

# Supporting nursing, midwifery and allied health professional students to raise concerns with the quality of care

**A systematic literature review**  
**June 2016**



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Supporting nursing, midwifery and allied health professional students to raise concerns with the quality of care is a project led by the Council of Deans of Health (CoDH). The project is governed by a Steering Group with representation from the Council and a student.

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### **Note**

Both the terms 'whistle-blowing' and 'whistleblowing' are found in the literature with no agreement as to which form is the more appropriate. This review uses the expression 'whistle-blowing' except where it is spelt 'whistleblowing' by the author being discussed.

### **Abbreviations**

For reasons of clarity we have sought to reduce the number of abbreviations used within the text. Here is a list of those that do appear:

CoDH - Council of Deans of Health

GMC - General Medical Council

HCPC - Health and Care Professions Council

NMC - Nursing and Midwifery Council

NPSA - National Patient Safety Agency

RCM - Royal College of Midwives

RCN - Royal College of Nursing

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## Executive summary

Speaking up and the reporting of concerns in practice is a crucial element of patient safety. When things go wrong, patients, their families and the public expect health professionals to be open and honest, to put things right where possible and to learn from their mistakes.

Following a number of reviews into the quality of care and patient safety in the UK, including *Review of the quality of care and treatment provided by 14 hospital trusts in England: overview report* (Keogh, 2013) and *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Francis, 2013) a change in reporting culture is actively being encouraged; a duty of candour has been implemented for providers and individuals to be open and transparent with service users. Registered healthcare professionals have a professional duty to report and act on concerns about patient safety. This duty also extends to students on pre-registration healthcare programmes who spend up to 50% of their course in a practice learning environment.

This report presents the findings of a literature review commissioned by the Council of Deans of Health of the evidence relating to nursing, midwifery and allied health profession students raising concerns about poor clinical practice or care. The report identifies that students often express a desire to raise concerns and can provide valuable insight into the delivery of care within healthcare settings; yet various complexities and challenges that exist can act as a barrier and impede reporting. Raising a concern carries an emotional burden for the student as they may be fearful of potential adverse consequences. Whilst students are now expected to report concerns, professional guidance suggests that the organisational culture within universities and practice environments remains a strong influence. Therefore, an open and fair learning environment is essential as students perceive giving less than positive feedback might be reflected in the outcome of practice-based assessments and damage their clinical placement experience.

The analysis of the evidence revealed that there is a lack of guidance for students on how to escalate a concern and a lack of clarity around concepts central to the reporting process, such as 'whistle-blowing'. Further analysis is needed to give clarification to these terms within the concept of raising concerns.

Universities have a clear role in aiding students through some of the challenges of raising concerns. Clear and substantial structures that help students understand relevant processes; professional and regulatory guidance should be in place. The report makes a recommendation that a comparison of higher education institution's policies on raising concerns should be undertaken across the UK to ascertain good practice.

Other key recommendations in the report include a study into the lived experience of healthcare students who have reported concerns on the quality of clinical care and practice, and further work on the use of safeguarding and safety incident processes.

# 1. Introduction and background

## Introduction

This report presents the findings of a systematic literature review commissioned by the CoDH on evidence relating to students of nursing, midwifery and the allied health professions reporting concerns about the quality of practice. Students undertake placements in a range of clinical and other practice-based learning environments within the NHS, social care, voluntary and independent sectors. As part of the placement process they both observe and participate in a diverse range of care and treatment interventions. It is possible that students will encounter differing levels of quality within clinical and other therapeutic environments, and some may fall below the standards they believe should apply.

## Aim of the review

The aim of this literature review was to systematically gather and synthesise the evidence around raising concerns with regard to poor quality care by students on pre-registration healthcare programmes.

## Objectives

With the above aim in mind the specific objectives of the review were to analyse and report:

- The UK policy drivers and public expectations for nursing, midwifery and AHP students
- Evidence in relation to barriers (and enablers) for students raising concerns
- The effect of workplace learning environments in terms of context and culture on reporting, including the impact of conflict between staff and positive team working practices
- The impact of higher education support mechanisms, including personal tutoring, link lecturers and practice education roles, in facilitating or hindering reporting
- The effect of student attributes and the use and impact of practice and education based support mechanisms in generating confidence to report
- Identification and analysis of the processes, mechanisms and strategies currently available in raising concerns with particular reference to good practice.

## Background

Since publication of the expert report on quality of care concerns in the NHS (DH, 2000), one of a number of key texts published in the UK and other countries ushering in patient safety as a cohesive concept and goal (see for example the Bristol Royal Infirmary Inquiry, 2001; Kohn et al., 2000; House of Commons Health Committee, 2009), significant moves have been made to shift healthcare towards a more positive safety culture. Although the notion of safety culture remains problematic in terms of definition and implementation, it is clear that 'the way things are done around here', probably the simplest explanation of what safety culture means (Reason, 2008), has changed and there is a considered and arguably sustained drive in the UK and other countries to enhance patient safety. The ability and readiness of staff and students to raise concerns about the quality of care is central to improvements in safety culture. Patient safety and quality are therefore inextricably linked in contemporary healthcare.

The concept of patient safety is defined as:

‘...an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient’ (World Health Organisation (WHO), 2011, p81).

Although much patient safety work is directed at the reduction of errors, fundamentally patient safety is about reductions in unnecessary harm (Vincent, 2010) and, as will be shown, that harm comes in a number of forms. Improvements in patient safety are therefore integral to improvements in the quality of healthcare. From an educational perspective the WHO (2011) ‘Patient Safety Curriculum Guide’ was an attempt to consolidate a clear focus upon patient safety in healthcare curricula and standardise education in this area, although the extent of its use in the UK remains unclear. The House of Commons Health Committee (2009) did note that patient safety, including human factors, had yet to be fully and explicitly integrated into education and training curricula, but those comments predate the WHO initiative. What was made clear by the former NPSA, was that a culture of ‘being open’ (NPSA, 2009) and being able to raise concerns, was required in the NHS, and this was both about the possibility of error and the limitations in performance and moral standards of colleagues.

Alongside the shift towards a more positive safety culture, systems have been introduced that acknowledge the threat, and in many situations the inevitability of error. Little shows this shift more clearly than the National Reporting and Learning Service (NRLS), which in the last twelve years has fundamentally changed the culture of reporting errors in the NHS. It is now much more common to acknowledge when errors occur and for practitioners to report those errors. Students may or may not be able to report using local NHS systems that feed in to the NRLS, depending on local policy and convention. However, students are likely to be increasingly aware of the responsibility to be error wary and to use their experience of error reporting and feedback mechanisms as a reflective learning tool to prevent recurrence and improve practice. (GMC/NMC, 2015). They are also likely to be aware of professional guidance on the matter, for example the various professional codes of conduct, the new duty of candour (GMC/NMC, 2015) and the ‘*Freedom to Speak Up*’ report (Francis, 2015).

Accompanying the rise of the patient safety agenda there has been an increase in the surveillance of quality measures from hand hygiene rates to publication of mortality indicators for hospitalisation (HSCIC, 2015). This rise in surveillance is providing an increasing wealth of evidence on the quality of healthcare provision. Much of that evidence, however, relates to the limitations of healthcare practice, tracking problems such as ‘Never Events’, those significant patient safety incidents that should not have occurred if the relevant policy and procedure had been followed (NHS England, 2014). Students like all healthcare staff are, therefore, much more conscious of the fact that threats to healthcare quality are common and sometimes serious (WHO, 2011). Violations, a type of error in which staff fail to adhere to policy, procedure or guidelines, are endemic in healthcare but uncommon, or at least actively and persistently guarded against, in industries with a positive safety culture, for example aviation (Carayon, 2007; Reason, 2008). The level of violations encountered in healthcare are relatively common and students, like others working in the healthcare context, are increasingly being made aware of the concerns this causes.

Listening to staff when they raise concerns related to incompetent and criminal practice is important to protect patients from the risk of mistakes and harm. An analysis of these problems in relation to medical staff, including the former general practitioner and multiple murderer, Harold Shipman,

showed that NHS organisations and professional bodies such as the GMC, had failed to have effective mechanisms in place to detect and deal with such practice early when it occurred (Milligan, 2007). That analysis also showed that organisations were often slow to listen to the concerns of practitioners and the public. In the case of Harold Shipman this contributed to him being able to murder of around 250 of his patients (Dame Janet Smith, 2002). Further analysis of these issues, challenging the idea that staff and/or organisations are often silent on failings they see in healthcare, can be found in Jones and Kelly (2014). They suggest that organisations may in a sense be deaf to the threats to quality, and patient safety, which exist within the organisation, thereby reducing the possibility of learning.

## 2. The legislation and policy context

### Legislative context

The rise of safeguarding in the last decade reflects concerns with shortcomings in systems for detecting incompetent and malicious practice. Within the four nations of the UK legislation<sup>1</sup> exists to protect individuals from abuse and harm. A breach of a duty of care by an organisation and individual healthcare practitioners can result in prosecution and sanctions by regulatory bodies. The Department of Health in England has made it clear that all healthcare practitioners have a duty to safeguard patients, particularly those who are unable to protect themselves (DH, 2011). The responsibility of staff and students to report concerns is set out in the 'Department of Health Principles of Safeguarding' which emphasises the importance of understanding feedback and reporting mechanisms (Betts, 2014),

The most relevant legislation for the purpose of this review is the Public Interest Disclosure Act (1998) for England, Wales and Scotland, and the Public Interest Disclosure Act (Northern Ireland) Order (1998), supplemented by the Enterprise and Regulatory Reform Act (2013). Within the NHS, the right of staff to whistle-blow is enshrined within the NHS Constitution (Health Act, 2009). Employees who reasonably believe that disclosure of confidential information is in the public interest are protected in law providing they do not act for personal gain. Unless it is unsafe or impractical, the legislation requires that concerns should normally be raised within the organisation before considering referring the matter to an external agency. The burden of proof lies with the person raising concerns, but if whistle-blowers are bullied or harassed, employers are vicariously liable for the actions of those behaving in this manner, unless they have taken reasonable steps to prevent victimisation. Those behaving in this manner will also be personally liable for their actions. The European Court of Human Rights has confirmed that Article 10 of the European Convention on Human Rights protects freedom of expression and therefore whistle-blowing (Heinisch v Germany, 2011, ECHR 1175). Summary guidance on the legal framework in relation to whistle-blowing can be found in the '*Freedom to Speak Up*' document (Francis, 2015).

### Policy and regulatory drivers

Students have an important place in reporting concerns about poor practice as highlighted in the Keogh report (2013). In the investigation into hospital trusts that were performing poorly Keogh used student nurses as part of the investigating team. As will be shown through the review reported here, in challenging poor care students can be a positive catalyst for change.

The Francis Inquiry's report (Francis, 2013) into the failings in patient care at Mid Staffordshire NHS Trust between 2005 and 2008 prompted in-depth reflection from every healthcare organisation, including regulatory bodies and higher education institutions (HEIs) involved in the education and training of healthcare students. Robert Francis QC summarised that the appalling suffering of many patients was primarily caused by 'serious failure on the part of a provider Trust Board', the Board failed to listen to patients and staff and neglected to 'tackle an insidious negative culture involving a

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<sup>1</sup> Domestic Violence, Crime and Victims (Amendment) Act (2012); Mental Health Act 1983; Mental Capacity Act 2005; Mental Health (Care and Treatment) Scotland Act 2003; Adults with Incapacity (Scotland) Act 2000; Mental Health (Amendment) (Northern Ireland) Order 2004; Corporate Manslaughter and Corporate Homicide Act (2007); Criminal Justice and Courts Act (2015).

tolerance of poor standards and a disengagement from managerial and leadership responsibilities'. Furthermore, NHS systems which should have identified and managed failings of this sort failed allowing sub-standard care and practices to continue. The Inquiry report made 290 recommendations, many specifically relating to the role of students as a source of information of the standards of care provided to patients. Francis recognises students are 'invaluable eyes and ears in a hospital setting.' He made recommendations that student surveys should be developed as their feedback is a valued source of information and proactive steps need to be taken to encourage students to be open about what they witness whilst in clinical settings and to protect them from adverse consequences arising from raising concerns. Whilst the body of the report focuses on the medical and nursing workforce, these recommendations are important and easily cut across other professions including midwifery and the allied health professions.

'*Freedom to Speak Up*' (Francis, 2015) advocated an open and honest reporting culture in the NHS. The aim of this review was to provide advice and recommendations to ensure that NHS staff in England feel safe to raise concerns and are confident that they will be listened to, with their concerns acted upon. The key themes that arose from the review in relation to the need for a cultural change were: an improvement in how raising concerns cases were handled; the need for measures to be put in place to support good practice; particular measures for vulnerable groups and the extension of legal protection. Principle 2, 'a culture of raising concerns', required organisations to reconceptualise concern-raising as part of their normal routine business and based on a shared belief, at all levels of the organisation, that raising concerns is a positive activity leading to a learning opportunity rather than a source of criticism. This echoed a key recommendation of the Berwick Report (2013) into patient safety, that the NHS should become a learning organisation with leaders who have the capability to lead change. The report recommended that the investigation of a concern should be the priority with any associated disciplinary action considered only when the facts had been established. This required managers to show that any action taken was justified and consistent with how others within the organisation had been treated. Principle 3 stated that the freedom to speak up depended on staff being able to work in a culture which was free from bullying and other oppressive behaviour. Bullying was seen as a safety issue as it deterred people from speaking up, as well as having implications for staff morale, attendance and retention.

