Clinical Placement Experiences and the Professional Values of Graduate Entry Nursing Students

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A thesis submitted in partial fulfilment of the requirements of Sheffield Hallam University for the degree of Doctor of Education

August 2022

Candidate Declaration

I hereby declare that:

1. I have not been enrolled for another award of the University, or other academic or professional organisation, whilst undertaking my research degree.

2. None of the material contained in the thesis has been used in any other submission for an academic award.

3. I am aware of and understand the University's policy on plagiarism and certify that this thesis is my own work. The use of all published or other sources of material consulted have been properly and fully acknowledged.

4. The work undertaken towards the thesis has been conducted in accordance with the SHU Principles of Integrity in Research and the SHU Research Ethics Policy.

5. The word count of the thesis is 58,984

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Award	**Doctorate in Education (EdD)**
Date of Submission	August 2022
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Abstract

Healthcare workers, including nursing students, must understand and operationalise their professional values to a high standard because they are vital to delivering quality healthcare. Time should be invested in explicitly identifying, developing and sustaining nursing students' professional values. Developing professional values is critical for student nurses, especially Graduate Entry Nursing (GEN) students on an accelerated nursing programme. This research sought to identify and examine the relationship between the clinical placement experiences and professional values of GEN Students.

A qualitative methodology with a social constructivist paradigm was adopted within a qualitative interview study design. Data were generated from two focus group interviews and 12 semi-structured interviews, that were analysed using Thematic Analysis (TA).

The findings suggest that a complex interdependent relationship exists between the clinical placement experiences and the professional values of the participants. The participants found that their clinical placement experiences allowed them to put into practice their professional values. Their professional values allowed them to approach and understand their clinical placement experiences. This research further suggests that professional values influence how student nurses deliver patient care and maintain patient safety and that clinical placement experiences change professional values. An unexpected finding was the emotional implications identified from the clinical placement experiences on their professional values as future nurses.

The GEN student group is viewed as unique because of their life experience, background, previous education, and skill set. As such, this research adds new knowledge regarding GEN students' understanding of their professional values and capacity to identify clinical placement experiences which were related to their professional values. Finally, this research provides a unique view into the GEN students' emotional awareness and management when working within the constraints of the current NHS. Professional values are a part of nursing and are here to stay.

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Dedication

"You are never alone. You are eternally connected with everyone". – Amit Ray

I dedicate this thesis to my parents, especially my late Dad, who always told me to "believe and have faith". I wish I could share this milestone with you, but I know that you are watching and will always be my guiding star.

I also dedicate this thesis to my daughter, Shakirah, who has shared the highs and lows of this journey with me, frequently saying "You got this, mum. You can do it". This journey was as much yours as it was mine in so many ways – I love you so much! I hope that I have inspired you, and that, one day, you too will have an opportunity to read for a Doctorate.

Finally, to all of my colleagues working on the frontline during the Covid 19 global pandemic, this is for you, who demonstrated professionalism, care and compassion and maintained your professional values during this difficult time. Last but not least, we must not forget the colleagues whom we have lost along the way.

Acknowledgements

"Human connections are deeply nurtured in the field of shared story." – Jean Houston

I wish to thank all of the amazing GEN student participants for their time and generosity in sharing their experiences with me; without their contribution, this research would not have been possible. I feel a deep sense of accountability to share their experiences. I know that they have all qualified as registered nurses already, and have no doubt that they are fantastic nurses, who are kind, caring and compassionate to their patients.

I also wish to thank my supervisors, Dr Fufy Demissie and Dr Joan Healey, for the immense patience they showed towards me. At times, I was very fixed on my ideas, but they allowed me the time and space to grow. I wish to thank them for their unwavering support during the laughter and tears; I have learnt so much during this process. I also wish to extend my thanks to Professor Mark Boylen for his time, advice, and professionalism in supporting me through the final stages of this process. Finally, I wish to thank Professor Carol Taylor, who started me on this journey before moving on to pastures far afield. I am eternally grateful to them all.

All of their love and support of my brothers and sisters have carried me through some tough times. I wish to thank them for sharing this journey with me. I will now have time to spend with them all. I also wish to say to my beautiful nieces and nephew that, if they believe enough, they can achieve anything.

I have lost count of the many times that I have called on my friends and colleagues for a quick chat; they will never know how much that meant to me. I have learnt a great deal from this process, and humility goes a long way.

Finally, thanks for the unwavering support of my furry kid, Cleopatra (AKA Cleo the cat).

List of abbreviations

A&E	Accident and Emergency
CCU	Coronary Care Unit
CPE	Clinical Placement Environment
CPR	Cardio-Pulmonary Resuscitation
CQC	Care Quality Commission
DNR	Do Not Resuscitate
GEN	Graduate Entry Nursing
GEM	Graduate Entry Medicine
HEE	Health Education England
HEI	Higher Education Institution
ICN	International Council of Nurses
ICU	Intensive Care Unit
NG	Nasogastric tube
NHS	National Health Service
NMC	Nursing and Midwifery Council
NPVS	Nursing Professional Values Scale
NPVS-R	Nursing Professional Values Scale-Revised
PACU	Post-Anaesthesia Care Unit
PNVS	Professional Nursing Values Survey
RN	Registered Nurse
RCN	Royal College of Nursing
RVS	Rokeach Value Survey
SA	South Africa
SEN	State Enrolled Nurse
SRN	State Registered Nurse
SSSA	Standards for Student Supervision and Assessment
UK	United Kingdom

Chapter 1: Introduction

1.0 Introduction

This chapter provides an overview of my Doctorate in Education, including my biography, the purpose and rationale, aim and objectives, research questions, methodological approach, key findings, and the structure of this thesis, which is elaborated on in the subsequent chapters.

