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'FEEL THE FEAR AND DO IT ANYWAY' ... NURSING STUDENTS' EXPERIENCES OF CONFRONTING POOR PRACTICE

ABSTRACT

Aim

The two aims of this study were, first, to explore nursing students' experiences and perspectives of reporting poor care, and second, examine the process by which they raised concerns.

Background

The nursing literature is replete with studies which explore nursing students' experiences of clinical placement. However only a small number explore students experiences of challenging poor care and how this is enacted in the practice setting.

Setting and participants

Fourteen nursing students from undergraduate pre-registration nursing programmes across three universities, two in the United Kingdom (UK) and one in Australia.

Design and analysis

This paper reports findings from narrative interviews about students' clinical experiences of reporting poor care. Data were audio recorded, transcribed verbatim and analysed using a constant comparison approach. Emerging themes were identified, discussed and verified by the researchers.

Results

Four montages from the narratives highlight the overarching themes: bullying, patient advocacy, lack of empathy and poor care. They demonstrate how, driven by an ethical imperative, students speak up when they witness poor care despite the difficulties of doing so: In some cases, the students in this study were prepared to continue speaking out even when initial concerns were dismissed.

Conclusion

Both practice and university teams have a responsibility to support students' development as ethical and courageous practitioners, able to recognise when care falls below an acceptable standard.

Key Words

Poor care, raising concerns, whistleblowing, nursing students, clinical placement.

Highlights

This paper highlights the vital role that students play in highlighting poor nursing care practices.

Nursing students are capable of reporting poor nursing care even when it might come at a cost to themselves.

Clinical and university education teams must support students' development to be able to challenge poor nursing care practices.

INTRODUCTION

The requirement to successfully undertake and complete a set number of hours in clinical settings is a mandatory feature of pre-registration nursing programmes across the world. Typically, this involves placement across a range of areas and specialties, with the student required to meet specified competencies across several domains including fundamental skills, professionalism, patient safety, team working and ethical practice. In doing this the students face several challenges (Lopez et al 2018, Christiansen et al, 2019). Aside from the difficulties associated with balancing family, financial and personal commitments, with shift work and the physical and emotional demands of practice, one of the major issues they must negotiate is how to fit in with mentors, supervisors and colleagues (Jack et al, 2018). This is not always achieved, with the result that students may feel isolated, unsupported, unfairly treated and in some cases unwanted. Experiences of this type may taint the student's view of the profession and cause stress, lowered motivation and attrition (O'Mara et al 2014, Thomson et al, 2017, Jack et al, 2018). Unsurprisingly, learners work hard to fit in and achieve a sense of belonging although the desire to be accepted conflicts with professional expectations and guidance and can result in learners compromising their professional integrity (Levett-Jones et al, 2009).

BACKGROUND

Nursing remains one of the most trusted professions in the eyes of the public in terms of honesty and integrity (Hutchinson, 2018; Milton, 2018). However, this trust is being eroded as a result of a series of high-profile healthcare reports that detail poor care delivery by nursing staff (Hindle et al, 2006; Mohr, 2009, Francis, 2013; Kirkup, 2015; Jones, 2018). At the same time, a steady stream of empirical work has also reported a growing catalogue of cases, which although perhaps less dramatic in terms of scale, describe care which has been disrespectful and demonstrates a lack of concern (Richards and Borglin, 2019; Reader and Gillespie, 2013). Frequent media reports of care failures and studies that have sought to understand the phenomenon of poor care, point to possible problems at the heart of the nursing profession (Ion et al., 2019). Nurses have been found culpable in several high-profile failures including the UK Mid-Staffordshire NHS Trust (Francis, 2013), Gosport War Memorial Hospital (Jones, 2018), and the Garling Report into

Acute Care Series in Australia (2008). Stronger leadership, shared values, improved communication and robust teamworking across professional groups were some of the recommendations made to improve the quality-of-care provision at all levels (Francis, 2013). Supporting nurses to deliver safe and effective care remains a priority for the profession and as such, educating students to identify and respond to instances of poor care is essential (Ion et al., 2019).

