Student nurses' lived experience of patient safety and raising concerns

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ARTICLE INFO

ABSTRACT

Introduction: Following the investigation into the Mid Staffordshire Hospital (United Kingdom) and the subsequent Francis reports (2013 and 2015), all healthcare staff, including students, are called upon to raise concerns if they are concerned about patient safety. Despite this advice, it is evident that some individuals are reluctant to do so and the reasons for this are not always well understood.

Study aim: This research study provides an insight into the factors that influence student nurses to speak up or remain silent when witnessing sub-optimal care.

Design: An interpretive phenomenological study using the principles of hermeneutics. The study took place in one university in the North of England and the sample consisted of twelve adult nursing students.

Methods: Following ethical approval and informed consent, each participant took part in individual semi-structured interviews over a three-year period. Data was transcribed and analysed using 'Framework for Applied Policy Research'.

Findings: Four key themes were identified: context of exposure, fear of punitive action, team culture and hierarchy. On the one hand, students recognised there was a professional obligation bestowed upon them to raise concerns if they witnessed sub-optimal practice, however, their willingness to do so was influenced by intrinsic and extrinsic factors. Students have to navigate their moral compass, taking cognisance of their own social identity and the identity of the organisations in which they are placed.

1. Introduction/background

Patient safety is an important and contemporary concept that underpins high quality care globally (Vincent, 2010; Fisher and Scott, 2013; NHS England, 2017). Risk in healthcare cannot be eradicated completely but it can be minimised through good practice and transparency. Arguably, the most influential report in recent years which elevated patient safety into the spotlight was the Mid Staffordshire Inquiry, calling for a more open and transparent culture in the NHS (Francis, 2013). Although this enquiry and subsequent report relates to UK healthcare delivery, there are implications for patient safety in a global context. A subsequent publication by Francis (2015) entitled: 'Freedom to Speak Up' focused upon the contribution that staff can make to patient care by raising concerns about matters of safety. Included in this report is reference to the role of student nurses, asserting that they are ideally placed to identify things that might be going wrong as they bring a new perspective and independent viewpoint. However, this is not completely straightforward. Whilst some student nurses may feel confident to report concerns, others choose to remain silent for fear of the potential consequences. The existing UK and international literature does not offer any definitive explanation of the factors that influence student nurses to raise concerns. This paucity prompted the author to undertake a small-scale (pilot) research study, the aim of which was to obtain an insight into student nurses experience of raising concerns. If we can understand the underpinning reasons that influence student nurses to speak up or remain silent, nurse educators will arguably be better equipped to support students and develop policies and guidelines to address this issue.

The overall aim of the research was to understand student nurses' perception of what they believe is a patient safety incident in their practice placements and understand the reasons that influence their willingness or reluctance to raise concerns about patient safety.

2. The research design

A qualitative approach to this research was selected, using the principles of hermeneutic phenomenology, a methodology recognised by early philosophers and later informed by Van Manen (2014). This approach allows the researcher to gain an insight into the individual's lived experience. Hermeneutics provides an interpretive perspective to

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explicate meanings and assumptions in the data by studying and interpreting narrative (Smith et al., 2013).

3. Sample and recruitment

A purposive sample of nursing students undertaking the BSc in Adult Nursing in a university situated in the North of England was used. This sampling approach was considered suitable, as it represents a type in relation to key criterion (Richie et al., 2014). The sample consisted of twelve student nurses in their first, second and third year of training and included eleven females and one male, their ages ranging from 18 to 45 years. The students represented a homogenous group who had shared similar experiences. The students were allocated to a variety of partnership trusts for their practice experience which allowed for a broader disparate variation of practice to be studied. The participants were recruited on a voluntary basis and strict ethical principles were adhered to.

4. Data collection

The data was collected using individual semi-structured interviews using a digital voice recorder and note taking by the researcher over a three-year period between 2013 and 2016. The interviews were conducted on university premises. Each interview lasted between 30 and 60 min. Six of the recordings were transcribed by the researcher, with the remainder transcribed by a member of university staff who had received ethical clearance.

5. Data analysis

Data was analysed using 'Framework' for applied policy research. This method of analysing data sits comfortably with the epistemological position of this research study and the intended outcome of informing policy. Using Framework provided an audit trail throughout the process of analysis. The tool allows researchers to generate themes from data by systematically searching for patterns and analysing content. This subsequently allows researchers to provide meaningful cognitive descriptions of the phenomena.