In responding to the Francis Report, the government supported the proposal to implement a duty of candour on both providers and individuals (see GMC/NMC, 2015a). The duty of candour requires the disclosure of information when something goes wrong with patients' treatment or care, or has the potential to cause, harm or distress. Minimum sets of training standards (SFH/SFC, 2013) and a code of conduct for support workers (SFH/SFC, 2013a) in adult health and social care were also introduced that included a requirement for the raising of concerns in practice.

The NMC and HCPC embarked on organisational-wide programmes of work in response to Francis' specific recommendations for the healthcare regulators. The NMC undertook a period of consultation and used feedback from a variety of stakeholders to revise the professional standards of practice and behaviour for nurses and midwives, '*The Code*' (NMC, 2015). Within the section of '*The Code*' headed 'Preserve safety' (NMC, 2015) that discusses the 'duty of candour', there is an explicit requirement for nurses and midwives to raise concerns immediately when patient and public safety is at risk (including the level of care people are receiving in the registrant's workplace or other care setting); or if they believe that a person is vulnerable, at risk or needs extra support and protection.

Nurses and midwives are also required to acknowledge and act on concerns brought to their attention and protect those from harm, detriment, victimisation or unwarranted treatment after a concern is raised (see also NMC, 2015b).

The HCPC responded to the Francis Report by developing an action plan (HCPC, 2015a; HCPHC, 2014) including a review of the existing memorandum of understanding with the Care Quality Commission. The HCPC Standards of Education and Training (SETs) have also been reviewed to strengthen how expectations for education providers are set out to ensure safety for service users and students in the practice learning environment. Following a public consultation the principles of 'duty of candour' proposed in the Francis Report were embedded within refreshed 'Standards of conduct, performance and ethics' published in 2016 (HCPC, 2016).

The effect of the Francis Report (2013) and the subsequent '*Freedom to Speak Up*' report (Francis, 2015) on the NHS, and on health and social care delivery within the UK, has been significant. The recommendations from the report have been cited within countless commentaries and used to justify a vast range of contemporary health and social care initiatives, innovations and developments. The actual impact of the report on the behaviour of health and social care professionals remains unknown and will require further research. The development of values-based recruitment, both within the NHS and higher education, the emerging values-based reflection (Wareing, 2016) and values-based practice movements (Fulford, 2004) represent a paradigm shift that is influencing the points of entry for prospective healthcare employees and the professionals of tomorrow.

### **The experience of students encountering unsafe or poor practice**

The NHS Constitution for England (Department of Health, 2015) makes a number of points relevant to this review. The document sets out the principles, values and rights of patients and staff with regard to the NHS. It makes a number of pledges in relation to the objectives of the NHS and some are relevant to students raising concerns. The most notable can be found in section 4b, 'Staff – your responsibilities'. It is stated that staff should aim "to provide all patients with safe care, and to do all you can to protect patients from harm" (p.14). Further on in this section the following statement is made, that staff have a responsibility:

'to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff \* or the organization itself, at the earliest opportunity' (p.15).

A footnote in the original document, indicated by the \* in the quote above, is added in which it is made clear the range of NHS staff this applies to, and student nurses and midwives are mentioned. This section also asks staff to contribute to a climate where the 'truth' can be heard with regard to errors and learning encouraged. Staff speaking up about errors is therefore being supported.

An illustration of the problems with the quality of care sometimes encountered and the response to whistle-blowing on poor practice can be found in the story of Graham Pink (Pink, 2015). Graham Pink became synonymous in the early 1990's with the phrase 'whistleblower' (Andrews, 2013). He was employed as a senior night duty charge nurse on three care of the elderly wards at Stepping Hill Hospital, Stockport. After being in post for 16 months he started to raise concerns about staffing levels and the poor standards of care he felt the patients were receiving (see Appendix 3).

The impact of the Graham Pink case remains contentious (Gallagher, 2010), but what is clear is that changes to legislation and the guidance used to deal with the raising of concerns were made in the period immediately after his case closed. The case of Margaret Haywood, who was struck off the professional register for breaching confidentiality by filming what she saw as poor practice, is described by Gallagher (2010). Ms Haywood was later reinstated to the NMC register after an appeal. The Gallagher article is a useful summary and analysis of the ethical issues for and against whistle-blowing. Further discussion on educational responses to unethical practice can be found in Grob et al. (2012).

Joanne Tonkin (Nursing Standard, 2011; Tonkin, 2011), a student nurse in Cambridge, witnessed on her first placement an intravenous medication error by a staff nurse who then told the patient not to report the error. The error involved a drug that the patient was allergic to, although they did not have a reaction. The student was concerned and informed the ward manager; the staff nurse had not reported the error. The case was subsequently referred to the NMC and the nurse, some three years later, was removed from the register. Joanne, who had to give evidence at the NMC hearing, stopped her course as a consequence of the incident but restarted after a break. In the second article Joanne describes how, under cross examination by the solicitor acting for the staff nurse, she was asked how she as a 'failed nursing student' could question the practice of a qualified nurse (Tonkin, 2011).

Duffy et al. (2012) in an editorial for the journal 'Nurse Education in Practice' asked if too much is being asked of students when it comes to whistle-blowing. Writing from the perspective of being a nurse educator, it was noted that students need to 'fit in' during placements as they are being assessed and will need to pass the assessment to progress on the course. Duffy et al. note that students, due to lack of experience, knowledge or understanding, may not be able to distinguish accurately departures from evidence based or recommended practice. Price et al. (2015) have taken these arguments forward and explored theoretical perspectives that can help explain why students might tolerate suboptimal care. They explore the concepts of conformity and cognitive dissonance and point to the likelihood that staff, including students, may find it difficult to challenge poor practice that they see. Students and new staff they suggest, on a review of the evidence, are likely to try to rationalise aspects of care they may not agree with, thus reducing the likelihood of challenge. Further discussion on these points can be found in Scammell (2015) in terms of the increased levels of protection being afforded to students who raise concerns.

In 2013 the issue of whistle-blowing was returned to frequently on the news pages of the nursing press. The Nursing Standard (2013) reported in March that the RCN was lobbying the government to amend legislation to give greater protection to 'nursing students who speak out about poor care...' Another news piece in the Nursing Standard (2013a) in June mentions the fear of bullying being a deterrent to students reporting poor practice, but no evidence of the research mentioned was found in the work of this review.

Another short article tells of how students are sometimes not listened to by staff (Anonymous, 2014). On an evening shift a student nurse was told by a patient he did not want to return to bed to have his sacral pressure sore dressed. The student informed the staff nurse and suggested that the night staff could do the task once he was in bed. The nurse got angry about this, raised her voice and tried to

drag the patient back to bed by the arm. Despite further requests from the student, the nurse persisted in getting him back to bed and changing the dressing. The student reported her concerns to the nurse in charge and the following morning reported the incident, in writing, to the ward manager and matron. The staff nurse was disciplined and left the trust a short while later. The student states she received full support from the university and the ward manager. Another news item from the same year reports on concerns raised at the RCN Education Forum in relation to the support required by students who raise concerns. The debate arose around the case of three healthcare assistants who were ill treating patients. Following reports made by students, and a police investigation, the three healthcare assistants (HCAs) were jailed for the ill treatment (Nursing Standard, 2013b; 2014; 2014a).

Elcock (2013) in a short article on students raising concerns summarises a number of points seen elsewhere in the literature. Like Duffy et al. (2012), Elcock makes it clear that students can fear that raising concerns will impact on their ability to complete the programme. Elcock identified three options for students who consider raising concerns: do nothing, feedback through evaluation of the placement, or raise the concern in the practice area or with education staff. It is suggested that students need opportunities to discuss concerns thereby enabling them to explore the validity of those judgements.

### **Supporting professionals and students to raise concerns**

The NMC website brings together a number of documents relevant to reporting concerns in the NHS. The site also contains a number of links to guidance on raising concerns including relevant legislation and NHS Codes of Practice. As such it is a useful resource for anyone seeking further information about raising concerns about practice. The NMC no longer produces specific written guidance for students in terms of a code of conduct. Students are expected to work towards the standards set out in '*The Code*' (NMC, 2015). The NMC makes clear reference to students in the '*Raising Concerns*' (NMC, 2015a) document. This is a practical document which sets out clearly the types of abuse and neglect to which it refers. It is interesting that with regard to students the advice implies, in terms of the order of the list given in section 18 on how to raise a concern, that students should raise concerns with a lecturer first, then the mentor. The preceding section suggests that the concern be raised with the person concerned or line manager, but students are not mentioned here. Further analysis on this document and the recent changes to the Public Interest Disclosure Act (1998) as it affects students can be found in Gasper (2015) who concludes that the NMC is suggesting that students only raise concerns externally after all internal mechanisms have been exhausted.

Although the NMC (2015a) is directing students towards mentors no clear mention of students reporting concerns about practice is made in the earlier NMC (2008) '*Standards to support learning and assessment in practice*' document. This sets out the expectations made of mentors supporting nursing and midwifery students. Brief mention is made of student concerns, but there is no reference to concerns relating to the quality of practice or the behaviour or performance of other staff. The words 'concern' and 'concerns' are almost exclusively used in relation to student performance and whether this is satisfactory in achieving the learning objectives for the placement.

The RCM produced a response to the Morecambe Bay report (Kirkup, 2015), as mentioned above, in which they commit to specific work on mapping out guidance for members on the duty of candour

(GMC/NMC, 2015) and the '*Freedom to Speak up*' document (Francis, 2015). The RCM (2015) also produced a position statement on raising concerns. In this the RCM makes it clear that midwives, including students, should speak out if they have concerns about the quality of care and should be supported and protected when doing so.

Unlike the NMC, the HCPC (2012) has produced 'Guidance on conduct and ethics for students', but it says very little about students reporting concerns about practice. It does state:

'If you are worried about a situation which might put someone at risk, you should speak to a member of the placement team or education provider' (p.9).

Beyond this there is no information that would guide students as to how, where and to whom to report concerns about practice. As mentioned above, the HCPC (2015a) have an action plan to address this. The escalation of concerns raised by registrants was mentioned in two other areas of the HCPC response, making it likely that any future revision of the code of conduct would include more emphasis on registrants raising concerns about the quality of practice they encounter. The guidance information on 'Duty to report' produced by the Chartered Society of Physiotherapy (2015) does apply to students and gives details on the obligation to report and the types of incident that may need reporting.

There has been recent policy development around the concept of duty of candour. The joint GMC/NMC (2015) document on the issue sets out the professional duty of candour and how to follow the principles set out in '*Good Medical Practice*' (GMC, 2015) and the NMC Code (NMC, 2015). It opens by stating that:

'Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care causes, or has the potential to cause, harm or distress' (p.1).

It goes on to state that the professional:

'...must also be open and honest with their colleagues, employers and relevant organisations...' (p.1).

It is unfortunate perhaps that there is no specific mention of students in the document, although doctors in training are mentioned once and are advised to raise concerns with a named person in the relevant medical deanery.

UNISON, a public service union with a significant healthcare student membership, has guidance on its website for 'Whistleblowing' (UNISON, 2015). It is defined as the act of disclosing information about wrongdoing in the workplace and can include unlawful activities, miscarriages of justice or reporting on risks to health and safety. It advises the raising of such concerns internally before any external disclosure and early support from its representatives. As with the NMC (2015a) website titled 'Raising Concerns', the UNISON site carries links to legislation and the Northern Ireland government services website (nidirect, 2014). The web site gives broad advice on whistle-blowing and, although relevant to healthcare, the sector is not mentioned.

The RCN has on-line and phone services available to members, who can be students, giving advice on raising concerns. Details on the number of calls made to the service can be found in Table 1 (below). Although it can be seen that a significant number of calls are made each month, and between 21 and 101 relate to whistle-blowing, very few were from students.

**Table 1: Telephone calls categorized as Whistle-blowing (WB) at the RCN (RCN Direct, 2015)**

	Total Contact to RCND Advice	Total WB Calls	Total Student WB Calls	WB % against Total Calls
Jan 2015	7,477	47	0	0.63
Feb 2015	7,271	32	2	0.44
Mar 2015	7,864	30	0	0.38
Apr 2015	7,037	25	1	0.36
May 2015	6,985	21	0	0.30
Jun 2015	7,487	28	2	0.37
Jul 2015	7,477	25	1	0.33
Aug 2015	6,559	37	0	0.56
Sep 2015	7,331	82	2	1.12
Oct 2015	7,449	101	0	1.36

This data was kindly provided by the Royal College of Nursing, November 2015.

The RCN at its annual Congress and Exhibition (RCN, 2015) convened a seminar titled, 'The Francis review: freedom to speak up identified student nurses as a vulnerable group'. A summary of the discussion held was obtained from the RCN. It does not specify how many students attended or spoke at the seminar but a number of recommendations were made in the two page summary and they are listed here. The students wanted:

- An independent person to speak to about raising concerns
- To be updated throughout and at the end of a concerns process
- To be protected from bullying as a result of raising concerns
- Not to fail assessments solely as a result of raising concerns
- Future employment not to be affected after raising concerns
- Guidance on raising concerns (it was noted that NMC guidance on the matter does not apply to students)
- Advice to seek help from the RCN or another trade union or professional regulator
- Recognition for raising concerns.

It was interesting that the first four of these, and the need for guidance on raising concerns, were also raised in the student focus group convened as part of the review reported here (see Appendix 1).

## Defining 'raising concerns' and whistle-blowing

From the healthcare and policy context sketched out above it can be seen that there is now a clear responsibility on students to report concerns about practice. As noted above those concerns may relate to what might be termed 'the everyday error', in that such things are seen as almost inevitable in the patient safety content, through to a failure to maintain required standards of care and the incompetent, malicious and criminal practice that can occasionally be encountered.