Healthcare workers, including nurses, must provide high-quality care and maintain patient safety. It is essential for student nurses to develop and maintain professional values, particularly GEN students on an accelerated nursing programme. Since GEN programmes are gaining momentum both nationally and internationally (Jamieson et al., 2020; Gerdtz et al., 2021). The literature surrounding GEN students suggests that this student group possesses a unique skill set compared to Bachelor of Science (BSc) nursing students (Stacy et al., 2015; Jamieson et al., 2020; MacDiarmid et al., 2021 and Jarden et al., 2021). GEN students have more extended clinical placements than BSc students and are equipped with previous education, work, unique backgrounds and life experiences (Jamieson et al., 2020). In addition, the recruitment of this student group differs from that of BSc students, since GEN students are required to have at least one-year of healthcare experience prior to commencing their nursing programme, which should total seven hundred and eighty hours. This means that applicants are required to achieve several proficiencies that correspond with year one of the BSc programme (DoHS, 2021). Furthermore, potential applicants are required to demonstrate their prior learning and experience with regard to a set of professional values (DoHS, 2021). This doctoral research is based on examining the relationship between the clinical placement experiences and professional values of the GEN student participants.

Professional values are inextricably linked to the nursing profession. The understanding and operationalisation of these professional values are known to

impact the care that patients receive (Ayla et al., 2018; Shafakhah et al., 2018; Poorchangizi et al., 2019a). Understanding professional values in nursing is vital and has been associated with quality nursing care, greater patient collaboration, increased job satisfaction and better nursing staff retention (Ten Hoeve et al., 2017; Poorchangizi et al., 2019b and Lee, et al., 2020). GEN students enter GEN programmes with a set of professional values gathered from their previous education, career and life experiences (Jamieson et al., 2020; MacDiarmid et al., 2021). Where and how these professional values are shaped, the challenges they encounter during their placements, and how they navigate and make sense of these experiences remain unknown (Jamieson et al., 2020).

This research was developed against the backdrop of seminal reports, such as the Winterbourne View (2013), Francis Report (2013) and Keogh Report (2013). These reports created an outcry from the public, media, and professional regulators regarding the sub-optimum care received by patients in the United Kingdom (UK) due to failings in a number of areas, one particular area was the lack of professional values. In particular, the Francis Report (2013) proposes recommendations, including clarifying the values and principles that support quality care and safety for all patients by suggesting a common set of values. *"We need common values, shared by all, putting patients and their safety first; a commitment by all to serve and protect patients and to support each other in that endeavour"* (Francis, 2013, p4).

More than eight years after these investigations, I still gather anecdotal evidence from colleagues and student nurses about similar incidents that have not made the news headlines. Therefore, it is imperative to recognise and understand professional values from the perspective of GEN students as future healthcare leaders to ensure that quality healthcare is delivered to all and that this rhetoric changes.

1.1 Researcher's Biography

> *Education is the great engine of personal development. It is through education that the daughter of a peasant can become a doctor, that the son of a mineworker can become the head of the mine, that a child of farm workers can become the president of a great nation. It is what we make out of what we have, not what we are given, that separates one person from another.*
>
> ***President Nelson Mandela (1918-2013)***

This quote by President Nelson Mandela rings true to me in many respects, having grown up during the struggles of apartheid South Africa (SA), where education was viewed as vital to implement change and make a difference for my generation. As a child, the values instilled in me were hope, respect, courage, kindness, belief, and, above all, humility. I still hold these values today, and they have developed throughout my career as a nurse and academic. Being a South African, female, Registered Nurse (RN) and academic with professional experience from SA, the Kingdom of Saudi Arabia (KSA), and the UK, I bring unique experiences from an international perspective to my research.

I completed my primary, secondary and initial tertiary education in SA. My true journey to education started in 1995 when I was accepted by a school of nursing that offered a four-year nursing programme as opposed to the two-year vocational training. It may sound like a cliché, but I always wanted to a nurse and nursing has been a part of me, because I always wanted to help people and make a difference. Throughout my nursing career and professional life, it was important for me to think and behave in certain ways and believe in 'certain things', which I now refer to as professional values, such as being 'caring', 'kind', 'compassionate' and a 'patient advocate'. While 'education' has been the one constant in my life, I believe that my professional values play a key role in who I am and the type of care I delivered to my patients. I have always had an ongoing appreciation of the importance of education and a desire to make a difference in society. I undertook a master's degree in medical

education to fuel my passion for teaching and sharing my knowledge and experiences while working full-time as a cardiac intensive care nurse. My dissertation explored the use of high-fidelity simulation when teaching advanced life support during a cardiac arrest.

I currently work as a Senior Lecturer in the Department of Health Sciences at a University in the north of England and have worked in the UK Higher Education system since 2010. I have several Departmental and Institutional roles, whilst teaching remains my primary focus. I have a strong commitment to Equality, Diversity, and Inclusion, and hence initiated and set up the Department's Equality, Diversity, and Inclusion Committee that I chaired. As part of a group of academics, responsible for the development and delivery of the nursing curriculum, I was involved in developing and delivering the GEN programme prior to conducting this research. My various roles and responsibilities have provided me with a dynamic perspective of nursing and nurse education within the current climate of change within healthcare and the National Health Service (NHS).