Unlike many tools that facilitate the indexing and sorting of data, Framework adds a further step: 'data summary and display'. This essentially consists of thematic matrices displaying all participants and themes plus subthemes. This allows the researcher to move back and forth between different levels of abstraction without losing sight of the raw data and furthermore it provides transparency (Richie et al., 2014; Kiernan et al., 2015; Kiernan and Hill, 2018).

6. Ethical considerations

Before commencing data collection, it was necessary to obtain ethical approval from the university Ethics Committee. All of the participants were assured of anonymity. Acknowledging the topic being researched was of a potentially sensitive nature, participants were provided with written and verbal information prior to participating in the interviews.

7. Findings

The study population consisted of 12 respondents, all of whom were adult nursing students. Face to face interviews were conducted and the following superordinate and subordinate themes were identified within the data:

A small example of the narrative provided by the participants will be presented by verbatim quotes:

7.1. Theme: context of exposure

It was necessary to glean an understanding of what the students perceived as sub-optimal care, therefore in order to do this effectively, there was a requirement to examine the context in which students were exposed to sub-optimal care. Some students had witnessed staff performing procedures incorrectly whereas others witnessed poor interpersonal and professional behaviours. The data revealed that medicine administration and patient handling were often perceived as key areas of concern:

'Er medicine management. I've seen quite a few common errors'.
(Participant A 1st year female student)

'Erm it was the first day of management placement and my mentor, we were doing the medication round and this elderly woman was prescribed erm 15 mg of codeine and we didn't have it on the ward; we only had 30 mg, so my mentor decided she would give the 30 mg and I said to her could she not check why she was only prescribed 15 because 15 is a bit of an unusual dose really: you don't normally see that. And she just said; no it won't kill her, it'll be fine and she gave it and I didn't really know what to do'.
(participant G 3rd year female student)

This is a significant finding as it demonstrates how students can sometimes be coerced to participate in practice that is not in line with legislation and professional behaviour.

Similar observations were reported in relation to patient handling:

'I think the main one I have seen is moving and handling. There is a big difference between what we have learned in uni and what I have seen. You know when you move someone up the bed and you use slide sheets? Well I've never really seen that on placement'.
(participant E 1st year female student)

There was a perception amongst students that they instinctively knew when something was wrong if it was transparent and conspicuous. Other areas of practice that rely perhaps more upon clinical decision making and professional judgement by the registrant can possibly lead to the student being reluctant to challenge what after all may be perfectly legitimate practice tailored to that individual patient.

'I'm doubting myself in what I know, but I am still a very junior member of staff compared to other people, so I might get something completely wrong and wouldn't want to look like a fool in front of my peers'.
(participant L 3rd year female student)

Whilst many of the patient safety issues identified by the students were of a tangible and physical nature such as patient handling and medication administration discussed above, others did allude to professional issues and in particular the attitude of some staff.

'When I raised my concern it was more about the professionalism of the staff. Erm and how the culture of the ward…the atmosphere didn't feel friendly…everybody was task orientated and there was no communication'.
(participant H 3rd year male student nurse)

'Erm in my previous placement in a local trust I reported an incident where it wasn't so much patients' physical safety but I felt that…well I witnessed a member of staff being quite demeaning and saying things which I thought were inappropriate'.
(participant J 3rd year female student)

All of the participants demonstrated that they were aware of the professional and moral expectation for them to speak up as well as the reasons why and this was particularly evident amongst the third year more senior students:

'I feel like every year through my degree, it's kind of got a little bit more serious so I think probably going from a third year to qualified, I would

be more inclined to raise those (concerns) even more so than now…'
'yes do you lose sleep because a patient came to harm or do you lose sleep because you raised a concern and are now worried about your reputation. I would never kind of step aside and be like oh it's not my place to say anything. You know, even as a student you have to be an advocate for your patients'.

(participant J 3rd year female student)

It was clear from the data that students were aware of the requirements of them to raise concerns if they witnessed care that appeared to be sub-standard, but their lack of experience determined whether they had the courage to do so.

