified that most of their learning and development of compassionate mental health nursing practices occurred within the practice context. As such, the case study focus was amended to fully explore how the team created and sustained a compassionate care environment capable of positively socialising students in compassionate mental health nursing practice.

Focus group findings uncovered factors present in placement areas that facilitated socialisation in compassionate mental health nursing practice. It was found that participants experienced a journey of socialisation when exposed to compassion enriched practice experiences (presented in figure 4.2: The Ladder of Socialisation in Compassionate Mental Health Nursing Practice). The factors underpinning the initial stages of the ladder supported students to internalise the value of compassion as a '*recipient'*, underpinned by factors that enhanced student feelings of safety, acceptance, inclusion and significance. The factors underpinning the latter stages of the ladder supported students to internalise the value of compassion as a '*giver'*. These stages were underpinned by enhanced experience of continuity between theory and practice, the role modelling of compassionate purpose, and feelings of achievement. All positive experiences resulted in students gaining a sense of permission to engage in compassionate mental health nursing practice. In combination, the factors identified as underpinning positive socialisation in compassionate practice and the meaning derived from those experiences[60] resulted in students experiencing an 'opening up' to opportunities to engage in compassionate care. Students were able to see beyond their own experience and both recognise and engage in compassionate mental health care opportunities[61].

Unfortunately, students also reported placement experiences in which their socialisation in compassionate mental health nursing practice was inhibited or suppressed. When exposed to compassion impoverished placement experiences, students journeyed through The Retrogress Ladder of Socialisation in Compassionate Mental Health Nursing Practice (as demonstrated in figure 4.3). In these situations, the combination of students being treated non-compassionately by practice staff, and exposure to role modelling of care lacking in compassion, resulted in students experiencing reduced capacity to engage in compassionate care. Furthermore, the factors present in these placements[62] resulted in students feeling vulnerable, unsafe and insignificant. The meaning derived from these negative experiences resulted in students becoming introspective and focusing upon their own needs, to the detriment of their ability to engage in compassionate mental health nursing practice.

[60] As listed in Appendix 29: All in this together – theme factors that support student socialisation in compassionate practice – pg403.
[61] As demonstrated in Figure 4.5: The opening up to compassionate practice pg199
[62] As listed in Appendix 30: Everyone for themselves – theme factors that inhibited student socialisation in compassionate practice – pg406.

Students reported mirroring non-compassionate care activities and attitudes in an attempt to 'survive' their experiences and at the furthest extreme recognised that care lacking in compassion became the norm as they were socialised into negative care practices. In these situations, students experienced a 'closing down' to compassion[63].

Case study findings (Chapter five) uncovered a number of factors that supported the creation and sustainment of a practice teams' ability to positively socialise students in compassionate mental health nursing practice[64]. It was found that factors that enabled team members to support student socialisation in compassion reflected the factors experienced by students through their socialisation journey. When team members experienced feelings of job security, safety, significance and support to maintain compassionate purpose from within the team, they were able to sustain the factors that positively supported student socialisation in compassionate mental health practice. When factors that supported the sustainment of the teams' ability to socialise student in compassionate care were present, these factors acted as a buffer to potential threats to compassionate practice[65].

The overarching aim of this chapter is to discuss the findings of this study in the context of the current literature. Furthermore, the contributions of this study are presented. However, first, in order to give full context, the strengths and limitations of the study are considered. The position of the research in terms of credibility, transferability, dependability and confirmability to support high quality research practices (Deniloco, Long and Bradley-Cole, 2016) was discussed in Chapter Three. However, authenticity criteria as reinterpreted by Nolan et al (2003) offers a criterion that is consistent with a constructivist approach and is applied to support the identification of strengths and limitations of the research.

[63] As demonstrated in Figure 4.6 – pg201.

[64] See Appendix 32: The factors that sustained the team's ability to socialise students in compassionate mental health nursing practice – pg411.

[65] See Figure 5.2 Factors that facilitate a teams' ability to support socialisation in compassionate practice – pg245 and Figure 5.3 Infiltration of threats to socialisation in compassionate practice when sustaining factors are removed – pg246.

6.1: Strengths and limitations of this study

The rationale for selecting the research paradigm, strategy, methods and analysis is explored and presented in detail in Chapter Three. Furthermore, the study design was initially considered against the "parallel" trustworthiness criteria (Lincoln and Guba, 1985). However, despite developing the parallel criteria as a pragmatic attempt to mitigate criticisms that qualitative research was less robust than quantitative research, Guba and Lincoln (1989) expressed concerns that the criteria was not consistent with the principles of constructivism. Indeed, Guba and Lincoln (1989) later challenged the criteria for trustworthiness, highlighting inconsistencies with the principles of constructivist research. Instead, they proposed "Authenticity criteria" that identified five key areas to take in to account when assessing the quality of constructivist research: fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity (Guba and Lincoln, 1994). Authenticity relates to the integrity and quality of the constructivist approach (Rodwell, 1998). A key element of the application of authenticity criteria is "*contextual betterment"* which should result from actions taken and teaching and learning that occurs as a result of the research (Rodwell, 1998, pg107).

However, the five principles of authenticity as presented by Guba and Lincoln (1989, 1994) have also received criticism, for the way in which the principles are articulated (Nolan et al, 2003). Nolan et al (2003) argued that the terminology of the original criteria was elitist and inaccessible to those from non-academic backgrounds (Nolan et al, 2003; Wilson and Clissett, 2011). Nolan et al (2003) therefore went on to suggest a re-labelling of the criteria to improve accessibility. The five principles are renamed by Nolan et al (2003) as:

- Equal access
- Enhanced awareness of the positions of self/own group
- Enhanced awareness of the position/views of others
- Encouraging action by providing rationale for an impetus for change
- Enabling action by providing the means to achieve (or begin to achieve) change.

As the stakeholders represented in this study are student mental health nurses and practice staff, it was reasoned that it was important to make the research as accessible and 'readable' as possible.

In addition to the consideration of applying Nolan et al's (2003) renamed authenticity criteria to support stakeholder engagement with the study, the criteria also resonated with my personal and professional values and my developing understanding of the research process. Indeed, "Equal access" spoke to my personal ethos of inclusion, while Enhanced Awareness of position of self/own group and position/views of others, resonated with my desire for "contextual betterment" (Rodwell, 1998) and understanding of the experiences and development of others. The knowledge and experience of engaging in constructivist research that I had developed also contributed to the decision to apply a quality criteria which was appropriately aligned with the principles of constructivism. Furthermore, I recognised that the decision to apply Nolan et al's (2003) renamed authenticity criteria, was consistent with the concept of reflexivity and the recognition of the researchers' preferences, knowledge, experience and impact upon the research process.

Each of the criteria are now considered in turn and exploration of how each relates to this study is presented.

Equal Access:

Equal access relates to Guba and Lincoln's (1989, 1994) original authenticity principle of fairness (Nolan et al, 2003; Wilson and Clissett, 2011). Equal access refers to a balanced presentation of all viewpoints (Wilson and Clissett, 2011). It aims to ensure that different constructions and perspectives are allowed to emerge, enabling all stakeholders to have a voice and that the worth of all contributions are seriously considered (Rodwell, 1998). Furthermore, it also includes stakeholder participation in analysis and interpretation of research data (Rodwell, 1998). The final aspect of equal access is that of attention to minority views; specifically, that those views that deviate from the majority consensus are evident in the research (Rodwell, 1998).

The rest of this section discusses the extent to which equal access has been met in this study.

First of all, consideration is given to whether constructions and perspectives of all stakeholders were sought (Rodwell, 1998). The study strategy included purposive sampling to support a wide range of voices being heard. Students of mixed gender, age, ethnic background and differing phases of journey through nurse education were included in the study. However, student participants were only recruited from one Higher Education Institution. As such the majority of their placement experiences were hosted within two NHS Trusts and Private, Voluntary and Independent sector placements in two geographical areas of the East Midlands. It must therefore be recognised that findings may not reflect student experience of socialisation in compassionate mental health nursing practice from other HEI's across the United Kingdom, or from global education/placement experiences, where alternative placement providers would be utilised. A further point for consideration is that all student participants volunteered themselves to take part in the research. As such it could be argued that the sample was open to bias, due to the potential of students only wishing to take part if they harboured extreme views (positive or negative) about their experiences. That acknowledged, student participants expressed a wide range of both positive and negative views and experiences, therefore providing some balance to data obtained.

Focus groups were cohort specific, therefore offering opportunity for intensification of constructions relevant to the cohort phase of study. Although student participants were encouraged to attend both focus groups for their cohort, the composition of the first and third-year focus groups was altered due to inevitable drop-out. This made it impossible for analysis and interpretation of the original focus group data to be fed back to all original focus group participants. Participants in the 2nd year cohort focus groups remained consistent but as previously stated, this was made up of only two participants. Although only two students attended this cohort focus group, participants equalled 25% of the cohort population and provided rich data.

Two focus groups were conducted per cohort. Data obtained from each of the six total focus groups were rich and insightful, but it was apparent by the end of the second focus group in each cohort that no new perspectives were emerging. This would suggest that despite the constraints of the study identified above, the principle of equal access was given due attention.

During the case study phase of the research, limited time was spent in the case study site area due to time and resource constraints. The 12 hours of observation were spread out over three separate occasions and allowed the observation of key team working tasks. The aims of the observation periods were however specific, with observation focused on relationships, mentoring and other compassion related activities, as identified in student participant individual interviews conducted prior to case study site access. The clear aims therefore reduced the potential detrimental impact of limited time spent at the case study site. Students were interviewed prior to site access and after their placement experience had ended. It was hoped that by allowing students to participate away from the placement itself, they would feel able to openly express their true views. However, it is acknowledged that the student participant who consented to participate in an individual interview while on placement with the team may have felt unable to be completely honest about her experiences. In order to encourage open and honest responses from this participant, the individual interview was conducted away from the placement environment and reassurances were provided that feedback would not be given to the team prior to completion of the placement experience. Furthermore, reassurance was also provided to team member participants that confidentiality would be maintained and that their responses to individual interviews would not be identifiable or repeated to others in the team, therefore encouraging team members of the case study site to express their views in an uninhibited way.

As stated above, the concept of equal access denotes that participants should also be involved in analysis of data. This was achieved for case study team member participants during a follow-up team visit in which findings were presented to team members present[66]. Focus group participants were also involved in commenting upon and reflecting upon findings from their cohort focus groups. However, due to time constraints student participants who recommended the case study site had completed their programmes of education before findings from the case study site could be presented to them. Therefore, constructions were fed back to a group of 2nd year mental health students who were not involved in the original focus groups[67]. Feedback received from these students was

[66] As specified in Section 5.4: Resonance of study findings, pg243
[67] As discussed in Section 5.4: Resonance of study findings, pg243.

insightful and students were able to recognise experiences highlighted in the data as being present in their socialisation in compassionate mental health practice. However, it is acknowledged that as students who nominated the placement and engaged in individual interviews prior to case study observation were not able to consider and comment on case study findings, equal access was not achieved for all participants in this study.

Enhanced awareness of the positions of self/own group and enhanced awareness of the position/views of others

Enhanced awareness of the position of self/own group criteria relates to Guba and Lincoln's (1989, 1994) original principle of ontological authenticity (Nolan et al, 2003; Wilson and Clissett, 2011). This is the degree to which participant awareness and understanding of the complex constructs underpinning the phenomena under investigation is enriched. It specifically relates to increased stakeholder understanding of the role of self of in the phenomena under investigation and the development of new insights in relation to this (Rodwell, 1998). This in turn leads to increased understanding of the role of others in the phenomena, therefore contributing to enhanced awareness of the position/views of others.

Enhanced awareness of the position/views of others relates to Guba and Lincoln's (1989; 1994) original principle of educative authenticity (Nolan et al, 2003; Wilson and Clissett, 2011). This principle considers whether participants experience increased understanding of the views and values of other stakeholders (Rodwell, 1998). This does not necessarily mean that participants agree with the views and values of others but rather that *"sympathy"* for these was developed (Rodwell, 1998 pg109). In addition to increased understanding of others, participants should also develop increased understanding of the factors that may result in the alternative views of others (Rodwell, 1998).

Student focus group participants gained enhanced awareness of both their own perspectives and the perspectives of others by taking part in the focus groups. As identified in 4.5: Student participant reflections on the focus groups, some participants identified that they developed greater conscious awareness of their experiences of positive socialisation in compassionate practice as a result of participation their participation in the focus groups. Some students were also able to acknowledge some of the factors that contributed to negative socialisation in compassionate practice and although they did not condone the

non-compassionate practice experienced, they demonstrated some sympathy and empathy for those staff members who did not always demonstrate compassionate practice[68], therefore demonstrating enhanced awareness of the position of others.

In addition, focus group participants indicated that they found the cathartic and reflective nature of the focus groups beneficial[69]. A number of participants identified that they valued the sense of shared experience. This was especially apparent when discussing negative experiences of socialisation in compassionate mental health practice. Participants stated that they felt reassured that it was not just them that had been exposed to negative experiences. This was also the case during the discussion of all findings with the 2nd year mental health nursing student group[70]. Furthermore, some of these students were able to identify with the experience of 'closing down' as a form of self-protection and demonstrated relief that they were not the only ones to have such experiences. Therefore, some focus groups participants achieved enhanced awareness of the position of self/their own group by engaging in the study.

When facilitating focus groups student participants asked for the facilitator's opinion based on experience as a mental health nurse, a previous student mentor and as an academic. It is possible that sharing of views, opinions and experiences of the constraints and challenges in the practice context could have enhanced student awareness of some of the barriers to compassionate practice. The aim of the sharing of these experiences was to engage in the principle of mutual collaboration to increase understanding of student experiences and perceptions and aid interpretation of the data, as consistent with constructivism (Rodwell, 1998). The co-collaboration approach therefore served to enhance researcher awareness of position of mental health nursing students. Furthermore, this approach supported researcher reflexivity (McCabe and Holmes, 2009), as it resulted in reflection and consideration of my role as an academic and the potential impact that I may have upon facilitating consistency between theory and practice and working to minimise the sense of guilt and blame that some academics may project on to students when they feel unable to

[68] As presented in 4.5: Student participant reflection on the focus groups, pg195.
[69] As presented in 4.5: Student participant reflection on the focus groups, pg195.
[70] As presented in 5.4: Resonance of study findings – pg242.

engage in compassionate practice[71]. Therefore, I also achieved enhanced awareness of the position of myself through engagement in this part of the study.

As identified in 4.5: Student participant reflections on the focus groups, some students reported experiencing benefit from engaging in the focus groups, identifying that they assisted them to develop understanding of themselves and others. It was suggested that all mental health students would benefit from similar placement de-briefing sessions facilitated by academics, and that these should be an established part of student mental health nurse programme of education going forward.

Team member participants from the case study phase also appeared to find value in taking time to reflect upon their experiences, roles and impact on student development. Participants demonstrated the ability to consider student perspectives through the individual interviews conducted; as contact with them was limited, they did not develop knowledge of the views of others as student participants did by engaging in the focus groups. However, during presentation of the preliminary findings to the team, they were able to consider and discuss the experiences of students in the team and experiences of other team members. They also reflected on their experiences of working in less compassionate care environments prior to commencing work with the case study team.

A further limitation should be highlighted in relation to power dynamics. The role of the researcher as both personal tutor to some students and programme leader for all students could be an issue. Whilst steps were taken to mitigate against this, the potential for some tensions to arise is acknowledged.

[71]See 4.3: Everyone for themselves, Billy no mates and feelings of isolation – pg179.

Encouraging action by provision of rationale for an impetus for change and enabling action by providing the means to achieve (or begin to achieve) change

Encouraging action by provision of rationale for an impetus for change relates to Guba and Lincoln's (1989, 1994) original principle of catalytic authenticity (Nolan et al, 2003; Wilson and Clissett, 2011). This principle states that the creation of enhanced understanding and new knowledge is inadequate for a constructivist inquiry (Rodwell, 1998). To meet this principle, the research must also evoke action for change (Rodwell, 1998).

Enabling action by providing the means to achieve change relates to Guba and Lincoln's (1989, 1994) original principle of tactical authenticity (Nolan et al, 2003; Wilson and Clissett, 2011). This principle means that any change that is evoked as a result of the research should be effective for the purpose of key stakeholders. It is recognised that these principles of authenticity are often not met by the end of a research project but that efforts should be made to ensure that they are met later (Rodwell, 1998).

Both rationale and impetus for this study are specified in Chapter One. Data were uncovered in student focus groups relating to some of the negative exposures that students had experienced in practice; this provided additional motivation for developing understanding and insights into how placement providers can facilitate positive socialisation in compassionate mental health nursing practice. Indeed, a strength of the study was responsiveness to the emergent data (Charmaz, 2014). The findings of this research will provide a useful framework for students, practice supervisors and assessors (previously mentors), placement area team members and managers, the wider organisation, nursing educators, policy makers and government, to better understand the complex factors underpinning socialisation in compassionate practice. Furthermore, placement providers (including the wider organisation) can begin to explore ways in which to create and sustain compassion enriched care environments that can support socialisation in compassionate practice. However, it is acknowledged that this is yet to take place and is rather a future aspiration of the research.

Furthermore, there is a commitment to making the results of the research widely available through article publications and conference presentations, based upon the research findings. The aim of this will be to enhance greater awareness of the issues underpinning socialisation in compassionate mental health nursing practice and to encourage action to be taken to enhance socialisation. In addition to this, since the commencement of the study, the researcher has been made programme leader for BSc (Hons) Nursing (with NMC registration) for all fields of nursing practice. Therefore, there is also commitment to influence and promote change, both internally to the programme and to work collaboratively with external practice partners, to enhance student experiences during their educational journey.

Although there have been limitations to this study, efforts have been taken to enhance the study's authenticity and meaning. Having discussed the strengths and limitations of this study, interpretation and discussion of results is presented throughout the remainder of this chapter.

6.2: Interpreting the results

Interpretation and discussion of the findings is presented in this section. First of all, findings from student focus groups and individual interviews are considered against Curtis's (2015) New Grounded Theory of Student Nurse Socialisation in Compassionate Practice. The Senses Framework (Nolan et al, 2006) is also presented as a theoretical perspective in which understanding of the findings from this study is enhanced. Finally, the impact of leadership on a teams' ability to sustain the factors required to support positive student socialisation in compassionate mental health nursing practice is discussed.

6.2.1: The New Grounded Theory of Student Nurse Socialisation in Compassionate Practice (Curtis, 2015) and this study:

As stated in Chapter Four, Curtis's (2015) New Grounded Theory of Student Nurse Socialisation in Compassionate Practice was used as a sensitising framework to guide and categorise focus group data. Therefore, it is perhaps unsurprising that data from student focus group participants strongly resonated with key findings as presented by Curtis (2015). This section considers The New Grounded Theory of Student Nurse Socialisation in

Compassionate Practice[72] and key findings from Curtis's study (Curtis, Horton and Smith, 2012; Curtis, 2015). Similarities and differences between the findings of Curtis and this study are discussed under the following headings throughout the rest of this section. These headings have been taken from Curtis's (2015) theory:

- Practice based interactions
- The reality of practice
- Emotional labour
- Dissonance
- Balancing future intentions

Practice based interactions:

Curtis (Curtis, Horton and Smith, 2012; Curtis, 2015) recognised that students derived meaning from their personal life, from theoretical influences and from practice-based interactions. It is of note that although participants in this study spoke of the impact of personal and theoretical experiences on their socialisation in compassion, they were able to draw upon practice experiences with greater ease to illustrate their socialisation in compassionate mental health nursing practice. As discussed previously, this resulted in a change of direction for the research, from exploring the whole praxis of socialisation in compassion, to specific exploration about the impact of practice experiences.

Figure 4.2[73] illustrates how students derived meaning from their practice experiences. Student experience of authentic compassion demonstrated towards them by practice staff resulted in the internalisation of the value of compassion as a recipient. This, in combination with:

- support to minimise dissonance between theory and practice[74]
- immersion in a compassionate care philosophy,
- the role modelling of compassionate practice
- opportunities provided to engage in compassionate practice

[72] See Figure 2.4: A New Grounded Theory of Student Nurse Socialisation in Compassionate Practice developed by Curtis, 2015, pg247)–pg62.
[73] See Figure 4.2: The Ladder of Socialisation in Compassionate Mental Health Nursing Practice – pg145.
[74] Discussed in greater detail in Dissonance (below) – pg265.

resulted in students internalising the value of compassion as both a 'receiver' and a 'giver'.

Within the practice experience, there are similarities between experiences of students reported in Curtis's research and this study, that support the concept of socialisation in compassionate practice. One such example is that participants in Curtis's study recognised that compassion required nurses *"having time"* (Curtis, Horton and Smith, 2012, pg292). The focus of this was in relation to nurses having time to engage in empathic relationships with service users. The importance of investing time in staff - service user relationships was also identified as a facilitator of compassionate practice in this study, but participants also valued the time that practice staff invested in relationships with them as students. The investment of time to develop relationship with students underpinned many of the factors that resulted in students experiencing a sense of permission to practice compassionately.

There has been considerable research conducted focusing on the importance of mentor – student relationships and it is recognised that positive relationships enhance student feelings of value, belonging and confidence (Brown, 2005; Curtis, 2015), and aids socialisation as they are more likely to ask questions and seek out opportunities for development (Bradbury-Jones, Sambrook and Irvine, 2007; Bray and Nettleton, 2007; Smith, 2012). The positive impact of the mentor-student relationship upon socialisation in compassionate mental health nursing practice was apparent in both Curtis's (2015) study and this study. Indeed, as demonstrated in figure 4.2[75], authenticity in relationship with students, practice staff taking students *"under their wing",* and practice staff supporting student feelings of camaraderie, were foundational steps experienced by students in the socialisation process. These experiences helped to reduce the sense of vulnerability often experienced by students. It is confirmed that feelings of vulnerability and quality of mentorship experiences are interlinked (Curtis, 2015). The vulnerability expressed by students in this study relating to doing *"what you need to do to pass"*[76], in which some students reported mirroring the attitudes and actions of mentors to maximise the chance of a positive assessment, reflect findings of other studies in which students reported

[75] Figure 4.2: The Ladder of Socialisation in Compassionate Mental Health Nursing Practice – pg145.
[76] See 4.3: Everyone for themselves – pg171.

prioritising developing a positive relationship with their mentor to enable positive assessment (Allan, Smith and O'Driscoll, 2011; Curtis, 2015). Unfortunately, this was a reality of surviving some placement experiences for some. This therefore further illustrates the impact of the power differential experienced by students in practice. Given this is not an uncommon experience, it perhaps should be explored in practice assessor (mentorship) preparation, to ensure that practice staff are aware of their influence on student engagement in compassionate care. The experience of the realities of practice is further discussed in the following section.

The reality of practice:

Curtis (2015) identifies that student exposure to the reality of practice has a significant impact upon their socialisation in compassionate practice. *"The McDonaldisation of nursing"* (Curtis, Horton and Smith, 2012, pg792; Curtis, 2015, pg244) was found to have a negative impact upon student feelings of vulnerability and ultimate socialisation in compassionate practice in Curtis's research (Curtis, Horton and Smith, 2012; Curtis, 2015). McDonaldisation in nursing refers to the interpersonal aspects of nursing care being limited in favour of efficiency, calculability, predictability and control (Austin, 2007) and results in imposed targets, task-orientated care activities and engagement in de-humanising practices (Curtis, Horton and Smith, 2012; Curtis, 2015). Student participants in this study reported exposure to similar experiences in placements which were viewed as having a negative impact upon their socialisation in compassionate practice[77]. In Chapter One – Background[78], it was suggested that differences in systemic challenges and the physical, psychological and emotional demands that occur within mental health nursing could mean that the factors underpinning socialisation in compassionate mental health nursing are potentially unique to the field of practice. However, although the roles of adult nurses and mental health nurses are undoubtedly different in many ways, the similarities between findings from Curtis's research (which focused on Adult field of practice nursing students) and this research (which focused on mental health field of practice nursing students) would suggest that many of the same challenges and barriers to compassionate care are present in both fields of practice. By extension, these barriers could be prominent in Child and Learning Disabilities nursing

[77] See Chapter Four – 4.3: Everyone for themselves, Prioritising the metrics – pg184
[78] See Chapter One –1.0: Background and rationale for the study – pg16.

fields of practice; additional research would need to be undertaken to identify similarities of experiences that impact socialisation in compassionate practice for students from all four fields of nursing practice.