There is a considerable body of literature examining nursing students' clinical placement experiences, but limited evidence about if, when and how they report poor care practices (Ion et al., 2017; Milligan et al., 2017). Fisher and Kiernan (2019) suggest that students carefully consider the personal consequences of raising concerns before doing so. This finding echo those of Ion et al. (2015) and Bellefontaine (2009) who identified that when students can foresee negative consequences of speaking up, they frequently decide against acting. As the requirements of professional bodies clearly emphasise the protection of the patient, those who witness poor care are expected to report it (NMC, 2018; NMBA, 2016). However, the reticence to report poor care is evident in the wider whistleblowing literature (Jackson et al., 2014), as well as in studies examining students' responses when encountering poor care (Ion et al., 2017; Milligan et al., 2017).

Drawing on Francis' idea (2013) that novice nurses approach clinical practice with a view which is untainted by years of experience, in this paper we explore nursing students' experiences of reporting poor care, with a specific focus on how this negotiated in practice. We explore cases where students put themselves in difficult situations with other clinical staff by raising concerns about an aspect of care quality. In doing this they run the risk of challenging those with power to negatively impact their learning experience. For the purposes of this paper, poor care is defined as instances of neglect, incompetence or abuse, which may or may not result in harm to patients. It can be distinguished from error and mistakes as these occur without intent. In contrast, poor care involves conscious action or omission (Ion et al, 2016).

METHODS

Study Aim

The aim of this study was to explore:

- nursing students' experiences and perspectives of reporting poor patient care; and
- the process by which the raising of a concern is enacted in the practice setting

Study Design

The experience of raising concerns about poor care is likely to be complex, contextually mediated and deeply personal. Therefore, the study explored students' experiences using narrative telephone interviews in which students were encouraged to tell their stories, beginning wherever, and however, they felt was most appropriate (Gubrium, 1993). This approach allowed for exploration of the students' individual perspectives of reporting poor care as well as enabling a holistic picture of their wider experiences to emerge.

Setting and Participants

This paper reports on selected findings from a mixed-methods inquiry with nursing students that explored their experiences of reporting poor care. The first phase of the study explored students' experiences using an online survey. The survey results, although mainly positive, revealed that students often witness poor and ineffective care practices during their clinical placements (Jack et al, 2020). The second phase of the study further explored students' perceptions and experiences using narrative telephone interviews in which students were encouraged to talk in-depth about reporting poor care

A convenience sample of 14 female nursing students, aged 18 – 45, were recruited from three universities, one in Australia and two in the United Kingdom. While each of these universities provides a three-four-year tertiary education program as the requisite preparation for registration as a nurse, they each differ in terms of curriculum models, student cohort size, and structure and length of the clinical placements. A cross-national approach was adopted as it was anticipated that this would illuminate the pertinent issues from a broad perspective.

Ethical Considerations

Ethics approval was obtained from each of the universities in 2019. An announcement and participant information statement were then posted on each university's electronic learning management system. Participants were informed that their involvement was voluntary, and they were asked to email the researchers if they wished to participate in interviews. Only students who provided written consent were included in the study.

Data collection

Semi-structured in-depth interviews were used to elicit nursing students' narrative accounts of raising concerns about poor patient care (undertaken by xx, xx and xx). The research team were experienced female qualitative researchers, not known to the students. Interviews were undertaken over the phone or face to face within the university setting, with no-one else present during the interview. There was no pilot testing, due to the open nature of the schedule and no repeat interviews. All members of the team had an interest in the topic of poor care and had volunteered to take part in the research. The interviews were of 35 – 50 minutes duration and were audio taped and transcribed with the participants' permission. No further interviews were undertaken following data saturation. Pseudonyms were inserted to protect the participants' anonymity. No participants dropped out of the study following interview. Transcripts were not routinely returned to the participants but were made available on request.

Data analysis

A constant comparison approach was used with the findings, including field notes, from each interview informing data collection in subsequent interviews. Data was independently analysed and coded, using a manual process, by members of the research team. Following individual coding, themes from each narrative were then compared, discussed and, where necessary reformulated by those who had conducted the original analysis. Where disagreements occurred, a third member of the team supported the process by providing an additional perspective, thus emerging themes were identified, discussed and verified by the researchers. All members of the research team were subsequently invited to review and comment upon the resultant analysis for each narrative. This approach helped to increase the

quality and depth of data as well as expanding on the early themes identified from each interview (Holloway & Wheeler, 1996). The research team agreed that the four chosen narratives best exemplified the wider data set in terms of their depth and breadth. The four narratives showed commonality in that each represented the ability of nursing students to report poor care. However, there was some difference both in terms of the reported incidents, setting, how reporting was enacted and implications of the students' actions.