## Whistle-blowing

Whistle-blowing is often used to describe situations in which serious concerns about practice have been raised. In a recent and very helpful narrative review of the broader literature on the concept (material from both inside and outside of healthcare), Jones et al. (2013) cite this as an influential definition of the concept of whistle-blowing:

'Disclosure by organisation members (former or current) of illegal, immoral or illegitimate practices under the control of their employers, to persons or organisations that may be able to effect action' (Miceli and Near, 1992 p.15).

A whistle-blower can be defined in the healthcare context as someone:

'...who identifies an incompetent, unethical, or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong' (McDonald and Ahern, 2000, p.314).

The authors compiled this definition as part of delivering a descriptive survey of the effect of whistle-blowing conduct on Australian nursing staff. On analysing the 95 questionnaires that were returned the authors concluded that blowing the whistle on misconduct was both personally and professionally risky and was an activity that could be a 'devastating experience' for the nurse. They described fear, intimidation and anxiety as consequences of the whistle-blowing act, with non-whistle-blowers reporting few professional reprisals.

The HCPC defines the concept thus:

'Whistleblowing is defined as the disclosure by an individual to the public, or those in authority, of mismanagement, corruption, illegality, or some other form of wrong doing in the workplace' (HCPC, 2015).

The most recent and perhaps the most significant document on raising concerns, was compiled by Sir Robert Francis (Francis, 2015). Although the phrase whistle-blowing does not appear in the title, it is used in the heading of each page of the review. The definition used is as follows:

"Whistleblower – a person who raises concerns in the public interest. For the purpose of concerns relating to the NHS, and in particular patient safety concerns, the term 'whistleblower' is used in this report to apply to those who speak up when they see something wrong usually relating to patient safety but also to the integrity of the system" (Francis, 2015, p.221).

Jones et al. (2013) note in their review and in further work related to workplace culture on whistle-blowing in health and social care (Key and Jones, 2013; Jones and Kelly, 2014) that the terms

'raising concerns', or 'the raising of concerns', are suggested as being more positive and less stigmatising for the reporter. The terms whistle-blowing and raising concerns have been used interchangeably by some authors, but Jones et al. see this as a problem as 'raising concerns' covers a wide range of issues, including ones that do not involve incompetent, unethical or illegal activity - concepts central to whistle-blowing. Jones and Kelly (2014a) also give a useful analysis of organisational failure in dealing with concerns about the quality of healthcare practice, which is sometimes referred to using concepts such as organisational deafness or silence. Using the work of Bjorkelo et al. (2011), Jones et al. (2013) describe five stages in the whistle-blowing process which, in a slightly adapted form for the purposes of this review, are listed in Table 2 (below). An analysis of the concepts of whistle-blowing and raising concerns in the perioperative environment can be found in Reid (2013), although no mention of students is made in the article.

**Table 2: The five stages in the whistle blowing process (Jones et al. 2013)**

<b>Discovery</b>	The activity that is a concern is observed.
<b>Evaluation</b>	The event is evaluated as wrong or illegal. The perceived cost and effort required by the whistle-blower is evaluated.
<b>Decision</b>	A decision is made to report the activity, or not. If the cost is perceived to be too high when balanced against the level of wrongdoing that was encountered the reporting of the event will be suppressed.
<b>Reaction to the whistle-blowing</b>	This can vary from the whistle-blower being victimised/persecuted to them being lauded for their actions.
<b>Evaluation of the reaction</b>	This will influence whether the whistle-blower, or others that watched this whistle-blowing process are likely to report in the future.

These are returned to in the conclusion.

## Raising concerns

It is clear from the discussion above that students in healthcare will inevitably encounter practice that is of concern to them. This may be because they observe an error, or perhaps an error that is not reported, or they may witness or participate in care or treatment that makes them feel uncomfortable. The student may feel that the standard of care and treatment they expect, or they have been taught to expect, has not been met. Returning to the definition of whistle-blowing by McDonald and Ahern (2000), if the failure involves incompetent, unethical or illegal activity, and a report is made to staff who have the power to do something about this, the phrase whistle-blowing could be applied. However, as Jones et al. (2013) make clear in their analysis of whistle-blowing in the healthcare setting, there are limitations to the use of this concept, in part because there is a need to encourage the reporting of a range of incidents. This seems particularly relevant in terms of the wide range of types of incidents that might be reported as described in the introduction to this review. As Jones et al. make clear, the blanket labelling of such activity as whistle-blowing may actually hinder reporting and this would be seen as a negative step in terms of attempts to promote a high quality, positive safety culture in healthcare. The phrase 'raising concerns' may become more common as it is

integral to the recommendations made by Francis. He noted that: "Raising concerns and being able to accept, with insight and without being defensive, concerns being raised about one's own practice is a fundamental skill that all NHS workers need to have" (Francis, 2015, p.139) and goes on to stipulate that these skills need to be 'embedded' in undergraduate and post-graduate curricula.

### **3. Methods**

#### **Approach to the literature review**

For the purpose of this review a systematic literature review is defined as a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise and analyse data from the empirical studies that are included in the review (Kiteley and Stogdon, 2014). A systematic literature search of relevant databases articles, journals, books, grey literature and websites was completed. To ensure that a broad range of material was reviewed aspects of narrative review methodology were also employed and can be seen in sections such as that on news, editorial and comment below.

#### **Review scope**

The review did not focus on wider sociological theory and evidence with regards to whistle-blowing. However, a useful summary on these issues can be found in Jones et al. (2013).

#### **The search - key words**

The following key words were used to search the literature:

Student, concerns, whistleblowing, whistle-blowing, quality, reporting, safeguarding, patient safety, poor care, competence, speaking up/out.

Synonyms, for example reporting/reported/report were utilised in the search. The key words were searched within the context of 'healthcare student' and the disciplines included were: nursing, midwifery, health visiting, paramedic, operating department practitioner, physiotherapist, chiropody, podiatry, speech and language therapist, orthoptist, occupational therapist, orthotist, prosthetist, radiographer, dietitian, and music and art therapist.

As advised in the requirements of the review social workers and social work were excluded from the search and review as were biomedical scientists, practitioner psychologists, clinical scientists and hearing aid dispensers.

#### **The search - databases**

The following databases were searched: CINAHL, Medline, ERIC, BEI, ASSIA, PsychInfo, British Nursing Index, Education Research Complete and a search made for relevant grey literature (see below). Google Scholar was also searched using the criteria stated here as it is acknowledged as a potentially useful literature searching resource (DeGraff et al., 2013) in terms of enhancing retrieval of material from internet sources.

Preference was given to the following recent literature, in order of priority:

- Peer-reviewed studies with evidence taking place in a healthcare higher education context
- Grey literature with findings from a healthcare higher education context
- Peer-reviewed studies with evidence drawn from the higher education setting
- Peer-reviewed studies with evidence taking place in any other setting such as industry.

As contracted, the search was completed on material made available from the year 2009 onwards.

**Table 3: The search - inclusion and exclusion criteria**

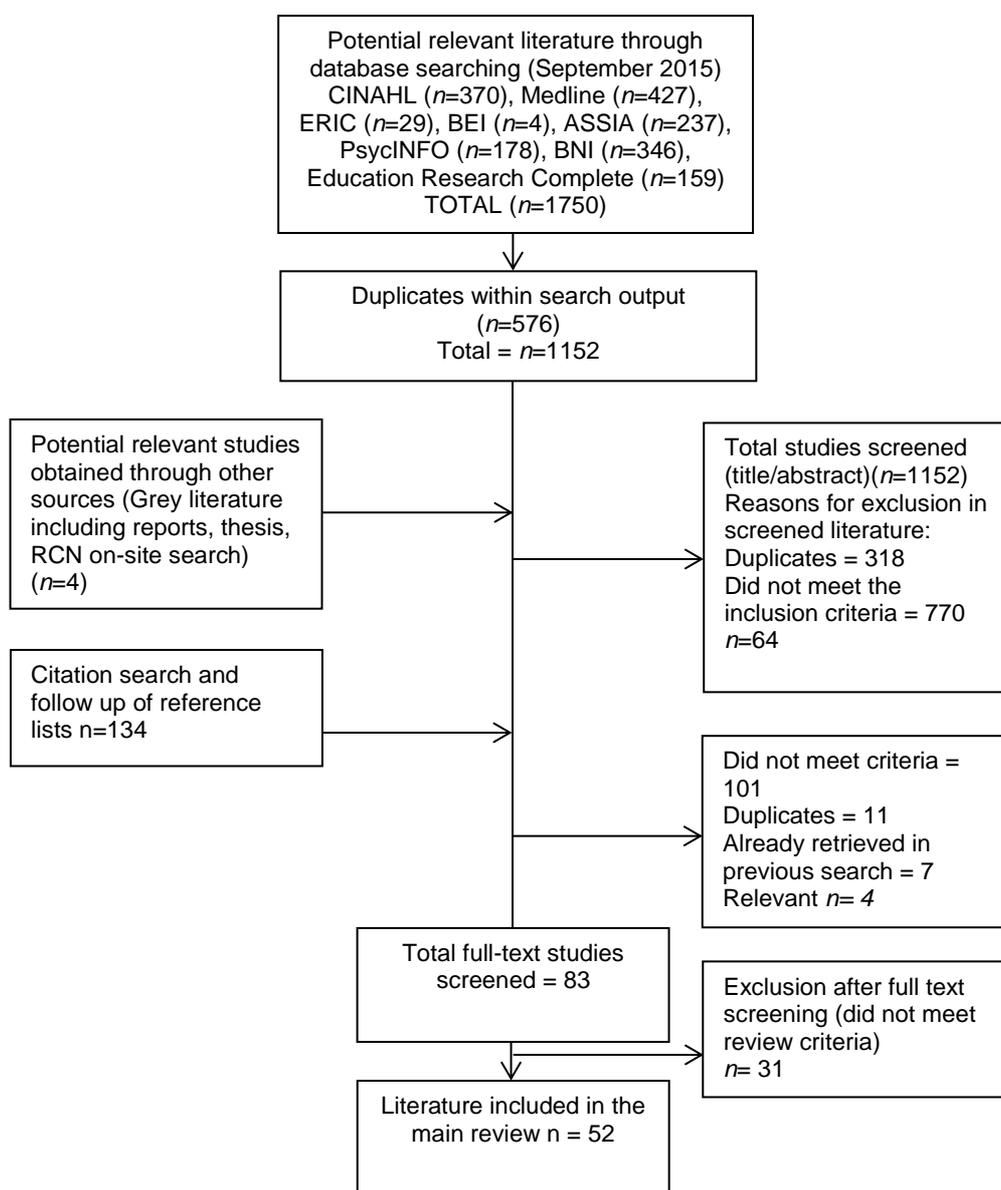
<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
Written in English	Material over 6 years old
Published in or after 2009	Literature that only explores wider sociological issues and whistle-blowing
Research, policy, guidelines, opinion and reflective accounts of nursing, midwifery and allied health profession students' experience of raising concerns	Literature that did not focus on concerns raised by students with regard to the actions of staff

In addition to the search strategy described above approaches were made to key regulatory and professional bodies including the NMC, RCN, RCM and the HCPC to ensure any work in progress, interim findings or research about to be initiated is included in the review.

By completing a broad and comprehensive search the team was able to collate information from a range of knowledge sources, an approach that is particularly useful in policy development (Kiteley and Stogdon, 2014). Once the material for inclusion in the main review had been identified a citation search was undertaken on the material that met the inclusion criteria. Reference lists of the material that had been identified as meeting the inclusion criteria were reviewed for other potential sources. In the forward search tracking was undertaken for material that was in press. The search process and results can be seen in Figure 1 (page 20).

**Figure 1: The search strategy results**

AB (whistleblow\* OR "raising concerns" OR patient safety OR safeguarding OR "poor care" OR reporting OR "speaking up" OR "spoke up" OR "speak up") AND AB student\* AND AB (nurs\* OR midwi\* OR perioperative OR physiotherap\* OR podiatr\* OR paramedic\* OR allied health OR orthoptist OR occupational OR prosthetist OR radiographer OR NHS)



## Grey literature

Grey literature comprises material that may not have been published through conventional routes (Kiteley and Stogdon, 2014) and can include newsletters, policy documents, some research, minutes of meetings, professional and regulatory body requirements, leaflets, internally printed reports, undergraduate and postgraduate theses and unpublished conference papers. Of the nine databases searched two produced results, the Base - Bielefeld Academic Search Engine (n=2) and the National Institute for Health and Care Excellence (n=4)

An on-site thesis search of RCN library, Cavendish Square, London was completed in October 2015 and no additional material that met the inclusion criteria of the review was found.

## **Methods of analysis**

The team decided against protocol-driven or mechanistic tools for the completion of the literature review, such as 'PICO or SPIDER' (Cooke et al., 2012) in favour of an approach that enabled the transfer of existing skills and research expertise in a collaborative manner. This acted as a safeguard, prioritising literature of a high level of sensitivity and specificity, but also allowed for the inclusion of material that met a wider definition of what constitutes knowledge. For the research material reviewed Sandelowski and Barroso's (2007) method of metasynthesis was adopted as it is a widely recognised framework that has been recently evaluated with regard to studies drawn from the field of health sciences (Ludvigsen et al., 2015). This method of qualitative research synthesis requires researchers to translate findings from primary studies into thematic statements in order to build a comprehensive description of events, relationships or conditions. This can be seen in the discussion section of the review. The review team utilised Sandelowski and Barroso's (2007) six step analytical method:

- I. Conception of the synthesis - involving the philosophical positioning of the core team (synthesists) and the recognition of their constructions of objectivity.
- II. Searching and retrieving the literature - an exhaustive, systematic and iterative searching process, including backward/forward citation searches.
- III. Appraising the findings - quality appraisal, utilising an individual and comparative appreciation and evaluation, drawing on tools of quality appraisal (for example Baernstein et al. 2007).
- IV. Classifying findings - classification, meta-summarising, extraction, editing and creation of group findings; calculation of effect sizes (if necessary).
- V. Synthesising findings into a metasummary through the aggregation of topics and themes.
- VI. Synthesising findings into a meta-synthesis by offering a final novel interpretation.