My research interest is based on my experiences as a nurse and academic. I have a professional role as a nurse and academic, and a commitment to developing and delivering nursing programmes in my current job. I am particularly interested in the experiences of the GEN student group as a whole and how they make sense of their professional values in the Clinical Placement Environment (CPE). My interest is two-fold; firstly, the GEN student group is viewed as different, as they not only develop professional values but also bring their own professional values and life experiences to their nursing programme (Neill, 2012; Stacey et al., 2015; Aubeeluck et al., 2016, Kaya et al., 2017; Jamieson et al., 2020). This raises the question of the GEN students' understanding of their professional values. Secondly, I wondered if a relationship exists between the GEN students' clinical placement experiences and their professional values. I was indeed influenced by what I read in the media and nursing journals regarding nurses demonstrating a lack of professional values and, therefore, a lack of care and compassion. The timing felt appropriate to conduct this research. Based on my experience of working closely alongside the GEN programme and four cohorts of

GEN students, I propose that GEN students present themselves and respond in sophisticated ways to their experiences related to professional values in the CPE. Finally, it is important to me, as a female, nurse, and academic, to use the platform of education as the greatest engine to make a difference in nursing and nurse education.

The following section discusses the seminal reports on the investigations into the poor care and lack of professional values displayed by healthcare professionals in UK hospitals. These seminal reviews form the backdrop to understanding the causes and consequences of a lack of professional values for patient care.

1.2 National Reviews of UK Hospitals

Several seminal reports identify sub-optimal standards of care and a lack of professional values such as care and compassion demonstrated by nurses and other healthcare professionals in NHS Trusts and Care homes in the UK. These reports include the Willis Report (2012), Berwick (2013), Winterbourne View Report (2013), The Francis Report (2013) and Keogh Report (2013). All of these reports emphasised the importance of patient-centred, compassionate, and well-informed care. This thesis only discusses the Winterbourne View Report (2013), The Francis Report (2013) and the Keogh Report (2013) that took place at a similar time to highlight the severity of a lack of professional values, professional standards and the impact of staff shortages on the quality-of-care patients receive.

1.2.1 Winterbourne View Report (2013)

Winterbourne View was a private hospital, registered to assess and treat people with learning disabilities, autism and mental health conditions. A whistle blower informed the Care Quality Commission (CQC) that they were concerned about the treatment that patients were receiving at Winterbourne View Hospital. However, CQC did not react to the whistle blower's complaints at the time. CQC (2015) is an independent regulator, responsible for monitoring and inspecting England's health and social care services by meeting the quality and safety requirements. Following a BBC Panorama programme on Winterbourne View, which exposed several failures, the hospital was

closed down, and a review immediately initiated. The review found that several people with learning disabilities, autism and challenging behaviour were inappropriately placed in hospitals and, as a result, stayed there for extended periods of time. Only some people experienced personalised care, which meant that many were far from home, unable to contact or spend time with their family. However, much wider concerns were exposed, including the poor quality of care that people received, with an overreliance on physical restraint. The staff members concerned were investigated and those involved in the abuse were sent to prison.

CQC (2015) and the Department of Health promised to work together to issue new recommendations on training standards, codes of conduct, better-commissioning methods and safe-guarding. Nevertheless, this was a damning review for the nursing profession, highlighting a serious lack of care and compassion. It is essential to recognise that the nursing staff at Winterbourne View were healthcare assistants rather than RNs and therefore unregulated by the NMC at the time.

1.2.2 The Francis Report (2013)

Sir Robert Francis was tasked with examining the causes of the numerous failings identified across the Mid Staffordshire NHS Foundation Trust. These included board members who were fixated on finance and other costs at the expense of quality patient care. This led to understaffing, a culture of poor treatment and a lack of care, that left many employees feeling helpless. As a result, a lack of professionalism and poor standards of performance developed, due to poor leadership and sub-standard staffing policies, which resulted in patients at the receiving end of poor care:

> *The complaints heard at both the first inquiry and this one testified not only to inadequate staffing levels, but poor leadership, recruitment and training. This led in turn to a declining professionalism and a tolerance of poor standards. Staff did report many incidents which occurred because of short staffing (Francis, 2013, p45).*

The investigation puts forward two hundred and ninety recommendations, including fundamental criteria for healthcare providers to include openness, transparency, and

candour across the healthcare system. To increase support for compassionate care and personalised treatment with greater healthcare leadership, Sir Francis identified the need to:

> *foster a common culture shared by all in the service of putting the patient first; Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated (Francis, 2013, p5).*

The Francis Report (2013) created a picture of the NHS being at breaking point, and recommended that immediate action be taken. However, Sir Francis's complete investigation report consists of one thousand seven hundred pages, while the executive summary consists of one hundred and twenty-five pages, containing two hundred and ninety recommendations. It is argued that the Francis Report is lengthy and onerous to read, while the number of recommendations itself can be viewed as a barrier. If changes are to be made to professional values, nursing standards and performance, it would have been far more helpful to have a succinct one- or two-page summary containing recommendations for immediate, urgent actions, followed by long-term recommendations so that healthcare professionals can easily engage with them.

1.2.3 The Keogh Report (2013)

Sir Bruce Keogh, the Medical Director of the NHS in England, has examined fourteen NHS Trusts where the death rates were higher than projected. The then Prime Minister David Cameron commissioned the Keogh investigation after the Francis Report, and the findings were made available to the public by the Department of Health (DoH) (2013). An inspection team visited each of the Trusts that had higher mortality rates compared to the previous two years.

A failure to take action in light of the available evidence raised concerns in the report. The findings indicate that patients received good quality treatment, but some received troubling and poor treatment. Sir Keogh identified patterns across the geographical locations of many of the NHS Trusts, suggesting that there existed pockets of poor care

and professional isolation. There was clear evidence that little action had been taken with regard to these identified concerns. For example, one NHS Trust report identified insufficient staffing levels, with some staff working for twelve consecutive days, and high weekend mortality rates, when the wards operated on minimal staffing levels. When the patients and their families had voiced concerns, they had been treated with a lack of compassion and dignity.

The Keogh Report stated:

> *As set out in the Compassion in Practice, directors of nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience* (The Keogh Review and special measures, p5).