A further reality of practice identified by participants in Curtis's (2015) study was that of emotional labour. Emotional labour is discussed in the context of this study in the following section.

Emotional labour:

The emotional labour of compassion is recognised as a key theoretical concept in Curtis's research (Curtis, Horton and Smith, 2012). In this study, student participants discussed the emotional labour of compassion at some length. The emotional labour associated with providing compassionate care was particularly recognised when students were exposed to compassion impoverished areas, in which they felt unsupported and in which staff lacked a shared philosophy of compassionate care. Students recognised that exposure to working with challenging behaviours that occur within the mental health field of practice (violence and aggression, self-harm and suicidality)[79] and lack of emotional support in managing these resulted in feelings of being physically and psychologically unsafe within the practice environment. Intensification of these feelings led to students prioritising their own security needs in an attempt to 'survive' the realities of practice and protect themselves against fatigue and burnout. This suggests that despite calls over the years for student mental health nurses to be better prepared for practice (Wynaden et al, 2000; van Rensburg, 2019), current preparation is either not enough to prepare students for the realities of mental health nursing practice or that preparation has not met changing needs. However, students need to be better prepared for some of the challenging behaviours that they may encounter within the practice context. Students should also be able to access practice supervision and team de-briefing to enhance their understanding and feelings of support and safety when exposed to such challenges.

[79] See 4.3: Everyone for themselves: Having the compassion knocked out of you – pg187.

Students in this study also experienced the emotional labour of practice staff projection of negative feelings, dissatisfaction, fatigue and burnout[80]. Students reported feeling unable to deal with the added emotional burden of practice staff negativity and this was a contributor to the student experience of 'closing down' to opportunities of compassion. This highlights the need for practice staff education regarding the impact of implicit and explicit role modelling of attitudes and behaviours to students, and the influence that this can have on student socialisation in mental health nursing practice.

Dissonance between professional ideals and exposure to the reality of practice during student nurse programme of study, which is underpinned by interactions between personal, practice and university-based experiences, was recognised in Curtis's (Curtis, Horton and Smith, 2012; Curtis, 2015) study. In this study is has been corroborated that university-based experiences and practice experiences were often at odds. The impact of this on socialisation in compassionate practice is discussed in the following section – Dissonance.

Dissonance:

Curtis (2015) found that students commonly experienced dissonance between their professional ideals, the gold standard of nursing care as taught in the classroom context, and the realities of practice. Despite well-established recognition of the negative impact of dissonance between theory and practice and the need to close the bridge the theory-practice gap (Rolfe, 2002; Monaghan, 2015; Curtis, 2015), students continue to experience dissonance between the theoretical and practice components of their programme of study (Greenway, Butt and Walthall, 2019; Shoghi et al, 2019). It is suggested that this is due to the theory-practice gap being a complex issue which is not yet fully understood (Shoghi et al, 2019). This therefore demonstrates the need for additional research to be conducted to increase understanding and contribute to greater student experience of consistency between theory, practice and student professional ideals.

This study reflected Curtis's findings, identifying experiences of continuity between theory and practice as having a positive impact upon student socialisation in compassionate mental

[80] See 4.3: Everyone for themselves: Having the compassion knocked out of you – pg187.

health nursing practice[81]. However, student experiences of dissonance between theory and practice and reduced opportunity to engage in professional ideals[82] inhibited socialisation in compassionate mental health nursing practice.

It was of note that student participants in this study stated that they did not recognise the importance or relevance of the theoretical aspect of their programme on their socialisation in compassionate practice. Students' having a lack of recognition of the positive impact of theory on their development is not a new phenomenon (Brown, 2005). However, although some participants explicitly stated that theory had no impact, there were times throughout the data in which participants both implicitly and explicitly acknowledged the importance of theory and the impact of theory on compassionate practice, therefore highlighting the impact that the theory can have on socialisation in compassionate mental health nursing practice.

An interesting issue raised in this research was that students experienced feelings of inadequacy which were re-enforced by some practice staff and academic staff[83]. In addition to feeling blamed by practice partners and academics for lack of compassionate practice, students also identified that some academics did not adequately support them to understand how they could put compassion as theorised into practice. This resulted in students experiencing the sense that unrealistic expectations were placed on them from both practice partners and teachers. The data therefore suggests that being told to be compassionate is not sufficient. Students need to be supported in developing practical, compassion enhancing techniques and in understanding how theory in relation to compassion might be applied in practice.

Some student participants recognised that access to supervision and reflection in the practice context was beneficial in supporting continuity between theory and practice. Students and practice staff recognised the value of student engagement in reflection in

[81] See 4.2: All in this together, Continuity of theory into practice – pg159.
[82] See 4.3: Everyone for themselves, Pie in the Sky – pg181.
[83] See 4.3: Everyone for themselves, Billy no mates and feelings of isolation – pg179.

reducing the experience of dissonance between theory and practice[84]. However, teaching strategies identified in the literature review utilised many different modes of reflection to support students to develop compassion. As a starting point reflection could be effectively incorporated in to practice de-briefing sessions which could be included in the theoretical component of the programme. This would not only offer an additional layer of support and reflection time (Farrington et al, 2019) for students but could also help to enhance academic staff understanding of student perspectives, experiences and the realities of contemporary practice. Formal practice-peer de-briefing sessions facilitated by academics within the University context might also be used to assist students to identify and reaffirm where they have done well or acknowledge where they have tried their best in challenging practice circumstances. Swartz rounds (Farr and Barker, 2017) could provide a model for this. An advantage of using this model would be that it would also encourage and prepare student to engage in Swartz rounds in the practice context. Engaging students in this could reduce the sense of unrealistic expectations being placed on students and assist in a greater sense of continuity between theory and practice.

Curtis (Curtis, Horton and Smith, 2012; Curtis, 2015) recognised that theoretical and practice exposures resulted in students attempting to balance their professional ideals against survival in the practice context and this is discussed in the context of this study in the following section.

Balancing future intentions:

As in Curtis's work (Curtis, Horton and Smith, 2012; Curtis 2015), student participants in this study also spoke of balancing their compassionate ideals against their future intentions. However, this was discussed in relation to exposure to compassion impoverished care contexts and was not seen in compassion enriched placement environments. Student participants spoke at length about practice situations which resulted in them focusing on self-achievement. The prioritisation of self-achievement over compassionate care in a placement was justified by feelings of insignificance in the role as student nurse. Some

[84] See 5.1: Characteristics of the team, The physical environment – pg206 and 5.3: It makes us what we are, We're all on the same page – pg226..

participants stated that they felt that they could delay engagement in compassionate care until they were registrants and felt they might be in a more powerful position to be able to enact compassionate care[85]. There is a key difference between the findings of this study and that of Curtis. Participants in Curtis's (2015) study felt that they had more opportunity to engage in compassionate care in their role as students due to recognised constraints of the demands of registered nurses (Curtis, Horton and Smith, 2012). However, although students in this study expressed difference in beliefs about future opportunities for engagement in compassionate care than participants in Curtis's study, it is of note that they too identified time, organisational pressures and fear of litigation as potential barriers to their engagement as future compassionate mental health nurses. This reflects perceived barriers identified in Curtis's (2015) study.

As identified in 4.4: The many shades of grey, students reported experiencing inconsistency, both between placement experiences and within placement experiences, in relation to factors that influenced their socialisation in compassionate care. It was identified that the balance of experiences had to weigh in favour of predominantly enriching placements (Brown, 2005) for positive socialisation in compassionate practice to be sustained. Where this did not occur, future intentions became the priority over current professional ideals. Ideally, students should be exposed to a full range of compassion enriched placements throughout their programme of education. However, as apparent in this research, this is not the current reality of practice. As such, students need to be equipped with better tools to manage the inconsistencies and limit the impact of compassion impoverished experiences on their socialisation. This further supports the introduction of practice de-briefing sessions being facilitated by academics within the university context as presented previously.

Summary:

The findings of this study echo findings from Curtis' (2015) New Grounded Theory of Student Nurse Socialisation in Compassionate Practice. It is acknowledged that although students from the different fields of nursing practice (Adult, Child, Learning Disabilities and Mental Health) may have differing practice exposures in terms of their care roles and expertise, experiences of socialisation in compassionate practice are not necessarily

[85] See 4.3: Everyone for themselves, Doing what I need to do to pass – pg189.

dependent on field of practice. Indeed, despite the differences between Adult and Mental Health nursing care, it is apparent that students derive similar meanings from the differing care experiences they have, which have a direct impact upon their socialisation in compassionate practice. It would be reasonable to suggest that this would also be the case for Child and Learning Disabilities student nurses', but further research should be conducted into these fields of nursing practice to increase understanding of the factors that influence socialisation in compassionate care.

Curtis (2015) provides useful recommendations for enhancing student socialisation within practice environments. However, this research has taken the next step in exploring the factors that are present in a compassion enriched placement environment, which sustain a teams' ability to support positive socialisation in compassionate mental health nursing practice. The following section utilises The Senses Framework (Nolan et al, 2006) as a theoretical perspective in which understanding of the findings in relation to this are enhanced.

6.2.2: The "Senses" – A framework to assist understanding of student nurse socialisation in compassionate practice

Although not conceptualised in relation to compassion, The Senses Framework was developed by Mike Nolan based on his experiences, both as a mental health practitioner working with older people and as a researcher. He was at the time, working as a Charge Nurse in a day hospital and noted how staff struggled to develop care goals where patients deteriorated slowly over time and cure was not an option. The Senses Framework was developed with the overall aim of improving older persons' care and the experience of staff caring for them (Nolan et al, 2006).

The link between the care environment in which the Senses Framework was developed and that of the case study site as an older persons' community care specialty team stimulated a consideration of the framework. The Senses Framework was developed following extensive research in older persons' care environments and introduced the concept of enriched and impoverished care environments. Nolan et al (2006) argued that care environments that were enriched for staff were also enriched for patients and family carers and introduced the

idea of relationship centred care in older persons-care. This was reflected in this study in which it was found that when staff worked in compassion enriched environments, their capacity to engage in compassionate interactions with students and service users was enhanced.

In the original Senses Framework, Nolan et al (2002) set out six *"Senses"* that were recognised by staff, older people and their carers as being present in an enriched care environment. Research conducted by Brown (2005) expanded the scope of the original Senses Framework, exploring the impact (positive and negative) of the *"Senses"* on the experiences of student nurses, and using the *"Senses"* to further understand core components of enriched and impoverished care environments. The six *"Senses"* created are applicable to staff, students, older people and their carers, although each *"Sense"* is contextual and created through differing factors for each group in the practice context.

The six *"Senses"* are:

- Security
- Belonging
- Continuity
- Purpose
- Achievement
- Significance

Appendix 33: The *"Senses*" according to Nolan et al (2006), is taken from the work of Nolan et al (2006) and specifies how each *"Sense"* was achieved in enriched older persons care practice environments, both for student nurses in the adult field of practice and for practice staff.

As stated above, The Senses Framework was created to enable staff working with the older person client group to develop clear care goals. One might therefore expect that there could be some alignment between the data from the case study site (an older persons' care specialty team) and the framework. In fact, some student participants in this study stated that they felt it was easier to engage in compassionate practice in older persons' care

environments[86]. However, this discussion was in relation to diagnoses and a service user demographic that they perceived as being easier to engage compassionately with. It was also reflective of student beliefs relating to deservingness of compassion (Goetz, Keltner and Simon-Thomas, 2010) for the service group.

In addition to The Senses underpinning relationships that led to enriched older peoples' care, the framework has also been effectively applied in mental health care contexts. Orr, Elliot and Barbour (2014) found that The Senses were beneficial for understanding and making improvements to relationship centred approaches to care in an adult drug service. It is evident then that the Senses Framework is transferable to a range of care settings and experiences. As compassionate engagement is underpinned by relationships (van der Cingel, 2009; Dewar, 2013; Pehlivan and Guner, 2019)[87] and participants in both phases of the research implicitly and explicitly discussed the impact of relationships on socialisation in compassionate practice, it is not surprising that data were well aligned to The Senses Framework.

It is of note that student participants in focus groups, and student and staff member participants from the case study site, spontaneously identified the importance of a number of The Senses and the impact they had on socialisation in compassionate practice (the need to feel safe and belong for example). Through the data analysis process, it became more apparent that participant responses resonated with The Senses Framework. However, many of the experiences underpinning each Sense in relation to socialisation in compassionate practice were different from the experiences of staff and students in the original research. Students spoke of the impact of:

- feeling safe (security),
- feeling accepted and included (belonging),
- the importance of links being made between theory and practice and consistency of relationships in practice (continuity),
- exposure to a shared team philosophy of compassionate care (purpose),

[86] See 4.2: All in it together, Permission to practice compassionately – pg168.
[87] See 2.2.3: The scope of compassionate nursing practice – pg51.

- being supported to feel that they could make a positive difference (significance)
- receiving positive feedback about compassionate interactions from practice staff and service users (achievement).

Likewise, the factors identified by practice staff as creating and sustaining the teams' ability to effectively socialise students in compassionate practice can also be seen through the lens of The Senses Framework. This included practice staff experiencing:

- feeling safe in a stable team environment (security),
- team cohesion (belonging),
- shared team philosophy of compassionate care (purpose),
- support to access appropriate mentorship training (continuity and achievement)
- the value placed on the role of student mentor by the team leader and wider team (significance).

As such, The Senses provide a useful framework in which to increase understanding of the experiences that enhance student socialisation in compassionate practice. The Senses Framework can also increase understanding of individual, team, leadership and organisational factors that support placement areas to sustain compassionate practice.

In addition, this study adds to the identification of characteristics of enriched care environments as identified by Brown (2005). Compassion is implicitly identified within "*Senses"* enriched care environments, but this study has made it explicit that student experience of compassion is a central feature in these environments. One could argue that enriched care environments are compassionate care environments. As such, this denotes that The Senses need to be experienced by students and practice staff to engage in compassionate care and sustain the factors that support socialisation in compassionate mental health nursing practice.

Appendix 34[88], merges content of the socialisation enhanced columns of table 4.1 (Chapter Four) and table 5.4 (Chapter Five) and aligns each of the factors identified as fostering compassionate care against each of The Senses. This could be used to develop awareness and understanding of the factors that support socialisation in compassionate practice and provide a platform for placement areas/organisations to consider how they could ensure these factors are present in future placement experiences.

Furthermore, Appendix 35[89], demonstrates alignment of each of the factors identified as inhibiting socialisation in compassion, in compassion impoverished care placement environments from table 4.2 (Chapter Four) against each of The Senses. This could be used for placements to review the factors that inhibit compassionate practice in a compassion impoverished placement area.

Appendix 36:[90] presents content from table 5.5 (Chapter Five), aligned to each of the Senses. This could be used by practice for teams/organisations to consider the how they can strengthen the factors required to socialise students in compassionate practice, and work towards ensuring that the future nursing work force is socialised in compassionate mental health nursing practice.

Appendices 34, 35 and 36, provide useful and digestible information for placement providers to consider the impact of practice experiences on student nurse socialisation in compassionate practice. However, it would be naive and unrealistic to expect practice partners to rapidly implement the changes and improvements required in all placement experiences to facilitate wider socialisation in compassion practice. As identified in Chapter Five, compassion enriched care environments are complex and difficult to develop and sustain. The fragility of compassion enriched environments was highlighted in the data[91]. Further work should be conducted to develop understanding of how compassion enriched teams could be sustained over a period of time. Additionally, the implementation or

[88] See Appendix 34: The application of the Senses to the factors that enhance socialisation in compassionate practice and are present in a compassion enriched placement experience – pg415.
[89] See Appendix 35: The factors that inhibit socialisation in compassionate practice and are present in a compassion impoverished placement experience and the impact on inhibition of the Senses – pg419.
[90] See Appendix 36: The factors that facilitate the placements' capacity to positively socialise student mental health nurses in compassionate practice and the application of each factor to The Senses Framework – pg422.
[91] See 5.3: It makes us what we are, Composition of the team – pg223.

provision of many of the facilitating factors to enhance socialisation in compassionate practice would require practice areas to engage in a cultural shift to support change of practice staff attitudes and working practices. This often takes considerable time to establish (Chambers and Ryder, 2012). However, this study could provide impetus for investing in the cultural shift required. Actions for compassion and factors for practice partners to consider implementing to support the development of compassion enriched care environments have been identified.

Leadership has a significant role to play in culture change and creating and sustaining enriched cultures of care and was a significant theme in the findings of this study. As such, this will be further discussed throughout the following section.

6.2.3: The impact of leadership on the teams' ability to sustain factors required to support positive socialisation in compassionate practice

As explored in Chapter Five, 5.3: *"It makes us what we are",* effective team leadership was recognised as a fundamental facilitative element of the case study site teams' ability to create and sustain the factors that supported positive student socialisation in compassionate practice. As discussed above effective team leadership resulted in enhanced staff experiences of The Senses of Security, Purpose and Significance in their job role. It is suggested that for staff to deliver compassionate care (and therefore expose students to the factors that support socialisation in compassionate practice), they too need to work in a compassionate environment (McQueen, 2000 in Dewar, 2013; Gallagher, 2004 in Dewar, 2013; Finfgeld-Connett, 2008 in Dewar, 2013, Tierney et al, 2017). When practice staff experience effective leadership, they feel safe, cared for and respected, and this results in increased engagement in compassionate care (Smith, 2008; Youngson, 2008; Cooper, 2013; Shuldham, 2019). Indeed, in much the same way as students experience internalisation of the importance of compassion and greater capacity to engage in compassionate practice, practice staff also benefit from being a recipient of compassion through their daily work. This coupled with role modelling of compassionate engagement and philosophy by the team manager resulted in staff being consistently socialised in compassionate practice, and therefore having greater capacity to engage in compassionate relationships with students,

co-workers and service users. This in turn sustained the teams' ability to socialise students in compassionate practice.

There have been a number of research studies (Adamson et al, 2011; de Zulueta, 2015; Quinn, 2017; West and Chowla, 2017; Saab et al, 2019; Sloan, 2019) exploring the concept and impact of compassionate leadership over recent years, and as early as 2013 the Health Secretary and Chief of Nursing in England were calling for health care leaders to move away from prioritising targets and commercial interests, and instead focus on increasing compassionate leadership in health care (Brown, 2013). A fundamental component of compassionate leadership is the leaders' ability to establish and maintain positive and supportive working relationships based on collaboration, inclusion and mutual respect (Shuldham, 2019). West and Chowla (2017) identify four key characteristics of the compassionate leader which are underpinned by engagement in relationship with staff members: Attending, Understanding, Empathising and Helping.

Attending requires the compassionate leader to invest time in attentively listening to staff members, including listening to frustrations that staff may experience, to ensure that they have an appreciation for the challenges that team members face in their daily work (West and Chowla, 2017). Understanding builds on attending and is where the compassionate leader appraises the situation and tries to understand the viewpoint and experience of the staff member (West and Chowla, 2017). Empathising involves the compassionate leader recognising the feelings of the staff member, being emotionally available and able to tolerate expression of emotion, resulting in deeper understanding of the feelings of the staff member and the situation (West and Chowla, 2017). The final component (Helping) involves the compassionate leader taking thoughtful and emotionally intelligent action to help the staff member overcome the situation (West and Cholwa, 2017). Furthermore, it is identified that a compassionate leader should:

- set the direction of the team (Shuldham, 2019)
- contribute to safe clinical decision making (Foster, 2019)
- promote staff learning and development

- ensure that necessary resources are available (West and Chowla, 2017)
- set the tone of a team culture of compassionate care (Shuldham, 2019)
- create a professional environment in which a healthy workforce is recruited and retained (King-Jones, 2011)
- provide staff with regular feedback, including highlighting areas of good practice as well as identifying areas for improvement (Adamson et al, 2012)
- identify positive care practices and affirm them as part of the service vision (Adamson et al, 2011)
- provide opportunity for compassionate actions to be engaged in regularly (Adamson et al, 2011).

These aspects facilitate a working environment in which staff and students can flourish. It was evident from the data that the case study team manager embodied all of these qualities. Moreover, practice staff participants recognised that the team manager created a culture of support where there was an absence of fear and rebuke. Opportunities were created for staff support (the weekly team meeting) and the team manager actively engaged in staff support by contributing to clinical decision making, therefore enhancing staff feelings of safety within the practice context. She demonstrated enhanced awareness of the challenges faced by team members due to her own previous clinical experience, but also by attentively listening and developing understanding of experiences encountered, resulting in proactive practices emerging to support team members. The team manager was also willing to invest in the team by ensuring that staff accessed relevant training and continual professional development relating to their roles as student mentors. This served to ensure that staff felt confident and prepared in their role as mentor. It also role modelled the perceived value of student nurses and increased staff feelings of significance in their role of practice educator. Practice staff therefore felt supported to flourish and develop in their roles. Furthermore, the team manager ensured students had access to an office computer which was specifically for student use. This not only reiterated that students were valued and welcome within the team context but also supported staff in their role as educators, by ensuring that students could access equipment to enhance learning opportunities within the team.

Case study participants also identified that that the team manager acted as a buffer between them and the demands of the wider organisation, further enhancing team members feeling of being cared for, supported and safe. West and Chowla (2017) recognise that a key role of the compassionate leader is to act as a buffer in this way to enhance staff support. Although case study participants did not recognise the wider organisation as supporting the sustainment of factors that resulted in positive student socialisation in compassionate practice, it is recognised that the organisation in which health care is delivered can either support or hinder compassionate nursing practice. Indeed, it is acknowledged that the process of compassionate care is not an individual experience and that the wider organisation should invest in creating a compassionate culture (Parker, 2002; Dewar, 2013, de Zulueta, 2015). Where the wider organisation fails to provide conditions for compassionate practice, compassionate enriched care environments may still exist, but this is created by individual managers' strong leadership skills, rather than being a consequence of the impact of the wider organisation (Whitby, 2015). It is further suggested that if health care organisations want to create the conditions in which compassionate care can thrive, investment should be made to reduce workloads and increase staff numbers (Whitby, 2015).

It has been established that students are exposed to compassion impoverished care environments throughout their programme of study, and as such it is important that health care organisations consider the impact of organisational demands (Barron, Deery and Sloan, 2017), and weak organisational leadership which is dominated by punitiveness, blame and task orientation (Patterson et al,2011; in Dewar, 2013). As suggested by Youngson (2008, in Dewar, 2013[92]), organisations should invest in developing action plans for creating and sustaining compassion enriched health care provision. However, these action plans would require insightful acknowledgement of the organisations role in fostering or inhibiting compassionate practice environments, authentic follow through, and role modelling by the wider organisation. A risk of tokenistic application of such action plans is that organisation staff members and student nurses may perceive the organisation as inauthentic. In turn, this

[92] See 2.2.3: The scope of compassion in nursing practice – pg51.

could heighten feelings of discontinuity and being unsafe in the working environment, which would inhibit individual scope for engagement in compassionate practice.

If nurses of the future are to be socialised in compassionate practice, it is essential for health organisations to recognise their role in developing places of work that can support student socialisation in compassionate practice. A framework by which to identify the factors that create and sustain a placement areas' ability to socialise student nurses in compassionate practice would therefore be beneficial. This would enhance organisational, leadership and team member understanding about the factors required to support socialisation in compassionate practice, and the role that each can play in achieving positive socialisation.