This approach helped to capture narrative statements, effects and suggestions from the literature that are responsive to the needs of contemporary healthcare environments.

## **Ethical issues**

As this is a review of literature there are two significant ethical issues to discuss. The first of these was sensitivity by the team in the review process to the fact that ethical issues might have arisen within the literature reviewed. This point will be returned to in the discussion section at the end of the report. The second point relates to the focus group that was convened as part of the review process. It was agreed in planning the review that a small focus group of healthcare students should be convened to help ensure that the review was grounded in students' experiences of raising concerns/whistle-blowing. Six students, a lay representative and three members of university staff attended the meeting. The students and lay representative were given an explanation of the purposes of the review and were asked to give consent prior to the meeting. Details of the meeting can be found in Appendix 1 and ethical permission for the focus group was sought and obtained from the Institute of Health Research Ethics Committee at the University of Bedfordshire.

## **Project management**

The project was co-ordinated from within the Department of Healthcare Practice at the University of Bedfordshire. The project lead was responsible for maintaining communication with the nominated member of the CoDH research steering group and the Senior Policy Officer. The task of delivery was divided into work packages. Details on the work packages used to structure the review can be found in Appendix 2.

## 4. Findings

### Introduction

This part of the review summarises and analyses the research literature identified from the systematic search of the literature. This section is structured around the three themes generated from a synthesis of the literature (Sandelowski and Barroso, 2007), which are:

- Empowerment and student voice
- Patient safety and speaking-up
- Reporting poor practice

The theme of 'empowerment and student voice' is distinct from 'patient safety and speaking-up' because it relates to the ability of students to choose to either report their concern, or remain quiet until they are able to exit the practice placement environment, particularly where students perceive that the environment is unsupportive. The literature suggests that students have the ability to recognise patient safety issues, both in clinical practice and within simulated learning environments when presented with a patient scenario or vignette. The theme of 'reporting practice' reflects the experiences of students who raised a concern and the particular dilemmas that they face while being compelled to report poor practice.

The key findings from each piece of literature will be summarised and conclusions and recommendations will be outlined in relation to each of the three themes. The penultimate part of the section will include a review of grey literature relating to harassment and bullying prior to a summary of the key features found within the literature search. As will be seen very little research was found directly relating to students raising concerns with the quality of practice. In terms of the methodology used little in the way of variation was found and few studies have been replicated. The range of healthcare student, in terms of discipline, is also limited.

### Empowerment and student voice

The theme of 'empowerment and student voice' was generated from qualitative research associated with students having the confidence and ability to communicate their concerns and the experiences they encountered with clinical staff when reporting a concern.

Two articles were found in relation to a longitudinal study utilising semi-structured interviews and focus group discussions that analysed issues around the empowerment of students in clinical practice (Bradbury-Jones et al., 2010; 2011). The first article focused upon the concept of empowerment, although the concept remained elusive in terms of a definition. Thirteen students joined the longitudinal study in year one of a pre-registration nursing course, with one leaving at the beginning of the second year. The research approach was stated as being hermeneutic phenomenology with annual semi-structured interviews and focus group discussions. It was difficult to draw any clear conclusions from the findings as presented by the authors.

The second article (Bradbury-Jones et al., 2011) made reference to the work of Hirschman (circa 1970) who developed a model to explain the loyalty behaviour of customers and employees. The model suggests that unhappy customers tend to 'exit' rather than 'voice' their concerns. In an employment setting an employee may choose to seek alternative employment in preference to

raising a concern. The findings suggest that in situations where nursing students feel they need to speak up they will either 'exit', which usually means not saying anything, or they will 'voice' their concern. The authors add that students will often use a 'negotiating voice' to raise the matter in a way that is less likely to lead to conflict with staff members. Strategies such as 'finding the appropriate moment' were mentioned by some students. Bradbury-Jones et al. suggest that the 'negotiating voice' is a compromise; a bridge between the 'exit' position of not saying anything (students on placements usually have to finish the placement so cannot simply leave) and the difficult position of 'voicing' the concern. The concept of voice is also discussed by Miceli and Near (1992) in relation to the concept of whistle-blowing in industry, as discussed earlier.

A study of the experience of verbal abuse, utilising a questionnaire sent to 156 third year student nurses, was completed by Ferns and Meerabeau (2009). They sought to explore reporting behaviours with regard to incidents of verbal abuse from patients, visitors and staff. A response rate of 73% was achieved with 51 students reporting they had suffered verbal abuse. 32 of the students had reported the incident and 19 had not. Not all reported incidents resulted in a positive response from the selected member of staff and feedback to students was sometimes lacking in terms of the outcome of the report. Students were less likely to report the incident if it involved staff members and was witnessed by a senior colleague. The authors noted a stated reluctance to report if the departmental culture was perceived to be unsupportive. The students perceived that they lacked power within the nursing hierarchy and felt that nothing would change. Findings included students feeling embarrassment and shock, but also feeling sorry for the abuser. It was concluded by Ferns and Meerabeau that under-reporting by students is significant and that students need more feedback following reporting. Further analysis on aggressive behaviour towards students can be found below in the section on bullying.

The literature that supports the theme of 'empowerment and student voice' suggests that students not only need to be empowered but require considerable support to voice a concern within environments whose structure has an impact on the perception of the support that they are likely to receive, or not, as the case may be.

### **Patient safety and speaking up**

The theme of 'patient safety and speaking-up' relates to the confidence that students require in being able to approach a senior member of staff to speak-up on a matter of patient safety.

In a UK study reporting the results of an on-line survey to which 488 students replied on observed hand hygiene, Gould and Drey (2013) note that nursing students often witness poor hand hygiene. A range of different situational hand hygiene violations were confirmed as occurring by the students. They saw medical staff as the least compliant group with regard to adhering to required infection control practice. The study does not explore how the student raised a concern but Gould (2014) went on to explore this in a later article. In this, Gould uses the term whistleblower to describe the student who raises concerns about hand hygiene. It is suggested that few students feel confident enough to approach a senior nurse manager about such matters, especially in the context of work pressures and low staffing levels.

The effects of a nursing leadership course (in the UK this would equate to a unit or module of study) on senior student nurses was explored by Kent et al. (2015). This quantitative pre-test, post-test

survey was administered to 63 students from a mid-western university in the USA during an eight week rotation element of the course. Strong evidence was cited on the reliability of the tool, but the data on this is not presented, apart from in summary form. The two sections of the survey relate to the students' confidence levels with regard to keeping patients safe and the level of comfort they felt with regard to speaking up on an issue of patient safety. The paper concludes that students could benefit from activities that support their ability to challenge authority figures as this requires confidence. It is suggested that simulation has a part to play in helping students practise raising concerns and questioning those in authority. In terms of results, no significant relationships with age, gender, or ethnicity on raising concerns was found. Although significant ( $p=0.001$ ) results were achieved with regard to 'Confidence in knowledge regarding patient safety' and 'Comfortable speaking of witnessing unsafe practices', there was no significant change in the students' ability to question someone in authority. The recommendations made were to emphasise teamwork, problem solving and effective workplace communication early in the academic component of the course. It is implied in the conclusion that students should be encouraged to challenge authority where necessary, a theme in patient safety where communication up and down the hierarchy is encouraged. Similarly, it was suggested that preceptors (mentors and/or instructors) encourage and expect students to raise a concern where necessary. Kent et al. refer to another study that explores students' reactions to patient safety issues that are encountered (Duhn et al. 2012). This cross sectional questionnaire based survey is not reviewed here as it is specifically about patient safety events and not raising concerns as defined within this review.

Another mixed methods study explored student nurses' perceptions of patient safety in both the clinical and educational setting (Stevanin et al., 2015). The work was completed in two Italian universities with bachelor of nursing students. The Health Professional Education in Patient Safety Survey (H-PEPSSIta) was administered and included a questionnaire section with Likert<sup>2</sup> scale responses and open-ended questions based on 23 items comprising six factors designed to measure self-reported patient safety knowledge and competence. The study primarily investigated and reported the perception of the students regarding their patient safety preparedness over the duration of the degree course, and the amount of 'close calls' and/or adverse events witnessed in their clinical training. The term 'adverse event' was used in the article to describe patient safety incidents. Part of the study explored the reactions of students when they experience an event that might jeopardise patient safety. The analysis and interpretation of the fifth objective of the tool ('recognizing, responding to and disclosing adverse events and close calls') was limited. Falls and drug administration errors were two of the commonest types of incidents reported by the students, with the latter becoming more frequently reported towards the end of the programme. It was evident that reporting fell during the second year and rose to its highest levels in the final year. In terms of relevance to this review the work lacked any clear analysis of the reporting of incidents that might have been considered, by the student, something other than a patient safety incident. There was no substantial analysis of how students disclosed the adverse events/patient safety incidents they encountered.

The article by Bressan et al. (in press) summarised findings of what appears to be the same study explaining how the questionnaire, the Health Professional Education in Patient Safety Survey translated into Italian, was validated in terms of reliability and validity. The sample size for the

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<sup>2</sup> A Likert Scale requires questionnaire respondents to indicate how strongly they agree or disagree with a series of statements using a four or five point scale

validation process is quoted as 574 in Bressan et al. but 573 in the Stevanin et al. (2015) article. Following translation, the tool was completed by the nursing students. The tool, as described above in the analysis of Stevanin et al., explored knowledge and competence regarding patient safety, and made brief mention of the issue of raising concerns. The authors state that the H-PEPSS is a valid instrument capable of evaluating nursing students' self-perception of patient safety knowledge. Little detail is given on the data retrieved, beyond the task of validating the tool, and a further paper on the findings would be helpful. Reading the work in the context of this review there is a link between patient safety and raising concerns, and the relationship can be an integrated one in that raising concerns is part of the task of improving safety culture. The approach described in this work could be used to measure students' knowledge and competence on the matter.

A qualitative study utilising interpretive phenomenology was completed in inner London by Bellefontaine (2009) with the aim of exploring what influences student nurses' ability to report potentially unsafe practice. Six second and third year students completed semi-structured interviews that included five open questions, one of which asked the student to recount the factors that affect the ability to report potentially unsafe practice. Content analysis of the interviews identified four main themes: the student-mentor relationship; actual or potential support provided by the practice area and/or university; the student's own confidence level and knowledge base; and fear of failing the placement. Bellefontaine links these findings, in terms of barriers to reporting, to barriers commonly seen in safety critical industries, making reference to NPSA initiatives. Although a small study, which as reported lacks detail on the methods used, it does make a link to the potential importance of mentorship in supporting students to raise concerns.

Killam et al. (2012) report on a study completed with first year Canadian Baccalaureate nursing students and their viewpoints on compromised clinical safety in clinical learning situations. There is no distinction or clarification made in the paper with regard to clinical and patient safety; the terms are used interchangeably. In total 94 students enrolled in the study, a convenience sample from first year classes. The inclusion criteria were official program enrolment, submission of a completed Q-sort and written consent to use the Q-sort in subsequent statistical analyses. No exclusion criteria were stated. The number of students who submitted and consented to the use of their completed Q-sorts for further analysis was 68. In response to the Q-sort question, "In a clinical setting, it is most unsafe when..." the following four discrete viewpoints and a consensus viewpoint were identified. The discrete viewpoints included an overwhelming sense of inner discomfort; practising contrary to conventions; lacking in professional integrity; and disharmonizing relations. These categories are repeated in a later article (Killam et al., 2013) which focused upon the first year students in the earlier study.

A further Canadian study used practice related patient safety incident scenarios designed by the authors to test whether students could see an incident within them. The researchers analysed what the students' interpretation of the incident was and if, and how, the student would report the perceived incident (Espin and Meikle, 2014). Ten students took part in the study reading five scenarios. Only one scenario generated agreement in all students that an incident had occurred. Three themes emerged from the analysis of the post scenario interpretation interview. These were: scope of practice; professional roles; and presence or absence of harm. In terms of methodology, the work lacks detail but is potentially useful for two reasons. Firstly, as an educational strategy the method carries some merit as it may help students to identify patient safety incidents. Secondly, the

authors make mention of a 'reporting ladder', a way of describing the process through which students can raise concerns. If they do not get a response, or are unhappy with the response to the report, they can move up to the next step in the ladder.

The literature that supports the theme of 'patient safety and speaking up' suggests that specific issues relating to patient safety are powerful triggers that prompt students to consider speaking-up and raising specific concerns. There are several barriers and enablers which operate as a 'push-pull' dynamic, including the quality of the mentor/mentee relationship; the perception of actual or potential support provided by the practice area and the university; the student's confidence level and knowledge base; and a fear of failing the placement. These factors may cause students to experience strong emotional responses. However, there is some evidence to suggest that tailored educational programmes, utilising authentic vignettes and programmes designed to build student confidence in the challenging of authority figures, enable students to act (speak up) once a patient safety issue has been identified.

### **Reporting poor practice**

The theme of 'reporting poor practice' arose from the experiences of students who have raised a concern, what their experience was, including the particular dilemmas that they faced, and what compelled them to report poor practice in the first place.