7.2. Theme: the fear of retribution

On the one hand, the participants unfalteringly demonstrated an awareness of their professional obligation to report substandard practice but this was challenged by a strong sense of 'survival', an urge to succeed and get through their placement and avoid 'trouble'.

'If I was on placement and raised a concern it would affect that placement then I might wait until the end or bring it to the university rather than approaching it on placement
It's human nature, when you go on to placement…you want to be liked and you want to get along with people and try…try to make the most of it and so doing something that is definitely going to compromise that would be difficult'.

(participant B 2nd year female student)

There was particular tension amongst the more junior students in their first year who felt that their inexperience and a desire to fit in prevented them from speaking up:

'I felt like I couldn't ask because obviously it was my first ward and placement and I didn't want to cause trouble…especially that early on. They might think that oh you're brand new and you don't know the way of the ward they just think that's the way it goes in uni'.

(participant E 1st year female student)

The lasting effect upon the student is also significant, as students perceive they may be 'labelled' as a troublemaker which may overshadow them on subsequent placements and affect their experience:

'I've seen it, if they decide that they don't like someone then they can make it quite hard. There were big rifts on my ward between certain members of staff and they could make it pretty hard'

(participant D 1st year female student)

'If you say something against one of them…they all know about it, do you know what I mean…
Like if it was a healthcare assistant…I know it sounds silly but they're quite forceful if they are all together'.

(participant K 3rd year female student)

'No I didn't challenge her because she was my mentor and she was the expert and had been on the ward for over 5 years so I didn't even think twice about it…you know I possibly wouldn't because they are qualified and I am learning off them…you want to get on with your mentor'.

(participant D 1st year female student)

Students discussed their reluctance to challenge registrants as they often perceived them as the 'experts'. This coupled with their own doubts about their knowledge base, added to their hesitance:

7.3. Theme: hierarchy

The concept of the existence of hierarchy within the healthcare arena was unanimous. The data suggests that students shared a common belief that paternalism existed between professions, and in particular between doctors and nurses.

In addition, experience, status and surprisingly the issue of 'age' became evident upon analysing the data.

'I would feel quite uncomfortable challenging them especially if they were a lot older than me just because of their age and how much experience they have had on the ward compared to me who has been there for two week'.

(participant E 1st year female student)

'Raising concerns is an age thing. I have actually had this conversation with my mentor. When I am qualified, I am young and just out of university so I am young and they will see me as younger and even though I have knowledge they might not see me as having much experience'.

(participant C 2nd year female student)

'I think they are very much interlinked. I mean obviously as age increases, it's likely that someone's going to be higher up the hierarchy'.

(participant J 3rd year female student)

It was also evident that students felt vulnerable when challenging non-qualified staff. The health care assistants are often recognised as established individuals within the team and some students find them formidable figures:

'They might think why is she raising a concern? She's come out on the ward, she's just started. She's a third year, she's not qualified and she's raising concerns about how we care for people, I've been here a long time and I know how to do my job so don't tell me otherwise sort of thing'.

(participant I 3rd year female student)

'Well I'm not sure what they are doing is correct practice but they have been on this ward for x amount of years and they've always done it like this and they would just say to me oh well you're a student you've been doing this for three years don't tell me how to do my job'.

(participant J 3rd year female student)

'You go to some wards, there will be the paternalism thing and it is: consultant, doctor, nurse, healthcare assistant, student. That's how it'll go'.

(participant K 3rd year female student)

By the very nature of their student status, some of the participants felt that this was an automatic inhibitor to raising concerns about more senior or experienced staff. This factor often determined whether students would speak up or remain acquiesce.

7.4. Theme: team culture

Team culture was a strong influence in the student experience. Participants indicated that the team in which they were working played a significant role in influencing their decision whether to raise concerns.

'I had a really good relationship with my mentor, which was something that definitely helped'.

(participant J 3rd year female student)

'Yes I think if your mentor…like you get on well with them and they create an environment where it's open and you can ask questions… then I'll ask more or if they did something and they knew it wasn't best practice then if they would explain why they had done it that way and not the way it said in the books'.

(participant E 1st year female student)

Conversely, mentors who lacked the level of support expected by students had a negative effect:

'My mentor was nice…but she didn't want to be my friend. You know, she wasn't particularly embracing me with open arms so I wanted to keep the relationship nice and I wanted to behave myself coz they can make life quite difficult…
My next mentor…

we had a more open discussion type of relationship. She would explain things so that was a much more relaxed relationship than with the mentor at the hospital, she would huff and puff and I know fine well that she would go to her friends and you know…say who does she think is'.