These reviews demonstrated significant evidence of some of the failings within the culture of the NHS Trusts. What is apparent, amongst the many other constraints and challenges existing within the NHS, was the clear lack of professional values and the capacity of the staff to operationalise them. It is now more important than ever to continue to provide quality care and adhere to professional values that meet those needs.

1.3 Purpose and Rationale of this Research

The purpose of this research is to examine the relationship between the clinical placement experiences and professional values of the GEN student participants. The previous two sections discussed the researcher's biography and the National Reviews of UK Hospitals. The following three sections will examine the purpose and rationale of this research, the aims and objective, the research question and the three research sub-questions that were created to facilitate the research process.

Nursing remains the largest workforce group in the UK and is grounded in professional values, much the same as other healthcare professions (DoH, 2016). Professional values in nursing are very important and, as such, the rationale of this research is

three-fold: firstly, the question of professional values in nursing, or the lack thereof, has come under some scrutiny by the media, politicians, and public (BBC, 2011; Winterbourne View, 2013; Francis, 2013; Keogh, 2013 and BBC, 2019). These concerns remain highly relevant today because of the continued pressures in the NHS. There were major concerns emphasised in the Francis Report (2013) and Keogh Report (2013), indicating that, at times, sub-optimal care was being delivered to patients in UK hospitals and care homes settings. The Francis Report created a bleak but accurate picture of the pressures and failings existing within the NHS. The challenge remains to examine the professional values of GEN students attending a shortened nursing programme with a unique skill set (WHO, 2020; MacDiarmid et al., 2021). Secondly, the scoping review identified a limited number of qualitative studies have focused on the professional values of student nurses in the UK and none on GEN students which are required to understand their clinical placement experiences and to provide support as they navigate this journey (Akhtar-Danesh et al., 2013; Kim et al., 2015; Kantek et al., 2017). Whilst the quantitative studies available help to clarify the professional values of BSc student nurses, they fail to explore the depth of the beliefs and perceptions arising from the student participants' experiences. The current research offers a qualitative methodology within a qualitative interview study design to develop an in-depth understanding of the perceptions and experiences of the GEN student participants. Thirdly, professional values are viewed as a social construct and, therefore, mean different things to different people because of the way in which they are understood and internalised. As such, the rationale for this research lies in the understanding, internalisation, and operationalisation of the GEN student participants' professional values so that they may deliver high-quality nursing care.

1.4 Aim and Objectives

This research aims to identify the relationship between and critically examine the implications of the GEN student participants' clinical placement experiences and professional values.

The objectives of the research are as follows:

Objective 1: to identify how the GEN student participants define professional values.

Objective 2: to understand the identified clinical placement experiences that change or shape the professional values of the GEN student participants.

Objective 3: to analyse the implications of the identified clinical placement experiences for the professional values of the GEN student participants.

1.5 Research Questions

The following questions were developed to capture the key areas of this research. The main research question is: **What is the relationship between the clinical placement experiences and professional values of the Graduate Entry Nursing student participants?**

To answer the main research question, the following sub-questions were explored:

Question 1: What are the definitions of professional values as understood by the GEN student participants?

Question 2: What experiences do the GEN student participants identify in their clinical placements that relate to their professional values?

Question 3: What are the implications of the identified clinical placement experiences for the GEN student participants' professional values?

These sub-questions guided the researcher to gather relevant information about the relationship between the clinical placement experiences and professional values of the GEN student participants. To begin to appreciate and understand their professional values, it was imperative to understand their definitions of professional values, their experiences related to their professional values and how these experiences affect how they operationalise their professional values. Furthermore, it is necessary to ask these sub-questions in this particular order to build an awareness and interpretation of the participants' perceptions and experiences with the aim of providing support for and effectively promoting their professional values.

1.6 Methodological Approach

Next, I will discuss the methodological approach and methods employed in this research. A qualitative research approach is ideal for illustrating and describing complicated topics in healthcare and nursing, and placing a special focus on the richness and depth of real-life experiences proved to be the most suitable method for this research (Creswell and Creswell, 2018; Aveyard, 2019). Qualitative research is aligned with providing descriptions and interpretations of a social phenomenon, extracting the participants' experiences and perceptions from within their specific social context. The very nature of the 'social phenomenon' that social constructivism postulates means that the creation of knowledge cannot be separated from the social world in which it is created (Mvududu and Thiel-Burgess, 2012). The use of a qualitative approach with a social constructivist paradigm was deemed appropriate when seeking a holistic, contextual understanding of the perceptions and experiences of the participants.

Silverman (2016) suggests that the research design should connect the data collection and the conclusion derived from the research questions. Therefore, a qualitative interview study design was considered most suitable for exploring the nature of contemporary social activities; namely, the professional values of the GEN student participants within the specific context of their clinical placements.

1.6.1. Methods

This section provides a brief overview of the methods used in this research, focusing on the participant selection, focus groups, and semi-structured interviews. Further details can be found in the methodology and methods Chapter 4.

Participant Selection

Participant selection within this research consisted of the intentional selection (purposive sampling) of the GEN student participants during their final placement of the programme. As reported by Everett et al. (2013) and Garrud and McManus (2018), the GEN student group's defining characteristics are a high degree of motivation due

to their preceding academic achievements and a demonstrated ability to perform well academically, drawing on the skills and knowledge gathered from their past experiences. GEN students are known to possess a level of maturity, real-life experience, and perspectives that can bring about change (Cangelosi, 2007; Neill, 2011; McKenna et al., 2017; Jamieson et al., 2020).