FINDINGS AND DISCUSSION - A MONTAGE

From the original sample, four narratives are presented here in the form of a montage. A montage is the combination of several contrasting and complementary textual images to make a composite picture with different voices, perspectives, and experiences being represented. Presenting such a picture is important to explore the topic of poor care. The textual images revolve around a central focal point to illustrate key issues or themes (Denzin & Lincoln, 2000). This contrasts to fractured text, which can arise from thematic analysis. In this paper these four narratives have been used to illustrate participants' experiences of reporting poor patient care in community, mental health, aged care and medical clinical settings.

Narrative 1. Laura's Story – 'It wouldn't ever stop me from reporting something that I wasn't happy with'

Laura's story takes place in a community setting during her second year as a nursing student and is focused on a potentially dangerous situation where she discovered a patient who was smoking whilst being nursed on an air mattress. She raised her concerns by questioning her colleague in the moment, although was ignored. She found support from another nurse, which enabled her to document her concerns:

She was smoking on an air mattress, and I was a bit worried about it... I noticed all the burn holes in her covers and a strong smell. So, I questioned the nurse that I was with, but she didn't seem very concerned. She just said, "Well she's bed bound so needs to be on the mattress". I wasn't very comfortable with that answer. I Googled it and found a report from the fire department about incidents on air mattresses and people that have died and that got me worried. So, I spoke to one of the other nurses

and she told me to report it on the computer system. So, I did it and I felt quite pleased with myself, and I thought that something would change.

However, when the team leader returned for her next shift, she made it clear to Laura that she did not approve of her actions. The team then treated her differently, displaying behaviours tantamount to bullying:

When I came back on to nights their whole attitude towards me was different. They said, "I see that you've put an incident report in"... They stopped letting me do things like writing notes. I went from actively doing stuff to being told to just sit there and watch, which was really upsetting. They didn't directly say that I shouldn't have done it to my face but it was completely different. One night I heard them calling me lazy and saying that I should be careful reporting [poor care] and one of the nurses said that they couldn't stand me.

The bullying behaviours had a psychologically adverse effect on Laura and her account of the situation was trivialised and summarised in a different way to how she remembered it, by the registered nurse involved:

I came back in, and I was just crying my eyes out and I said that I wanted to go. I was really upset because of the lazy comment because all my feedback from previous placements has said how proactive I am. When I came back [to university] I spoke to my supervisor about it and he already knew because the nurse had already sent a long e-mail ... but she made out that nothing bad had happened and that I must have misheard something

Despite her ordeal, Laura maintains that she would continue to advocate for the patients as their safety is of paramount importance:

In nursing you look after your patients and your patients are the most important thing. So it [this experience] wouldn't ever stop me from reporting something that I wasn't happy with and something that put a patient at risk.

Laura's narrative highlights the need to overcome the fear of reporting in order to promote patient safety. Speaking out took courage and an ability to seek out further

information, in this case from the fire department, after her concerns were ignored by the registered nurse. Laura's story identifies the action she took in order to address a potentially fatal risk to a patient's safety. Her account demonstrates that speaking out takes both courage and determination. To check the validity of her feelings she reviews specialist guidance on the dangers of smoking in bed - in effect she seeks evidence to confirm that her actions are appropriate. Her story had similarities to the other narratives across the full sample, which revealed students being treated differently if they raised questions about poor practice. This often led to students keeping quiet, due to fear of reprisals.

Narrative 2. Lewis' Story: 'I felt I wasn't supported at that time, and it upset me'

In this narrative Lewis, a second-year nursing student described an experience, which took place within an older people mental health setting. Lewis raised his concerns by speaking up during the event to stop colleagues' delivery of poor care:

A patient came into the ward I was working on. Their mobility wasn't very good and they were highly anxious because of this. I walked her to a chair in the dining room but the chair didn't have any arms so she didn't feel confident. As I went to take her to another chair, one of the staff members ~~staff~~ was impatient and grabbed hold of her trousers and just pushed her into the chair. I spoke up there and then and told them not to do that.

Lewis was concerned that speaking out might have an adverse effect on him passing his placement, so apologised for his actions, even though his mentor agreed that he had acted appropriately:

The staff member rushed off and told the senior nurse in charge. I also spoke to the senior nurse and explained my point of view but they told me that I didn't have the experience that the other staff member had ... they knew what they were doing and I should apologise. I wasn't going to argue my point because I didn't want it to affect my placement, so I went and apologised. I also spoke to my mentor who told me that I'd done the right thing.