(participant D 1st year female student)

As well as the students' relationship with their mentors, the relationship between other team members was influential in setting the type of environment in which to work and learn:

'*I've been on wards where it has been good in the way that even though the manager is friends with the staff, they sort of put that aside and still take it like professionally'.*

(participant K 3rd year female student)

8. Discussion

This research study was designed to elicit the lived experience of student nurses and glean an insight into the factors influencing their ability to speak up or remain silent if they witnessed sub-optimal care. During the process of analysis and development of the thematic framework, four super-ordinate themes were identified which have enabled us to acquire an appreciation of student beliefs and values. Student behaviour appears to be influenced by both intrinsic and extrinsic factors. The discussion around these key four areas will be addressed collectively as concepts arose which appeared to merge.

A predominant factor in the findings suggests that social identity plays a fundamental part in recognising the inter-connectivity between existing strands of knowledge in this topic area. Social identity theory and the relationship with organisational identity became the conceptual framework in this study.

What is apparent is that all of the participants were aware of the importance of patient safety and perceived it as a tenet of quality care. In addition, they were cognisant of the professional requirements expected of them if they witnessed poor practice. What the findings suggest however, is that the decision to raise a concern is dependent essentially on moral courage. Students possess a fundamental desire to 'fit in' and survive their placement in order to achieve successful assessment and avoid potential punitive action. This supports the earlier work of Levett-Jones and Lathlean (2009), Latchman (2008), Eby et al. (2013) who discuss students' desire to 'belong' and 'not rocking the boat'. However, they must balance this with their desire to 'do the right thing', preserve patient safety and act in accordance with the Professional code (NMC, 2015).

Levett-Jones and Lathlean (2009) uncovered data which revealed that student nurses feared being labelled as 'trouble makers' if they raised concerns. Later Eby et al. (2013) found that those fears still existed amongst learners when in their clinical placements.

This current research offers further insight into reasons why student nurses may be willing or reluctant to raise concerns regarding practice. The participants alluded in much of their narrative to their identity as a student nurse and their perceived position within the practice team. Identity has long- been recognised as an established concept of how we view who we are. (Jenkins, 2008). Whilst there are contested understandings of identity through psychological, sociological and anthropological theories, there appears to be a broad consensus that a sense of self is shaped through a fluid process of interactions between the individual and societal structures to which we are all exposed (Brennan and Timmins, 2012). Identity is developed during childhood but continues through relationships and structures within society. Identity is also linked to our exposure to groups and organisations. These core aspects of identity developed during our early life span can also be reshaped and manipulated through our career aspirations. Ashforth (2001) observes private realms of life have gradually become proliferated by institutionalised and industrialised societies. This inevitable colonisation by organisations becomes increasingly mediated by roles.

These different roles he argues can be learned and enacted by individuals. They can also become fluid and interchangeable and do not always sit with personal philosophies and beliefs. If Ashforths' assertions are correct, then it can be argued that on commencement of nurse training, identity is manipulated by the groups and institutional behaviours students' become exposed to. Students face a dichotomy between their own social identity and that of the organisation. Healthcare delivery has a longstanding history of being delivered in institutionalised environments where conformity and obedience were the norm. There have been attempts to theorise and understand the role of institutions and social control imposed on those who lived and worked in them (Goffman, 1961; Foucault, 1973). Social conditioning of individuals is achieved by stripping them of their personhood and enforcing them to participate in activities designed to fulfil the institutional aims and objectives. Whilst arguably healthcare has moved on, similarities can be seen with regard to the fluidity of social identity in student nurses. These observations are important, because the findings in this research appear to echo similar behaviours despite the advancement of nurse education and a move into the twenty first century with a new generation of young adults. It is perhaps significant that as nurse education and nursing has developed over the past few decades, many of its staff remain in the system, still carrying the legacy of a different culture which is in turn passed down the chain.