According to MacDiarmid et al. (2021), the significance of the GEN student group is based on their motivation and enthusiasm about studying nursing, their personal experiences of nursing, and the clarity that nursing offers in terms of their career progression. They also guide the design of the intensive nursing programme due to their defining characteristics. Students who wish to engage with a GEN programme undertake a reflective process of assessing their current career status and future career plans. The participants in this research reported that nursing would provide them with a secure, sustainable career path, potentially creating new horizons or possibilities that extended beyond their previous work and life experiences. It is, therefore, important for education providers to establish educational processes that are strongly linked to students' professional values and clinical placement environments. The participants' characteristics are elaborated on in chapter 5.

Focus Groups

Focus groups were chosen because they offer a breadth of understanding of the experiences and perceptions of a homogeneous sample. All of the participants were studying on their final placement on the same nursing programme. Focus groups promote discussion and the sharing of ideas and experiences as well as encouraging debate on a specific area (Creswell and Creswell, 2018). Therefore, focus groups (n=2) were deemed appropriate for obtaining data for this research. In addition, focus groups elicit shared experiences from participants who share comparable traits (homogeneous sampling) through group dynamics whilst producing a breadth of understanding of their experiences and perceptions.

There are caveats about using focus groups compared to individual interviews, which can be less effective in terms of covering a specific topic in-depth. Creswell and Creswell (2018) suggest that a particular disadvantage of a focus group is that the participants may not share their honest, genuine thoughts on the issues discussed, and

may hesitate to voice their opinions, especially if these differ from those expressed by the other participants.

Semi-structured Interviews

Semi-structured interviews are considered appropriate when little is known about a phenomenon or a detailed understanding of it is required (Moser and Korstjens, 2018a). Semi-structured interviews (n=12) were the second source of data collection, to gain a clearer understanding of the significance of the participants' experiences and an in-depth impression of the phenomenon from their perspective.

The rationale for using focus groups before the semi-structured interviews is that the views discussed during focus group discussions can be followed-up through semi-structured interviews (Gray, 2014). At the same time, the individual interviews produced an in-depth understanding, with the opportunity to use follow-up questions. This was particularly helpful in teasing-out the relationship between the professional values and clinical placement experiences of the participants.

1.6.2. Analytical Framework

The previous section discussed the methods employed in this research. This section will explore the analytical framework of Thematic Analysis using Braun and Clarke (2006, 2013) before presenting the key findings of the research.

Braun and Clarke (2006) assert that Thematic Analysis (TA) intends to capture a level of pattern-matching or themes in relation to the research question(s). The methodology chapter elaborates on the analytical framework (Chapter 4). When answering the research questions, TA was considered the most appropriate approach for capturing the themes across the data sets reflecting the GEN student participants' collective experiences and perceptions. whilst not losing the nuances of the individual participants' responses, which were drawn out using excerpts from the data.

TA was chosen over content analysis because the latter focuses mainly on the quantification of data. For example, content analysis counts the number of times a code is used in a data set. In comparison, TA explores the patterns and themes across a data set (Braun and Clarke, 2013). That said, TA is not without drawbacks and the

phased approach of the analysis can be viewed as a limitation; for example, the phases may fail to capture the actual meaning of a complex narrative (Kiger and Varpio, 2020). Nowell et al. (2017) suggest that the use of themes can dilute the participants' individual identities. Nevertheless, TA effectively fulfilled the aims and objectives of this research.

1.7 Key Findings

There was a complex interdependent relationship between the participants' clinical placement experiences and their professional values. Their clinical placement experiences allowed the participants to practise their professional values. In return, their professional values allowed them to approach and understand their clinical placement experiences. It is within this relationship, the participants defined their professional values and identified experiences, such as nursing care and clinical mentors, as a crucial aspect of understanding their professional values. The key findings are discussed in further detail in the findings Chapter 5.

These key findings are as follows:

- Overall, the participants' definitions of professional values were related to delivering quality nursing care, maintaining patient safety, and acting as a patient advocate.
- The participants identified the two most significant clinical placement experiences that had a relationship with their professional values as their experiences of nursing care related to their professional values and their experiences of engaging with their clinical mentor.
- The implications of the participants' clinical placement experiences for their professional values were twofold: their emotional awareness and emotion management related to their professional values as future nurses.

This research adds new knowledge about the GEN student participants' understanding of their professional values and capacity to identify certain professional values that were related to their clinical placement experiences. The findings point out that clinical placement experiences enhance the definitions of the professional values grounded

within them and provide a unique view of their emotional awareness and management while working under the pressure of the current NHS constraints. Furthermore, demonstrating practice resilience and tenacity will stand them in good stead to become future leaders and managers of the NHS and also reflects the crucial role assigned to clinical placements.

1.8 Significance of this Research

The significance of this thesis is that it challenges the nursing profession to identify and recognise professional values of GEN students in contemporary nursing practice. The data identify the detailed day-to-day experiences that student nurses encounter when striving to operationalise their professional values and the importance of well-structured, organised, and well-facilitated clinical placements. This research demonstrates that professional values are intrinsically linked to the personal values of the individual, which is further discussed in Section 5.7.1.1. In addition, there exist contradictions between the professional values of the student nurses and the values of the NHS to deliver quality care. The findings of this thesis identify challenges related to operationalising professional values in the clinical placement environment, that is responsive to cultural and organisational change. Any attempt to embed professional values in the clinical placement environment requires a strategy that recognises and alleviates the organisational constraints.

1.9 Structure of the Thesis

This thesis consists of seven chapters arranged to present the various phases of the research process, as illustrated in Table 1.