A small amount of the literature dealt directly with the issue of students raising concerns. A qualitative study completed in the UK by Ion et al. (2015) was undertaken using semi-structured interviews with 13 students who were asked to explore perceptions, values and what they felt was important around the issue of raising concerns about practice. The study was very much couched in the role of educational institutions and development of strategies to support students. The interviews were transcribed and coded by the research team into themes. It was concluded that raising concerns is difficult; some students feel morally compelled to, yet many are aware of the potentially negative consequences and implications. It was also noted that some students see such events as an inevitable background to their pre-registration journey.

Rees et al. (2014) conducted an on-line survey of nursing students' most memorable professional dilemmas. It involved 294 nursing students from 15 UK nursing schools. A questionnaire was used based upon previous research undertaken by the same authors with medical students (Monrouxe and Rees, 2012). The majority of the incidents occurred in hospitals, although it was noted that this may be linked to the fact that this is where most of the students' placements took place. Almost 80% of the students reported acting in the face of a dilemma although there was little detail on how the report was made, who it was reported to, or outcomes from a report. Students did talk of the possible sanctions they could face if they raised a concern. A comparison is made with the earlier work that was undertaken with medical students (Monrouxe and Rees, 2012) and it is suggested that the nursing role of advocacy can influence students as they appeared to be more likely to raise concerns, although this appeared to relate to concerns about healthcare assistant behaviour.

Primary outcomes from the narrative analysis related to:

- Patient care dilemmas, instigated by healthcare professionals and workers
- Student abuse
- Patient care dilemmas, instigated by students

- Patient consent dilemmas

Examples of each of these are given using quotes from the students. It was concluded that nursing students should be given a safe space by educational providers in which to narrate the dilemmas they have seen. Rees et al. (2014) closed the article described above by pointing to future work in this area that they would be conducting. That was reported in Monrouxe et al. (2015) which reports the results of another large on-line UK questionnaire that sought to understand the prevalence of healthcare students witnessing or participating in something that they thought was unethical (professional dilemma) during a placement. In total 2397 medical students and 1399 healthcare students participated. Of the latter, 756 were nursing, 268 pharmacy, 201 physiotherapy and 174 dentistry students. Overall 10% of all the respondents reported having experienced no professional dilemmas over the last year. The remainder of the participants reported witnessing or participating in breaches of patient dignity or safety and the majority also reported being the victim of workplace abuse. 47.5% of female and 36.2% of male healthcare students reported having witnessed clinicians breaching patient dignity or safety. In terms of instigating such breaches, 28.8% of female and 27.5% of male healthcare students reported that they themselves had done this. Observing the undertaking of an examination/procedure without valid consent was reported by 17.3% of female and 13.6% of male respondents. 19.1% of female and 12.4% of male healthcare students reported instigating this. The concept of 'habituation' was used to describe the finding (pattern one) that the respondents seemed to become less distressed with increasing exposure to dilemmas. This applied to the medical students, along with pattern two which was more distress with increased exposure to dilemmas that could not be justified. Only pattern two was stated as applying to healthcare students. It was noted that a large number of respondents suffered emotional distress for months and sometimes up to a year after witnessing a professional dilemma. This was a large study and unusually, when compared to the other material in this review, it combined the views of medical and other healthcare staff. It also sought to explore the possibility of gender differences, something that again is rare in the literature in this area. What it did not do was clarify how many, or what types, of the incidents witnessed were reported either internally or externally. It was concluded from the findings that women were more likely to claim distress as an impact on self. From an educational perspective the authors argue that consideration be given to teaching emotional regulation to help students to manage distress, thereby perhaps reducing burnout and the numbers leaving healthcare. Another UK based study by Rees et al. (2015) studied workplace abuse narratives as recounted by 69 students: 29 dentistry, 15 physiotherapy, 13 nursing and 12 pharmacy students. Narrative style interviews with the participants were completed to elicit personal professional dilemmas, referred to as Personal Incident Narratives in the Monrouxe et al. (2014) article, they had encountered. Seventy nine abuse narratives were encountered, but that abuse had typically been directed at the student not the patient. Of the 44 students who reported acting in the face of abuse, only ten reported the perpetrator. Details on reasons for action and inaction are given, with the students' failure to challenge being associated with the negative impact it might have on the relationship with the perpetrator and the poor assessment results that might follow for the student.

The same study (Rees et al., 2015) was also reported in Monrouxe et al. (2014). The interviews required students to recount personal incident narratives. Two hundred and twenty six of these were analysed and the classifications deduced were: student abuse (predominantly verbal); patient safety; dignity breaches; and dilemmas around challenging others and whistle-blowing.

A mixed methods qualitative study on student nurse belongingness in clinical placements was completed by Levett-Jones and Lathlean (2009). Eighteen nursing students were recruited and the data was collected through semi-structured interviews. Thematic data analysis was undertaken but detail on this is lacking. The results showed that while students were expected to comply with recognised standards and codes of practice, they also felt a need to comply with unacceptable nursing practices as they were reluctant to endanger their sense of belonging to the group. Whilst compliance could at times lead to guilt and regret, it was often seen as the lesser of two evils from the students' perspective – it was often better to comply than to be rejected or risk ostracism. A second article by Levett-Jones et al. (2015) explored the primary concerns of student nurses going out on to their first placement but makes no reference to whistle-blowing or raising concerns.

The study by Mansbach et al. (2010) involved 112 physical therapy students in Israel. Two case study vignettes were reviewed by the students who then completed a five point Likert scale response questionnaire. The vignettes were designed to present the student with a dilemma involving loyalty to the patient or to colleagues and management. A high response rate was achieved with students being more likely to 'blow the whistle' internally rather than externally. The manager's behaviour was rated more serious than the colleague who did not report the patient fall. Mansbach et al. note a trend towards retraction of the report by the student as the event is escalated. Further research on the notion of internal and external reporting was reported in Mansbach and Bachner (2010a), but involved qualified nursing staff and so is not reviewed here.

Another study was published on work with physiotherapy students by the same authors (Mansbach et al., 2012) in which they sought to answer three questions: Are physiotherapists and physiotherapy students willing to take action to prevent misconduct in order to protect a patient's interests? Are they willing to report the misconduct either within or outside the organisation? and thirdly, are they willing to report a colleague or manager's wrong doing?. The study was completed with 126 undergraduate students and 101 certified physiotherapists in Israel. The participants were presented with two vignettes – one describing a colleague's misconduct and the other describing a manager's misconduct. Both groups rated their own willingness to take action to change the harmful situations in the scenarios very highly. The certified physiotherapists perceived a colleague's misconduct as being more serious than the students did, and were more willing to intervene internally. The students were more prepared than the certified physiotherapists to take such action externally. The students perceived the manager's misconduct as being more serious than the certified physiotherapists did, and also reported a greater readiness to intervene externally on this. A drawback with this study is the hypothetical nature of the responses. Comparisons between the students and qualified staff were possible, but how this might translate into action in real situations is unclear. The study does have pedagogical and practical implications in that the use of the vignette approach might better equip students and physiotherapists with the necessary tools to confront such problematic situations. The authors suggest that for students, this would involve integrating the subject of whistle-blowing into the curriculum in order to broaden the basis of ethical education, providing an additional anchor for the principle of the patient's best interests. They suggest it would furnish prospective physiotherapists with the tools to handle similar situations in future practice. In addition to studying the ethical aspects of reporting misconduct, the authors recommend that researchers and practitioners should also consider whistle-blowing as a tool for advocacy and social intervention, and that research undertaken in other health professions, particularly nursing, should be referred to.

Further research with nursing students was undertaken by Mansbach et al. (2013) using methods similar to an earlier study they had undertaken with qualified nursing staff. Eighty two nursing students in Israel completed a questionnaire containing two vignettes and were asked to decide whether to whistle-blow. Nursing students' age, gender, marital status and country of origin were not significantly correlated with the severity of misconduct and the decision to whistle-blow either internally or externally. Both vignettes were rated as serious by the students with the scores for the behaviour of management rated more serious than that for a colleague. The likelihood of participants whistle-blowing to people within the organisation was higher than that of approaching external organisations, significantly so. As with other research here that deals with rating of self-expectation rather than actual reporting patterns, it is difficult to judge what the students might actually do in real situations. Mansbach et al. (2013) recommend the inclusion of whistle-blowing, the related law and ethical issues into the curriculum.

A further study was undertaken by Mansbach and colleagues (2014), again in Israel, using the same vignette methods to compare qualified nursing staff and student willingness to blow the whistle to protect patients' interests. Eighty two undergraduate students and 83 experienced nurses took part by reading two vignettes. The students then completed a multiple-choice questionnaire. Nursing students perceived the severity of misconduct to be lower when compared to the qualified staff evaluation of the vignette, but the students were more willing to report, both internally and externally. The article by Chiou et al. (2009) describes the creation of a web-based incident reporting system for nursing students in Taiwan. Although described as a study by the authors the paper describes the creation and evaluation of the reporting system for incidents such as needle-stick injuries and medication errors. The before and after comparison appeared to show an improvement in the quality of information gained and an increase in the number of reports, from 15 in the five years prior to introduction to 31 in the first year of use. It was suggested that opening up the system to completion away from the educational and practice environments might have contributed to the increase in reporting.

The literature that supports the theme of 'reporting poor practice' in part suggests that gender can be a factor in relation to the prevalence, impact and effect of reporting a concern on students, regardless of their professional grouping. Consequently, there appears to be a need for educators to provide students with educational programmes that build emotional resilience to help students to manage the distress that can arise from reporting in addition to the moral dilemmas discussed in the previous section. The literature suggests that students' failure to report poor practice is associated with the negative impact it might have on their relationship with the perpetrator and the possibility that their reporting may lead to a poor practice-based assessment outcome. Interestingly, there appears to be a difference in students' perceptions of poor practice arising from the misconduct of a manager as opposed to a clinician in terms of the behaviour of a manager being seen as more serious than that of a colleague.

## **Bullying and harassment**

Consideration was given to the inclusion of bullying and whether the concept was relevant to the focus of the literature review. If a student raises a concern related to the clinical practice they are witnessing, there is a risk that they will, as a response, be subject to sanction by staff. Students are very aware of this, particularly with regard to a possibly negative impact on the assessment of their own practice as a key outcome for the successful completion of their practice-based learning.

A significant amount of literature on bullying was encountered, but little of it met the inclusion criteria for this study. The article by Bowllan (2015) is a good example of the limitations seen for the purposes of this review. Bowllan, using work originally carried out on school children, defines bullying as abusive conduct that can be verbal and non-verbal, repeated over time with the intention of harming an individual. Within healthcare the notions of horizontal and lateral violence and harassment are often used. What this article does not do is clarify and analyse the possible link between the raising of concerns and the bullying of students. It was not clear to what extent the bullying of students, in whatever form it takes, is attributable to the student having raised a concern about practice. The PhD study by Geller (2013) explored the concepts of Bullying, Harassment and Horizontal Violence (BHHV) in nursing students in the USA. The experience of BHHV was measured using a tool called the BEHAVE survey. This was generated for the research from two other tools previously used in this field of study. A total of 32 students completed the BEHAVE tool with 72% of them reporting experiencing bullying-like behaviour and 46.8% of those incidents originated from a nurse. The tool used did examine reporting behaviour and found 34.8% of students had reported the behaviour of concern.

Linked to the concept of bullying was other material related to students dealing with difficult situations, in this case under the heading of disruptive behaviour (Hutcheson and Lux, 2011). This article from the USA describes a teaching method, reading theatre, a scripted storytelling method, to raise awareness and to help students respond appropriately to disruptive behaviour. Most students responded positively to the teaching at the time it was delivered but a lack of support was noted from some academic staff. Using a Likert scale it was found that students had a raised sense of awareness, but students were concerned about confronting such behaviour with clinical staff as it might affect their clinical situation. Further research, in this case a qualitative descriptive study on disruptive behaviour that sought recommendations to educators by nine staff nurses, was conducted by Lux et al. (2014). The purpose of this study was to explore the role of nursing education in decreasing disruptive behaviour in the work environment. The educational strategies identified by the staff nurses included learning to communicate with hostile individuals and giving and receiving constructive criticism. There is no clear mention within the description of the research and its findings of the issue of students raising significant concerns with regard to the practice they have encountered.

A PhD study by Schaefer (2014) in the USA sought to analyse whether educating senior nursing students to recognise negative behaviour (NB) determines if they would report or abstain from reporting NB in clinical settings. The study compared two student groups, one of whom had the intervention of a one-hour training programme on recognition and the reporting of NB. Both groups viewed the same videoed vignettes. Significant differences were found in identifying nonverbal abuse and this led to the author suggesting that education should focus students on covert forms of negative behaviour. As with other studies reviewed here this work focuses on recognising negative behaviour in staff rather than how it might be reported.

Another issue that might lead students to raise concerns is sexual harassment. As noted by Cugin and Fish (2009) in an Australian mixed method study, the incidence of reported sexual harassment is high in the nursing population. Detail was lacking on the methodology utilised in the study that consisted of an analysis of 538 questionnaires and 23 in-depth interviews. 171 of the 251 student

responders reported being subject to sexual coercion, unwanted sexual attention or gender harassment. Results between the two data collection methods used were sometimes contradictory, with the interviews suggesting that medical staff were the main perpetrators of harassment and the questionnaire results finding it was patients. There is no clear conclusion with regard to how students should report such harassment or how management and organisations might facilitate and support such reporting.