As discussed above, The Senses Framework (Nolan et al, 2006), provides a useful framework by which to increase understanding of the factors underpinning socialisation in compassion. Furthermore, Sloan (2019) suggests that the presence of The Senses (Nolan et al, 2006) enables health care leaders to both build and sustain effective relationships with staff. As compassionate care is underpinned by relationships (von Dietz and Orb, 2000; van der Cingel, 2009; Dewar, 2013; Kneafsey et al, 2015; Perez-Bret, Alitisent and Rocafort, 2016; Pehlivan and Guner 2019), it is of no surprise that compassionate leadership is also underpinned by effective relationships. This further highlights the need for the facilitation of The Senses (Nolan et al, 2006) within the practice context. However, research on how relational leadership can be created, enhanced and sustained within the health care context is currently limited (Sloan, 2019).

6.3: The definition of compassion – revisited

A working definition of compassion based on the literature was developed and presented in chapter Two (2.2.4: Compassion: The meaning, origins and scope in nursing practice). The aim of developing a definition prior to data collection was to guide data collection by supporting the recognition of examples of compassion in the practice context. The definition, presented below, was based upon synthesis of literature reviewed prior to commencing data collection:

Compassion comprises of the identification of vulnerability or suffering in another. It is complex due to its subjectivity and may be visible through the demonstration of numerous qualities, attributes and values. It is underpinned by the nurses' interpersonal skills and the ability to engage in emotional connection. It is this emotional connection that leads to engagement in meaningful action generated towards the other, aiming to address the observed vulnerability or alleviate the identified suffering.

Findings presented in Chapter Four and Five are consistent with the definition developed above. Indeed, when discussing characteristics of compassionate staff, student participants identified staff recognition of both student and service user vulnerability and actions to reduce the identified vulnerabilities as a key indicator of compassion. Student participants recognised that compassion was visible through numerous staff qualities, attributes and values and that the practice staff who exemplified compassion had the ability to engage in appropriate interpersonal processes to develop relationships with students, service users and other staff members. It is of significance that when discussing compassionate nursing staff, student participants highlighted the importance of staff engaging in compassionate relationships with everyone that they worked with day-to-day (including students, team members, members of the interdisciplinary team and carers/family) and not solely towards service users. This however is not incorporated into the definition above. Furthermore, the findings illustrate the importance of authentic demonstration of qualities, attributes and values that exemplify compassionate practice, which was not included in the original definition. The definition below is an amended definition which incorporates these fundamental elements of compassionate mental health nursing practice and reflects the findings of this study:

*Compassionate mental health nursing comprises of the identification of vulnerability or suffering in another. It is complex due to its subjectivity and may be visible through the authentic demonstration of numerous qualities, attributes and values which are directed towards **all** within the care environment. Compassion in mental health nursing is underpinned by the nurses' interpersonal skills and the ability to engage in emotional connection. It is this emotional connection that leads to engagement in*

meaningful action generated towards the other, aiming to address the observed vulnerability or alleviate the identified suffering.

Now that a revised definition of compassion which is relevant to mental health nursing has been presented, the following section considers the contribution of this study to enhancing knowledge regarding student mental health nurse socialisation in compassionate mental health nursing practice.

6.4: The contribution of this study to theory

This section explores the contribution of this study to the enhancement of understanding of student nurse socialisation in compassionate practice and the socialisation experiences of mental health student nurses.

This research extends existing international literature where there is a dearth of research exploring student nurse socialisation in compassionate nursing practice. To my knowledge, this is the first empirical study both in the UK and globally that has researched student mental health nurse socialisation in compassionate mental health nursing practice. As such, this research enriches understanding and engagement with the lived experience of student mental health nurse experience of compassion and the factors that enhance and inhibit their ability to engage in compassionate mental health nursing practice. Furthermore, it has provided an important and unique insight into the factors that create and sustain a practice teams' ability to support student socialisation in compassionate mental health nursing practice.

The definition of compassion that was developed following synthesis of the literature and analysis of the findings, brings together key components of previous definitions[93], which are relevant to compassionate mental health nursing care including the identification of the complexity of compassion (Curtis, 2015) and the notion that compassionate care is underpinned by interpersonal skills and the ability of the nurse to enter in to relationships with service users (Dewar, 2011). The definition reinforces that compassion may be a result

[93] As presented in 2.2.1: The meaning of compassion -pg40 and 2.2.3: The scope of compassion in nursing practice - pg51.

of the identification of vulnerability rather than purely a result of witnessing suffering (Dewar, 2011). The amended definition highlights compassionate interactions in practice environments transcend the relationship between staff member and service user and actually includes relationships with all within the care environment. The amended definition also recognises the importance of authentic demonstration of the qualities, attributes and values that underpin compassionate practice.

In addition to providing a definition for compassion in mental health nursing practice, the findings of this research suggest that compassion breeds compassion and that for students and staff to maintain and demonstrate their compassionate ideals, practice environments must cultivate the environmental conditions (The Senses, Nolan et al, 2003) to support the development and sustainment of compassion enriched care environments. Indeed, the responsibility of wider mental health service provision in supporting the conditions that are required to cultivate and sustain compassion enriched mental health care environments is highlighted. In combination, the definition of compassion in mental health nursing care and the identified associated conditions, provide greater clarity of compassion as applied to mental health nursing care.

The findings presented in Chapter Four, have also corroborated research cited in Chapter Two in which it is suggested that compassionate appraisals underpin compassionate practice and that compassion is only demonstrated to those viewed as being deserving of compassion (Goetz, Keltner and Simon-Thomas, 2010). Indeed, findings presented in 4.3: Everyone for themselves – Prioritising the metrics; demonstrate that students are exposed to staff stigmatisation of certain service users due to presentation of challenging behaviours or symptoms associated with specific mental health diagnoses (Emotionally Unstable Personality Disorder/ Borderline Personality Disorder). The stigma that is projected onto these service users resulted in decisions about deservingness for compassion and also resulted in justification of care lacking in compassion demonstrated towards the group. This research has therefore contributed to increased identification of those mental health service users who may be at increased risk of experiencing care that is lacking in compassion. Furthermore, the study has identified that students are at an increased risk of mirroring staff beliefs and behaviour and internalising care lacking in compassion as a norm

of mental health care, therefore potentially perpetuating mental health care that lacks compassion. With this knowledge, educational strategies could be adopted to challenge some of the beliefs regarding deservingness and stigma directed towards specific mental health disorders, symptoms and presentations. The aim of such strategies should be to challenge the stigma and discrimination present in mental health services to mitigate student exposure to these experiences in practice.

As identified in Chapter Two – Literature review[94], several reflective teaching strategies have been previously developed to enhance compassionate practice (Leffers and Martins, 2004; Dewar and MacKay, 2010; Winch et al, 2014; Adamson and Dewar, 2015; Jack and Tetley, 2016; Waugh and Donaldson, 2016; Hofmeyer et al, 2018; Pettit et al, 2019). Findings of this research suggests that developing a model of compassionate reflection which is based on The Senses and utilises The Ladder of Socialisation in Compassionate Mental Health Nursing Practice, which encourages students to reflect upon specific thoughts underpinning the compassionate appraisals[95] would be beneficial in students developing compassionate thinking. This will assist students to challenge their own values, socio-cultural beliefs and decisions about compassionate engagement in practice (Farrington et al, 2019), as well as supporting them to recognise the stigma and discrimination aimed towards some service user diagnosis that may otherwise be accepted as the norm. Findings also suggest that compassionate reflection should also be engaged in to further develop knowledge and understanding of the psychological processes underpinning compassionate practice and increase student awareness of compassionate appraisals and the concept of deservingness (van der Cingel, 2009; Goetz, Kiltner and Simon-Thomas, 2010) which as discussed above is relevant to mental health nursing care.

In addition, the research has contributed to increased clarity about the scope of compassionate mental health nursing practice, identifying actions and attributes of compassionate mental health nurses, as reported by student mental health nurses.

[94] See 2.3.2: The impact of theoretical nurse education on socialisation in compassionate practice – pg62 and Appendix 5: Strategies to develop/teach compassion discovered in the literature -pg344.
[95] Refer back 2.2.2: The origins of compassion, Evolutionary theory and compassion – pg43 and Figure 2.3: Appraisal processes underpinning the decision to engage compassionately with another (amended from Goetz, Keltner and Simon-Thomas, 2010, pg356) – pg47.

Furthermore, the study has highlighted that student nurse socialisation in compassionate mental health nursing practice is influenced not only by relationships that staff engage in with service users but also through relationships with other members of the immediate and wider care team and through relationships that staff engage in with students themselves.

The thesis provides a new model of socialisation in compassionate practice that encompasses individual, organisational, cultural and temporal components and provides authentic and practical applications to both nurse education and mental health nursing. It links to and further develops the New Grounded Theory of Student Nurse Socialisation in Compassionate Practice (Curtis, 2015) and The Senses Framework (Nolan et al, 2006). Thus, this thesis offers a unique theoretical lens through which student mental health nurse socialisation in compassionate mental health practice can be illuminated.

The depiction of socialisation in compassionate nursing practice in which students experience an opening up to compassion in compassion enriched practice environments and a closing down to compassion in compassion impoverished practice environments provides important insight into factors that foster and inhibit compassionate practice. The theoretical foundations of the model have been derived from and are grounded in the data. The adoption of an emic perspective enabled the sociocultural contexts and experiences of student mental health nurses to be articulated from their own perspective, therefore providing greater validity to the study's findings.

Now that the contributions of this study have been discussed, the Chapter closes with a summary.

6.5: Discussion summary

The focus group findings of this study strongly echo Curtis' (2015) New Grounded Theory of Student Nurse Socialisation in Compassionate Practice. However, this study has further considered the factors present in a compassion enriched practice environment which support the sustainment of a teams' ability to positively socialise students in compassionate mental health nursing practice. The Senses Framework (Nolan et al, 2006) has been presented as a theoretical framework which can increase understanding of the factors

underpinning socialisation in compassionate practice within the practice context. Increased understanding of this could prove beneficial in practice areas and the wider organisation, as it facilitates both to acknowledge and identify their roles in supporting student and staff socialisation in compassionate nursing practice. Furthermore, the impact of leadership on the teams' ability to sustain the factors required to support positive socialisation has also been discussed. Finally, the contributions of this study have been presented.

The following chapter, Chapter Seven – Conclusion and recommendations, concludes the thesis, offering a summary of the research and consideration of whether key research questions have been answered. Recommendations for future practice and research are made. Finally, a reflection of the research process is presented.

Chapter Seven: Conclusion and recommendations

7.0: Introduction to the chapter

This thesis has provided insight into the factors that foster and inhibit student mental health nurse socialisation in compassionate practice within the practice component of their programme of study. Furthermore, the conditions required to create and sustain a practice placement teams' ability to foster socialisation in compassionate practice have been presented and explored.

Therefore, the aims of this chapter are to:

i. discuss the extent to which the original research questions have been answered
ii. to outline the implications of the study and make recommendations for future research and practice
iii. reflect upon the research process.

7.1: Addressing the research questions

In Chapter One, the aims of the research were stated, and three research questions were posed:

- What are the experiences of compassion for student mental health nurses?
- What are the factors in practice placements that influence student mental health nurses in their development as compassionate mental health nurse practitioners?

And;

- How can placement providers facilitate positive socialisation in compassionate mental health nursing practice for mental health nursing students?

Chapter four explored the findings of student mental health nurse participant focus groups in which they identified and discussed experiences in the practice context that had both fostered and inhibited their socialisation in compassionate mental health nursing practice.

Students reported numerous experiences that supported their socialisation in compassionate mental health nursing practice. All of these experiences were underpinned by practice staff willingness and ability to engage in positive relationships in the care context. These experiences resulted in students experiencing a journey of socialisation in compassionate practice in which they transitioned from 'recipient' of compassion to 'giver' of compassionate care. This journey is mapped out in figure 4.2: The Ladder of Socialisation in Compassionate Mental Health Nursing Practice[96]. When exposed to compassion enriched environments, students experienced an 'opening up' to compassion in which they were able to see beyond their own needs and opened up to the needs of others[97]. The 'opening up' resulted in increased opportunity and desire to engage in compassionate mental health nursing care.

However, students also reported placement experiences in which their socialisation in compassionate practice was inhibited in compassionate impoverished placement areas. These experiences resulted in students journeying though The Retrogress Ladder of Socialisation in Compassionate Mental Health Nursing Practice[98], in which they felt under threat and therefore engaged in self-protection as a means of survival through these negative experiences. In these instances, students experienced a 'closing down' to both opportunity and desire to engage in compassionate mental health nursing practice[99]. Some students mirrored the negative attitudes and practice witnessed in an attempt to increase their feelings of acceptance and belonging within the team. Repeated exposure to such environments resulted in some students internalising practice lacking in compassion as the norm of mental health nursing, and therefore replicating negative actions and attitudes in their established practice.

Chapter Five presented the findings from a single site case study that had been recommended by student participants as being a placement experience in which they'd had a positive socialisation in compassionate practice experience. Observations and individual interviews with case study site practice staff and students who recommended the

[96] Figure 4.2: The Ladder of Socialisation in Compassionate Mental Health Nursing Practice – pg145.
[97] As demonstrated in Figure 4.5: The 'opening up' to compassionate practice – pg199.
[98] Figure 4.3: The Retrogress Ladder of Socialisation in Compassionate Mental Health Nursing Practice – pg146.
[99] As demonstrated in Figure 4.6: The 'closing down' to compassionate practice – pg201.

placement were utilised. Findings uncovered factors that were present that supported the teams' ability to create and sustain the conditions required for staff to effectively socialise student mental health nurses in compassionate practice. The thesis has therefore answered all research questions posed.

In Chapter Six, findings from student focus groups and individual student interviews were considered against the New Grounded Theory of Student Nurse Socialisation in Compassionate Practice, as developed by Curtis (2015). Findings echoed Curtis' research, highlighting similarities of the socialisation in compassion experience between Adult nursing students (as in Curtis' study) and Mental Health student nurses. This research has however built upon Curtis' study by exploring the sustaining factors in a compassion enriched practice environment, that supports a teams' ability to positive socialise students in compassionate mental health nursing practice. The Senses Framework (Nolan, 2006; Brown et al, 2008) was presented as a theoretical framework by which to increase understanding of the factors that underpin student socialisation in compassionate practice, and the sustaining factors that support a teams' ability to positively socialise students in compassionate practice. The Senses also provided an accessible and digestible framework by which educationalists, practice staff, practice managers and health care organisations can identify the role that each play in student socialisation in compassionate mental health nursing practice. This would be beneficial in supporting practice partners to reflect upon what needs to be done to effectively facilitate socialisation in compassion practice going forward. Furthermore, the impact of leadership on the teams' ability to effectively socialise students in compassionate mental health nursing practice was discussed. Finally, 6.4: The contribution of this study to theory, presents the knowledge developed as a result of engaging in this study. This section identifies that additional clarity has been developed regarding a definition of compassion that is applicable to mental health nursing, the scope of compassion in mental health nursing practice and also surrounding those mental health services users who may be at heightened risk of receiving care that is lacking in compassion.

The following section draws upon key areas identified in Chapter Six – Discussion, to make recommendations for future practice.

7.2: Implications of the study and recommendations for future practice

The implications of this study and recommendations for future practice are presented in this section. Recommendations are made for:

- Practice partners
- Approved Educational Institutions (AEI's)
- Policy Makers
- Future Research

Implications and recommendations for Practice partners:

The aim of this research was not to criticise members of the mental health nursing workforce, but rather to uncover the features that support student socialisation in compassionate mental health practice and increase awareness of practice staffs' impact on student socialisation. Although students identified numerous factors in compassion enriched practice contexts that support their socialisation in compassionate practice, they also identified characteristics of compassion impoverished practice environments, which many participants had unfortunately been exposed to throughout their programme of education. The findings could therefore be used by practice teams, managers and the wider organisation to identify the experiences that support socialisation in compassionate practice, with the aim of developing action plans for increasing the positive experiences of student placements that lead to effective socialisation in compassionate practice. Furthermore, the uncovering of conditions present in compassion enriched environments could be utilised by practice team managers and the wider organisation to identify their role in supporting staff to socialise student in compassionate nursing practice. With this knowledge, compassion impoverished organisational and team cultures that inhibit the conditions that create and sustain the ability to effectively socialise students in compassionate practice can be recognised, and plans put in place to begin to facilitate effective cultural change.

In addition, the research has highlighted the need for practice staff to develop greater awareness of the impact (implicitly and explicitly) that they have as role models to students.

This could be facilitated through engagement with educational opportunities and is presented in the following section.

Implications and recommendations for Approved Educational Institutions:

As identified previously, practice staff would benefit from education relating to the power dynamic between staff and students which results in increased student sense of vulnerability, and the impact that this has on engagement in compassionate practice. This is something that should be further addressed in the preparation of practice staff as student supervisors and assessors and should be included within the curriculum of any educational provision for practice supervisors and assessors.

Approved educational institutions (AEI's) for nurse education should also engage in work to better prepare student mental health nurses for some of the real-life challenges that they may encounter in practice (including challenging behaviour and constraints of practice). Pre-placement briefings could assist in managing expectations and ensuring that students are aware of sources of support during their placement experiences, to help reduce the sense of vulnerability often experienced. AEI's also need to work with practice partners to ensure that students are able to access practice supervision and team de-briefing, to enhance understanding and feelings of support and safety when exposed to challenges within the practice context.

Academics should facilitate post-placement de-briefing sessions in which students are able to reflect on the challenges experienced within practice. However, academics need to approach such sessions with supportive optimism and ensure that students do not feel blamed for not challenging care when compassion is lacking. These de-briefing sessions could be beneficial in supporting students to develop the knowledge and practical techniques to engage in compassionate practice, despite the barriers in the practice context and offer opportunity for developing student peer support and a sense of student camaraderie.

Implications and recommendations for policy makers:

In order to demonstrate the authentic understanding of and commitment to facilitating the provision of compassionate care, policy makers need to recognise the incompatibility of the drive for person-centred care and compassionate practice. Person-centred care focuses on individual service user needs and interactions (Nolan et al, 2004). However, McCormack (2001) suggests that there is a need to step away from the individualistic view of care delivery and instead focus on care the recognises both the individual needs of service user's whilst also acknowledging the impact and importance of relationships. Indeed, Dewar's (2011, pg263) definition of compassion[100] and the definition of compassion developed through engagement in this study, both identify that the nurse's interpersonal skills and ability to enter into beneficial relationships with service users and others in the care environment are the cornerstone of compassionate practice. It is however recognised that these relationships extend the service user-nurse relationship and that in order to achieve relationship-centred care, relationships with all involved in service user care (carers, co-workers, student nurses, other disciplines) need to be fostered (Nolan et al, 2004). In order for front line staff to engage in compassionate care, the relational underpinning of compassion needs to be acknowledged and facilitated by policy makers. Policy should therefore refer to relationship-centred care, which is compatible with compassionate care delivery. To demonstrate authentic commitment to facilitating the delivery of compassionate care, consideration of the investment required to achieve relationship-centred care would also need to be considered.

Furthermore, it is recommended that policy makers review mental health quality metrics. Indeed, as demonstrated in this study there is a perception that prioritisation of some metrics in mental health care, limits staff and student opportunity to engage in compassionate mental health nursing practice. Consideration needs to be given to metrics imposed and consultation should be engaged in to understand the impact that individual metrics may have on the delivery of compassionate mental health nursing practice.

[100] As cited on pg43.

Implications and recommendations for future research:

Additional research should be conducted into the compassionate care and compassion socialisation experiences of students from the Child and Learning Disabilities Fields of nursing practice. This would help develop understanding of similarity of experience between these FOPs and adult and mental health nursing students. The unique challenges that are encountered in practice in relation to compassion for child and learning disabilities nursing students could also be identified.

It is also suggested that any future research investigating the impact of pedagogical methods of enhancing compassionate care are conducted as longitudinal studies. These studies should examine the longitudinal benefits and challenges of implementing classroom-based activities to enhance compassionate practice.

Finally, it is recommended that additional research is conducted to develop understanding into how compassion enriched practice teams can be created and sustained over a period of time. In addition, more research exploring the role of the manager/organisational leadership in creating compassionate care environments should be conducted. Any future research regarding this should explore how compassion enriched teams can be achieved across the different fields of nursing practice. This would ensure fair consideration of the specific factors that may influence the creation and sustainment of compassionate teams within nursing specialties.

7.3: Personal reflection of the research process

Engagement in this research process has proven to be quite the eye opener for me, as both a mental health nursing registrant and as an academic. As consistent with the principles of reflexivity, I have engaged in in-depth personal reflection, considering my impact upon all stages of the research process. Some of the key points of my reflections on the impact of the study are presented in the rest of this section.

Engagement in this in-depth reflection has illuminated the roots of my philosophy of aiming to be compassionate. I recognise that I was socialised to be compassionate towards other from a young age. As a female from a liberal, Christian family, there was always a sense of

expectation from my close and extended family, that I would be kind, caring and compassionate towards others. I recall being challenged by my parents as a child for "uncharitable" thinking and actions and encouraged to problem solve to help others. I recognise now that this has provided me with "a head start" in compassion. However, our students come from diverse backgrounds and may not have experienced this early socialisation in compassion towards others which may have an impact upon their engagement in compassionate mental health nursing practice.

As stated in 1.1: Impetus of the study, throughout the 23 years since I commenced my own nursing journey as a student mental health nurse, I have had witnessed both great acts of compassionate care as well as '*care'* in which compassion has been entirely absent. I do not profess to be perfect – far from it, but if I were to be asked if I view myself as a compassionate individual, I would say *"Yes, on the whole".* I say on the whole, as I recognise that although I aim to be compassionate and acknowledge that I had a "head start" to compassion in my upbringing, there have been occasions throughout my career in which I have struggled to engage in compassionate care. The service user who would phone me on a daily basis for two years and threaten to cut my *"t***s off and boil them in oil"*; the service user who would repeatedly threaten to do terrible things to children that I love; both of these are examples in which my compassion towards the individual, despite the struggles they experienced due to illness, was impaired.

I have also recognised times in my academic life where I have lacked compassion for others. I now recognise that the compassion I experience for students, other academics and stakeholders is negatively affected when "The Senses" are not present in my own working life. I feel empowered by this knowledge. The recognition of the inhibited presence of the Senses has reduced the sense of disappointment and blame that I previously felt towards myself (and others) when I was not able to enact my compassionate ideals. Indeed, rather than blame myself (or others), I have invested energy to challenging some of the barriers present within the wider organisation and have encouraged the organisation to recognise their role in supporting compassion towards others. I sincerely hope that by assisting students to recognise the presence or absence of the Senses in their working life, that I might assist them to do the same.

Although as a registrant, I was aware of some of the barriers present in practice that impact the delivery of compassionate care, I was struck by the frequency and number of negative placement experiences that student participants discussed in focus groups. Some students appeared traumatised by their experiences (for example the student who discussed exposure to repeated ligaturing on a placement[101]). I have reflected upon my experiences in practice and recognise that I have also been exposed to some of these barriers in practice. However, I have not been as adversely affected as some of the students involved in the study. I recall being better "protected" as a student, in comparison to some of the students in this study, which I feel enhanced a sense of safety within the profession and had a direct influence on developing the courage required to challenge some negative practices that I later witnessed as a registrant. I now recognise that I had lost sight of the reality of student experiences in contemporary mental health care and have perhaps been too dismissive when students have identified challenges in practice previously. This may have contributed to exacerbating the sense of "blame" that student participants reported in relation to discussing the challenges of compassionate practice within the academic context. This is something that I will be hyper-conscious of in my future academic and nursing practice. Going forward, I will always aim to truly hear the students experience and approach such discussions with a non-judgemental approach. I will be cognisant of the individual challenges that might occur that may impact compassionate practice. In this sense, engagement in this study has been genuinely transformational for me and has resulted in re-evaluation of my position and influence within academia.