Table 1: Structure of the Thesis

No	Chapter	Content
1	Introduction	Overview of this research, aim and objectives, research question, and outline of the methodological approach and key findings.
2	Background	Overview of the GEN programme, role and function of clinical placements, nature of values, and setting the scene for the rest of the thesis.
3	Review of the Literature	Critique of the existing literature that guided and influenced the research questions and research design. The themes identified from the review are presented, while identifying the gap in the research field.
4	Methodology and Methods	Justification for the research approach and the reasons for adopting a qualitative interview study design. Focus groups and semi-structured interviews were used as the data collection tools, followed by Thematic Analysis.
5	Findings and Analysis Section 1	Overview of the participants' profiles and analysis of their personal values.
	Findings and Analysis Section 2	The findings related to the three sub-questions. A significant, complex relationship was found between the GEN student participants' clinical placement experiences and professional values.
6	Discussion of Findings	The penultimate chapter discusses the key findings in relation to the research sub-questions and available literature.
7	Recommendations and Conclusion	The final chapter concludes with my reflexivity, original contribution to knowledge, and limitations of this research including recommendations.

Source: (Author, 2023)

1.10 Chapter Summary

This chapter provided an introduction to and overview of this thesis. The following Chapter 2 positions the background information of the GEN programme, experiences of mature students, associated developments in nurse education and the nature of values.

Chapter 2: Background

2.0 Introduction

This chapter provides a background for this research, beginning with a brief overview of nurse education and the shared experiences of Graduate Entry students. The nature of GEN programmes follows and the vital role of clinical placements in supporting professional values. I then discuss the nature of values, focussing on a psychological and sociological perspective, which has addressed the historical development of values. This is followed by the professional values in nursing and the healthcare system in the UK. The final two sections discuss the professional regulatory body's professional values in the form of the NMC Code (NMC, 2018a) and the Code of ethics (ICN, 2012) concluding with the NHS's values.

2.1 Brief Overview of Nurse Education

The past two decades has seen significant changes to nursing and nurse education, transforming it from vocational training at the bedside that was struggling to identify itself as a profession into a professional discipline (Sellman, 2011). It should be acknowledged that there exist international differences between the perceptions of nursing as a profession. Countries such as Australia, the USA, and Canada understand the nursing identity in a similar way to the UK. Hence, the UK context of professional values will be explored because it underpins my research environment. However, the internalisation and operationalisation of professional values of nursing remain influential internationally too. The debate continues about how best to develop, deliver, and monitor the quality of nursing and midwifery education programmes in the UK, emphasising professional values and behaviour (NMC, 2018a). The Nursing and Midwifery Council (NMC) is central to the leadership of nurse education and professional regulation of RNs and midwives in the UK. The NMC requires that nurses and midwives work within the Code of Professional Standards of Practice and Behaviour (NMC, 2018a), which is a set of standards that incorporate professional

values and behaviour to safeguard the public. Hence, the Code also serves as a benchmark for the professional values that nurses should uphold (NMC, 2018a).

Preceding the year 2000, nursing followed an apprentice model, where nurse training took place in teaching hospitals. Students had two options: complete a two-year programme and qualify as a State Enrolled Nurse (SEN) or complete a three-year programme and qualify as a State Registered Nurse (SRN). While on these two programmes, student nurses were considered part of the workforce (Traynor, 2013). The commencement of 'Project 2000' saw the abolition of the SEN training (Traynor, 2013). The delivery of nurse education was transferred to universities, and the Diploma in Nursing became the minimum academic level for registration with the NMC. Students were given supernumerary status when undertaking clinical placements and were not counted as part of the workforce. By 2010, the NMC (2010) announced that all pre-registration nursing programmes would last three years, with an equal length of theory and practice hours. It was not until 2013 that the NMC proclaimed that all pre-registration nurse education would be provided at degree level. Arguably, this is when nursing joined the professional ranks, in line with other healthcare professions in the UK. Traynor (2013) asserts that the nursing profession had to demonstrate a professional contribution and, therefore, adopt nursing models and emphasise evidence-based nursing care. Sellman (2011) suggests that professional nursing values are the principles that are congruent with human dignity, integrity and caring, which are overseen by a professional framework such as the NMC Code, meaning that a standard set of professional values is symbolic of excellence and should be integrated into the nursing profession.

2.2 The Nature of GEN Programmes

The concept of graduate nursing, referred to as an undergraduate degree in nursing, dates back to the 1960s in the UK (Allan and Jolley, 1982). The University of Edinburgh was the first HEI to deliver a degree programme in nursing (Marsh, 1976; Brooks, 2011). Altschul (1987) refers to a two-year, experimental nursing programme introduced at St George's hospital for graduates in the early 1960's, which was arguably the beginning of the GEN programmes that we know today. GEN programmes

are accelerated or fast-track two-year nursing programmes. According to Raines and Sipes (2007), the rationale behind GEN programmes was three-fold: firstly, to address the shortage of nurses; secondly, to increase the number of graduate 'ready' nurses at the point of registration; and, thirdly, to attract a diverse range of graduates into the nursing profession. The rationale for GEN programmes remains much the same today (Jamieson et al., 2020; MacDiarmid et al., 2021).

Placing the GEN programme into the wider context of other nursing programmes, until recently the route into nursing was limited to the BSc degree programme (three years) in the UK with an option to undertake an additional year of study to complete an integrated master's programme MNurs (four years). This was viewed as the main route to becoming an RN. However, nursing now offers multiple routes into the profession, such as the nursing apprenticeship degree (four years), nursing associate programme (two years), and the direct entry Master of Nursing MSc (two years), which is also referred to as the GEN programme (HEE, 2019b). As a result, the nursing student population is becoming increasingly heterogeneous in terms of ethnicity, maturity, educational background, and work experience, with a shift away from student cohorts who traditionally comprised young, female school leavers.