The article by Stevens and Cook (2015) explored the issues of safeguarding and, albeit briefly, the potential role of students in reporting concerns over poor practice in England. A qualitative approach was used to analyse a 10% sample of students' reflective assignments. In all 59 assignments were subject to scrutiny. The focus of the student assignment was a reflective account of a critical incident they had encountered or an analysis of legal and policy frameworks in safeguarding, again linked to an event encountered in practice. The student assignment was reviewed to analyse which taught concepts had been utilised by the student. On review, if issues of concern were found in the assignment screening processes the matter could be referred to a Practice Learning Facilitator. This was done in four assignments. There is an element of surveillance in the approach espoused in this article. Little is said in terms of a direct link to students raising concerns, but by scrutinising student assignments it is suggested that insights into practice can be gained. What is not clear is how the accuracy of the student observations might be monitored. Similarly, there is no discussion on the ethical issues raised in terms of using students as a means through which to identify potential shortcomings in practice. In a sense what appears to be happening in this article is a move towards the vicarious reporting of concerns by students. What the long term effects would be on students, in that they might moderate descriptions to reduce the chances of issues of concern being raised, is not dealt with.

A short article by a student nurse identified as Emily (2015) describes how, following feedback from patients about the quality of care, she began to see problems with what is termed 'not best practice' in the piece. The student reported the case to the university safeguarding lead and went on to meet with the matron and ward sister. Staff members were subsequently disciplined. It is made clear that the student found this experience difficult and had been reluctant to speak out in case it affected her placement. A descriptive article by Steen (2011) explores similar issues for midwifery students in the UK utilising the 'Start Treating Others Positively' (STOP) strategy. Workshops are described which help students to deal with conflict encountered in placements. The article is mentioned here as assertiveness skills are relevant to students' ability and willingness to raise concerns, although this link is not made in the article.

## 5. Discussion

### Objectives of the review

This section opens with a summary of findings as relevant to the objectives of the review.

- **The UK policy drivers and public expectations for nursing, midwifery and AHP students**

It was clear that students are now expected to report concerns related to the quality of healthcare practice. Such reporting includes patient safety incidents, illegal and immoral activity, and incompetent practice. This came across particularly strongly in the review of legislation and professional guidance and is likely to have increasing influence on organisational culture in the medium to long term (GMC/NMC, 2015). There is clear emphasis given to the need to report concerns, for example within the repercussions of the Francis report (Francis, 2013; 2015) and the urgency with which its recommendations have been dealt with by bodies such as the HCPC, NMC and RCM. There was, however, a lack of clarity in the literature on when, how and to whom students should report. Information is available, for example through the NMC, HCPC, UNISON and RCN websites, but there was little in the way of a coherent approach found in communicating this to students. Aspects of the reporting mechanisms for students will vary depending on the country in the UK in which the student is undertaking practice.

Universities have a role in helping to clarify when, how and to whom students should report concerns to although merely putting this information into policy documents is unlikely to be sufficient on its own. A clear communication strategy would help articulate this information to students. Universities also have a role in monitoring the student's experience of raising concerns, looking out for variations and gaps.

- **Evidence in relation to barriers and enablers for students raising concerns**

The barriers to reporting encountered included a lack of clarity in some of the material with regard to definition of the concepts 'raising concerns' and 'whistle-blowing'. This was particularly problematic with regard to patient safety and the different types of patient safety incidents that can occur. If students were clearer on this they would be better placed to make an appropriate report. Another barrier was the potential reaction of staff when a concern about the quality of practice was raised. The research showed that students are aware that raising concerns might adversely affect their progress in placement and might even be reflected in lower assessment grades as given by the practice staff assessing them (see for example Bellafontaine, 2009).

The bulk of the research and literature reviewed related to nursing students with less being found on other disciplines, with physiotherapy being the next most studied group. With the latter the bulk of the research relates to one group of authors (Mansbach et al. 2010; 2014) and is reliant upon methods that asked students to anticipate what they would do rather than what happened in practice. Mansbach et al. recommended in their early work that future research focus on the experience of students, only to go on to repeat scenario based studies.

In terms of enablers an important recent positive move has been the breaking down of the historical delineation between qualified staff and students in terms of guidance, policy and procedure on raising concern. As clarified in the '*Freedom to Speak Up*' document (Francis, 2015), healthcare students will be included in the wider definition of worker and this may simplify the situation in that

structures and mechanisms for reporting concerns will be amalgamated. Students will increasingly look to the guidance and policy used by qualified staff. Further enablers included opportunities for students to review and get feedback on vignettes of practice that include examples of incidents that might warrant reporting. Educational assessments, requiring students to reflect on and analyse aspects of practice that have raised concerns for them, were another enabler.

- **The effect of workplace learning environment in terms of context and culture on reporting, including the impact of conflict between staff and positive team working practices**

Students, like others delivering care and treatment, are obliged to report and report early as set out in the duty of candour (GMC/NMC, 2015). If the claims made in the literature and policy reviewed here are to be believed students should be reassured that if they raise a concern they are more likely to be dealt with in a positive way, both by individual practitioners and organisations. Having said this, some of the literature pointed to the slow change that can take place in work culture (see for example Duffy et al. 2012), and healthcare has historically operated what has very much been a blame culture (Vincent, 2010). As already mentioned, students are aware that any less than positive feedback they give to practitioners might reflect badly on the assessment of their practice. Moreover, recommendations regarding training will only improve student reporting of concerns if the organisational environment in which they work is perceived to support and encourage the escalation of concerns. Similarly, research findings will only impact positively on service development and improvement if organisational cultures value research transfer into policy and practice. Future moves towards an open and fair learning environment, with a more open reporting culture, will therefore be particularly important. Such a move might be reflected in areas such as the RCN Direct advice line mentioned in Table 1 (page 14). Up to 1.36% of the calls made to the line are from students, and perhaps this will rise. However, if students are offered more open and fair reporting systems by educational providers and within the placement areas they are sent to calls to such a service, be it on-line or by phone, will be less necessary.

- **The impact of higher education support mechanisms, including personal tutoring, link lecturers and practice education roles, in facilitating or hindering reporting**

No research was found on the impact of link lecturer or practice educator roles in supporting students who raise concerns. Similarly no research was found that directly evaluated the impact of personal lecturers in the student reporting process. University staff were noted as being supportive by students in some of the literature, but this finding has to be considered anecdotal. It was evident in the literature that raising concerns carries an emotional burden for the student, and might involve sanctions against them from staff members or organisations (Monrouxe et al., 2014; 2015). Unless students believe that they are likely to be supported they are unlikely to report. If students are to be clear as to how and when they should report concerns, educational institutions will have to be more specific about what raising concerns means, what the relationship is with patient safety and where whistle-blowing may fit in. In trying to achieve this both practice and education will need to consider securing time for staff to deal with those concerns and support the students involved.

- **The effect of student attributes and the use and impact of practice and education based support mechanisms in generating confidence to report**

Some of the research reviewed attempted to analyse a range of student attributes, including for example the impact of gender and age on reporting. In the case of the Cugin and Fish (2009) study this related to student nurses encountering sexual harassment, which was more common in the

female participants. In Monrouxe et al. (2014; 2015) male participants were likely to classify themselves as experiencing no distress when confronted with dilemmas in the practice environment. They also noted that a process of 'habituation' can occur in students where they become less distressed with exposure to experiences that aid learning, and 'disturbance' where they are exposed to dilemmas that could not be justified. A point in relation to the latter is the possible rise in attrition from the course if 'disturbance' is encountered too often by students.

The potential effect of student reports of concerns with practice on evaluation and assessment of the students' own performance was noted and students understand that this might affect both current and future placements. Words such as 'brave' and 'courageous' (Nursing Standard, 2011; 2013) have been used to describe students who have raised concerns. Reading the students' own accounts also shows what a difficult decision it can be to raise a concern (see for example Tonkin, 2011; Anonymous, 2014). Evidence was found that educational interventions that sought to clarify the nature of patient safety and safeguarding, and what might require reporting in terms of incidents, can enhance subsequent student reporting (Espin and Meikle, 2014; Kent et al., 2015).

- **Identification and analysis of the processes, mechanisms and strategies currently available in raising concerns with particular reference to good practice**

There was a lack of guidance found on how to escalate concerns, although safeguarding processes and structures appear to be helpful for students. Further concept clarification in terms of the relationship between safeguarding and patient safety would benefit researchers and those seeking to devise further policy and guidance in the field.

Somewhat surprisingly there was no substantial comment on the concept of surveillance within the literature. Although encouraging students to speak up is a positive shift in terms of being consistent with effective team working, flattening the hierarchy and enhanced communication (see for example NPSA/NRLS, 2009), the increasing emphasis being given to students reporting poor practice could be framed as surveillance. Francis (2013) hinted at this in that he openly advocated for the use of students in reporting poor practice. Some of the literature did explore students' ability to identify poor practice (Duffy et al., 2012; Stevens and Cook, 2015), both in terms of patient safety and practice that would be considered illegal or immoral. What seems to be important here is the accuracy of students' judgements on what constitutes poor practice. As mentioned, the lack of clarity with regard to what types of concerns students might face may hinder reporting.

It is helpful here to return to the framework offered by Jones et al. (2013) as outlined in the definition of whistle-blowing given in the opening of the review. It has been adapted to more broadly cover the concept of raising concerns (Appendix 4) and illustrates key findings from the review and recommendations for educational practice.

- **Limitations of the review and ethical issues**

The review was not required to analyse material from social work or medicine and there may be literature from those fields that would apply in principle to other healthcare students. Similarly the review was not required to encompass the wider sociological literature on whistle-blowing, yet the small amount that is mentioned in the introductory sections here shows that potentially useful theoretical literature and research might be found and applied to the task of supporting students. Some literature relevant to students raising concerns may be found in the discourse around 'moral

distress' in students, but this phrase was not used in this review. Finally, a review of earlier literature, prior to 2009, might yield other useful literature and perhaps also allow further comparison to be made in terms of how far the agenda on raising concerns has moved and where it may go next.

No significant ethical issues were encountered in terms of the conduct of research during the review of the literature. The use of students' assignments to identify poor healthcare practice, arguably a form of surveillance, does seem to warrant further ethical consideration.

**Figure 3 Summary of the barriers and enablers to students raising concerns about poor practice**

Barriers	Enablers
Lack of clarity of the concepts 'raising concerns' and 'whistle-blowing'	Guidance, policies and procedures on raising concerns
Awareness of how whistle-blowers might be treated	Learning opportunity for students
Personal and professional risk	Professional requirements to raise concerns

## 6. Recommendations

### 6.1. Recommendations for future research

After reviewing the literature, and the dearth of research found on students raising concerns with the quality of healthcare practice, the review team suggest the following research priorities be addressed:

1. A concept analysis be undertaken to clarify and classify the various elements within the concept of raising concerns. This could help future researchers to more carefully frame studies and would benefit students in terms of them understanding the different types of concerns with the quality of practice they might encounter.
2. Qualitative research into the lived experiences of healthcare students who have reported concerns on the quality of clinical care and practice. The aim of such research could include identification of the types of incidents reported and barriers and enablers to speaking-up that had been experienced by participants. Consideration should be given to the inclusion of former students (qualified staff) in this research as they may feel more able to openly comment.
3. A comparison of raising concern policies in higher education institutions (HEI) across the UK and an evaluation of the consistency of HEI policies to ascertain best practice. The data gathered can be used to develop an exemplar policy that focuses upon the need to report, what to report and how to report. This could be tailored where necessary for use in England, Scotland, Northern Ireland and Wales.
4. Alongside clarification of the concept 'raising concerns' further research be undertaken into bullying and horizontal and lateral violence. The cause of such behaviour towards students from healthcare staff may be linked to students raising concerns with the quality of practice.
5. Research to be undertaken into the use of safeguarding and patient safety incident processes by students in raising concerns about the quality of practice. Safeguarding and patient safety processes appear to give students guidance on the need to report, what to report and how to report and therefore warrant further study.

### 6.2. Recommendations for educational institutions

In light of the findings of this review it is suggested that higher education institutions undertake a review of current healthcare curricula to determine how and when raising concerns with the quality of practice is discussed with students. We recommend the review include consideration to the following:

1. Clarification of the concepts 'raising concerns' and 'whistle-blowing' alongside the notions of internal and external reporting.
2. HEIs should monitor 'raising concerns' activity in terms of student experience, satisfaction with the process and the frequency of reporting.
3. Raising of concerns is consolidated as a theme throughout the programme and students are informed of the mechanisms through which concerns can be raised (See action 18.2 in '*Freedom to Speak Up*' (Francis, 2015).
4. Where possible link such initiatives to the WHO Patient Safety curriculum guide and the centrality of open reporting in positive safety cultures (GMC/NMC. 2015).
5. Expand and enhance the use of safeguarding in educational provision as a framework useful to the identification and reporting of particular types of concern with regard to the quality of practice.

6. Clear and substantial structures should be in place to help students understand the relevant legislation, policy and professional guidance, available from introductions at the outset of programmes to preparation for becoming a member of the workforce towards the end of the course of study.

## 7. Conclusion

This report summarises the findings of a systematic literature review with regard to students of nursing, midwifery and the allied health professions reporting concerns about the quality of practice. The report is timely in that threats to the quality of care and treatment are now more openly discussed and are subject to frequent scrutiny. The issue of students raising concerns with regard to the quality of practice is crucial as they, like all healthcare practitioners, have an increasingly important role to play in generating and delivering feedback. Students, to repeat the analogy drawn in the Francis report (2013), bring a fresh pair of eyes to practice environments and this can allow them to see, sometimes more clearly than permanent staff, the limitations and strengths of the care and treatment being delivered. They may not always evaluate the quality of care accurately, perhaps due to a lack of knowledge and experience, but as transitory members of staff they will bring a different and potentially useful perspective. The place and contribution of healthcare students in raising concerns therefore needs further research, both in relation to the students themselves and the systems in which they will undertake practice placements. It seems reasonable to suggest that students are in a stronger position now than they have been in the past, in terms of having any concerns they raise listened to.