Furthermore, the insight into the reality of student experiences has left me concerned about the lack of support for student mental health nurses in relation to exposure to such experiences in practice. In my role as both Subject Lead for Mental Health and Programme Leader for nursing, I have been in a privileged position in which I can influence change, to increase support for student mental health nurses. I have therefore introduced and facilitated Mental Health Field of Practice (FOP) pre- and post-placement briefing sessions for first year students. The aim of the pre-placement sessions is to enhance student

[101] See 4.3: Everyone for themselves, Having the compassion knocked out of you – pg187.

preparation for placement, and to make them aware of routes of support and that they have the opportunity to consider how they might cope with challenging circumstances in practice. The post-placement FOP sessions offer students the opportunity to reflect on their experiences and develop action plans in collaboration with their peers for how they might manage challenging incidents in the future. Anecdotally, these have been well received by first year students. However, this research has highlighted that students from all years of study would benefit from opportunities to reflect and access support to understand some of the distressing situations that are exposed to in mental health nursing care. I have also worked with key practice stakeholders to ensure that students are included in de-briefing sessions following clinical incidents. That said, there is still work to be done to improve the experiences of student mental health nurses. I am committed to doing what I can, both in my role in academia and also in promoting the findings of this research, to ensure that student mental health nurses are able to enact their compassionate ideals as students and as our mental health nurses of the future.

An exploration of the socialisation of student mental health nurses in compassionate mental health nursing practice: A constructivist enquiry.

Joanne Sharpe

Faculty of Health and Life Sciences

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Appendices:

Appendix 1: Literature search strategy

Search question 1: What is known about the meaning, origins and scope of compassion in contemporary nursing practice?

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward following next level of review – review of titles for relevance:
Academic Science Premier	Compassion AND nurs* AND (concept analysis OR definition) (ALL TEXT)	1990 – 2016	Full text Academic Journal Grey Literature Books	6,376	To great a yield – search refined. (See below)
	Compassion AND nurs* AND (concept analysis OR definition) (Title)	1990 – 2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	0	0
BND	Compassion AND nurs* AND (concept analysis OR definition) (ALL TEXT)	1990 - 2016	Full text Academic Journal Grey Literature Books	2,924	To great a yield – search refined. (See below)
	Compassion AND nurs* AND (concept analysis OR definition) (Title)	1990 - 2016	Full text Academic Journal Grey Literature Books	3	2
		March 2016 – December 2020	As above	0	0
CINHAL	Compassion AND nurs* AND (concept analysis OR definition) (ALL TEXT)	1990 - 2016	Full text Academic Journal Grey Literature Books	3,842	Too great a yield, search refined (see below)
	Compassion AND nurs* AND (concept analysis OR definition) (TITLE)	1990 - 2016	Full text Academic Journal Grey Literature Books	706	6
		March 2016 – December 2020	As above	0	0
Cochrane	Compassion AND nurs* AND (concept analysis OR definition) (ALL TEXT)	1990 - 2016	Cochrane Reviews Cochrane protocols Trials Clinical Answers Editorials Special collections	14	0
		March 2016 – December 2020	As above	7	0
PsycInfo	Compassion AND nurs* AND (concept analysis OR definition) (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	43	3

		March 2016- December 2020	As above	22	4
Pubmed	Compassion AND nurs* AND (concept analysis OR definition) (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	474	7
		March 2016 – December 2020	As above	166	11
Science Direct	Compassion AND nurs* AND (concept analysis OR definition) (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	363	5
		March 2016 – December 2020	As above	57	0
SCOPUS	Compassion AND nurs* AND (concept analysis OR definition) (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	101	8
		March 2016 – December 2020	As above	62	8
Zetoc	Compassion AND nurs* AND (concept analysis OR definition) (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	0	0
				Total taken forward for after review of titles for relevance:	**54**

Search question 2: What is known about student mental health nurse / student nurse socialisation in compassionate practice?

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward for next level of review – review of titles for relevance:
Academic Search Premier	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	920	Too great a yield – search refined
	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	129	2
		March 2016 – December 2020	As above	0	0
	Compassion AND socialisation OR socialization AND student nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	0	Yield too low – search extended
	Compassion AND socialisation OR socialization AND student nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	456	Yield too great – search refined.
	Compassion AND socialisation OR socialization AND student nurs* (ABSTRACT)	1990-2016	Full text Academic Journal Grey Literature Books	3	2
		March 2016 – December 2020	As above	2	0
	Compassion AND student mental health nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	5	1
		March 2016 – December 2020	As above	16	0
	Compassion AND student nurs* AND learning OR teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	183	Yield too great – search refined
	Compassion AND student nurs* AND learning OR teaching (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	0	Yield too low – search extended
	Compassion AND student nurs* AND learning OR teaching (ABSTRACT)	1990-2016	Full text Academic Journal Grey Literature Books	21	4
		March 2016 – December 2020	As above	16	2

Total taken forward for review of titles:	11

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward for next level of review – review of titles for relevance:
British Nursing Database (BND)	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	590	Too great a yield – search refined
	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	0	No results – search extended
	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ABSTRACT)	1990-2016	Full text Academic Journal Grey Literature Books	2	1
		March 2016 – December 2020	As above	1	0
	Compassion AND socialisation OR socialization AND student nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	2,680	Too great a yield – search refined
	Compassion AND socialisation OR socialization AND student nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	5	2
		March 2016 – December 2020	As above	0	0
	Compassion AND socialisation OR socialization AND student nurs* (ABSTRACT)	1990-2016	Full text Academic Journal Grey Literature Books	41	5
		March 2016 – December 2020	As above	0	0
	Compassion AND student mental health nurs* AND learning OR teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	150	Yield too great – search refined
	Compassion AND student mental health nurs* AND learning or teaching (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	0	Yield too low – search extended

	Compassion AND student mental health nurs* AND learning or teaching (ABSTRACT)	1990-2016	Full text Academic Journal Grey Literature Books	5	1
	Compassion AND student nurs* AND learning OR teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	1,932	Yield too great – search refined
	Compassion AND student nurs* AND learning OR teaching (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	0	Yield too low – search extended
	Compassion AND student nurs* AND learning OR teaching (ABSTRACT)	1990-2016	Full text Academic Journal Grey Literature Books	5	1
		March 2016 – December 2020	As above	1	0
				Total taken forward for review of titles:	10

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward for next level of review – review of titles for relevance:
CINAHL	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	61	2
		March 2016 – December 2020	As above	27	0
	Compassion AND socialisation OR socialization AND Student mental health nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	5	1
		March 2016 – December 2020	As above	3	0
	Compassion AND socialisation OR socialization AND student nurs* (FULL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	488	Yield too great – search refined
	Compassion AND socialisation OR socialization AND student nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	0	0

	Compassion AND socialisation OR socialization AND student nurs* (ABSTRACT)	1990-2016	Full text Academic Journal Grey Literature Books	8	2
		March 2016 – December 2020	As above	0	0
	Compassion AND student mental health nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	19	0
	Compassion AND student nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	2,961	Yield too great. Search refined.
	Compassion AND student nurs* AND learning or teaching (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	2	1
				Total taken forward for review of titles:	6

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward for next level of review – review of titles for relevance:
Cochrane	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ALL TEXT)	1990-2016	Cochrane Reviews Cochrane protocols Trials Clinical Answers Editorials Special collections	0	0
		March 2016 – December 2020	As above	0	0
	Compassion AND socialisation OR socialization AND student nurs* (ALL TEXT)	1990-2016	Cochrane Reviews Cochrane protocols Trials Clinical Answers Editorials Special collections	260	Yield too great – Search refined
	Compassion AND socialisation OR socialization AND student nurs* (TITLE)	1990-2016	Cochrane Reviews Cochrane protocols Trials Clinical Answers Editorials Special collections	14	1
		March 2016 – December 2020	As above	0	0
	Compassion AND socialisation OR socialization AND student mental health nurs* (TITLE)	1990-2016	Cochrane Reviews Cochrane protocols Trials Clinical Answers Editorials Special collections	3	0

		March 2016 – December 2020	As above	0	0
	Compassion AND student nurs* AND learning or teaching (ALL TEXT)	1990-2016	Cochrane Reviews Cochrane protocols Trials Clinical Answers Editorials Special collections	12,700	Yield too great – search refined
	Compassion AND student nurs* AND learning or teaching (TITLE)	1990-2016	Cochrane Reviews Cochrane protocols Trials Clinical Answers Editorials Special collections	1,628	Yield too great – search refined
	Compassion AND student mental health nurs* AND learning or teaching (TITLE)	1990-2016	Cochrane Reviews Cochrane protocols Trials Clinical Answers Editorials Special collections	1,628	Yield too great – search refined
	Compassion AND student mental health nurs* AND learning or teaching (TITLE)	1990-2016	Cochrane Reviews Special collections	1	0
		March 2016 – December 2020	As above	0	0
				Total taken forward for review of titles:	1

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward for next level of review – review of titles for relevance:
PsycInfo	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	191	Yield too great – search refined
	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	60	2
		March 2016 – December 2020	As above	0	0
	Compassion AND socialisation OR socialization AND Student mental health nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 –	As above	0	0

		December 2020			
	Compassion AND socialisation OR socialization AND student nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	4	1
		March 2016 – December 2020	As above	2	0
	Compassion AND student mental health nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	1	0
		March 2016 – December 2020	As above	1	0
	Compassion AND student nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	18	3
		March 2016 – December 2020	As above	12	4
				Total taken forward for review of titles:	10

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward for next level of review – review of titles for relevance:
PubMed (MEDLINE)	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	1,703	Yield too great – search refined
	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	14	0
		March 2016 – December 2020	As above	111	3
	Compassion AND socialisation OR socialization AND Student mental health nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	20	0
		March 2016 – December 2020	As above	0	0
	Compassion AND socialisation OR socialization AND	1990-2016	Full text Academic Journal Grey Literature Books	65	1

	student nurs* (FULL TEXT)	March 2016 – December 2020	As above	156	8
	Compassion AND student mental health nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	4,971	Yield too great – search refined
	Compassion AND student mental health nurs* AND learning or teaching (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	18,793	Yield too great – search refined
	Compassion AND student nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	1,137	Yield too great – search refined
	Compassion AND student mental health nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	51	1
		March 2016 – December 2020	As above	0	0
				Total taken forward for review of titles:	13

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward for next level of review – review of titles for relevance:
Science Direct	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	3	0
		March 2016 – December 2020	As above	5	0
	Compassion AND socialisation OR socialization AND Student mental health nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	534	Yield too great – search refined
	Compassion AND socialisation OR socialization AND Student mental health nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	3	0
		March 2016 – December 2020	As above	4	0
	Compassion AND socialisation OR socialization AND student nurs* (FULL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	799	Yield too great - Search refined.

	Compassion AND socialisation OR socialization AND student nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	3	0
		March 2016 – December 2020	As above	6	0
	Compassion AND student mental health nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	34	0
		March 2016 – December 2020	As above	24	0
	Compassion AND student nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	66	1
		March 2016 – December 2020	As above	40	1
				Total taken forward for review of titles:	2

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward for next level of review – review of titles for relevance:
Scopus	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	0	Yield too low – search extended
	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ABSTRACT)	1990-2016	Full text Academic Journal Grey Literature Books	0	Yield too low – search extended
	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	37	3
		March 2016 – December 2020	As above	1	1
	Compassion AND socialisation OR socialization AND Student mental health nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	29	4
		March 2016 – December 2020	As above	0	0
	Compassion AND socialisation OR socialization AND	1990-2016	Full text Academic Journal Grey Literature Books	62	7

	student nurs* (FULL TEXT)	March 2016 – December 2020	As above	6	1
	Compassion AND student mental health nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	184	7
		March 2016 – December 2020	As above	6	1
	Compassion AND student nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	364	Yield too great – search refined
	Compassion AND student nurs* AND learning or teaching (TITLE)	1990-2016	Full text Academic Journal Grey Literature Books	0	Yield too low – search extended
	Compassion AND student nurs* AND learning or teaching (TITLE / ABSTRACT / KEYWORDS)	1990-2016	Full text Academic Journal Grey Literature Books	0	Yield too low – search extended
	Compassion AND student nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	580	Yield too great – search refined
	Compassion AND student nurs* (TITLE / ABSTRACT / KEYWORDS)	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	165	13
				Total taken forward for review of titles:	37

Database:	Keyword, Boolean operator and truncation combinations:	Dates:	Other limiters:	Outcomes:	Total put forward for next level of review – review of titles for relevance:
Zetoc	Compassion AND Socialisation (OR Socialization) AND Mental Health Nurs* OR Student Mental Health Nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	0	0
	Compassion AND socialisation OR socialization AND Student mental health nurs* (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	0	0

		March 2016 – December 2020	As above	0	0
	Compassion AND socialisation OR socialization AND student nurs* (FULL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	0	0
	Compassion AND student mental health nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	0	0
	Compassion AND student nurs* AND learning or teaching (ALL TEXT)	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	0	0
	Compassion AND Student nurs	1990-2016	Full text Academic Journal Grey Literature Books	0	0
		March 2016 – December 2020	As above	0	0
				Total taken forward for review of titles:	0
				Total taken forward for after review of titles for relevance:	**90**

Appendix 2: Sources included in phase one of the literature review

Author/s:	Title:	Date:	Country:	Article / Research type:
Adamson et al	Leadership in compassionate care programme: Final Report.	2011	UK	Programme Report
Barron, Deery and Sloan	Community mental health nurses' and compassion: an interpretative approach	2017	UK	Interpretive qualitative study
Bond et al	The concept of compassion within UK media-generated discourse: A corpus-informed analysis	2018	UK	A corpus-informed discourse analysis
Curtis	Socialisation in Compassionate Practice	2015	UK	Book
Dewar	Caring about caring; an appreciative inquiry about compassionate relationship centred care.	2011	UK	Appreciative inquiry - PhD thesis
Dewar	Cultivating compassionate care	2013	UK	Conceptual paper
Dewar and Nolan	Caring about caring: Developing a model to implement compassionate relationship centred care in an older people care setting.	2013	UK	Appreciative inquiry
Dewar, Pullin and Tocheris	Valuing compassion through definition and measurement	2011	UK	Action Research
Dewar et al	Clarifying misconceptions about compassionate care	2013	UK	Discussion paper
Durkin, Usher and Jackson	Embodying compassion: A systematic review of the views of nurses and patients	2018	Australia	A systematic Literature Review
Galetz	The empathy-compassion matrix: Using a comparison concept analysis to identify care components	2019	USA	Literature Review
Gerace	Roses by other names? Empathy, Sympathy and compassion in mental health nursing	2020	Australia	Discursive paper
Goetz, Keltner and Simon-Thomas	Compassion: An evolutionary Analysis and Empirical Review	2010	USA	Conceptual paper
Knaak, Mantler and Szeto	Mental illness-related stigma in health care.	2017	Canada	Discursive paper
Kneafsey et al	A qualitative study of key stakeholders' perspectives on compassion in health care and the development of a framework for compassionate interpersonal relations	2015	UK	Exploratory, qualitative study
McCaffrey and McConnell	Compassion: A critical review of peer-reviewed nursing literature	2015	Canada	Discursive paper
Pehlivan and Guner	Compassionate care: Can it be defined, provided and measured?	2019	Turkey	Discursive paper
Perez-Bret, Altisent and Rocafort	Definition of compassion in health care: A systematic literature review	2016	Spain	A systematic Literature Review
Ring and Lawn	Stigma perpetuation at the interface of mental health care: A review to compare patient and clinician perceptions of stigma and borderline personality disorder.	2019	UK	Literature review
Schantz	Compassion: A concept analysis	2007	USA	Conceptual paper
Sinclair et al	Compassion: a scoping review of the health care literature	2016	Canada	Literature review
Straughair	Exploring compassion: implications for contemporary nursing. Part 1	2012	UK	Conceptual paper

Straughair	Exploring compassion: implications for contemporary nursing. Part 2	2012	UK	Conceptual paper
Tehranineshat et al	Nurses', carers', and family caregivers' perceptions of compassionate nursing care	2019	Iran	Qualitative exploratory study
Tierney et al	Enabling the flow of compassionate care: a grounded theory study	2017	UK	Grounded theory study
van der Cingel	Compassion and professional care: exploring the domain	2009	The Netherlands	Conceptual paper
von Dietze and Orb	Compassionate care: a moral dimension of nursing	2000	Australia	Conceptual paper

Appendix 3: Sources included in phase two of the literature review

Author/s:	Title:	Date:	Country:	Article / Research type:
Adamson et al	Leadership in compassionate care programme: Final Report.	2011	UK	Programme Report
Adamson and Dewar	Compassion in the nursing curriculum: making it more explicit	2015	UK	Action Research
Bond et al	The concept of compassion within UK media-generated discourse: A corpus-informed analysis	2018	UK	A corpus-informed discourse analysis
Brown et al	Transforming students' views of gerontological nursing: Realising the potential of 'enriched' environments of learning and care: A multi-method longitudinal study	2008	UK	A multi-method longitudinal study
Brown et al	Practical compassions: Repertoires of practice and compassion talk in acute mental healthcare	2013	UK	Exploratory study
Crawford et al	The Language of Compassion in Acute Mental Health Care	2013	UK	Discursive paper
Curtis	Socialisation in Compassionate Practice	2015	UK	Book
Curtis, Horton and Smith	Student nurse socialisation in compassionate practice: A grounded theory study	2012	UK	Grounded Theory Research
Dewar	Cultivating compassionate care	2013	UK	Conceptual paper
Dewar and Mackay	Appreciating and developing compassionate care in an acute hospital setting caring for older people	2010	UK	Action Research
Durkin, Gurbutt and Carson	Stakeholder perspectives of compassion in nursing: The development of the compassion strengths model	2019	UK	Qualitative exploratory study
Edward	The phenomenon of resilience in crisis care mental health clinicians	2005	Australia	Phenomenological study
Geraghty, Oliver and Lauva	Reconstructing compassion: should it be taught as part of the curriculum	2016	Australia	Discursive paper
Hall	Helping nurses reconnect with their compassion	2015	UK	Discursive paper
Hofmeyer et al	Teaching compassionate care to nursing students in a digital learning and teaching environment	2018	Australia/ South Africa / UK / USA	An exploratory, descriptive qualitative study
Jack and Tetley	An interpretive phenomenological study using reflective poetry to explore how compassion is both understood and experienced by student nurses	2016	UK	Phenomenological study
Johnson, Haigh and Yates-Bolton	Valuing of altruism and Honesty in Nursing Students: A Two Decade Replication Study	2007		Replication study
Kneafsey et al	A qualitative study of key stakeholders' perspectives on compassion in health care and the development of a framework for compassionate interpersonal relations	2015	UK	Exploratory, qualitative study
Leffers and Martins	Journey to compassion: meeting vulnerable populations in community health nursing through literature	2004	USA	Discursive paper
Maben, Cornwell and Sweeney	In praise of compassion	2010	UK	Discursive paper
Mackintosh	Caring: the socialisation of pre-registration student nurses: a longitudinal qualitative descriptive study	2006		Longitudinal descriptive study

Melia	Learning and Working. The occupational socialisation of nurses	1987	UK	Book
Murphy et al	The impact of nurse education on the caring behaviours of nursing students	2009	UK	Single cross section survey
Pettit et al	Releasing latent compassion through an innovative compassion curriculum for Specialist Community Public Health Nurses	2019	UK	Qualitative study
Richardson, Percy and Hughes	Nursing therapeutics: Teaching student nurses care, compassion and empathy	2015	UK	Literature review
Straughair	Exploring compassion: implications for contemporary nursing. Part 1	2012a	UK	Conceptual paper
Straughair	Cultivating compassion in nursing: A grounded theory study to explore the perceptions of individuals who have experienced nursing care as patients	2019	UK	Grounded Theory study
Warelow and Edward	Caring as a resilient practice in mental health nursing	2007	Australia	Discursive paper
Waugh and Donaldson	Students' perceptions of digital narratives of compassionate care.	2016	UK	Narrative research
Winch et al	Understanding Compassion Literacy in Nursing Through a Clinical Compassion Café	2014	Australia	Discursive paper

Appendix 4: Identified characteristics, skills and actions of a compassionate nurse:

Characteristics / skills / actions required to be viewed as a compassionate nurse (in alphabetical order):	Author:
Ability to build rapport	• Tierney et al (2017) • Terhranineshat et al (2019)
Ability to connect with the sufferer	• Peters (2006) in Dewar (2013) von Dietz and Orb (2000)
Ability to predict suffering	• Sinclair et al (2016)
Ability to self-manage	• Barron, Deery and Sloan (2017)
Ability to sustain positive relationships	• Kneafsey et al (2015) • Tierney et al (2017) • Terhranineshat et al (2019)
Acceptance	• Galetz (2019)
Accessibility	• Pehlivan and Guner (2019) • Terhranineshat et al (2019)
Acting to uphold justice	• Downie and Calmen (1994) in von Dietz and Orb (2000)
Affectionate	• Pehlivan and Guner (2019)
Approachability	• Pehlivan and Guner (2019)
Attentiveness	• von Dietz and Orb (2000) • Tierney et al (2017)
Being a dedicated presence	• von Dietz and Orb (2000) • Durkin, Usher and Jackson (2018)
Caring	• Gerace, (2020)
Celebrating	• Dewar (2013)
Collaborative working with patients	• Dewar (2013) • Pehlivan and Guner (2019)
Commitment	• von Dietz and Orb (2000)
Compromising	• Dewar (2013)
Competence (Clinical)	• Terhranineshat et al (2019)
Consideration of the patients' perspective	• Dewar (2013) • Pehlivan and Guner (2019) • Gerace, (2020)
Courage	• Dewar (2013)
Curiosity	• Dewar (2013)
Demonstrating emotional warmth	• von Dietz and Orb (2000)
Demonstration of respect	• von Dietz and Orb (2000) • Pehlivan and Guner (2019) • Terhranineshat et al (2019)
Devoted	• Pehlivan and Guner (2019)
Effective communication skills (with patients' families and other staff)	• Dewar (2013) • Sinclair et al (2016) • Bond et al (2018) • Kneafsey et al (2015) • Tierney et al (2017) • Pehlivan and Guner (2019) • Terhranineshat et al (2019)
Emotional engagement	• Dewar (2013)
Expressed togetherness	• Dewar (2013)
Genuineness	• Kneafsey et al (2015) • Sinclair et al (2016)
Giving freely of oneself	• von Dietz and Orb (2000)
Giving the patient time	• von Dietz and Orb (2000) • Durkin, Usher and Jackson (2018)

	• Pehlivan and Guner (2019) • Gerace, (2020)
Helping	• von Dietz and Orb (2000) • Pehlivan and Guner (2019)
Humanity	• Dewar (2013) • Galetz (2019)
Humility	• Dewar (2013)
Identifying and reacting to suffering	• von Dietz and Orb (2000) • Perez-Bret, Atisent and Rocafort (2016) • Durkin, Usher and Jackson (2018) • Galetz (2019)
Intuitive care	• von Dietz and Orb (2000)
Kindness	• Kneafsey et al (2015) • Tierney et al (2017) • Galetz (2019) • Pehlivan and Guner (2019) • Terhranineshat et al (2019)
Knowing the patient	• von Dietz and Orb (2000)
Listening	• von Dietz and Orb (2000) • Sinclair et al (2016) • Bond et al (2018) • Kneafsey et al (2015) • Pehlivan and Guner (2019)
Non-judgemental	• Galetz (2019)
Noticing	• Dewar (2013)
Offering emotional support	• Pehlivan and Guner (2019) • Terhranineshat et al (2019)
Offering support in a crisis	• von Dietz and Orb (2000)
Offering understanding	• von Dietz and Orb (2000) • Pehlivan and Guner (2019) • Terhranineshat et al (2019)
Patient-centredness	• Galetz (2019) • Pehlivan and Guner (2019)
Persistence	• von Dietz and Orb (2000) • Terhranineshat et al (2019)
Patience	• Pehlivan and Guner (2019)
Personal integrity	• Pehlivan and Guner (2019)
Positive attitude	• von Dietz and Orb (2000)
Professionalism	• Pehlivan and Guner (2019) • Terhranineshat et al (2019)
Provision of individualised care	• von Dietz and Orb (2000)
Responding in a meaningful way	• Pehlivan and Guner (2019)
Sensitivity	• Galetz (2019)
Showing interest	• Pehlivan and Guner (2019)
Solidarity and offering of consolation	• von Dietz and Orb (2000) • Galetz (2019)
Thoughtfulness	• von Dietz and Orb, (2000)
To act with non-maleficence	• Downie and Calmen (1994) in von Dietz and Orb (2000)
Utilitarianism	• Downie and Calmen (1994) in von Dietz and Orb (2000)
Willingness to demonstrate vulnerability by engaging and sharing in the suffering	• Sinclair et al (2016) • von Dietz and Orb (2000)
Willingness to self-sacrrifice	• Pehlivan and Guner (2019)