GEN programmes are gaining momentum in the UK and remain an attractive option for the nursing profession due to the shorter duration (DoH, 2016). Nevertheless, nursing programmes in the UK are inevitably controlled by the needs and demands of the NHS, the availability of finance, and the vision for nurse education at the time (DoH, 2016), which means that nurse education programmes are governed by education and healthcare needs that eventually dictate the direction of travel. However, other elements are at play, such as the availability of quality clinical placements and suitably prepared clinical mentors.

GEN programmes internationally are demonstrating traction too with unique variations, particularly in New Zealand (New Zealand Nurses Organisation), Australia (Australian College of Nursing), Canada (Canadian Association of Schools of Nursing) and the USA (American Association of Colleges of Nursing). There are differences that exist between the GEN programmes, and each country chooses a distinctive name to

represent and separate the GEN programme from other nursing programmes. Examples include the GEN programme; second-degree programme; accelerated (master's) in nursing programme; master's entry programme; non-traditional nursing programme, and Master's (MSc) in Nursing (Pellico et al., 2011; Doggrell and Schaffer (2016). The development of GEN programmes presents innovative nursing curricula designs from shared learning with other nursing programmes to interprofessional learning (Gertz et al., 2021). These variations in the programmes are based on the nurse education standards of the country and the healthcare plan; some variations include entry requirements, programme and placement duration and course structure, with some programmes offering a research component such as a dissertation and others not (Downey and Asselin, 2015, Everett et al., 2013). Some GEN programmes require a pre-programme anatomy and physiology module for students that do not hold a health-related degree (Gertz et al., 2021). By contrast, some GEN programmes require accreditation to prior learning (ALP) to be mapped to the GEN programme standards and have the requirement of prior healthcare experience (Stacey et al., 2014).

The GEN programme at my institution accepted graduates with a previous degree in a Health Science-related subject and or a first or second upper-class degree classification. The graduates must have at least one year of healthcare experience prior to applying and this should equate to having at least seven hundred and eighty hours upon starting the programme. One hundred and fifty of these hours must be worked under the supervision of an RN who can sign off against the proficiencies for stage one of the BSc programme. Those graduates without a health-related degree were required to map their prior learning to a set of learning outcomes by demonstrating and providing evidence that they had completed all of the required learning outcomes for the first part of the programme. The GEN programme provides students with lengthy clinical placements, ranging from sixteen to twenty weeks, in various healthcare settings. These extended clinical placements provide the opportunity to develop clinical knowledge, professional values, clinical skills, and critical reasoning through the process of professional socialisation (Lee and Yang, 2019). In addition, the GEN programme was developed using creative and innovative teaching, learning and assessment strategies, for example, problem-based learning (PBL), high fidelity

simulation, and assertion-reason questioning (ARQs) to assess and build on their graduate skills. The GEN programme was developed to better prepare students for the current challenges that face the nursing profession (Jamieson et al., 2020; MacDiarmid et al., 2021). The GEN students were taught and assessed at a higher academic level (level 7) than other nursing programmes to ensure a high level of criticality and analysis was obtained. The cohort intakes were markedly smaller than those for the BSc nursing programmes; this was due to the programme being newly developed at the time. By the nature of the GEN programme, it is intensive and fully loaded, alternating theory and clinical placement blocks to ensure the NMC standards for education (NMC, 2010) were met within two years. This GEN programme typically enabled graduates to complete with a Post-Graduate Diploma in adult nursing (PGDip Adult Nursing) within two years instead of three and gain professional registration with the NMC.

2.3 The Nature of Clinical Placements

Clinical Placements are a physical setting, often associated with organisational values that are influenced by political, economic, and social factors (Karimi et al., 2014). Clinical placement experiences in this research are the point where theory and practice meet; for example, learning opportunities become available, and a practice assessor (referred to as a clinical mentor) facilitates and supports learning and assessment (RCN, 2017). The Clinical Placement Environment (CPE) represents a dynamic element of acquiring and developing professional values (Baldwin et al., 2014).

Clinical placements are generally anxiety-provoking experiences for many student nurses for several reasons: a lack of confidence, lack of experience, the unfamiliar environment, new terminology, and a fear of the unknown (Neill, 2011; Aubeeluck et al., 2016). Therefore, it is crucial to understand the nature and importance of the clinical placements against the backdrop of the current national shortage of nurses in the UK (DoH, 2016). The nursing profession is under strain due to a lack of funding, limited bed availability, the decreasing number of nurses, and an ageing population with complex health needs (DoH, 2010). A greater demand is placed on student nurses in the clinical placement environment, particularly the GEN student group, with clinical

placements lasting as long as six months (Neill, 2011). The clinical placement is significant and provides a realistic introduction to the nursing profession and the challenges upon entering it. Brown et al. (2012) claim that clinical placements are fundamental to how students construct their professional development as they enter the nursing profession. The process of professional development can be viewed as a continuum whereby student nurses gain knowledge, skills, confidence and an identity that is congruent with the nursing profession as they progress towards professional registration, further iterating the vital role clinical placements have on student nurses' experiences.

In the UK, nurse education programmes are split equally into 2,300 theory and 2,300 clinical placement hours (NMC, 2018a). The time spent on clinical placement is so significant that it affects whether students stay on the nursing programme (Crombie et al., 2013). The purpose of clinical placements is to gain knowledge from real-life experiences and acquire clinical skills, critical reasoning, and the ability to balance knowledge with the skills learnt (Neill, 2011; 2012). Hence, the role and purpose of clinical placements remain vital in supporting professional values, clinical skills acquisition, critical thinking, and decision-making (Dinmohammadi et al., 2013).