The desire to be accepted by the team and remain 'on side' was a strong theme in the findings of this study. All of the student nurses interviewed, alluded to a desire to be accepted within the practice placement team. This desire to belong was often an impediment to challenging practice. This is commensurate with findings in much of the existing literature. Melia (1987) in her seminal work over three decades earlier, described the experiences and socialisation of hospital trained nurses. The dominant strategy amongst nurses was 'getting the work done', 'fitting in' and 'learning the rules'. Student nurses conformed rather than challenged practice and in fact were discouraged from questioning more senior staff members. It is argued therefore that the theoretical underpinning of social identity and its relationship with organisational identity is key to understanding the willingness or reluctance of student nurses to raise concerns.

On analysing the data, it became apparent that the antecedents of identification and group behaviour permeated strongly amongst the participants. However, the context in which student nurses experience these challenges with identity is varied and is perhaps attributed to the way in which nurse education is delivered. Since the early part of the 21st century, nurse education has moved into the Higher Education system with students educated in the university setting and their practice placements taking place in partnership healthcare trusts. This in itself places the student in a position where they are exposed to two institutions: the university and the hospital and healthcare setting. The student is then faced with a multiplicity of demands on their identity. Firstly, they enter the programme possessing their own individual identities comprising gender, social role and status. Secondly, they are then exposed to the concept of group identification and catapulted into finding their role within that peer group, which can often be challenging. Thirdly, they are socialised into the hospital - healthcare environment where they are exposed to the accepted social norms and expected behaviours. The transition can often be challenging and complex with different institutional demands placed upon them. The experience can often be fluid as they move back and forth as university students in a higher education environment and nursing students in the healthcare setting. Their social identity can be rather fragile during this transition process as the student attempts to establish and re-establish the social and professional hierarchies expected of them (Ashforth and Mael, 1989). In order to achieve the stage of identification, a cognitive sense of membership is necessary and also an evaluative one which is related to value connotations and a desire to remain in the 'in group' (Tajfel, 1982). It is likely that this fluidity will continue as nurse training and education expands with the introduction of 'home grown'

students in apprenticeship schemes. As nurse educators, it is essential we recognise this so we are able to appropriately support students who raise concerns.

9. Limitations of research

The study is restricted to student nurses from one university in England and focuses upon students undertaking the BSc Adult field of nursing thus limiting the data to one particular field of nursing. Nonetheless, there are comparable similarities in students' experiences with those identified in the literature. It is suggested that this can be transferable to the broader student population and it is for the reader to decide.

Every effort has been made to ensure trustworthiness in this research study. Framework for applied policy research provides a fifth stage of data analysis: summary and display which offers transparency to the reader. In addition, the researcher kept a reflexive diary throughout the study to ensure authenticity and trustworthiness throughout the research trajectory.

10. Conclusion

This study has identified the influencing factors that determine student nurses' decision to raise concerns about sub-optimal practice or remain silent. These factors fall into intrinsic and extrinsic factors. Commensurate with earlier studies, the findings indicate that students possess ethical and moral values aligned with the will to act as the patient's advocate and prevent harm. However, this is challenged by their overarching desire to survive.

On commencement of this study there was paucity in the literature in relation to the student nurse voice. This research study goes some way in adding to the body of knowledge that is in existence. The findings in this research support the work of other researchers who have identified that students strive for a sense of belongingness in their clinical placements and this can inhibit them from speaking up. In addition, this research provides further insight and understanding of how student nurses behaviours are shaped by their social identity, which is sometimes at odds with the identity of the organisation. They often fear reprisal from their colleagues and this is not restricted to their mentors, other registrants or those in authority but includes unqualified staff who are recognised as established in their roles. The research has revealed that essentially human factors exist in student nurse behaviour, with students recognising their junior status and its perceived inter-connection with others in the team. In addition, they discussed the significance of age as well as experience as a determining factor in their willingness to speak up. Students require the assurance that robust and effective support mechanisms are in place as a safety net when they do raise their concerns.

What is encouraging from this study is that whilst some students are reluctant to raise concerns, others are willing to and do speak up when care is suboptimal. This suggests that nurse education is influential in promoting a candid and transparent workforce. In order to support students who find themselves in this difficult situation, we as nurse educators need to be able to support them in navigating their moral compass.

The discussion and recommendations in this study offer further dialogue to help us better understand student nurses' beliefs and behaviours in relation to patient safety. Ultimately it is intended that this research will inform policy and practice with the overall aim of preserving and promoting patient safety.

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