Appendix 5: Strategies to develop / teach compassion discovered in the literature:

Author/s / date:	Strategy described in the literature:	Key findings regarding socialisation of compassion / development of compassion identified:
Adamson and Dewar (2015)	Module content and assessment redesigned to include compassionate skills and delivered to third year student nurses with the aims of enhancing learning about compassionate care and making compassionate care practices more explicit in their programme of education. The new module content and assessment were evaluated by online discussion	• Listening to stories included in the module, helped students maintain focus on compassionate care and recognise the impact of small acts of compassion • Key points for future consideration identified including: - Relative weight needs to be given to compassionate care actions, rather than focus purely on technical skills - Student reflections on compassionate care are important - Actor-patients support explicit learning about compassionate interactions
Dewar and MacKay (2010)	Appreciative action research using observations, interviews and discussion groups aimed at enabling nurses, patients and carers to develop action plans with the intention of developing compassionate care responses *Students nurses not specifically recruited for this study but research outcomes identified the importance of embedding key processes in future nursing education.	• Three key processes (1: "*knowing who I am and what matters to me, 2: understand how I feel and 3: work with me to shape how things are done")* assist with the delivery of compassionate care and should be embedded in policy, practice and nursing education.
Hofmeyer et al (2018)	Qualitative study using an online module consisting of 4-6 hours of learning time, 5000 words, using a question and answer format. Each section concluded with reflective questions. Reflections were then discussed with a tutor and other students.	• The online module increased insight in to factors that cultivate and inhibit compassion • The online module supported development of deeper understanding of the links between self-compassion, resilience and burnout • Participant understanding of the importance of compassionate care increased • The module provided opportunity for participants to reframe their previously held attitudes, beliefs and values • Participants felt that insights developed would positively influence their practice
Jack and Tetley (2016)	An interpretive phenomenological study using reflective poetry to explore how compassion is both understood and experienced by student nurses	• Educators need to develop teaching strategies and practices that explore student thoughts and feeling about compassionate care • Using reflective poetry, provides educators with the opportunity to role model personal behaviours that exemplify compassion to support applied understanding in student nurses in relation to expectations • Reflective poetry can help students to understand the risk factors associated with compassion fatigue and develop knowledge and skills to

		reduce the potential of CF in their future practice.
Leffers and Martins (2004)	Development of a human caring pedagogy in which student nurses examined scenarios of human suffering in creative literature to develop their levels of compassion for vulnerable people.	• The use of literature helped students to reflect on their own emptions and alter previously held opinions about vulnerable, marginalised and stereotyped groups. • There was an increase in students demonstrating compassionate concern for vulnerable groups Students reported exposure to issues such as racism, vulnerability and other cultures were new experiences which assisted in the understanding of others
Pettit et al (2019)	The Compassionate Mind Model (CMM) was embedded in a post-graduate nurse curriculum with the aim of assisting registrants to recognise their own facilitators and inhibitors to compassionate care. Mindfulness was used to support participants to develop increased levels of self-compassion. Reflection, positive role modelling of compassion, restorative supervision and one to one support were included to help cultivate compassionate practice. Compassionate nursing values were continually assessed. *Participants were registered nurses, but outcomes of the study deemed transferable to future nursing education	• Self-compassion contributes to fostering compassionate both in terms of professional care and personal life experiences • Positive role modelling, effective leadership and a compassionate organisational culture have a positive impact upon compassionate care
Waugh and Donaldson (2016)	Qualitative study evaluating a narrative pedagogy in which compassionate stories (provided by other student nurses) were presented via digital audio format. Students completed a questionnaire to provide feedback on their learning and preferences of digital learning.	• Narrative pedagogy using pre-recorded stories assisted student nurses to: - Recognise examples of compassionate practice - Develop professional identity - Reflect on placement learning • Use of the digital narrative pedagogy beneficial in student preparation for practice and mentor preparation • Role modelling of both academic and practice staff identified as important in student development of compassionate knowledge
Winch et al (2014)	Developed a clinical compassion café with the aim of assisting participants to develop compassion literacy, reaffirm their compassionate ideals and provide an opportunity for nurses to share their personal and organisational frustrations by providing a space for reflection. The café approach was utilised to facilitate discussion about case scenarios with the aim of encouraging participants to consider the impact of the experience of compassionate nursing care. *Participants were registered nurses, but outcomes of the study deemed transferable to future nursing education	• participant compassion satisfaction improved both individually and organisationally.

Appendix 6: Focus Group Agenda

Equipment:
Recorder x2
Prompt question sheet
Note pad
Pen
Refreshments
Consent forms

1) Introduction of self and research
2) Opportunity to ask questions
3) Consent form completion
4) Focus group questions
5) Summary
6) Opportunity for participants to ask questions
7) Information on what is next

Appendix 7: Focus Group Topic Questions

What do you think compassion is?

Does compassion differ from empathy?

Assuming that everyone here is compassionate, what do you think are the life influences that have affected your personal levels of compassion?

Do you think you are consistently compassionate?

If not, why are the factors that negatively affect your levels of compassion towards others?

Do you think that people can people be taught to be compassionate or do you think it is an inate quality? Why? If you think it can be taught – how? How did you learn compassion?

Do you think it is essential for mental health nurses to be compassionate? Do you think this differs from other fields of practice?

What do you think are the barriers to compassionate MH nursing care?

Can you give examples of what you think compassionate mental health nursing care looks like?

What are your expectations of placements in terms of compassionate practices? Can you reflect back to before your first placement – what were you expecting? Has this been realised in your experiences of placements?

How would you identify a compassionate nurse?

What influence has the theory component of your course had on your development of compassionate practice? (Which has had the most influence – placement or theory?)

How do you think we could make improvements at University to further enhance students compassionate qualities?

Is there anything else that you would like to emphasise or do you have any questions you would like to ask me?

Appendix 8: Focus Group Participant Information Sheet

Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Information Sheet for Mental Health Nursing Students (Phase 2).

My name is Joanne Bird and I am a Mental Health Lecturer here at De Montfort University. I would like to invite you to take part in this research study which in being carried out in order for me to attain a Doctorate in Philosophy (PhD). Before you decide if you want to be involved, I would like you to understand why the research is being done and what it would involve for you. I am happy to go through the information sheet with you and answer any questions you have. Please talk to others about the study if you wish. Ask me if there is anything that is not clear. My contact details are at the end of this sheet.

What is the purpose of this study?

Nurses have been heavily criticised recently for lacking compassionate responses to those in our care. There is little research that focuses upon student mental health nurses and the development of compassion. This study seeks to explore how student nurses are socialised in compassionate practice through experiences they engage in during their programme of study for their nursing degree. I am interested in learning more about the influence of clinical placements and the theory aspect of the nursing programme on your experience of developing compassionate nursing responses.

Why have I been invited to take part?

You have been asked to take part because you are a mental health nursing student at De Montfort University.

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What does taking part involve?

Taking part involves joining between 6 and 12 other mental health students from your year in 2 focus groups one in April 2015 and the second in November 2015 to discuss your understanding and experiences of compassionate mental health nursing.

Do I have to take part?

No – taking part is entirely voluntary. If you would prefer not to take part, you do not have to give any reason. If you choose to take part you can still leave the project at any time, without giving a reason. Either way you are free to keep this information sheet. Taking part in the study will have no effect upon your progression on your programme of study.

What will happen to me if I take part?

If you decide to take part in the project, please let me know by completing the enclosed reply slip and returning by getting in touch with Joanne Bird at jbird@dmmu.ac.uk or by phone on 01162013804. I will then get in touch with you and tell you more about the project and invite you to take part in the focus groups.

The focus groups, which will take about an hour, will take place in a private room at De Montfort University. Before we begin, I will ask you to sign a consent form and will ask your permission to audio record what you say. It is important that you understand that this study is not concerned with identifying poor practice but should this be disclosed senior clinical managers and the University safeguarding lead will be informed. You will be invited to attend two focus groups, one at the beginning of the academic year and one towards the end of your academic year.

At the end of the second focus group, in addition to discussing your experience of compassionate care, you will be asked to identify any clinical areas that in your opinion demonstrate compassionate practice which has helped you to develop as compassionate practitioners. From the suggestions that you make, I will select some placement areas to visit to observe for compassionate practice. If a practice area is selected that you have suggested, I will get in touch with you at a later date to organise an individual interview with you to gain further in-depth information from you about the area. You will also be asked to identify any academic staff from DMU who in your opinion, have helped you develop as a compassionate practitioner. Any staff identified will be invited to a focus group to discuss their views and experiences of compassionate care.

Expenses and payments

Participants will not be paid to participate in the study. As stated above, focus groups will be organised around your existing timetable so as not to clash with your course requirements and I will also organise the focus groups for a day when you will be on campus for other things, so you will not incur any additional travel expenses to participate.

What are the disadvantages to taking part?

Although you are a student mental health nurse, talking about experiences in care environments can be difficult. For some people it can invoke feelings of worry and sadness and it may remind you of poor experiences of care. I will provide each participant with a sheet with useful support numbers for you to access further support should you need to.

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What are the benefits of taking part?

There are no direct benefits to you. However the discussion during the focus groups will allow you to spend time in sharing your experiences. This can be a helpful and some people enjoy the opportunity to reflect on clinical practice that research participation sometimes offers.

Will my taking part in the study be kept confidential?

Some quotes from the focus groups will be used in the final report of the research and in articles and presentations I will make. However, your name or details that will identify you or any other person will not be included in anything I write and will not be mentioned in any presentations made. Procedures for handling, processing, storage and destruction of study data meet the requirements of the Data Protection Act 1998.

Ethical and legal practices will be adhered to and all information about you will be handled in confidence. If you join the study, the data collected for the study will be looked at by authorised persons from De Montfort University who sponsor the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the University will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Any personal data (address, telephone number) will be kept for 6 months after the end of the study so that I am able to contact you about the findings of the (unless you advise me that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data. Your participation in the study will remain confidential and I will not be discussing your participation within the School of Nursing or with practice colleagues.

All digital recordings that are taken in focus groups and in individual interviews will be encrypted before being stored on computer at De Montfort University. The encrypted audio files will be destroyed at the end of the project and the transcriptions will be securely stored, as required by research governance, for 7 years.

What happens if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected up to that point cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study?

The results will be used within my PhD thesis. I will write articles for publication and may put information onto a website and present results at National and International conferences. I also hope that the outcomes of the research may be used to guide potential suggestions for changes to future mental health nurse educational courses.

Who is organising this study?

This research is unfunded and is being organised by Joanne Bird, Senior Lecturer in Mental Health from De Montfort University as part of her Doctorate in Philosophy (PhD) studies.

Who is reviewing this study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by an NHS Ethics Committee (project ethics reference number: 166000) and has approval from Leicestershire Partnership Trust Research and Development Department. The research has also been approved by the De Montfort University Research Ethics board.

What happens if there is a problem?

If you have a concern about any aspect of this study, the researcher will do her best to answer your questions. (jbird@dmu.ac.uk Tel: 0116 2012804)If this is not satisfactory then please contact Professor Jayne Brown who is the project supervisor jbrown@dmu.ac.uk Tel: 0116 201 3961.

If you remain unhappy and wish to complain formally, you can contact Professor Martin Grootveld (Chair of the Health and Life Sciences faculty research ethics committee) mgrootveld@dmu.ac.uk
Tel: 0116 2506443.

Appendix 9: Reply Slip

Contact: Joanne Bird

7.09 Edith Murphy House, De Montfort University,

The Gateway, Leicester, LE1 9BH

Tel: 0116 2013804 jbird@dmu.ac.uk

Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Reply Slip

Please tick as appropriate

Dear Joanne,

I would like more information about the study. ☐

I would like to take part in the research project: "Exploring undergraduate mental health nursing student experience in compassionate practice: A phenomenological study". ☐

Name:	
Telephone:	
Email:	
The best way to contact me is:	Phone / Email
The best day and time to contact me is:	

Appendix 10: Letter of invitation to Case study site team manager

Contact: Joanne Bird

7.09 Edith Murphy House

De Montfort University

The Gateway

Leicester

LE1 9BH

Tel: 0116 201 3804

jbird@dmu.ac.uk

Dear Colleague,

Your clinical area has been identified by a student mental health nurses at De Montfort University as somewhere that supports the development of compassionate care practices. Consequently I would like to invite your team to take part in the in-depth case study aspect of my PhD research which is being carried out with the aim of exploring Undergraduate Student Mental Health Nurse socialisation in compassionate practice.

An information sheet is included with this letter which provides details of the study and what it would involve if you and your team were to take part.

If you decide you would like to take part in the study or you would like further information please get in touch with Joanne Bird on 0116 201 3804 or by email at

jbird@dmu.ac.uk or complete the reply slip enclosed in this pack and return it to the address above.

Thank you for reading this letter, if you have any queries please feel free to contact me at the address above.

Yours sincerely,

Joanne Bird

Senior Lecturer in Mental Health Nursing / Academic Lead for Mental Health.

Appendix 11: Participant Information sheet for practice staff

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Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Information Sheet for Clinical Staff.

My name is Joanne Bird and I am a Mental Health Lecturer at De Montfort University. I would like to invite you to take part in this research study which in being carried out in order for me to attain a Doctorate in Philosophy (PhD). Before you decide if you want to be involved, I would like you to understand why the research is being done and what it would involve for you. I am happy to go through the information sheet with you and answer any questions you have. Please talk to others about the study if you wish. Ask me if there is anything that is not clear. My contact details are at the end of this sheet.

What is the purpose of this study?

Nurses have been heavily criticised recently for lacking compassionate responses to those in our care. There is little research that focuses upon student mental health nurses and the development of compassion. This study seeks to explore how student nurses are socialised in compassionate practice through experiences they engage in during their programme of study for their nursing degree. I am interested in learning more about the influence of clinical placements and the theory aspect of the nursing programme on the experience of developing compassionate nursing responses.

Why have I been invited to take part?

You have been asked to take part because your clinical placement area has been identified by student mental health nurses as being an area that demonstrates good levels of compassionate care and has assisted them in developing as compassionate mental health nursing practitioners.

Do I have to take part?

No – taking part is entirely voluntary. If you would prefer not to take part, you do not have to give any reason. If you choose to take part you can still leave the project at any time, without giving a reason. Either way you are free to keep this information sheet. You can take part in the observation phase of the study without committing to participate in the individual interview phase.

What will happen to me if I take part?

Your team manager will need to agree that your clinical area as a whole will take part in the project. The observation, will take place the over the course of four hours, at a convenient time arranged with the team manager. Before the observation begins, your team manager will be asked to complete a team consent form and each individual staff member who does not wish to be involved in the study will be given the opportunity to opt out of participation.

It is important that you understand that this study is not concerned with identifying poor practice but should this be observed senior clinical managers and researcher supervisors will be informed. I will not interfere with your daily tasks and my role will purely be observational. At the end of the observation, I will return to the University to complete my field notes. Following the observation, I will arrange to meet with staff who wish to participate in individual interviews with the aim of gaining more in-depth understanding about the clinical area. Each individual interview will last 20 / 30 minutes and I will arrange a private room in your clinical area for interviews to take place. Individual interviews will be digitally recorded and you will be asked to sign a consent form to participate in the individual interviews. After the individual interviews are completed my contact with you in regards to the research will be complete.

Expenses and payments

Participants will not be paid to participate in the study. I will come to your clinical area for the observations and interviews so you will not incur any travel expenses

What are the disadvantages to taking part?

Although you are a mental health care professional, you may find being observed in the clinical area or talking about your professional experiences of compassion difficult. For some people it can invoke feelings of worry and sadness and it may remind you of poor experiences of care. If this occurs you can access staff support services that can provide information about organisations who can offer further support should you need it.

Leicestershire Partnership NHS
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What are the benefits of taking part?

There are no direct benefits to you. However the discussion during the individual interviews will allow you to spend time in sharing your experiences. This can be a helpful and some people enjoy the opportunity to reflect on clinical practice that research participation sometimes offers.

Will my taking part in the study be kept confidential?

Some quotes from the observation and the individual interviews will be used in the final report of the research and in articles and presentations I will make. However, your name or details that will identify you or any other person will not be included in anything I write and will not be mentioned in any presentations made. Procedures for handling, processing, storage and destruction of study data meet the requirements of the Data Protection Act 1998. Your participation in the study will not be discussed with colleagues at De Montfort University or with practice colleagues.

Ethical and legal practices will be adhered to and all information about you will be handled in confidence. If you join the study, the data collected for the study will be looked at by authorised persons from De Montfort University who sponsor the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the University will have your name and work address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

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Any personal data (work address, telephone number) will be kept for 6 months after the end of the study so that I am able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Any field notes taken and digital recordings will be encrypted and stored on computer at De Montfort University to assist with analysis. Project data will be securely stored, as required by research governance, for seven years.

What happens if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw, then the information collected up to that point cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study?

The results will be used within my PhD thesis. I will write articles for publication and may put information onto a website and present results at National and International conferences. It also hoped that the research outcomes may lead to suggestions for changes being made in future educational courses for undergraduate mental health nursing students.

Who is organising this study?

This research is unfunded and is being organised by Joanne Bird, Senior Lecturer in Mental Health at De Montfort University as part of her doctoral studies.

Who is reviewing this study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by the NHS Ethics committee (IRAS project ethics reference number:166000), DMU Ethics committee and has approval from Leicestershire Partnership Trust Research and Development Department.

What happens if there is a problem?

If you have a concern about any aspect of this study, the researcher will do her best to answer your questions (contact details below). If this is not satisfactory then please contact Professor Jayne Brown who is the project supervisor **jbrown@dmu.ac.uk** Tel: 0116 201 3961

If you remain unhappy and wish to complain formally you can contact Professor Martin Grootveld (Chair of the Health and Life Sciences faculty research ethics committee) **mgrootveld@dmu.ac.uk**
Tel: 0116 2506443.

What if I have any queries or concerns after reading this information sheet?

Please feel free to contact me if there is anything you need answered. I will be happy to talk to you.

Leicestershire Partnership NHS
NHS Trust

DE MONTFORT UNIVERSITY LEICESTER

Joanne Bird. Email: jbird@dmu.ac.uk or Tel: 0116 201 3804

Or you can write to me at:

3.12 Edith Murphy House, De Montfort University, The Gateway, Leicester, LE1 9BH

Thank you for reading this information sheet.

Appendix 12: Reply Slip – Case study team

Contact: Joanne Bird

7.09 Edith Murphy House, De Montfort University,

The Gateway, Leicester, LE1 9BH

Tel: 0116 2013804 jbird@dmu.ac.uk

Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Reply Slip

Please tick as appropriate

Dear Joanne,

I would like more information about the study. ☐

I would like to take part in the research project: "Exploring undergraduate mental health nursing student experience in compassionate practice: A phenomenological study". ☐

Name:	
Telephone:	
Email:	
The best way to contact me is:	Phone / Email
The best day and time to contact me is:	

Appendix 13: Invitation to practice staff to participate

Contact: Joanne Bird
7.09 Edith Murphy House
De Montfort University
The Gateway
Leicester
LE1 9BH
Tel: 0116 201 3804
jbird@dmu.ac.uk

Dear Team Member,

Your clinical area has been identified by a student mental health nurses at De Montfort University as somewhere that supports the development of compassionate care practices. Consequently I would like to invite you to participate in a research study exploring the socialisation of student mental health nurses in compassionate nursing practice. There are two ways in which you may participate, observation of practice and one to one interviews.

Your team manager has agreed that I can carry out observations of your clinical area over a two day period to examine the daily practices of your clinical area and explore the influences that affect student socialisation in compassionate nursing practice. The focus of this study is health care professionals and I will not be gathering data relating to service users. If you do not wish to take part in the observation, you have the opportunity to opt out and no data will be collected about you during the observation process. If however you do not return the form below to your team manager or to the researcher directly, it will be assumed that you agree to be included in the observational aspect of the study.

I will also be undertaking one to one interviews with some members of staff who volunteer to participate. All staff who agree to be observed in practice will be invited to be interviewed but you can agree to be observed without agreeing to be interviewed as well.

An information sheet is included with this letter which provides details of the study and what it would involve if you were to take part. **If you decide you would like to take part in the study please get in touch with Joanne Bird on 0116 201 3804 or by email at jbird@dmu.ac.uk or complete the reply slip enclosed in this pack and return it to the address above.**

Yours sincerely,

Joanne Bird
Senior Lecturer in Mental Health / Academic Lead for Mental Health / PhD researcher.

✂

Title of the study: Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

I understand that Joanne Bird will be conducting the above study at my work place.
I **do not** wish to be included in this study.

Signed: **Date:**

Please return this form to your team manager or to Joanne Bird (Researcher) as soon as possible if you do not wish to take part in the study.

Appendix 14: Poster for Clinical area access

Leicestershire Partnership NHS Trust

DE MONTFORT UNIVERSITY LEICESTER

- My name is Joanne Bird.
- I am a Lecturer in Mental Health Nursing at De Montfort University.

- Leicestershire Partnership Trust have given me permission to undertake some research at Clinical sites to explore the way in which student mental health nurses are socialised in compassionate mental health nursing practice.
- I will be carrying out observations in the clinical area to assess how members of the care team might contribute to the socialisation of students.
- I am not observing service users or visitors within the clinical area and no information about service users or visitors will be collected and used in the research. However, if you wish to you can complete an opt out form and I will not observe any of your interactions with staff.
- Please feel free to ask me any questions you may have or speak to the nurse in charge or your keyworker if you have any concerns about my observation of staff.

Appendix 15: Practice Staff opt out form

Contact: Joanne Bird
7.09 Edith Murphy House
De Montfort University
The Gateway
Leicester
LE1 9BH
Tel: 0116 201 3804
jbird@dmu.ac.uk

Dear Team member,

Your team has been identified by a student mental health nurses at De Montfort University as somewhere that supports the development of compassionate care practices.

Your team manager has agreed that I can carry out observations with the team to examine the daily practices that occur in the clinical area and explore the influences that affect student socialisation in compassionate nursing practice. The focus of this study is health care professionals and **I will not be gathering data relating to service users**. However, you can still opt out of being observed if you wish by completing the opt out form attached.

Yours sincerely,

Joanne Bird
Senior Lecturer in Mental Health / Academic Lead for Mental Health / PhD researcher.

Title of the study: Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

I understand that Joanne Bird will be conducting the above study at…….

I **do not** wish to be included in this study.

Signed: **Date:**

Please return this form to…….. (the team manager) or to Joanne Bird (Researcher) as soon as possible if you do not wish for your interactions with staff to be observed during the observation period.

Appendix 16: Service User opt out form

Contact: Joanne Bird
7.09 Edith Murphy House
De Montfort University
The Gateway
Leicester
LE1 9BH
Tel: 0116 201 3804
jbird@dmu.ac.uk

Dear……..,

…….. has been identified by a student mental health nurses at De Montfort University as somewhere that supports the development of compassionate care practices.

…… (team manager) has agreed that I can carry out observations of …….. over four hours to examine the daily practices that occur in the clinical area and explore the influences that affect student socialisation in compassionate nursing practice. The focus of this study is health care professionals and **I will not be gathering data relating to service users**. However, you can still opt out of being observed in your interactions with staff if you wish by completing the opt out form attached.