Lewis was left feeling angry and that his ability to advocate for the patient was viewed negatively. Further, he felt that staff wanted to avoid conflict at any cost and this desire was prioritised over support for him:

I was furious inside. I felt let down, that the senior nurse didn't see it as poor care and, I'm making an assumption here, but it seemed that they didn't care what had happened but just didn't want any conflict. So, I felt I wasn't supported and it upset me.

The event sharpened his awareness to other instances of poor care, although he explains this by citing short staffing and staff exhaustion:

I started to see smaller things then although there was good care, there was also a lot of poor care. Staff seemed to be exhausted, affected by short-staffing and having to work late. Their attitudes were more negative than positive which affected patient care – quite drastically in some instances.

Lewis's narrative illustrates the personal struggles nursing students often experience when attempting to report poor care. While Lewis' initial reaction was instinctive, reporting a staff member who mishandled the patient, the dismissive attitude of the senior nurse left him feeling frustrated and concerned about the potential personal consequences of further escalating his concerns. The wider sample revealed similarities to Lewis's story in that students were often dismissed by senior staff when they reported poor care or important information, for example, about the acutely deteriorating patient. Students often felt that they were not respected for the knowledge and skills they had, due to their novice status.

Lewis' later reflection in the narrative about the exhaustion of staff members could be read as a post hoc rationalising of the negative behaviour. Taken alongside the dismissal of his concern and the fact that he was made to apologise for speaking up in the first instance it may also explain his strategic decision not to contest the position taken by the senior nurse and to remain silent despite witnessing further instances of poor practice. Here silence is a tactic to survive and may be something that the whistle-blower may need to cultivate from time to time.

Narrative 3. Gabby's Story – 'Doing that made overcome my fears'.

In this narrative Gabby, a second-year nursing student, describes a challenging situation where she felt compelled to respond to a patient's clinical deterioration, yet, by doing so had to go against the advice of senior registered nurses. She raised her concerns to another member of the interprofessional team and in him, found the support she needed. She reported how the environment was uncondusive to learning from the outset:

My medical placement wasn't easy. It was one of those wards where the nurses didn't want students, and sometimes when you did what you thought was a correct procedure you'd be laughed at.

I was looking after Jo, a man in his eighties with cellulitis of the legs and multiple other comorbidities who'd been in hospital for a few months. He was depressed and anxious, complaining all the time and ringing his call bell a lot. I remember one day holding his hand while he was crying on the phone to his wife and begging her to come back to the hospital.

Gabby described that the registered nurses lacked empathy and that they disbelieved Jo, when he reported breathing difficulties:

But the nurses were not empathetic, and they didn't seem to care about him as a person. They'd say disparaging things about him like "he's just anxious" or "he's putting it on". They were quite blunt with him too. Like, if he said "Oh, I'm finding it hard to breathe" they'd just say, "Your oxygen's on ... your breathing will be OK".

Gabby role modelled clinical competence by raising her concerns about Jo's vital signs although she was ignored and treated with lack of respect. This led to her feeling upset and stressed:

So, what happened was I went in to take his vital signs and his respiratory rate was 30 and his oxygen saturations were 90%. I literally ran out to the nurse and said, "Oh this is what's happening. Can you come and help me?" She said, "I'm too busy ... ask the other nurse." So, I went to the other nurse and she said, "Just put the chart on the doctor's desk, I'm busy too". I wanted to cry because I was so stressed and upset that they didn't care.

Gabby showed courage by approaching the doctor herself. This left her in a difficult situation as she did not have enough knowledge to be able to answer his questions and felt overwhelmed:

In the end I decided to ask doctor myself. I went up to him and showed him Jo's vital signs and said "Look, he's not doing well, this is what's happening."

Thankfully he went and saw him straightaway. Both the nurses saw that I was with the doctor but still didn't come to help. And the doctor was asking me questions that I couldn't answer. I told him I was a student, but he kept talking to me as if I had been nursing for years. I felt so overwhelmed and I was nervous that I'd done the wrong thing by not initiating a rapid response.

In the end the doctor ordered a higher oxygen flow rate and said to monitor the patient more closely. But by the next day Jo had to be transferred to the cardiac ICU. So, he had been deteriorating and it was really upsetting that the nurses didn't really care or do anything.