As the early sections in this review and the recent '*Freedom to Speak Up*' report show (Francis, 2015), a cultural change is being called for in healthcare, a change in which the raising of concerns of whatever type is both encouraged and increasingly obliged in some situations. Reporters are generally being dealt with more positively, yet this review shows that this is a complex area and one that lacks clarity around the meaning of concepts central to that reporting process - raising concerns, whistle-blowing and where these sit within the patient safety and safeguarding agendas. The delivery team hope that the analysis and findings of this review will contribute positively to efforts, including future research and policy development, aimed at supporting students in understanding where, when, and how to raise concerns with the quality of healthcare practice.

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# Appendices

## Appendix 1: Notes from the student/lay representative focus group

### Outline

An informal focus group was convened with six students and a lay representative to discuss the aim and objectives of the review. The purpose was to ensure the literature review was grounded in students' experiences of raising concerns/whistle-blowing. The students and lay representative were asked to consent prior to the meeting. The students were self-selected and had responded to an open invitation sent to two third year pre-registration nursing groups on two different geographical sites; around 200 students. The meeting was also attended by a second senior lecturer with an interest in this area of study and a member of the University research bid support team.

### Purpose and questions asked

It was made clear the meeting was informal and its purpose was not to gather data. The project lead offered support to students at the end of the meeting, including if necessary follow up meetings, should the discussion raise issues that they found stressful or difficult. The project lead was aware that at least two of the students had been directly involved in raising concerns about healthcare staff. Following a period of open discussion the following questions were asked of the group:

- What do you think the key words (used in the review) relate to?
- What do the phrases 'Raising concerns' and Whistle-blowing' mean to you?
- What information have you been given, or are you aware of, that would support or guide you in raising concerns?
- What would you have liked in place on the programme with regard to these issues?
- Have you heard of the RCN Direct online advice guide and telephone facility?
- Do you have other things you would like to discuss in relation to these matters?

### Summary of key points

There was a lot of discussion around the concept of culture in the practice placement environment, and whether students could change that culture if it was not positive. This linked to raising concerns in that the student would make a judgement as to whether raising an issue would make a difference. They agreed that they were transitory members of staff in that they were going into an area that had a staff team and they might, therefore, have little impact on the culture of the placement. They were also aware that assessment of their own practice might be adversely affected if they raised concerns resulting in lower grades. They were clear that they had to be tactful in how they raised the concern. They agreed that it was important to raise concerns where problems were seen, but were unlikely to go outside the team they were working in to do this. In part they saw this as a patient confidentiality issue, hence keeping it within the practice area. They did acknowledge that the University, as an outside agency, would perhaps support them. The students agreed that seeing a University link lecturer was a rare event but they felt they would be able to speak to lecturing staff if necessary.

There was frequent mention of Safeguarding and it was clear that the students saw this as a mechanism through which concerns could be raised. It gave them structure and they were often

actively encouraged on orientation to a placement to use the system if necessary. Some hospital and community Trusts were proactive in making these mechanisms clear to students but some organisations and practice areas were not – there was a perceived lack of consistency on this.

The students were very keen that confidentiality was maintained if they raised a concern. They were clear that word gets around when concerns are raised by students, and often the student is identified even when confidentiality had been either implied or stated by the staff member. Further to this, word can go around outside the practice area and come back to haunt the student at a later date. The students would have liked a clear person to go to should they need to report, someone that is available, and a more positive response from staff when concerns are raised. They were keen on the possibility of a phone application to report concerns, although not clear how that would be managed, and were clear that patient safety incidents should be reported through patient safety systems.

In summary this was a positive meeting and no new areas of relevance with regard to the key words and search strategy used in the review were identified. The students did prefer the phrase 'raising concerns' to 'whistle-blowing' as they saw the latter as being akin to telling on people.

## **Appendix 2: The work packages used to structure delivery of the review**

**Work package 1** - A background review of contextual literature and policy was written to double check that the search strategy and key words used within it were comprehensive and inclusive. The project team met at initiation of the project and agreed details with regard to management of the literature search and the subsequent analysis process.

**Work package 2** - The main search was initiated using the agreed key words, inclusion/exclusion criteria and databases. A summary of the search and its results was then circulated to the core members for comment. At this point the Project Lead met with six students and one lay representatives to introduce the review process, its aims and the search strategy and facilitate a discussion with regard to their own understanding of what raising concerns and whistle-blowing means. Feedback from the meeting was consistent with the key words and issues being found in the literature up to that point of the review.

**Work package 3** - Aspects of the literature, such as the news comment and editorial were analysed and the search for grey sources of literature was completed in with a citation search of the reference list of retrieved material. At this point work package 2 was revisited to check if further material might be available.

**Work package 4** - The search log and thematic summaries of the material were circulated to the core team in with requests to review individual pieces of literature. In addition to email and phone correspondence, two core team meetings were organised to facilitate the process described of analysis described above.

**Work Package 5** - The final draft report and other deliverables were generated for presentation at the close of the contract period.

**Work package 6** - The final report was delivered on within the agreed timeframe along with the completed lessons learned log.

## **Appendix 3: Graham Pink summary – an NHS whistle-blower**

### **Graham Pink – an NHS whistle-blower**

A key name in nursing, and to a lesser extent the public domain, when whistle-blowing is mentioned is Graham Pink. His case is examined in detail here as it portrays a number of relevant issues in clarifying the nature, and to some extent the outcomes, of being a whistle-blowing. Graham Pink became synonymous in the early 1990's with the phrase 'whistleblower'. In the recent book he describes his views on the events that led to his eventual dismissal (Pink, 2015). He was employed at the age of 58 as a senior night duty charge nurse on three care of elderly wards at Stepping Hill Hospital, Stockport. After being in post for 16 months he started to raise concerns about staffing levels and the poor standards of care he felt the patients were receiving. The book consists of a narrative of his experiences, supported by excerpts from letters and other evidence he compiled at the time. It includes some of the replies he received from management, media and government officials.

The early part of the book makes it clear, through detailed patient dependency descriptions of the workload on the ward during a night shift, that he perceived the staffing levels to be too low for the care and treatment the patients required. He notes that these patients could be acutely ill and, unlike the average younger sick patient in the hospital, would commonly have multiple health problems. Examples of what we would now define as patient safety incidents are described for the reader along with examples in which patients were deteriorating and this was either missed, treatment delayed, or other patients were disadvantaged as staff had to concentrate on the very sick patient/s.

His role was as a charge nurse that moved between wards adding support and co-ordination. He was, however, frequently 'warded' due to lack of staff. The phrase refers to a change in role in which he was allocated to work on one ward and this would occur as a consequence of low staffing levels. Graham's primary concern, and the cause of the threats to the quality of care he was both seeing and participating in, was staffing levels. There were, he felt, not enough staff to deliver the care and treatment the patients required with any reasonable level of dignity. The detail of some of his evidence does leave the reader clear that significant threats to the safety and quality of care were occurring. Having said this, the book is inevitably skewed towards his perception of events and lacks detail on the views of management.

Graham initially raised his concerns verbally on a number of occasions with the night nurse manager and, in his view, made it clear that if there was no improvement in the staffing levels he would put those concerns in writing. This he did in August 1989 by writing to the chair of the Stockport Health Authority. Reading the book now, in a context in which practitioners are generally familiar with patient safety incident reporting and safeguarding processes, it seems unusual to raise such a concern with an external agency without exhausting other possible avenues within the hospital first. Graham admits, 'In one sense, I was out of order by bypassing the normal line-management' (p.24) but goes on to state '...I believed the situation was so serious and urgent that my direct approach to the most senior person I knew of was justified' (p.24).

The book proceeds by describing further extracts from evidence and letters written on the general failure of the hospital, and the health authority, to improve staffing levels. The rapid and then consistent escalation, in terms of the seniority of the persons and organisations written to, is made

clear, culminating in letters to the then Secretary of State for Health, Kenneth Clarke MP, and even the Prime Minister, Margaret Thatcher. He was by his own admission a prolific writer claiming to have penned around 17,000 words in 49 letters, although this was not to be the final count.

It is evident that his relationship with the hospital management was not positive. The style of the letters is generally detailed and factual, in that Graham recounts the inadequacies in the standards of care he had seen and participated in. It is clear through the examples given, some of which are quite upsetting, that he was very unhappy with the levels of care he and other staff were able to give due to the time restraints placed upon them by poor staffing. In terms of his attempts to convey this message, some of the letters are rather florid in style, as the language and phrases used are sometimes complex and perhaps over elaborate. There is also a sense of a 'crusade' at times, a notion supported by the fact that he offered to work on a voluntary basis to 'free-up money' to employ other staff. As Graham makes clear, his financial position was such that he could afford to do this. This may not have strengthened either the credibility of his position, or the arguments he was making in the eyes of managers and even those in parliament; he could write freely without fear of a financial burden should he lose his job. The issue of writing style and freedom to work if necessary unpaid, are mentioned here as they probably did little to endear either him as a person, or the points he was raising, to the people he was writing to.

Inevitably perhaps, given the context within which he was working and the threats to safety and quality that he operated within, the hospital management team were able to find errors in his practice. They were also able to accuse him of breaching confidentiality by raising patient stories with the press – his case was also the subject of the television programme, 'World in Action'. The outcome was that he was subject to a disciplinary process in which he was found guilty of gross misconduct. He appealed this decision, to little effect, and when he refused the offer of a post in the community on night duty, he was dismissed. The details of the disciplinary process, and the reasons for it, are dealt with in some detail in the book. His case was also referred to the professional body of the time, the United Kingdom Central Council for nursing, midwifery and health visiting. The UKCC found he had no case to answer but did investigate the chief nursing officer of the Stepping Hill Hospital. It was not clear in the book what the outcome of this was.

The impact of the Graham Pink case remains contentious, but what is clear is that changes to legislation and the guidance used to deal with the raising of concerns changed in the period immediately after his case closed. His name appeared several times in the material included in this review and the publication of his book was rather timely in light of the initiation of this literature review.

**Appendix 4: The stages of raising concerns, summary of the literature and recommendations for educational practice, adapted from Jones et al. (2013)**

<b>Stages in the raising concerns process</b>	<b>Summary of key aspects of this review</b>	<b>Recommendations for educational practice</b>
<b>Discovery</b>	Students are increasingly aware of the possibility of error and other forms of unnecessary harm in healthcare. Both the healthcare and public agendas also make it clear that lapses in quality should be reported.	Facilitate with students the ability to identify the different types of incident they may encounter. Introduce and analyse with them definitions of the concepts patient safety incidents, raising concerns, and whistle-blowing.
<b>Evaluation</b>	Students are increasingly being encouraged to report concerns with regard to the quality of practice and have a wider range of knowledge on which to judge the origins of the lapse/s in care. The definitional lack of clarity around raising concerns and whistle-blowing may not facilitate accurate assessment by students.	Use vignettes to illustrate the different threats to quality students might encounter. Use these and other educational strategies, for example simulation, to enhance students' assessment skills in relation to whether concerns are present and classification of those concerns. Evaluation of practice placements by students should become obligatory thereby enhancing feedback skills with regard to the quality of practice.
<b>Decision</b>	The decision to report the activity, or not, is a difficult one for students who can feel vulnerable due to the transient nature of placements and the reliance they have on staff to assess and feedback on their performance. The cost for students can involve them being labelled as a trouble maker/difficult student and they may receive lower scores in assessment of their clinical practice.	Consideration to be given to support mechanisms provided by educational institutions for students who raise concerns. Where necessary additional support should be put in place including procedural and university staff support. Information given to students should specify the various reporting mechanisms available and clarify the meaning of internal and external reporting. Joint working with healthcare staff in this area would be particularly supportive.

<b>Reaction to the whistle-blowing</b>	Students are aware that they can be disadvantaged and even victimised for raising concerns. The legislation, policy and professional guidance available is increasingly supportive of the student who raises concerns.	Educational institutions re-assess the systems through which students are supported and formalise mechanisms that acknowledge, and where relevant reward, students who report legitimate concerns. Where possible these processes should link to healthcare provider systems.
<b>Evaluation of the reaction</b>	Little was found in the literature on this stage, although the shift towards a more positive response to those who raise concerns, which was evident, is likely to promote future reporting.	Educational institutions collate data on concerns raised by students and the outcomes of the concern process. This information should be feedback to new students as a key strategy when trying to promote reporting is giving reporters feedback.

## Appendix 5: Data extraction table and summary of the 23 research studies reviewed

	Author – year	Aim	Student group and country	Design	Sample size	Results/Key findings
1.	Bellafontaine (2009)	To explore what influences student nurses ability to report potentially unsafe practice.	Nursing, UK	Qualitative, interpretive phenomenology. Semi-structured interviews asking students to recount factors that affect their reporting.	N=6	The students talked of fear of blame and not always reporting incidents they had seen. Four themes were identified: the student-mentor relationship, actual or potential support for the report from the practice area and University, the students confidence and knowledge levels, and fear of failing the placement.
2.	Bradbury-Jones (2010; 2011)	Empowerment of students and student voice in being able to comment on the clinical practice experienced.	Nursing, UK	A three year longitudinal study utilising annual semi-structured interviews and focus group discussions. Data analysed using hermeneutic phenomenology.	N=13 One student left the study at the end of the first year (n=12)	Based on work by Albert Hirschman who constructed an exit, voice and loyalty model in research on employee loyalty. The findings suggests that students either have a voice' or 'exit' with regard to raising concerns. There is a bridge between these, but the exit option means students do not have to raise their concern. Exit meant not raising the concern with staff. Students were more likely to find a voice later in the course and would find an appropriate moment to raise the concern to lessen the personal impact in terms of their progress on the course.
3.	Bressen, (2016). See also Stevanin et al. (2015)	To validate the reliability and validity of the Health Professional Education in Patient Safety Survey(H-PEPSS).	Nursing, Italy	A quantitative validation study of the tool using a cross sectional design.	N=574	The questionnaire measures student's awareness and understanding of patient safety. It is concluded that the H-PEPSS tool, as translated, is valid and capable of measuring and supporting students understanding of patient safety. The authors suggest the tool can be used to enhance the curriculum and its delivery in relation to patient safety. Students may then be more likely to raise concerns. Some of the more direct questions on speaking up were omitted from the tool by the revising panel.