Yours sincerely,

Joanne Bird

Senior Lecturer in Mental Health / Academic Lead for Mental Health / PhD researcher.

Title of the study: Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

I understand that Joanne Bird will be conducting the above study at…….
I **do not** wish to be included in this study.

Signed: **Date:**

Please return this form to…….. (the team manager) or to Joanne Bird (Researcher) as soon as possible if you do not wish for your interactions with staff to be observed during the observation period.

Appendix 17: Individual interview schedule practice staff

Draft interview guide for clinical staff.

Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Equipment required:

Quiet room without distractions, comfortable seating and table, water, tissues, consent forms and paper copies of information sheet, digital recorder and spare batteries, notebook with question guide. Create a relaxed environment to promote active listening.

Interview:

Introduce self as the researcher interested in nurse education and re-emphasise the voluntary nature of participation, protection of confidential information / anonymity.

Obtain written consent and provide a paper copy to the participant, plus determine if that want a transcript of the interview emailed.

Remind the participant of their freedom to leave at anytime and commence the digital recorder.

Background Information:

- How long have you worked in MH care?
- How long have you worked in this clinical environment?
- What is your professional title?
- Are you a student mentor?
- Is there an aspect of MH care that you have a particular interest in?

Pre-registration training understanding:

- In your own mind, what do you consider are the main aims of pre-registration nurse education?
- Values: What do you consider are the main professional values in nursing?
- Your clinical area has been identified as demonstrating compassionate care and helping students to develop as compassionate practitioners – why do you think that is?

Acquiring values of nursing profession:

- What do you understand by compassionate nursing?
- What does compassionate MH nursing look like and how would I recognise it in your clinical area?
- How do staff here help instil professional values in student learning?
- Do you see any difficulty in helping student nurses develop and utilise professional values such as compassion?
- Can you give me some examples of how students learn professional values in your clinical environment?
- In what ways does your clinical area support the development of compassionate practice?

Is there anything you would like to change to improve the preparation of our future nurses?

Participants will be thanked for their time and for sharing their experiences and thoughts with the researcher.

Appendix 18: Individual interview guide students

Draft Interview Guide for Students discussing the clinical placement or academic they recommended in Phase 2.

Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Equipment required:

Quiet room without distractions, comfortable seating and table, water, tissues, consent forms and paper copies of information sheet, digital recorder and spare batteries, notebook with questions guide and to make observations. Create a relaxed environment to promote active listening.

Interview:

Introduce self as the researcher interested in nurse education and re-emphasise the voluntary nature of participation, protection of confidential information / anonymity.

Obtain written consent and provide a paper copy to the participant, plus determine if they want a transcript of the interview emailed.

Remind the participant of their freedom to leave and anytime and commence the digital recorder.

Background Information:

- How long have you been a student here?
- Did you have any mental health care experience prior to commencing the course?
- What made you decide to become a mental health nurse?

Recent placements:

- Can you tell me about the placement you identified as assisting you to develop compassionate practice and your feelings and experiences when caring for patients / service users?
- Tell me your reasons for considering it a compassionate clinical area.
- Was the whole team compassionate? Or specific team members? Why do you think that was?
- Can you describe a specific example of compassionate practice in the area?
- How did the placement affect the way that you think?

- Can you tell me about your most recent placement (if different from above) and your feelings and experiences when caring for patients / service users? What affected this? What were the differences between the area that you identified as being compassionate?

- Where or from who have your learned how to care?
- What do you understand by “compassion”?

Participant will be thanked for their time and for sharing their experiences and thoughts with the researcher.

Appendix 19: Team member consent for individual interviews

Participant CONSENT FORM: Individual Interview

(Version 1: 01/08/2015)

Title of Study: Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Approved by: NHS Ethics Committee, Leicestershire Partnership Trust Research and Development Department and De Montfort University Ethics Board. (IRAS project ethics reference number:166000).

Name of Researcher: Joanne Bird

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1 dated 13/07/2016 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without legal rights being affected. I understand that should I withdraw then the information collected to that point cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from De Montfort University. I give permission for these individuals to have access to these records. ☐

4. I give permission for the researcher to collect, store, analyse and publish information obtained from my participation in the study. ☐

5. I understand that anonymous direct quotes from the interview may be used in the study reports and subsequent publications. ☐

6. I agree to take part in the above study. ☐

_____	_____	_____
Name of Team Manager	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature
_____	_____	_____
Name of Principal Investigator	Date	Signature

(One copy for the researcher's records and one copy for the participant to be provided)

Appendix 20: DMU ethical approval

DE MONTFORT UNIVERSITY LEICESTER

HLS FREC Ref: 1484

12th February 2015

Joanne Bird
PhD Candidate

Dear Joanne,

Re: Ethics application – Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study. (ref: 1484)

I am writing regarding your application for ethical approval for a research project titled to the above project. This project has been reviewed in accordance with the Operational Procedures for De Montfort University Faculty of Health and Life Sciences Research Ethics Committee. These procedures are available from the Faculty Research and Commercial Office upon your request.

I am pleased to inform you that ethical approval has been granted by Chair's Action for your application. This will be reported at the next Faculty Research Committee, which is being held on 2nd April 2015.

Should there be any amendments to the research methods or persons involved with this project you must notify the Chair of the Faculty Research Ethics Committee immediately in writing. Serious or adverse events related to the conduct of the study need to be reported immediately to your Supervisor and the Chair of this Committee.

The Faculty Research Ethics Committee should be notified by e-mail to hlsfro@dmu.ac.uk when your research project has been completed.

Yours sincerely,

M. Grootveld

Professor Martin Grootveld
Chair
Faculty Research Ethics Committee
Faculty of Health & Life Sciences
De Montfort University

Appendix 21: Leicestershire Partnership agreement to carry out research

Leicestershire Partnership NHS
NHS Trust

A University Teaching Trust

Leicestershire Partnership NHS Trust
Riverside House
Bridge Park Road
Thurmaston Leicester
LE4 8PQ

Tel: 0116 295 0030
www.leicspart.nhs.uk

26 July 2016

Private & Confidential

Joanne Bird

Dear Joanne Bird

RE: An Agreement between Leicestershire Partnership NHS Trust and De Montfort University for a Licence to Operate within the Leicestershire Partnership NHS Trust as a Honorary Researcher.

I am pleased to confirm that the Leicestershire Partnership NHS Trust is prepared to grant you a licence to operate as a Honorary Researcher the terms of which are set out below.

General

This licence to operate is from 01, August, 2016 until 01, June, 2018. You will be based at Honorary Researcher but may be requested to provide cross cover within other sites managed by Leicestershire Partnership NHS Trust.

This appointment does not create any contract of employment between yourself and Leicestershire Partnership NHS Trust. There is no obligation on the Trust to provide you with

any set amount of work, or for you to work a set number of hours per week. Your entitlement to pay, annual leave, sick pay and other employment benefits will be the responsibility of your employing organisation. Your period of working under this licence to operate will count as continuous NHS employment as you remain a substantive employee of De Montfort University. This licence to operate will be withdrawn if your employment with De Montfort University is terminated. In the event that you wish to withdraw from this appointment please notify your *employer/place of study* and Victoria Peach for Leicestershire Partnership Trust.

This licence to operate can be terminated at any time by either party giving four weeks notice.

Absence From Duty

In the event of your absence from scheduled duty for reasons of sickness or any other reasons, you must notify Victoria Peach as soon as possible on the first day of absence.

Liability

The Trust accepts vicarious liability for any damages arising from your clinical negligence. If, however, you have substantive employment with another NHS Trust, then liability for your clinical negligence will remain that of your substantive employer. You may wish to consider obtaining your own cover for other liabilities which you may incur.

The scope of your duties will remain in accordance with the responsibilities within your De Montfort University job description and contract of employment in your substantive paid post, i.e. with your employer De Montfort University.

You will be expected to adhere to the policies and practices operated within the wards, departments, or other work areas in which you are working.

Professional Registration

You are required to maintain appropriate professional registration during the period that you have a licence to operate with the Trust and to provide evidence of ongoing registration if required.

Research Governance Framework

The Leicestershire Partnership NHS Trust manages all research in accordance with the requirements of the Research Governance Framework for Health and Social Care. You must comply with all reporting requirements, systems and duties of action put in place by the Trust to deliver research governance.

You are advised to familiarise yourself with the Framework document, which can be accessed through the Internet at www.doh.gov.uk/research

Disclosure and Barring Service (DBS) Clearance

A DBS check is required for appointments where contact with children or vulnerable adults is likely to occur. This must be completed by De Montfort University prior to the commencement of this licence to operate.

This requirement is subject to review and any change of policy which may extend the scope of the clearance required.

Criminal Charges and Disciplinary Issues

If during the period of this licence to operate you are charged with any criminal offence (which includes road traffic speeding offences), or if you are facing disciplinary action in relation to your substantive employment, you must report this to Victoria Peach as soon as possible, without waiting for the outcome of any criminal charges or disciplinary proceedings.

Policies and Procedures

You are required to make yourself familiar with and act in accordance with the policies and procedures of the Trust.

Equal Opportunities

The Trust is an Equal Opportunities employer. You are expected to abide by the terms of the Trust's Equal Opportunities policies and to co-operate with all measures introduced under those policies.

Health and Safety

The Trust attaches great importance to the safety of its employees and others, such as yourself, and recognises its duties under the Health & Safety At Work Act 1974. It is necessary for management and persons working within the Trust to work together positively to achieve a situation compatible with the provision of proper services to patients/clients where personal injuries and hazards to the health of persons working within the Trust and others can be reduced to a minimum. It is accepted that it is a management function to do all that is possible and practicable within available resources in the fields of construction, operation and the maintenance of buildings, plant, equipment and facilities to achieve such a situation.

Where appropriate, and within available resources, safety training will provided by the Trust together with the necessary safety devices and protective clothing.

For your part, you will be required to carry out your duties in a manner which is safe to yourself and others, and to co-operate by bringing to the notice of a manager any activity which could adversely affect any person who may be within the Trust or working situation.

Fire Prevention

It is essential that you know the fire precaution arrangements in the Trust's premises and you should read and thoroughly understand the Fire Notices that have been posted. It is a condition of this licence to operate that you familiarise yourself with the procedure to be followed in the event of fire and participate in drills, as and when required.

Accidents on Duty

All accidents and hazards at work, however apparently trivial, must be reported immediately to the Head of Department, Supervisor or senior member of staff on duty, as appropriate.

Confidentiality

During the period of your licence to operate you may have access to information designated by the Trust as being of a confidential nature and you must not divulge, publish or disclose such information without the prior written consent of the Trust.

Examples of confidential information include that relating to patients/clients, the business affairs of the Trust which is of a sensitive nature, details about Trust employees, and information held on Trust databases.

You may have access to, or be responsible for, patients/clients personal records and these must be treated with the utmost confidentiality and kept in as safe and secure manner at all times.

Improper use of or disclosure of confidential information will be regarded as a serious disciplinary matter.

Interest In Contracts

If it comes to your knowledge that the Trust has, or is proposing to enter into, a contract in which you have any financial interest, whether direct or indirect, and the contract is now one of which you are personally a party, you must as soon as possible give notice in writing to the Trust of your interest.

Acceptance of Gifts and Hospitality

You must not accept, or offer, gifts or hospitality of any kind from or to contractors, agents, firms, individuals or organisations with whom you deal under your licence to operate. Trivial articles such as calendars, diaries and similar items clearly issued for advertising purposes are not subject to this rule.

Personal Property

During the course of your appointment the Trust will not normally accept responsibility for the loss of, or damage to, any personal property. You are strongly advised to take out a private insurance for the damage to, or loss of, any personal property whilst on the Trust's premises.

Intellectual Property Rights

Upon commencement of any research project involving Leicestershire Partnership Trust's patients, carers or staff discussion of the intellectual property rights should be undertaken with Leicestershire Partnership Trust's clinical Lead.

Acceptance

If you agree to accept this licence to operate on the terms specified, please sign the form of acceptance below and return this copy of the offer to me. A second copy of this letter is enclosed, which you should also sign and retain for future reference.

Yours sincerely

Daniel Norbury
Human Resources

FORM OF ACCEPTANCE – PLEASE DO NOT DETACH

I hereby accept the offer of a licence to operate mentioned in the foregoing letter and subject to the conditions set out. I understand that I am not an employee of the Trust and accept that I have no rights or claims against the Trust on termination of the licence to operate.

Signed……Date……

Copy to: Victoria Peach

Leicestershire Partnership Trust

Appendix 22: IRAS Ethical approval

Health Research Authority

Miss Joanne Bird
De Montfort University
Leicester
LE1 9BH

Email: hra.approval@nhs.net

07 December 2016

Dear Miss Bird

Letter of HRA Approval

Study title:	**Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.**
IRAS project ID:	**166000**
Protocol number:	**1**
REC reference:	**16/HRA/5064**
Sponsor	**De Montfort University**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities

- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **166000**. Please quote this on all correspondence.

Yours sincerely

Natalie Wilson

Assessor

Email: hra.approval@nhs.net

Copy to: *Professor Martin Grootveld, De Montfort University, Sponsor contact*
Dr David Clarke, Leicestershire Partnership NHS Trust, Lead NHS R&D contact

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	*Version*	*Date*
Covering letter on headed paper [Cover Letter 10/09/16]	V1	10 September 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity]		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity]		
Interview schedules or topic guides for participants [Individual interview schedule]	version 1	01 August 2015
IRAS Checklist XML [Checklist_27092016]		27 September 2016
Letters of invitation to participant [Case study manager invitation]	version 1	01 August 2015
Other [Manager reply slip]	version 1	01 August 2015
Other [Consent form - manager case study]	version 1	01 August 2015
Other [Clinical Staff Participant information sheet]	version 1	01 August 2015
Other [Individual interview consent form]	version 1	01 August 2015
Other [Invitation for clinical staff to participate]	version 1	01 August 2015
Other [Observation opt out form]	version 1	01 August 2015
Other [Research poster for clinical areas]	version 1	01 August 2015
Other [Observation participant thank you letter]	version 1	01 August 2015
Other [individual interview participant thank you letter]	version 1	01 August 2015
Other [GANTT chart detailing proposed study timeline]	version 1	01 August 2015
Other [Copy of section D1 IRAS form signed decleration by CI]	V1	10 September 2016
Other [Statement of Activities]	2	07 December 2016
Other [Schedule of Events]	2	07 December 2016
Participant information sheet (PIS) [Participant Information Sheet - Clinical Managers]	1	01 August 2016
Participant information sheet (PIS) [Particpant Information sheet - Clinical Staff]	version 1	01 August 2015
REC Application Form [REC_Form_27092016]		27 September 2016
Research protocol or project proposal [Research Proposal]	version 1	01 August 2015
Summary CV for Chief Investigator (CI) [Curriculum Vitae]	Version 1	01 August 2015
Summary CV for supervisor (student research) [Supervisor CV]	V1	09 September 2016

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and

clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in

England, please refer to the, *participating NHS organisations*, *capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Joanne Bird

Tel: 01162013804

Email: jbird@dmu.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	Evidence and signatures have been provided separately for part D1 of the IRAS form. This is has been made available to R&D office via the HRA Portal.
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	This is a non-commercial, single site study taking place in the NHS. A Statement of Activities has been submitted. Trust specific documents are also being used with the participating NHS organisation, therefore the Statement of Activities will not act as

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			the agreement between Sponsor and site.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	Sponsor is not providing funding to participating NHS organisations.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	
6.3	Devices – MHRA notice of no objection received	Not Applicable	
6.4	Other regulatory approvals and authorisations received	Not Applicable	

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
This is a non-commercial, single site study. Therefore, there is only one site-type involved in the research. Research activity includes clinical observations and interviews with NHS staff. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.
Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research**. • Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix. • The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Local Collaborator (LC) is expected at participating NHS organisations.

Sponsor specific training has been undertaken prior to commencing the research. The Chief Investigator (CI) may be required to under Trust specific training.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

Appendix 23: Consent form Case study site team manager

Participant CONSENT FORM: Clinical Observation – Team manager consent.

(Version 1: 01/08/2015 IRAS:166000)

Title of Study: Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Approved by: NHS Ethics Committee, Leicestershire Partnership Trust Research and Development Department and De Montfort University Ethics Board. (IRAS project ethics reference number 166000).

Name of Researcher: Joanne Bird

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1 dated 13/07/2016 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my team participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without legal rights being affected. I understand that should I withdraw then the information collected to that point cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from De Montfort University. I give permission for these individuals to have access to these records. ☐

4. I give permission for the researcher to collect, store, analyse and publish information obtained from participation in the study. ☐

5. I understand that anonymous direct quotes from observation field notes may be used in the study reports and subsequent publications. ☐

6. I agree for the clinical area for which I am team manager, to take part in the above study. ☐

_____	_____	_____
Name of Team Manager	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature
_____	_____	_____
Name of Principal Investigator	Date	Signature

(One copy for the researcher's records and one copy for the participant to be provided)

Appendix 24: Focus Group consent form

Leicestershire Partnership NHS Trust

DE MONTFORT UNIVERSITY LEICESTER

Participant CONSENT FORM: Focus Groups

(Version 1:02/04/2015)

Title of Study: Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Approved by: NHS Ethics Committee, Leicestershire Partnership Trust Research and Development Department and De Montfort University Ethics Board.

Name of Researcher: Joanne Bird

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1 dated 13/02/15 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without legal rights being affected. I understand that should I withdraw then the information collected to that point cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from De Montfort University. I give permission for these individuals to have access to these records. ☐

4. I give permission for the researcher to collect, store, analyse and publish information obtained from my participation in the study. ☐

5. I understand that the focus group will be recorded and that anonymous direct quotes from the focus group may be used in the study reports and subsequent publications. ☐

6. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature
_____	_____	_____
Name of Principal Investigator	Date	Signature

(One copy for the researcher's records and one copy for the participant to be provided)

Appendix 25: Individual interview consent form

Participant CONSENT FORM: Individual Interview

(Version 1: 13/07/2016)

Title of Study: Exploring undergraduate mental health nursing student experience of socialisation in compassionate practice: A phenomenological study.

Approved by: NHS Ethics Committee, Leicestershire Partnership Trust Research and Development Department and De Montfort University Ethics Board. (project ethics reference number: 166000).

Name of Researcher: Joanne Bird

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1 dated 13/07/2016 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without legal rights being affected. I understand that should I withdraw then the information collected to that point cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from De Montfort University. I give permission for these individuals to have access to these records. ☐

4. I give permission for the researcher to collect, store, analyse and publish information obtained from my participation in the study. ☐

7. I understand that anonymous direct quotes from the interview may be used in the study reports and subsequent publications. ☐

8. I agree to take part in the above study. ☐

_____	_____	_____
Name of Team Manager	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

_____	_____	_____
Name of Principal Investigator	Date	Signature

(One copy for the researcher's records and one copy for the participant to be provided)

Appendix 26: Summary of data analysis process utilised in this study

Effective data management:	Immersion in data through: • Researcher transcription of all focus groups and individual interviews within 48 hours • Observation field notes typed up within 24 hours by the researcher • "Reliving" of data collection events documented in support memos • Digital recordings revisited to support ongoing interpretation and understanding • Re-reading of transcripts to support constant comparisons
NVIVO-11 as a data management tool:	All transcripts and field notes uploaded to NVIVO for initial coding: • Word-by word coding • Line-by-line coding Memos stored as nodes to link to relevant content and support identification of emerging themes Nodes utilised to facilitate comparisons in data and identify emerging themes Mindmap tool utilised to identify repeated words to support identification of themes Text searching tool utilised to cross check themes across all data
Advanced coding:	➢ In vivo coding utilised to extract deeper meaning from data and to develop analytical categories ➢ Focused coding used to generate conceptual codes, identify initial codes that were most analytically robust and to identify new threads of analysis
Identification of major categories:	Major categories identified through: • Coding and recoding • Reflective discussions with the supervisory team • The use of reflective memos • Discussions with participants • Memo writing, freewriting, narrative and discourse writing and diagramming • Reflective consideration of categories to be raised for theoretical concepts, dependent upon meaningful data and evidence of relationships with other categories
Exploration through the lens of existing conceptual frameworks:	➢ Phase one data examined through the conceptual lens of the socialisation in compassionate practice framework (Curtis, Horton and Smith, 2012; Curtis, 2015)
Co-construction of themes, categories and theory with participants:	Co-construction utilised throughout all phases of study to support reflexive mutual collaboration in interpretation and conceptualisation.

Appendix 27: Summary of research design choices

Research domains:	Research design choices:
Methodology:	Qualitative
Paradigm:	Constructivist Ontology: Constructivism – reality is socially constructed, subjective and may change Epistemology: Subjective meanings and motivating actions are acceptable knowledge Axiology: The researcher is part of what is being researched
Strategy:	Case Study (underpinned by the work of Stake, 1994; 1995)
Methods:	Phase One - Focus Groups: Six focus groups in total with student mental health nurses from De Montfort University (two focus groups with first years, two with second years and two with third year students) Participants in focus groups made recommendations for practice areas worthy of case study – single case study site selected
	Individual semi- structured interviews Four individual interviews with participants from phase one who recommended the practice site for case study – conducted prior to observations being conducted. Five individual interviews conducted with staff members who worked within the case study site and one individual interview with a student on placement with the team in the timeframe of the case study. These interviews were conducted in between practice observations and after all observations has been completed. Observations of practice site – three observations lasting four hours each Observer-as- participant model of observation utilised - Observation 1: Observation of team member conducting assessment / visits at a nursing home - Observation 2: Observation of team member and student nurse while on daily community visits and at the team base - Observation 3: Observation of all team members who attended a weekly team meeting
Analysis:	Grounded Theory Approach (underpinned by the work of Charmaz, 2004. 2006, 2014) NVIVO utilised as a data management tool. Iterative approach taken to data analysis Initial/ in vivo / focused coding supported by the use of memos, freewriting, narrative and discourse writing and the use of diagrams and tables Sensitising Concept – New Grounded Theory of Student Nurse Socialisation in Compassionate Practice (Curtis, 2015) utilised to guide analysis of phase one data. Collaborative discussions with participants utilised to support the development of themes, categories and theoretical concepts. Analysis of reflective journal and the in-depth consideration of the impact of the researcher on the research process.