Like Laura, Gabby justifies her decision making by prioritising the patients' needs over her discomfort:

I've thought about it quite a lot and I don't ever want to develop that attitude of not caring. I've learnt that little changes in people's condition can be very big signs, and that even as a student I have to step up when other people aren't doing their job ... which is a really scary thing. But as long as your patient is okay ... in the end, that's all that matters.

Gabby's narrative illustrates how

overcoming the fear of speaking out requires moral courage and, in this case clinical acumen- her concerns are supported by knowledge of normal physiology and the signs of acute deterioration.

Despite doing the right thing by raising and escalating her concerns, her actions did take an emotional toll. Gabby described wanting to cry, feeling stressed, upset and

overwhelmed, not just because of the patient's deterioration, but because of the nurse's uncaring attitude. Findings from the wider sample were commensurate with Gabby's story in terms of them witnessing a lack of empathy from more experienced staff. Often, students reported lack of time as a rationale for uncaring attitudes although in some cases, they felt that colleagues were suffering burnout, and this led them to prioritise their own emotional needs over those of others.

Narrative 4. Phoebe's Story – 'Just small things that happen all the time'.

Phoebe's story takes place in a residential aged care facility during her first placement as a nursing student. This narrative illustrates how it is sometimes the small, seemingly inconsequential things, that can have the biggest impact on patients and are sometimes the most memorable for students.

When I was thinking about poor patient care it was quite difficult to pick just one incident, because what we tend to see is not hugely significant, major incidents, but just small things that happen all the time.

Phoebe described a distressed patient, being cared for by a team who prioritised their own conversation, in a foreign language, above providing the required reassurance and empathy:

One incident that I do remember clearly was when a resident needed a shower and three staff members were helping her out of bed with a hoist. The staff were having a conversation in their own language and they didn't say a word to the resident who was obviously confused, distressed and frightened. Into the bathroom, and into the shower ... the whole time, there was no communication with her, and the staff didn't seem at all concerned. It was so upsetting watching her distress, especially when she should feel cared for and safe.

Phoebe steps in to improve the quality of care provision by role modelling good practice although the staff did not even seem to recognise there was a problem with their behaviour:

It was very early in my placement and I wasn't meant to be providing any hands-on care. But it got to a stage where I just had to just step in. I tried to explain to the lady and said, "We're just going to help you have a shower." She grabbed onto my hand and settled down a bit. I think she felt better knowing

what was going on and that there was someone paying attention to her. She had been vocalising quite a lot and trying to grab on to the hoist but after I spoke to her, she didn't seem so scared. But the staff looked at me like I was crazy, like they thought it was unnecessary to explain anything. I don't think they intended to treat her badly, which almost makes it worse in a way, that they didn't even recognise what they were doing or see their care as problematic in any way.

Phoebe described the difficulty for students being able to challenge staff about poor care, due to potential effects on ongoing working relationships. However, she holds their behaviour up as negative role modelling in contrast to her own empathic behaviour:

Afterwards I talked to my facilitator about what happened but not the staff. It's very difficult to have those conversations as students as you have to work with the staff for the rest your placement. But seeing those types of incidents, you definitely think, "Oh, I really hope that I can be someone who always takes the time to deliver compassionate care." I really hope I don't become like that ... burnt-out or with compassion-fatigue. It would be just terrible to one day treat people like that. But I guess, in a way, witnessing poor care is even more educational than witnessing good quality care, because it really highlights why it shouldn't happen.

Phoebe's story is revelatory on many levels. In terms of the act of raising a concern, where others have spoken out, she does this by demonstrating an alternative way of delivering care - she intervenes by modelling good practice. She does this despite being in the company of three other nurses who were leading the intervention and whose standards were very different from her, but also from the perspective of a first year student whose designated role is that of observer - she steps outside this to be an active care deliverer. Moreover, by her own account, this example of poor practice is indicative of a wider issue of substandard care in that setting. As such her action might be a direct challenge to a prevailing culture of indifference, highlighting how poor care can happen during the everyday events and minutia of daily routines. In this context, poor care can become normalised and almost invisible, except to the outside witness and, most importantly to the person who is vulnerable, fragile or

frightened — and for whom, experiences such as the one described above, are a far cry from 'normal'. Overwhelmingly, the full sample revealed several occasions when students showed leadership by role modelling effective skills and through sound clinical knowledge. They were unwilling to compromise their own high standards, although as the montages presented here revealed, this was often at a personal cost to themselves.