4.	Cogin and Fish (2009)	To examine the prevalence of sexual harassment in nursing and factors that contribute to such behaviour.	Nursing, Australia	Mixed methods with a postal questionnaire (538) and in-depth interviews (23).	n=538	The study concluded that the prevalence of sexual harassment in nursing is high and patients are the most likely perpetrator. A conceptual framework highlighting the contextual factors linked to sexual harassment is presented. Female students reported sexual harassment at much higher rates than male students. It was not clear how and to whom sexual harassment might be reported by the student.
5.	Espin and Meikle (2014)	Fourth year nursing students perception of events potentially harmful to patients and the reporting of those incidents.	Nursing, Canada	A descriptive qualitative study utilising 5 different scenarios from practice. Participants read the scenario and then verbally responded with regard to their interpretation.	N=10	Four of the clinical scenarios were designed to be interpreted as incidents and one was a near miss. Three themes emerged from the analysis of the interview and student responses: scope of practice; professional roles; and presence or absence of harm. As an educational strategy the method may help students to identify patient safety incidents. The authors make mention of a 'reporting ladder', a way of describing the process through which students can raise concerns. If they do not get a response, or are unhappy with the response to the report, they can move up to the next step on the ladder.
6.	Ferns and Meerabeau (2009)	To explore the reporting behaviours of students who experienced verbal abuse.	Nursing, UK	A researcher generated descriptive questionnaire survey.	N=144	Fifty one students reported suffering verbal abuse. Thirty-two of those students (62.7%) stated that they had reported the incident, with four incidents resulted in formal documentation. The most frequent feelings reported by respondents were embarrassment and feeling sorry for the abuser. It was concluded that both higher education institutions and healthcare providers should consider establishing processes for formal reporting and documentation of incidents of verbal abuse.

7.	Geller (2013)	To examine the experience of bullying, horizontal violence and harassment in the final year of study.	Nursing, USA	A quantitative survey of bullying, harassment and horizontal violence using the BEHAVE survey tool.	N=32	The BEHAVE survey tool was generated from two other tools previously used in this field of study. 72% of the students reported experiencing bullying like behaviour and 46.8% of those incidents originated from a nurse. The tool examined reporting behaviour and 34.8% of students stated they had reported the behaviour of concern, 5 to another student and clinical instructor, with the other 3 being to faculty staff and a preceptor in one case.
8.	8/ Gould and Drey (2013)	To explore students experience of infection control in placements.	Nursing, UK	Quantitative 19 question on-line survey using a Likert scale and one open question.	N=488	All participants reported witnessing lack of compliance with infection control requirements with 75% witnessing failure to cleanse hands between patients. Two of the respondents had raised concerns about infection control breaches with the ward manager. In both cases they subsequently received poor ward reports.
9.	Ion et al. (2015)	To analyse factors influencing student nurse decisions to report poor practice.	Nursing, UK	Qualitative study using semi-structured interviews.	N=13	In the theme 'I had no choice', students felt obliged to report. This was linked to personal ethical drivers influencing reporting decisions. 'Consequences for self', related to the student considering the personal and professional consequences, including the impact on their placement grade. 'Living with ambiguity' related to situations that were not clear-cut for the student, or they put off reporting, sometimes looking to other staff for guidance. Students expressed feeling guilty in such situations realising reporting could be deterred. In the 'being prepared' theme students stated the professional requirement to report was clear but support might be lacking, including from the University. There was evidence of acclimatisation found, a term used to explain situations in which reactions to poor care and bullying can become dull over time, and students might adopt similar practice as a way of coping.

10.	Kent et al. (2015)	Effects of a course and placement on speaking-up.	Nursing students, USA	Quantitative pre-test, post test design utilising the Health Professional Education in Patient Safety Survey (H-PEPSS).	n=63	The students completed the H-PEPSS and then completed a short course on raising concerns/challenging authority figures. This was followed by a clinical placement and then the survey was completed again. No significant relationships were found with regard to age, gender or ethnicity on the expressed possibility of raising concerns. An increase in confidence in speaking up was found in the post-test ( $p \geq 0.001$ ).
11.	Killam et al. (2012)	To explore first year students viewpoints on what constitutes unsafe practice.	Nursing, Canada	Q-methodology, using a blend of quantitative and qualitative elements.	n=94	This data set is part of a larger study aimed at identifying priorities for safe clinical practice described by nursing students across four years of a baccalaureate program (see also Killam, 2013). Participants ranked statements representative of multiple understandings of a topic of interest, called a concourse. The concourse was developed from an integrated literature review. Four viewpoints were identified (1) overwhelming sense of inner discomfort; (2) practicing contrary to conventions; (3) lacking in professional integrity; and (4) disharmonizing relations. These relate to when practice is most unsafe. There was no substantial linkage of these issues to how the student might raise a concern with the safety of practice.
12.	Killam et al. (2013)	To explore first year nursing students understanding of safe clinical practice.	Nursing, Canada	Q-methodology, using a blend of quantitative and qualitative elements.	n=68	As with Killam 2012, a concourse was developed from an integrated literature review. Four discrete viewpoints were identified by the students with regard to viewpoints on un-safe clinical situations: (1) overwhelming sense of inner discomfort; (2) practicing contrary to conventions; (3) lacking in professional integrity; and (4) disharmonizing relations. There was no substantial linkage of these issues as to when and how the student might raise a concern with the safety of practice, but the study does shed light on the ability of students to identify unsafe practice.

13.	Levett-Jones and Lathlean (2009)	To present selected findings on the relationship between belongingness, conformity and compliance in student clinical practice.	Nursing, UK and Australia	Case study utilising sequential qualitative data collection – interviews with thematic analysis.	n=18	Of the sample 12 students were from Australia and 6 from the UK. The students' placement experiences spanned a continuum from those who reported a high degree of belongingness to provoking intense feelings of alienation. Students who felt insecure, isolated or ostracised were more willing to conform and less likely to question practices with which they felt uncomfortable. It is noted that students with such feelings are unlikely to report concerns with practice. Conversely, when students felt sure of their acceptance and place in the clinical environment, they were less likely to comply with the directives of registered nurses if they felt that to do so might put patients at risk.
14.	Mansbach et al. (2010)	To analyse the dilemma of whistle-blowing in terms of self-reported willingness to report misconduct; either internally or externally.	Physiotherapy, Israel	Questionnaire with multiple-choice questions and two practice vignettes.	n=112	The study suggested that physiotherapy students regard acts detrimental to patients as serious and that students were willing to act, particularly if the misconduct was perpetrated by a manager. Whistle-blowing internally was more likely to be considered by students than blowing the whistle externally. This study appears to have generated the two later studies [see below].
15.	Mansbach et al. (2012)	To explore whether practitioners and students were willing to take action to prevent misconduct by a colleague or manager to protect a patient.	Physiotherapy, Israel	Questionnaire study analysing responses to two vignettes - being loyal to a colleague and being loyal to management.	n=227 123 physiotherapy students 101 Physio-therapists	The concept of whistleblowing was utilised within the study. Both groups saw acts that were detrimental to patients as serious and were willing to act. Some differences were seen, with the students seeing managers misconduct as being a more serious concern, whereas the qualified staff saw the colleagues behaviour as more serious. The students showed a greater tendency towards both internal and external whistleblowing and the authors attributed this to a lack of understanding of the possible consequences of such reporting.

16.	Mansbach et al. (2013)	To explore the willingness of nursing students to take action to report misconduct of a colleague or manager.	Nursing, Israel	Questionnaire with multiple-choice questions and two vignettes.	n=82	Acts detrimental to patients were regarded as serious with participants scoring highly with regard to their willingness to act and change a situation. The results suggested that participants were wary of exposing a colleague externally (rather than blowing the whistle internally) in terms of the consequences for a wrongdoer. The authors recommend that ethical education [containing topics such as whistle-blowing] should be provided to ensure students are aware how best to raised concerns.
17.	Mansbach (2014)	To compare experienced nurses to nursing students with regard to willingness to blow the whistle to protect the patient.	Nursing, Israel	Questionnaire with multiple-choice questions and two vignettes.	n=165 83 nurses 82 nursing students	Both experienced nurses and nursing students regarded acts detrimental to patients as serious. Although nursing students regarded the severity of misconduct significantly lower to experienced nurses, students were reported as having a greater readiness to blow the whistle, both internally and externally.
18.	Monrouxe et al. (2014). See also Rees et al. (2015)	To analyse narratives of dilemmas, the types of dilemma encountered and how they are narrated by students.	Dental, pharmacy, nursing and physiotherapy, UK	A qualitative cross sectional design utilising narrative interviewing in discipline specific groups or individual interviews.	n=69, 29 dentistry 13 nursing 12 pharmacy 15 physio'	A total of 226 personal narratives were analysed. The researchers sought to understand and compare between disciplines the events that were recounted as dilemmas and the amount of emotional work created for the student. Nine themes emerged and a sub-theme of 'challenging and whistleblowing'. In this sub-theme some students had recounted both failing to challenge behaviour they saw as problematic and successfully challenging both peers and senior staff. Some students had noted that reporting might simply lead to nothing happening or them being marked down in assessments.

19.	Monrouxe et al. (2015)	To identify the most common types of professionalism dilemmas and analyse these in terms of gender and reported levels of moral distress.	Medical and healthcare students (nursing, pharmacy, physiotherapy and dentistry), UK	Two cross sectional online questionnaires.	n= 3796 2397 medical 1399 health- care students	Overall 10% of all the respondents reported having experienced no professional dilemmas over the last year. The most common dilemmas were student abuse and patient dignity and safety dilemmas. Participants reported witnessing or participating in breaches of patient dignity or safety and the majority also reported being the victim of workplace abuse. 47.5% female and 36.2% male healthcare students reported having witnessed clinicians breaching patient dignity or safety. In terms of instigating such breaches, 28.8% of female and 27.5% of male healthcare students reported that they themselves had done this. Observing the undertaking of an examination/procedure without valid consent was reported by 17.3% of female and 13.6% of male respondents. 19.1% of female and 12.4% of male healthcare students reported instigating this. The study does not focus on whether the incidents encountered were reported.
20.	Rees et al. (2014)	To analyse nursing students' written narratives of the 'most memorable' professionalism dilemmas they have encountered in practice.	Nursing, UK	An online survey of narratives provided by students from 15 UK nursing schools which were subject to a thematic and discourse analysis.	n=294	A number of themes were: patient care dilemmas instigated by healthcare personnel, student abuse (poor behaviour towards students), patient care dilemmas instigated by students, and consent dilemmas. Examples of students reporting incidents are discussed with 79.3% saying they had done this, but detail on how and to whom is lacking. Students need to have a safe forum in the formal curriculum to construct emotionally coherent narratives of professionalism dilemmas to help them cope with previous and future dilemmas. Nurse educators should role-model the sharing of professional dilemmas with students.

21.	Rees et al. (2015). See also Monrouxe et al. (2014)	To explore the types of workplace abuse students of healthcare encounter.	Healthcare, UK	Qualitative. Three individual narrative interviews and 11 group interviews. All were transcribed and subject to Framework analysis.	n=69 29 dentistry 15 physio' 13 nursing 12 pharmacy.	There were many similarities between the different student groups. Seventy nine abuse narratives were reported. Although narrators described individual, relational, work and organisational factors contributing to abuse, they mostly cited factors relating to perpetrators. Participants stated that they acted in the face of their abuse in 55.7% of cases but no detail is given on how or to whom reports were made. Students who did nothing in the face of abuse typically cited the perpetrator-recipient relationship as the main contributory factor.
22.	Schaefer (2014)	To determine if senior baccalaureate nursing students were able to recognise overt and covert forms of negative behaviour.	Nursing, USA	A mixed method post-test only interventional study. A comparison was made between two groups; one received the intervention of a one-hour training programme on recognising and reporting negative behaviour.	n=71	Through a series of 6 video vignettes simulating clinical experiences students were asked to identify various types of negative behaviour. The study focused upon recognising negative behaviour from staff and the reporting of the behaviours. In terms of experiencing negative behaviour, 52 students (73.2%) stated they had, but only 21 students had reported it. The authors claim the low reporting rate found is a problem as the behaviours are more likely to persist whilst reporting remains low. All the students said they would report the negative behaviours seen in the vignettes. No statistically significant differences were found between the two groups.
23.	Stevanin et al. (2015). See also Bressen et al. (2016)	To describe the knowledge and competence of students with regard to patient safety through the use of the H-PEPSSIta survey.	Nursing, Italy	A cross-sectional design using qualitative and quantitative data including 23 open-ended questions to measure self-reported patient safety knowledge and competence.	n=573	Students indicated that 46.9% of placement areas visited were perceived as unsafe and 28.8% of students witnessed an adverse event. Only brief mention is made of the reporting of the patient safety incidents encountered by students. Through the responses given in the study students were recounting the types of incidents seen. Observing and reporting illegal or immoral activity did not appear within the tool used. It was concluded that patient safety knowledge in the sample was high.



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