Appendix 28: Summary of how the study meets parallel criteria – quality assurance

Parallel criteria:	Parallel criteria evidenced in this study:	Section of reference:
Credibility	Qualitative methodology most appropriate to uncover factors underpinning student mental health nurse socialisation in compassionate nursing practice	3.1: Qualitative or Quantitative
	Ontological, epistemological and axiological position of the research / research consistent with a constructivist paradigm and well aligned to a qualitative methodology	3.3: Paradigm
	Case study strategy appropriate to support in-depth exploration of issues underpinning the phenomenon under investigation and allowed multiple data collection methods to be utilised to support gathering of robust, appropriate triangulation of data	3.4.1: The selection of a qualitative strategy for data collection
	Research strategy evolved based on findings from phase one – focus groups to phase two case study. Case study site was recommended by participants who'd had experience of socialisation in compassionate practice through placement experiences at the case study site (purposeful sampling)	3.5.2.1: Case study selection
	Selection of well evidenced methods of data collection	3.5.1.1: Focus Groups – the theory 3.5.2.1: Case study selection 3.5.2.2: Semi-structured interview – the theory 3.5.2.3: Practice observations – the theory
	Reflexivity engaged in with in-depth consideration of the impact of the researcher on the study and reflexive mutual collaboration engaged in	3.6.3.8: Conceptualisation
Transferability	The research design described in explicit detail to ensure that the study design could be replicated	3.5.1.2: Focus Group recruitment 3.5.1.4: Focus group operationalisation 3.5.2.1: Phase two case study selection 3.5.2.1.2: Phase two case study recruitment 3.5.2.1.3: Phase two case study operationalisation 3.5.2.2.1: Semi structured interviews - operationalisation 3.5.2.3.1: Practice observation operationalisation 3.5.2.4: Reducing the potential for the Hawthorne effect

Dependability	Chosen methodology / methods are trustworthy	3.1: Qualitative or Quantitative 3.3: Paradigm 3.4.1: The selection of a qualitative strategy for data collection 3.5.1.1: Focus Groups – the theory 3.5.2.1: Case study selection 3.5.2.2: Semi-structured interview – the theory 3.5.2.3: Practice observations – the theory
	Research carried out with integrity and transparency	3.5.2.4: Reducing the potential for the Hawthorne effect 3.5.2.5: Ethical considerations 3.6.3.8: Conceptualisation
	Ethical considerations – approval received from DMU, NHS research ethics and LPT R&D	3.5.2.5: Ethical considerations
	Consent received from all participants and full details of the study provided for all participants	3.5.2.5: Ethical considerations
Confirmability	Collaborative discussions with participants supported both additional analysis of emerging themes, categories and concepts but also provided opportunity for participants to provide feedback confirming how finding and conceptualisation of findings resonated with their experiences	3.6.3.8: Conceptualisation

Appendix 29: All in this together – theme factors that supported student socialisation in compassionate practice

All in it together		
Theme:	Socialisation enhanced by:	Meaning created:
Authenticity in compassionate care	• Student exposure to genuine positive interactions between practice staff and service users / students / each other / others • Practice staff expressed attitudes consistent with their interactions with others • Practice staff demonstrate a positive attitude to working with students • Practice staff present as friendly, approachable, patient and non-intimidating • Practice staff demonstrate authentic interest in student well-being • Practice staff demonstrate authentic concern for student wellbeing and acts of self-care • Practice staff support students to develop coping strategies and resilience • Practice staff take a genuine personal and professional interest in the student • Practice staff present as; spontaneous, flexible and responsive to student needs	• Students experience increased feelings of: Shared humanity / equality in relationship with staff / student value / personal significance / psychological and emotional safety • Students feel supported to engage in compassionate practice • Increased sense of permission to engage in compassionate practice • Reduced feelings of fear and anxiety
Under their wing	• Identification of student vulnerability and actions to reduce vulnerability • Students supported to work autonomously but provided with accessible support as required • Staff demonstration of kindness / friendliness / approachability / supportiveness / authentic concern for students / patience / non-judgemental attitudes / be willing to advocate for students • Access to Informal support provided by other students in the placement area • Active attempts made by practice staff to accept and include students as a member of the team • Practice staff "looking out" for students and offering support as they would other team members • Practice staff offer appropriate support to students • Practice staff make active attempts to enhance student feelings of belonging and acceptance within the team • Practice staff ensure that students are introduced to other staff and service users • Practice staff invite students to take part in work tasks • Practice staff recognise student value • Students are made to feel like they matter	• Students feel "looked after" • Increased feelings of psychological and emotional safety • Students made to feel that they matter resulting in increased feelings of personal and professional values and significance • Students feel accepted and included • Students feel cared for • Students feel that they have been treated compassionately leading to internalisation of the positive impact of compassion
Camaraderie and feeling like part of the team	• Practice staff and other students provide clarity regarding expectations placed on the student during the placement experience • Practice staff make efforts to ensure that students feel wanted • Practice staff make efforts to ensure that students feel welcome • Practice staff invest time in orientation of the student to the care environment • Practice staff introduce students to other team members and service users by name • Practice staff learn and use the students name / preferred name	• Students feelings of acceptance and inclusion. • Students feel wanted. • Students feel like a part of the team. • Enhanced feelings of psychological and emotional safety • Student ability to "settle" into the placement is enhanced • Students feel valued and significant as both students and individuals.

	• Practice staff demonstrate willingness to enhance relationships with students by inviting them to share breaks, join in with team social events and take part in care activities • Support from other students in the practice context	
Continuity	• Practice staff engage in consistently supportive relationships with students • Students are given the opportunity to ask questions without fear of rebuke or ridicule • Practice staff offer support to students to apply theory to the practice context • Academic staff utilise practice examples in the theory component of the programme • Academic staff have currency in practice and acknowledge contemporary challenges of practice • Practice staff role model the use of evidence-based practice in their daily work • Practice staff invest time to discuss and reflect upon care activities engaged in • Practice staff engage students in discussion regarding rationale for care activities and professional judgements • Students are exposure to consistent delivery of compassionate care • Practice staff engage students in reflective discussions regarding compassionate practice	• Reduction in feelings of fear and rebuke • Classroom experienced seem more relevant to students and they begin to understand the application of theoretical concepts in practice • increased student knowledge and tolerance of symptoms profiles. • Increased student understanding of the antecedents to service user presentations • Reduction in assumptions about service users' needs • Increased engagement in compassionate care practices • Increased experience of empathy for service users • Increased understanding of care rationale
Having shared goals	• Shared team ethos of compassion • Shared team compassionate care goals • Practice staff prioritise compassionate care • Practice staff communicate the significance of compassionate care to students • Practice staff role model engagement in compassionate care practice • Students are supported to access team supervision in which challenges / barriers to compassion are explored	• Bridges the gap between theory and practice, reducing experience of dissonance between the two • Experience of how theoretical concepts are applied in the reality of practice • Students recognise the significance of compassionate care and increased understanding of the benefits associated with it • Student becomes emersed in the spirit of compassionate care • Students aim to replicate the compassionate philosophy, goals and actions role modelled by the team • Staff better able to maintain and re-invigorate their compassionate ideas, creating consistency of compassionate practice
Prioritising the meaning	• Practice team members recognise and communicate the importance of compassionate care • Team members demonstrate prioritisation of engagement in compassionate care • Team members make active attempts to engage in compassionate care • Practice staff role model a willingness to enter into patient centred therapeutic relationships with service users • Practice staff role model engagement in authentic compassionate relationships with service users • Practice staff demonstrate willingness to "go the extra mile" to engage with service users • Practice staff motivate students to engage in compassionate practice by recognising it as an achievement • Practice staff provide students with opportunities to engage in compassionate care	• Students feel that they are valuable • Students feel that they can make a positive difference to service user experience • Students feel that they are personally and professionally significant • Students aspire to replicate compassionate role models • Increased student identification, prioritisation and maintenance of compassionate purpose • Student realisation that compassionate actions can be achieved through small, creative and person-centred interactions • Students recognise that compassionate practice is possible and achievable • Increased feelings of personal and professional achievement • Increased likelihood of students attempting to engage in compassionate practice

Being supported to achieve	• Practice staff offer students opportunities to engage in personal and professional development • Practice staff make expectations that students should engage in compassionate practice, clear, through their expressed values, ideals and role modelling of compassionate engagement • Practice staff provide guidance to students for ways in which they can engage in compassionate practice • Students are provided with feedback from service users and practice staff about their positive impact on a service users experience • Practice staff provide students with opportunities to feel that they are able to make a difference • Practice staff encourage and support students to engage in compassionate care	• Feelings of personal achievement • Feelings of professional (clinical and programme) achievement • Students experience increased feeling of significance due to perceptions that they can make a difference • Students experience increased motivation to engage with compassionate care • Students feel supported to achieve • Increased feelings of permission be granted for students to engage in compassionate care
Permission to practice compassionately	• Team leader / the organisation demonstrate commitment to compassionate values, with consistency between identified values and treatment of staff members and service users • Role modelling of compassionate interactions directed towards practice staff by the team manager / wider organisation • Practice staff engage in active attempts to support physical, emotional and psychological safety of students • Practice staff, team manager and the health organisation provide consistent permission for students to engage compassionately • Practice staff provide guidance to students on how they can engage compassionately	• Student understanding and acknowledgement that compassionate care is the norm and expected • Students feel that attempts to engage in compassionate care will be supported • Students mirror the actions of compassionate staff • The importance of compassionate care is re-enforced • Students feel enhanced levels of safety, support and encouragement which results in increased levels of self-permission to engage in compassionate practice • Likelihood of students engaging in compassionate practice increased

Appendix 30: "Everyone for themselves" – theme factors that inhibited student socialisation in compassionate practice

"Everyone for themselves"		
Theme:	Socialisation Inhibited by:	Meaning created:
Being Fake	• Practice staff demonstrate inauthenticity in their relationships with service users / students / other staff • Evident disconnect between the actions of practice staff and their expressed feelings and thoughts • Student exposure to practice staff burnout and compassion fatigue • Student exposure to a practice culture of blame • Apparent disconnect between the organisation, health policy values and the support offered to practice staff • Practice staff express fear of blame and rebuke to students	• Students have reduced trust in practice staff • Students feel unsafe (psychologically and emotionally) • Students feel the need to moderate their true-self • Students mirror inauthenticity as an act of self-preservation • Students guarded in their relationships with practice staff • Fears of inauthenticity in future placements which impacts engagements at future placement opportunities
Being seen as a problem	• Practice staff express the belief that students create problems within the practice context • Practice staff negatively criticise students, rather than engage in constructive criticism • Students being made to feel that they are an inconvenience by practice staff • Practice staff who communicate that students create unnecessary workload • Practice staff demonstrate negative attitudes towards working with students • Practice staff negatively criticise students, for engaging in acts of compassion	• Students feel that they are an inconvenience • Students feel unwanted and unwelcome • Students feel isolated, embarrassed, useless and fearful of engaging in compassionate practice • Reduction in student desire / willingness to engage in compassionate practice • Student increased feelings of fear that assessment would be negatively impacted • Increase in student feelings of vulnerability • Students feel that they have to moderate their compassionate ideals and actions • Students mirror poor staff attitudes and actions in an attempt to fit in. • Students fail to challenge poor practice
"Billy no mates" - isolation	• Students feel isolated and alienated from the team • Negative practice staff attitudes towards students • Students are not invited to participate in team camaraderie • Practice staff make assumptions about student knowledge and experience • Practice staff have unrealistic expectations of student knowledge and skills • Practice staff make negative assumptions about students • Practice staff communicate a lack of recognition of the value of students • Practice staff communicate a lack of value for 1st year students learners • Practice staff lack of recognition of students as unique learners • Practice staff communication of negative assumptions about all students • Practice staff communication of lack of recognition of the value of students	• Students feel isolated, separated and alienated from the rest of the team • Students feel unsafe • Students present an inauthentic version of themselves as a mode of self-protection • Students feel unsupported • Students experience increased fear of criticism and rebuke • Students feel under-valued and insignificant • Student feelings of acceptance negatively impacted • Student feelings of inadequacy

	• Practice staff lack of genuine interest in students as individual learners with unique and valuable life experiences	
"Pie in the sky"	• Practice staff criticism of students for trying to apply theoretical content of their programme into practice • Inconsistency between risk adversity in organisations and teaching in theory component of the programme / evidence-based practice • Student exposure to practice staff fear of blame and rebuke relating to occurrences of untoward incidents • Students experience disconnect between theoretical and practice elements of the programme • Lack of illustrative examples used in the classroom to demonstrate how theory can be applied to practice (academic staff) • Practice staff fail to role model compassionate care • Practice staff do not engage students in discussion regarding the rationale for care and care decisions • Student exposure to staff pressures created by lack of investment, resources and work-load • Student exposure to staff receiving a lack of support from the organisation in their job role • Students experience of fear that their placement assessment will be negatively affected by engaging in compassionate practice (if the assessor does not demonstrate compassion towards others) • Practice staff expression of lack of value of contemporary nurse education • Practice staff lack of recognition of the relevance of the theoretical component of the programme of education • Practice staff communicate negative criticism of the students programme of education	• Students feel bewildered and uncertain of their role and how to respond in care situations • Student replication of poor standards of care that they have witnessed • Student acceptance that poor standards of care are the reality of the job • Students less likely to challenge poor practice • Reduced opportunities for students to engage in compassionate practice • Increase in risk aversion by students • Increase in acceptance and engagement in coercive and paternalistic care practices by students • Increased student confusion about how theory relates to the reality of care • Reduction in student feelings of safety • Reduction of student experience of achievement • Reduction in student feelings of acceptance in the practice environment • Reduction in student feelings of personal and professional significance and worth • Student mirror poor practices exhibited by practice staff • Reduction in student confidence and esteem • Students less likely to challenge the status quo of the care environment where poor practice occurs • Student increased fear of job security • Student increase of acts of self-preservation / protection • Students less likely to engage with positive risk taking due to fear of rebuke / blame
Prioritising the metrics	• Organisation prioritisation of tasks over practice staff and students engaging in compassionate practice • Apparent disconnect between the organisational guiding vision and organisational requirements regarding the requirements of workload • Apparent disconnect between national guidance, government investment and the realities of practice • Practice staff prioritisation of tasks over relationships with service users • Burden of work tasks that reduce the scope for service user contact • Student exposure to staff pressures created by lack of investment, resources and work-load • Practice staff demonstration of discrimination / stigma towards certain health diagnoses (i.e. Personality Disorders) • Practice staff role modelling of justification for their lack of compassionate engagement • Practice staff lack of recognition or communication of recognition of the positive impact of compassionate practice to students	• Student Inhibition of compassionate purpose • Student feelings of fear and insecurity • Student prioritisation of tasks at the detriment of compassion due to fear of rebuke, and litigation • Students justify reduced compassion • Student stigmatisation and discrimination against those service users who are perceived as problematic / challenging or who have certain diagnosis or personal history • Reduced feeling of significance for students and practice staff • Lack of positive re-enforcement of the benefits / importance of compassionate practice • Lack of recognition of the importance of compassionate practice

	• Practice staff prioritisation of metrics and staff over compassionate care interactions	
"Having the compassion knocked out of you"	• Practice staff project their feelings of dissatisfaction and negativity regarding the profession • Student experience of burnout and / or compassion fatigue • Students experience a lack of support when exposed to challenging situations (i.e. self-harm, suicide attempts, violence and aggression) • Weak leadership from the team manager / wider organisation • Student exposure to a practice culture of blame • Student exposure to practice staff experience of burnout and / or compassion fatigue • Practice staff role model or advise students to reduce engagement with services users to avoid burnout / fatigue	• Student compassionate ideals and the ability to engage compassionately diminished • Student reduction in feelings of compassionate purpose • Student reduction in feelings of physical, psychological and emotional safety • Student experience of compassion fatigue and / or burnout • Students re-focus from service user priority to self and self-achievement priority • Increase in student feelings of guilt / self-contempt / depersonalisation • Students feel insignificant • Students become desensitised to service user distress • Students find reasons to justify their lack of compassion
"Doing what I need to do to pass"	• Students experience fear that their placement assessment will be negatively affected by engaging in compassionate practice (if the assessor does not demonstrate compassion towards others) • Students feeling that they have to "please" the assessor to pass the placement • Practice assessors lacking in compassionate ideals and practice • Practice staff minimisation of student significance and their ability to make a difference in the care context • Students lacking insight in to how they can make a difference • Practice staff role modelling of a lack of understanding of the significance of compassion	• Student feelings of demotivation • Student confusion about their identity as a future nurse • Student feelings of stagnation • Students question career choice • Student prioritisation of practice assessment over compassionate clinical achievements. • Student self-achievement prioritised • Students change behaviour to "please" mentors • Students mirror the negative attitudes, values and beliefs of mentors • Compassionate practice becomes secondary to student progression through the programme • Students view compassion as a future aspiration rather than a requirement of the present, limiting scope for engagement in compassionate practice • Student minimisation of the significance of compassionate engagement • Student justification of the lack of compassion, thereby giving themselves permission to prioritise achievement first • Student lack of engagement in authentic "compassionate" care • Student reduction in feelings of significance • Students resort to "going through the motions" with limited emotional engagement
Self-protection	• Students experience a lack of support when exposed to challenging situations (i.e. self-harm, suicide attempts, violence and aggression) • Weak leadership from the team manager / wider organisation • Student exposure to a practice culture of blame	• Student sense of permission to engage in compassionate practice inhibited • Students feel that they have to protect themselves from threats posed in the environment • Students feeling fearful or physical, emotional and psychological threats • Students become introspective and focus on own needs • Students enter "survival mode" and exclusively attend to their own needs • Students experience a reduced desire and scope to engage in compassionate practice

Appendix 31: That's what makes it such an amazing placement – theme factors that supported student socialisation in compassionate practice

All in it together		
Theme:	Socialisation enhanced by:	Meaning created:
"The gift of time"	• Practice staff willingness to invest time in student development and preparation • Students exposure to a supportive team culture • Practice staff demonstrate compassion towards each other • Practice staff support each other to engage in compassionate practice • Practice staff invest time in developing relationships with students • Practice staff role model acts of advocacy • Practice staff role model investment in developing compassionate therapeutic relationships with service users • Practice staff role model investment of time in relationships with service users, families and others • Practice staff invest time in to supporting the needs of service users, their families and other staff members • Practice staff provide high quality mentorship • Practice staff recognition of student vulnerability • Practice staff invest time in supporting student vulnerability • Practice staff offer support and patience when working with students with additional learning needs • Practice staff invest time to support students to develop outside of their comfort zone • Practice staff allow students to engage in self-directed learning, and self-identification of learning needs, while offering a supportive safety net	• Students able to recognise increased opportunity for personal discovery, learning and achievement • Students feel prepared for the challenges that may be encountered in the working day • Students feel valued • Student confidence is enhanced • Students feel supported • Students feel safe and secure within the practice context • Students experience enhanced connections with other team members • Students feel accepted • Students experience enhanced feelings of self-worth • Students more likely to acknowledge difficulties and access support • Students more likely to try new or challenging learning opportunities • Increase in student motivation to try new things • Students feel that they are recipients of compassion • Students recognise the importance of compassion between team members • Students feel that the placement is a safe space in which to learn • Increased student knowledge of how theory and practice relate • Students recognise increased opportunities to engage in acts of advocacy • Students feel that they can make a positive difference to the lives of service users • Students recognise opportunities to engage in collaborative care partnerships • Student internalisation of the importance of investing time with service users
"Teamwork makes the dream work"	• Team stability (emotional maturity / regulation of team members and low staff turnover) • Team cohesiveness – team members get on with each other and support each other • Practice staff engage in calm and supportive interactions with each other • Team shared ethos of peer support • Practice staff role model the importance of team cohesion and stability to students • All team members (regardless of discipline) proactive in offering learning opportunities to students • Student support and encouragement is provided by all team members (regardless of discipline)	• Students feel increased emotional and psychological safety • Students feel wanted by the whole team • Students experience enhanced feelings of integration • Students feel valued • Student confidence is increased • Students more likely to push own limits and work outside of their comfort zone • Students feel significant • Students feel genuinely valued by team members • Students feel accepted and included • Students recognise increase opportunity for achievement • Students experience internalisation of the importance of compassion as the recipient

	• Provision of accessible equipment and resources for student use (i.e. IT equipment) • Practice staff role model compassion which is directed to the student • All team members proactively support student integration into the team	• Students feel more inclined to engage in compassionate practice
"They put in a marathon"	• Practice staff demonstration of willingness and active attempts to form relationships with service users • Practice staff demonstrate the willingness to "go the extra mile" to form relationships with students • Practice staff demonstration of personal sacrifice to build relationships (financially, emotionally and the provision of time) • Practice staff sacrifice (financial, emotional, additional investment of time) to support student development • Practice staff demonstration of investment in student developmental and learning opportunities • Practice staff engaging students in reflective discussions (formal and informal) • Practice staff explaining rationale for care and problem solving to overcome care challenges • Effective utilisation of time throughout the working day (i.e. travel time) to engage students in reflective discussions • Practice staff demonstrate the willingness to "go the extra mile" to include students in the team	• Students feel valued • Students feel accepted • Students feel cared for • Students able to make links between theory and practice • Students feel that practice staff are genuinely supportive of student achievement and development
Compassionate purpose from implicit to explicit	• Role modelling of compassionate purpose by practice staff • Practice staff supporting students to "read between the lines" to identify implicit examples of compassionate purpose, making the implicit – explicit • Practice staff engaging students in pre and post care discussions • Practice staff providing clear rationale for contacts with Service users and care activities engaged in	• Student internalisation of the importance of compassionate engagement • Student recognition of specific purpose of care activities engaged in • Students experience and increased understanding of their role • Students recognise additional ways in which they can compassionately interact with service users

Appendix 32: The factors that sustained the teams' ability to socialise students in compassionate mental health nursing practice

Sustainment of factors that socialise students in compassionate practice		
Theme:	Influences that support positive socialisation (from "All in this together" and "That's what makes it such an amazing placement").	Factors that support sustainment of conditions required for socialisation in compassionate practice
Composition of the team	• Team cohesion • Team stability • Effective team working • Effective communication between team members • Role modelling of compassionate practice by practice staff • Students feeling safe while on placement • Students being supported to work outside of their comfort zone • Shared team philosophy of compassionate care • Shared team sense of compassionate purpose	• Small team size • Maturity / experience of team staff / established nature of the team • Team member support of each other • Absence of fear of rebuke from other team members • Clearly defined roles of each team member • Team members embrace roles and expertise of other team members • Team member genuine value for each other's expertise and roles • Recruitment includes assessment of individual staff values • Established nature of the team supports new staff socialisation in established team philosophy • Provision of emotional support between team members, to work through care challenges • Team members able to enter into open dialogue regarding care challenges • Team members engage in compassionate interactions with each other • Practice assessors are supported in their roles as practice educators by other team members
"We're all on the same page"	• Shared team compassionate values • Shared team compassionate purpose (towards both service users and students) • Staff / student motivation to engage in compassionate practice • Non-judgemental, supportive and compassionate relationships between staff and staff and students • Staff investment of time with service users • Staff willingness to go the extra mile • Staff demonstrating of compassionate purpose direct towards each other and students • Staff engagement in open dialogue regarding challenges of care • Authenticity of compassionate practice • Positive role modelling • Student encouragement to work with all team members • Students feel wanted and valued • Students acknowledged as unique learners • Reduced dissonance between theory and practice • Staff investment of time in reflection • Increased feelings of student value	• Clearly defined roles of each team member • Team members embrace roles and expertise of other team members • Team member genuine value for each other's expertise and roles • Recruitment includes assessment of individual staff values • Established nature of the team supports new staff socialisation in established team philosophy • Provision of emotional support between team members, to work through care challenges • Team members able to enter into open dialogue regarding care challenges • Absence of fear of rebuke or censor from other team members • Team members engage in compassionate interactions with each other • Practice assessors are supported in their roles as practice educators by other team members and team leadership • Individual team members have an established sense of compassionate purpose • Team members have an individual and collective passion for the care specialty • Team members recognise the value and significance of service users that they work with • Collaborative team opportunities to discuss care challenges and action plan to resolve challenges provided

		• Team members recognise the importance and value of other health professionals and their role in service user care • Team members invest in non-judgemental, supportive, compassionate working relationships with each other and other health care staff • Team members engage in acts of compassion towards each other, underpinned by recognition of supportive team relationships • Team members recognise their impact that their attitudes, behaviours and actions can have on students on placement with the team • Team awareness of their impact as role models for students on placement with the team • Team members are aware of what is required in their role as supporters of students • Team members are aware of and able to identify student vulnerability • Proactive team approach taken to reducing student experience of vulnerability • Team members recognise that student aims and needs vary • Team members recognise the need for a flexible approach in working with students, according to individual needs • Team members have clear purpose regarding their roles as practice educators / assessors • Team members engage in reflection to improve own practice • Team members harbour positive attitudes about students • Team members enjoy working with students and recognise the value of students in the practice context • Team members recognise the importance and value of their roles as practice educators / assessors • Team member feelings of physical, emotional and psychological safety within the team context
Established mentorship management	• Positive attitudes towards students • Team shared responsibility for student experience • Students feeling supported • Staff sense of purpose re role as a mentor	• Development of team changes to support students – both planned changes and changes that have occurred as a result of the natural team development process • Lead mentor and associate mentor allocation • Students allocated to mentors on a rotational basis providing staff with recuperative breaks from mentorship role • Leadership re-enforcement of aims for positive placement experiences • Team members supported to attend training to become recognised practice educators / assessors • Team members supported to attend continual professional development opportunities to maintain currency on the role as practice educator / assessor • Practice staff recognition and engagement in the use of reflection to improve own practice • Team members recognise that students support their continual development and learning • Team members recognise that students can also teach them new concepts and skills based on their educational and life experiences

"The flavour of the team is set from the top"	• Staff feelings of safety (emotional, psychological and physical safety) and feelings of employment security • Internal team support • Staff feelings of being valued • Staff given the opportunity to voice their concerns • Staff feelings of significance and value • Staff increased capacity to engage in the scope of compassion • Reduced risk of staff fatigue / burnout • Staff feel protected • Increased feelings of student significance • Values placed on staff role as mentors • All team mentors have access mentorship training and updates • Equipment made available for student to fully participate in team-work • Increased continuity between theory and practice	• Team manager recognition of the emotional impact of work engaged in by the team • Team manager facilitates a supportive culture for all staff • Team manager contributions to clinical a problem solving • Team manager clear sense of purpose of the managers role • Team manager awareness of the importance of compassionate leadership to set the tone of team ethos / compassionate culture • Team manager acts as a buffer between the demands of the wider organisation and team member • Team manager acknowledgement of the value of students • Managerial prioritisation of staff attending mentor updates • Team manager role modelling of the significance of students to other team members

Appendix 33: The "Senses" according to Nolan et al (2006)

The "Sense":	Factors that create the sense for staff:	Factors that create the sense for students:
Security	• Structured mechanisms for clinical supervision and mentorship • Experienced staff available for role modelling and problem-solving • Freedom to challenge poor practice without censure • Known boundaries in which to operate • Having clear and explicit goals	• Students feel well prepared • Students feel supported • Students have help to talk things through • Students feel that staff are highly skilled and knowledgeable
Belonging	• Core team of stable staff • Blurring of roles • Clear sense of belonging to a team • Strategies for keeping staff informed	• Students are made to feel welcome • Students feel like part of the team • Staff appreciate the importance of learning opportunities for students • Students are able to identify with older people • Students feel they belong to their cohort and the wider student body
Continuity	• Team nursing / named nursing as the system for organising care • Wards having designated therapy staff • Integrated multi-disciplinary documentation encouraging continuity of communication • Limiting the number of medical teams providing care to one ward • Explicit process for inducting new members of staff	• A clear and effective relationship between placement and the university • Exposure to a clear philosophy of care • Consistent relationships
Purpose	• Clear therapeutic rationale for care • Investing in resources in creating effective leadership • Regular appraisal and goal-setting for all staff • All staff encouraged to review practice and suggest improvements	• Students feel that they have something to aim for • Students actively manage the placement
Achievement	• Recognition of effort • Designated additional responsibilities • Being able to provide the best possible care	• Students find placements inspiring • Seamless links between university and placements • Students experience personal achievement
Significance	• Investment in personal professional development • Opinions valued and listened to • Adequate equipment to carry out role • Work with older people valued and recognised as important	• Students feel that they matter • Students feel that working with older people matters

(Taken from Nolan et al, 2006 – Staff senses pg 26 and 27; Student senses pg116-122).