DISCUSSION

The students who participated in this study talked at length about their reporting of poor care and analysis of their narratives identified significant incidents that impacted upon their experiences. The montage presented in this paper is a powerful reminder that poor care still exists across a full range of health care settings and across two international settings and three sites in two countries

Recognising and challenging poor care is important for patient safety, although due to their role and position in the workplace, nursing students might not always feel able to speak up (Fagan et al, 2016). Challenging others might negatively impact on their successful completion of the placement and how they are treated by staff (lon et al, 2015). However, our data indicate that, regardless of the challenges, some students were prepared to speak out about what they consider to be poor clinical care. In each of the four narratives, this is done in the practice setting in real time. This is particularly significant for patients, as it creates an opportunity to change practice in the moment and thereby reduce distress and improve safety.

For these students, challenging practice is driven by the need to act in accordance with personal belief and professional guidance, which overrides fear and the possibility of negative outcomes. In doing this they demonstrate moral courage - in this case doing the right thing regardless of fear and the perceived need to fit in with permanent staff (Bickhoff et al 2016). Further, they demonstrate a high level of concordance with the guidance of their respective national regulatory bodies (NMBA, 2016; NMC, 2018).

The behaviour of the students in this sample, supports the view that nurses are sometimes seen as everyday heroes. They often act altruistically and selflessly helping people in need, reporting failures, despite sometimes risking their own

health, wellbeing and/or position (MacDonald et al, 2018). The narratives discussed clearly illustrate how even novice nurses are driven by an ethical imperative to speak up when they witness poor care. Students might be unfamiliar with the prevailing cultural norms and values in different health care contexts (Ion et al., 2019; Fagan et al., 2016) and this provides further challenges for students to speak up. Students in this study paid for speaking out by being ignored, criticised and treated with lack of respect and these findings are commensurate with previous research in this area (Bellefontaine, 2009; Levett-Jones and Lathlean, 2009; Ion et al, 2015, Jack et al., 2020). They observed silence and collusion, which is often aimed at protecting staff rather than patients (Mannion and Davies, 2015). Non-physical violence towards nursing students is common and registered nurses are frequently the main perpetrators (Hopkins et al, 2014). This leads to students reconsidering nursing as their intended career and being often reluctant to report bullying due to fear of reprisals from staff, meaning that the incidence is underreported (Budden et al, 2017). Registered nurses are students main role models for learning how to care although our data suggested that it was the learner, rather than staff, who modelled good practice often in difficult circumstances. There is an important wider conversation in relation to how nursing students are supported to develop leadership competence, which is relevant here. Leadership education tends to sit at the end of undergraduate nursing curricula (Scammell et al, 2020) although this is unhelpful to prepare students to report poor care, if they are unclear about their leadership role. It remains critically important that the nursing workforce role model safe and empathic care and also respond appropriately when students demonstrate the moral courage to raise concerns (Jack et al., 2017; Jack and Hamshire, 2019).

The narratives in this study suggested that some nursing students were able to overcome their fear in to challenge poor care and this was driven by the need to avoid negative consequences for the patient. On these occasions, challenge was enacted in several ways; through immediate questioning of staff decision making; speaking up and challenging others in the moment; locating other health professionals for support, or, through active role modelling of effective practice. Enacting the raising of concerns was accompanied by emotion such as anxiety and in some cases, took place due to frustration at the poor care that the students observed. Challenging poor practice is more likely to occur when students feel they

have the skills to do so, for example, following appropriate education and the development of coping skills (Kent et al, 2015; Birks et al, 2017) and specific educational initiatives have been shown to be effective (Hogan et al, 2018). However, along with the education and skills development, the environment needs to be supportive for nursing students, to avoid the culture of silence and collusion being perpetuated (Mansbach et al, 2013).

CONCLUSION

This paper adds a contribution to the ongoing conversation about care of vulnerable people, the prevailing cloak of silence which helps to maintain the status-quo and the experiences of nursing students who attempt to speak out to challenge it. Nursing students have a vital role to play in driving positive change and it remains a challenge to educators to support this process. Universities have the responsibility to provide rigorous curricula and bespoke interventions which not only explore ethics but provide practical educational support for students to equip them with the communication tools to enable speaking out. Further, interventions to support students to role model positive caring behaviours should be encouraged alongside a wider leadership education narrative. By doing so, the professional development of future nurses who have the courage and wisdom to act ethically can be enhanced and a culture where patient safety is paramount can be promoted.

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