Appendix 34: The application of the Senses to the factors that enhance socialisation in compassionate practice and are present in a compassion enriched placement experience

The Sense:	Characteristics:	Facilitators:
Security	Authenticity in compassionate care	• Student exposure to genuine positive interactions between practice staff and service users / students / each other / others • Practice staff expressed attitudes consistent with their interactions with others • Practice staff demonstrate a positive attitude to working with students (Atack et al, 2000) • Practice staff present as friendly, approachable, patient and non-intimidating (Grey and Smith, 2000)
	Under their wing	• Identification of student vulnerability and actions to reduce vulnerability (Kaldal, Kristiansen, and Uhrenfeldt, 2018) • Students supported to work autonomously but provided with accessible support as required (Ibrahim,2011) • Staff demonstration of kindness / friendliness / approachability / supportiveness / authentic concern for students / patience / non-judgemental attitudes / be willing to advocate for students (Grey and Smith, 2000) • Access to Informal support provided by other students in the placement area (Peyrovi et al, 2005)
	Camaraderie and feeling like part of the team	• Practice staff and other students provide clarity regarding expectations placed on the student during the placement experience (Aston, Aston, and Hallam, 2014) • Support from other students in the practice context (Gilmour, Kopeikin and Douché, 2007)
	Permission to practice compassionately	• Team leader / the organisation demonstrate commitment to compassionate values, with consistency between identified values and treatment of staff members and service users (West et al, 2014) • Role modelling of compassionate interactions directed towards practice staff by the team manager / wider organisation (Bridges et al, 2017) • Practice staff engage in active attempts to support physical, emotional and psychological safety of students (Grey and Smith, 2000)
	The gift of time	• Practice staff willingness to invest time in student development and preparation • Students exposure to a supportive team culture (Cooper, Courtney-Pratt and Fitzgerald, 2015) • Practice staff demonstrate compassion towards each other • Practice staff support each other to engage in compassionate practice
	Teamwork makes the dream work	• Team stability (emotional maturity / regulation of team members and low staff turnover) (Luo and Wang, 2009) • Team cohesiveness – team members get on with each other and support each other (Apker et al, 2006) • Practice staff engage in calm and supportive interactions with each other (Apker et al, 2006) • Team shared ethos of peer support • Practice staff role model the importance of team cohesion and stability to students • All team members (regardless of discipline) proactive in offering learning opportunities to students
Belonging	Under their wing	• Active attempts made by practice staff to accept and include students as a member of the team (Levett-Jones et al, 2009) • Practice staff "looking out" for students and offering support as they would other team members • Practice staff recognition of and support of student vulnerabilities

	Camaraderie and feeling like part of the team	• Practice staff make efforts to ensure that students feel wanted (Nolan, 1998) • Practice staff make efforts to ensure that students feel welcome (Nolan, 1998) • Practice staff invest time in orientation of the student to the care environment (Worrell, 2007) • Practice staff introduce students to other team members and service users by name (Grey and Smith, 2000) • Practice staff learn and use the students name / preferred name • Practice staff demonstrate willingness to enhance relationships with students by inviting them to share breaks, join in with team social events and take part in care activities
	The gift of time	• Practice staff invest time in developing relationships with students • Practice staff offer support and patience when working with students with additional learning needs
	Teamwork makes the dream work	• All team members (of all disciplines) take a proactive approach to supporting student learning and offering learning opportunities to students through the placement experience • Provision of accessible equipment and resources for student use (i.e. IT equipment)
	They put in a marathon (Going the extra mile)	• Practice staff make effort to form relationships with students and include them within the team (Atack et al, 2000) • Practice staff sacrifice (financial, emotional, additional investment of time) to support student development
Continuity	Having shared goals	• Shared team ethos of compassion • Shared team compassionate care goals • Practice staff prioritise compassionate care
	Continuity	• Practice staff engage in consistently supportive relationships with students (Atack, 2000; Levett-Jones et al, 2009) • Students are given the opportunity to ask questions without fear of rebuke or ridicule • Practice staff offer support to students to apply theory to the practice context (Myall et al, 2008) • Academic staff utilise practice examples in the theory component of the programme • Academic staff have contemporary practice insights / experiences and acknowledge contemporary challenges of practice • Practice staff role model the use of evidence-based practice in their daily work (Perry, 2009) • Practice staff invest time to discuss and reflect upon care activities engaged in (Percy and Richardson, 2018) • Practice staff engage students in discussion regarding rationale for care activities and professional judgements • Students are exposure to consistent delivery of compassionate care • Practice staff engage students in reflective discussions regarding compassionate practice (Percy and Richardson, 2018)
	Permission to practice compassionately	• Practice staff, team -manager and the health organisation provide consistent permission for students to engage compassionately • Practice staff provide guidance to students on how they can engage compassionately
	The gift of time	• Practice staff role model acts of advocacy (Hanks, 2008)
	They put in a marathon (going the extra mile)	• Practice staff utilise time in the working day effectively, to engage students in informal reflective discussion (Foster et al, 2015)
Purpose	Authenticity in compassionate care	• Practice staff demonstrate authentic concern for student wellbeing and acts of self-care (Egan et al, 2019)
	Having shared goals	• Shared team ethos of compassion • Shared team compassionate care goals • Students are invited to participate in team supervision to discuss challenges and reflect on their ability to engage compassionately
	Prioritising the meaning	• Practice team members recognise and communicate the importance of compassionate care (Apker et al, 2006) • Team members demonstrate prioritisation of engagement in compassionate care • Team members make active attempts to engage in compassionate care • Practice staff role model a willingness to enter in to patient centred therapeutic relationships with service users

		• Practice staff role model engagement in authentic compassionate relationships with service users • Practice staff demonstrate willingness to "go the extra mile" to engage with service users • Practice staff motivate students to engage in compassionate practice by recognising it as an achievement
	Being supported to achieve	• Practice staff offer students opportunities to engage in personal and professional development (Jokelainen et al, 2013) • Practice staff make expectations that students should engage in compassionate practice, clear, through their expressed values, ideals and role modelling of compassionate engagement • Practice staff provide guidance to students for ways in which they can engage in compassionate practice
	The gift of time	• Practice staff role model investment in developing compassionate therapeutic relationships with service users (Richardson, Percy and Hughes, 2015) • Practice staff invest time in to supporting the needs of service users, their families and other staff members
	Teamwork makes the dream work	• Practice staff role model compassion which is directed to the student • The team have a team ethos of peer support (Cowie and Wallace, 2000)
	They put in a marathon (going the extra mile)	• Practice staff engage students in reflective care discussions (Percy and Richardson, 2018) • Practice staff utilise time in the working day effectively, to engage students in informal reflective discussion (Foster et al, 2015)
	Compassionate purpose: from implicit to explicit	• Practice staff role model compassionate purpose to students • Practice staff support students to "read between the lines" to identify implicit examples of compassionate purpose, making the implicit – explicit • Practice staff provide clear rationale for contacts with Service users and care activities engaged in
Achievement	Prioritising the meaning	• Practice staff demonstrate the prioritisation of compassionate care provision • Practice staff provide students with opportunities to engage in compassionate care
	Being supported to achieve	• Students are provided with feedback from service users and practice staff about their positive impact on a service users experience • Practice staff provide students with opportunities to feel that they are able to make a difference (Walker et al, 2014) • Practice staff encourage and support students to engage in compassionate care
	The gift of time	• Practice staff provide high quality mentorship (Myall et al, 2008) • Practice staff recognition of student vulnerability • Practice staff invest time in supporting student vulnerability • Practice staff invest time to support students to develop outside of their comfort zone • Practice staff invest time in student developmental opportunities (Löfmark, and Wikblad., 2001) • Practice staff role model investment of time in relationships with service users, families and others
	Teamwork makes the dream work	• All team members (regardless of discipline) proactive in offering learning opportunities to students • Student support and encouragement is provided by all team members (regardless of discipline) • Provision of accessible equipment and resources for student use (i.e. IT equipment)
	They put in a marathon (going the extra mile)	• Practice staff utilise time in the working day effectively, to engage students in informal reflective discussion (Foster et al, 2015)
Significance	Authenticity in compassionate care	• Practice staff take a genuine personal and professional interest in the student • Practice staff demonstrate authentic interest in student well-being • Practice staff support students to develop coping strategies and resilience (Lopez et al, 2018; Liang et al, 2019; Walsh et al, 2020) • Practice staff present as; spontaneous, flexible and responsive to student needs
	Under their wing	• Students feel "looked after" • Practice staff offer appropriate support to students (Evans and Kelly, 2004)

		• Students are made to feel like they matter • Practice staff make active attempts to enhance student feelings of belonging and acceptance within the team (Levett-Jones et al, 2009) • Practice staff ensure that students are introduced to other staff and service users • Practice staff invite students to take part in work tasks • Practice staff recognise student value
	Having shared goals	• Practice staff communicate the significance of compassionate care to students • Practice staff role model engagement in compassionate care practice (Perry, 2009; Vinales, 2015) • Students are supported to access team supervision in which challenges / barriers to compassion are explored
	Prioritising the meaning	• Practice staff demonstrate prioritisation of compassionate care
	The gift of time	• Practice staff invest time into student preparation for work tasks • Practice staff invest time to develop relationships with students (Levett-Jones et al, 2009) • Practice staff offer students with additional learning needs support and patience • Practice staff allow students to engage in self-directed learning, and self-identification of learning needs, while offering a supportive safety net • Practice staff role model acts of advocacy (Hanks, 2008)
	Teamwork makes the dream work	• All team members (regardless of discipline) offer students support • All team members proactively support student integration into the team • Provision of accessible equipment and resources for student use (i.e. IT equipment)
	They put in a marathon (going the extra mile)	• Practice staff demonstrate the willingness to “go the extra mile” to include students in the team • Practice staff demonstrate the willingness to “go the extra mile” to form relationships with students • Practice staff sacrifice (financial, emotional, additional investment of time) to support student development

Appendix 35: The factors that inhibit socialisation in compassionate practice and are present in a compassion impoverished placement experience and the impact on inhibition of the Senses

The Sense:	Characteristics:	Inhibitors:
Security	Being Fake	• Practice staff demonstrate inauthenticity on their relationships with service users / students / other staff • Evident disconnect between the actions of practice staff and their expressed feelings and thoughts (King-Jones, 2011) • Student exposure to practice staff burnout and compassion fatigue • Student exposure to a practice culture of blame • Apparent disconnect between the organisation, health policy values and the support offered to practice staff • Practice staff express fear of blame and rebuke to students
	Being seen as the problem	• Practice staff express the belief that students create problems within the practice context (King-Jones, 2011) • Practice staff negatively criticise students, rather than engage in constructive criticism (King-Jones, 2011)
	Billy no mates – Isolation	• Students feel isolated and alienated from the team (Levett-Jones et al, 2009) • Negative practice staff attitudes towards students (King-Jones, 2011) • Students are not invited to participate in team camaraderie (Levett-Jones et al, 2009)
	Pie in the sky (dissonance between theory and practice)	• Practice staff criticism of students for trying to apply theoretical content of their programme into practice (King-Jones, 2011 • Inconsistency between risk adversity in organisations and teaching in theory component of the programme / evidence-based practice • Student exposure to practice staff fear of blame and rebuke relating to occurrences of untoward incidents
	Prioritising the metrics	• Organisation prioritisation of tasks over practice staff and students engaging in compassionate practice
	Having the compassion knocked out of you	• Practice staff project their feelings of dissatisfaction and negativity regarding the profession • Student experience of burnout and / or compassion fatigue (Michalec, Diefenbeck, and Mahoney, 2013).
	Self-protection	• Students experience a lack of support when exposed to challenging situations (i.e. self-harm, suicide attempts, violence and aggression) • Weak leadership from the team manager / wider organisation • Student exposure to a practice culture of blame
Belonging	Being seen as the problem	• Students being made to feel that they are an inconvenience by practice staff (King-Jones, 2011) • Practice staff express the belief that students create problems within the practice context (King-Jones, 2011) • Practice staff who communicate that students create unnecessary workload (King-Jones, 2011) • Practice staff demonstrate negative attitudes towards working with students (King-Jones, 2011) • Practice staff express the belief that students create problems within the practice context (King-Jones, 2011) • Practice staff negatively criticise students, rather than engage in constructive criticism (King-Jones, 2011)

	Billy no mates – Isolation	• Students feel isolated and alienated from the team (Levett-Jones et al, 2009) • Negative practice staff attitudes towards students (King-Jones, 2011) • Students are not invited to participate in team camaraderie (Levett-Jones et al, 2009) • Practice staff make assumptions about student knowledge and experience • Practice staff have unrealistic expectations of student knowledge and skills • Practice staff make negative assumptions about students • Practice staff communicate a lack recognitions of the value of students (King-Jones, 2011)
	Pie in the sky (dissonance between theory and practice)	• Practice staff criticism of students for trying to apply theoretical content of their programme into practice (King-Jones, 2011)
Continuity	Pie in the sky (dissonance between theory and practice)	• Students experience disconnect between theoretical and practice elements of the programme (Curtis, Horton and Smith, 2012; Curtis, 2015) • Lack of illustrative examples used in the classroom to demonstrate how theory can be applied to practice (academic staff) • Practice staff fail to role model compassionate care • Practice staff do not engage students in discussion regarding the rationale for care and care decisions (Curtis, Bowen and Reid, 2007) • Practice staff criticism of students for trying to apply theoretical content of their programme into practice (King-Jones, 2011) • Inconsistency between risk adversity in organisations and teaching in theory component of the programme / evidence-based practice • Student exposure to staff pressures created by lack of investment, resources and work-load • Student exposure to staff receiving a lack of support from the organisation in their job role
	Prioritising the metrics	• Apparent disconnect between the organisational guiding vision and organisational requirements regarding the requirements of workload • Apparent disconnect between national guidance, government investment and the realities of practice
Purpose	Being seen as the problem	• Practice staff negatively criticise students, for engaging in acts of compassion
	Pie in the sky (dissonance between theory and practice)	• Student exposure to staff pressures created by lack of investment, resources and work-load
	Prioritising the metrics	• Practice staff prioritisation of tasks over relationships with service users • Burden of work tasks that reduce the scope for service user contact • Student exposure to staff pressures created by lack of investment, resources and work-load • Practice staff demonstration of discrimination / stigma towards certain health diagnoses (i.e Personality Disorders) • Practice staff role modelling of justification for their lack of compassionate engagement (Jack, Hampshire and Chambers, 2017) • Practice staff lack of recognition or communication of recognition of the positive impact of compassionate practice to students
	Having the compassion knocked out of you	• Practice staff project their feelings of dissatisfaction and negativity regarding the profession • Student exposure to practice staff experience of burnout and / or compassion fatigue • Student experience of burnout and / or fatigue (Michalec, Diefenbeck and Mahoney, 2013) • Practice staff role model or advise students to reduce engagement with services users to avoid burnout / fatigue (Dewar et al, 2014)
Achievement	Being seen as the problem	• Practice staff negatively criticise students, for engaging in acts of compassion (King-Jones, 2011)
	Pie in the sky (dissonance between theory and practice)	• Students experience fear that their placement assessment will be negatively affected by engaging in compassionate practice (if the assessor does not demonstrate compassion towards others) • Practice staff criticism of students for trying to apply theoretical content of their programme into practice (King-Jones, 2011)

	Doing what I need to do to pass	• Students experience fear that their placement assessment will be negatively affected by engaging in compassionate practice (if the assessor does not demonstrate compassion towards others) • Students feeling that they have to "please" the assessor to pass the placement • Practice assessors lacking in compassionate ideals and practice • Practice staff minimisation of student significance and their ability to make a difference in the care context (King-Jones, 2011)
Significance	Being seen as the problem	• Practice staff express the belief that students create problems within the practice context (King-Jones, 2011) • Practice staff negatively criticise students, rather than engage in constructive criticism (King-Jones, 2011)
	Billy no mates – Isolation	• Practice staff communicate a lack of value for 1st year students learners (McKenna et al, 2003) • Practice staff have unrealistic expectations of student knowledge and skills • Practice staff lack of recognition of students as unique learners • Practice staff communication of negative assumptions about all students • Practice staff communication of lack of recognition of the value of students (King-Jones, 2011) • Practice staff lack of genuine interest in students as individual learners with unique and valuable life experiences
	Pie in the sky (dissonance between theory and practice)	• Practice staff expression of lack of value of contemporary nurse education • Practice staff lack of recognition of the relevance of the theoretical component of the programme of education • Practice staff communicate negative criticism of the students programme of education
	Prioritising the metrics	• Practice staff prioritisation of metrics and staff over compassionate care interactions
	Having the compassion knocked out of you	• Student experience of burnout and / or compassion fatigue (Michalec, Diefenbeck and Mahoney, 2013)
	Doing what I need to do to pass	• Students lacking insight in to how they can make a difference • Practice staff role modelling of a lack of understanding of the significance of compassion

Appendix 36: The factors that facilitate the placements' capacity to positively socialise student mental health nurses in compassionate practice and the application of each factor to The Senses Framework.

The Sense:	Characteristics:	Facilitators:
Security	Composition of the team	• Small team size • Maturity / experience of team staff / established nature of the team • Team member support of each other • Absence of fear of rebuke from other team members
	We're all on the same page	• Clearly defined roles of each team member • Team members embrace roles and expertise of other team members • Team member genuine value for each other's expertise and roles • Recruitment includes assessment of individual staff values • Established nature of the team supports new staff socialisation in established team philosophy • Provision of emotional support between team members, to work through care challenges • Team members able to enter into open dialogue regarding care challenges • Absence of fear of rebuke from other team members • Team members engage in compassionate interactions with each other • Practice assessors are supported in their roles as practice educators by other team members and team leadership • Team members experience feelings of physical, emotional and psychological safety within the team context
	Established mentorship management	• Students allocated to mentors on a rotational basis providing staff with recuperative breaks from mentorship role
	The flavour of the team is set from the top	• Team manager recognition of the emotional impact of work engaged in by the team • Team manager facilitation of a supportive culture for all staff • Team manager contributions to clinical a problem-solving • Team manager acts as a buffer between the demands of the wider organisation and team member
Belonging	Composition of the team	• Small team size • Maturity / experience of team staff / established nature of the team • Team member support of each other • Team members embrace roles and expertise of other team members • Team member genuine value for each other's expertise and roles
	We're all on the same page	• Whole team approach (regardless of discipline) to the provision of learning opportunities for students
Continuity	Established mentorship management	• Team members supported to attend training to become recognised practice educators / assessors • Team members supported to attend continual professional development opportunities to maintain currency on the role as practice educator / assessor • Practice staff recognition and engagement in the use of reflection to improve own practice • Development of team changes to support students – both planned changes and changes that have occurred as a result of the natural team development process • Lead mentor and associate mentor allocation • Leadership re-enforcement of aims for positive placement experiences
Purpose	Composition of the team	• Small team size with an established staff compliment • Shared team philosophy of compassionate care

		• Team member values assessed at interview to ensure they fit with wider team values • New team members exposed to the team norm of compassionate practice • New team members made aware of the expectation that they will engage in compassionate practice
	We're all on the same page	• Individual team members have an established sense of compassionate purpose • Team has a specialty focus • Team members have an individual and collective passion for the care specialty • Team members recognise the value and significance of service users that they work with • Collaborative team opportunities to discuss care challenges and action plan to resolve challenges provided • Team members recognise the importance and value of other health professionals and their role in service user care • Team members invest in non-judgemental, supportive, compassionate working relationships with each other and other health care staff • Team members engage in acts of compassion towards each other, underpinned by recognition of supportive team relationships • Team members recognise their impact that their attitudes, behaviours and actions can have on students on placement with the team • Team awareness of their impact as role models for students on placement with the team • Team members are aware of what is required in their role as supporters of students • Team members are aware of and able to identify student vulnerability • Proactive team approach taken to reducing student experience of vulnerability • Team members recognise that student aims and needs vary • Team members recognise the need for a flexible approach in working with students, according to individual needs • Team members have clear purpose regarding their roles as practice educators / assessors • Team members engage in reflection to improve own practice • Team members harbour positive attitudes about students • Team members enjoy working with students and recognise the value of students in the practice context • Team manager clear sense of purpose of the managers role • Team manager awareness of the importance of compassionate leadership to set the tone of team ethos / compassionate culture • Team manager acknowledgement of the value of students
	Established mentorship management	• Leadership re-enforcement of aims for positive placement experiences
Achievement	Established mentorship management	• Team members recognise that students support their continual development and learning • Team members recognise that students can also teach them new concepts and skills based on their educational and life experiences
	The flavour of the team is set from the top	• Managerial prioritisation of staff attending mentor updates
Significance	Composition of the team	• Team members engage in joint working across the disciplines in the team • Clearly defined roles of each team member • Team members embrace roles and expertise of other team members • Team member genuine value for each other's expertise and roles
	We're all on the same page	• Team members recognise the importance and value of their roles as practice educators / assessors
	The flavour of the team is set from the top	• Managerial prioritisation of staff attending mentor updates • Team manager role modelling of the significance of students to other team members