Although the CPE is essential, it is not without challenges; it is fraught with the longstanding issues of a lack of resources and often an unpredictable real-life environment (Neill, 2011; Courtney-Pratt et al., 2012; RCN, 2020). Undoubtedly, all of these situations provide challenges for student nurses, at the heart of which lie professional values. That said, the importance of clinical placements in nurse education remains undisputed because it is within the CPE that the reality of nursing is experienced, seen, and heard (Courtney-Pratt et al., 2012; Baldwin et al., 2014; Stacey et al., 2015; Papastavrou et al., 2016). Examples of CPE in this research are Intensive Care Unit (ITU), Accident & Emergency (A&E), community-based care or in a patient's home and the General Practice (GP).

2.4 The Nature of Values

Kaya and Boz (2019) created a model to understand and apply professional values within the nursing profession consisting of three concepts: individual values,

professional values and nursing care quality. This thesis proposes a model that contains four main concepts: personal values, professional values, professional regulatory values and NHS values, to understand and apply professional values within the nursing profession. Each of these four concepts will be discussed in turn in this chapter, beginning with the nature of values.

The nature of values, also known as axiology, comes from the Greek word *Axios* meaning worth, goodness or value (Rokeach, 1973). This view complements the Greek philosophers Socrates, Plato, and Aristotle's view that values represent beliefs that guide actions that help us determine the worth, goodness, or value that is inextricably linked with society because values influence behaviour (Barker, 2012). Value theories have been a feature of the social sciences from the early twentieth century, with the inception of the work of Emile Durkheim (1964), providing a religious connotation to the social phenomenon of values. A later theorist Rokeach (1973, p5), a social psychologist, studied the nature of values and provided the following definition, "*An enduring belief that has a specific mode of conduct or end-state of existence is personally or socially preferable…*". The definition suggests a connection between beliefs, personal and socially accepted values. Rokeach accepts that values can change and develop over time because they consist of cognitive, affective and behavioural elements (Rokeach, 1968). Hence, Rokeach (1973) developed a values instrument called the Rokeach Value Survey (RVS) to measure the importance of values in any given situation. Schwartz (2012, p3), also a social psychologist, describes values as "*desirable goals that motivate action*". This implies that values are motivated by the pursuit of goals, and so limited to broad motivational aims. Schwartz (1992) argues that values are influenced by education, society, and professional groups by their very nature. As such, Schwartz (2012) offers ten motivational values that are linked to each other in a circular pattern, signifying the motivation that each value articulates; however, some values are more significant than others to an individual at any given time.

A definition offered from a nursing perspective by Rassin (2008, p614) described values as "*what is right, good or desirable and motivated by both social and professional values*". This definition indicates that values guide individuals or groups to decide what

is important to them. Defining values has posed challenges because values are related to morals, beliefs, and needs. For example, when faced with a dilemma, one should ask not what I can do but what I should do. However, values remain a contested concept in the literature, offering philosophical and psychosocial perspectives.

An alternative perspective of values is offered by Beauchamp and Childress (2012), referring to ethics or biomedical ethics. They identify four biomedical ethical principles: autonomy, beneficence, non-maleficence, and justice. Autonomy refers to respecting an individual's view by making informed choices. Beneficence means acting in the patient's best interest and so may conflict with autonomy. For example, a patient may decide on the best treatment option for them at the time, but the healthcare professionals may disagree based on their knowledge and experiences. This means the patient may be denied the right to autonomous decision making. Thus, beneficence entails carefully considering the benefits and risks while respecting the patient's decisions. Non-maleficence is the avoidance of causing harm to a patient. Arguably, all treatment options involve a degree of harm; nevertheless, the harm must not outweigh the benefits of the treatment. Finally, justice means equally sharing the risks and benefits, such as the idea that patients in comparable situations should be treated similarly. The principles of biomedical ethics are closely linked to values, in the view that ethics considers behaviour either right or wrong and values consider beliefs, needs and motivation. Moreover, values are viewed as an important element to an individual (Rokeach, 1973). The following two sections will explore personal values before discussing professional values.

2.5 Personal Values

Personal values are the elements that are important to an individual, such as their beliefs, that guide the behaviour and decision-making in an individual's life (Rokeach, 1973). Blais and Hayes (2016) suggest that the development of personal values begins in the early life stages of an individual through the progression of socialisation. These personal values are learnt and influenced by the family, society, culture, religion, politics, and economic status (Blais and Hayes, 2016). The influences on the development of personal values are far more significant on the individual, often involving more than one stimulus. Furthermore, acquiring personal values is a

continuous process of gaining and exhibiting beliefs and behaviour that are central to the individual's functioning within the immediate community and beyond. Personal values are influenced by unique perspectives of an individual's needs and motivation (Schwartz, 2012).

Rassin (2008) asserts that personal values are intrinsically developed needs that are rationally expressed through behaviour. When personal values are developed, it impacts on the actions taken and decisions made in any situation. On that basis, when an action is taken or a decision made, it may reflect what has been developed and holds true for the individual at the time. Therefore, one might argue that personal values guide an individual's beliefs and behaviour and offer a sense of individuality. Nevertheless, developing personal values is not a quick, one-off process but a steady, lifelong process for an individual. Rassin (2008, 2010) further suggests that personal values are an assortment of beliefs that guide an individual's behaviour and choices in life. That said, Rassin (2010) acknowledges other vital aspects that affect nurses' personal values, such as their level of education and number of years of experience. All of these are important because they influence nurses' decision-making, behaviour, and even the type of care they provide. Personal values may be less susceptible to change because they provide structure, motivation, and purpose for the individual, which have developed over a long time. It is critical to understand personal values before identifying and understanding professional values because personal values are the internal compass of an individual (Rassin, 2008). Professional values, on the other hand, are acquired through professional groups, which have been described as inherently complex in nature (Norman, 2015).

2.6 Professional Values

Professional values are the elements that guide the professional behaviour within a professional group (Moyo, 2016). In nursing, professional values are vital because they translate into professional activities that direct nursing care and decision-making, thereby influencing patient care (Moyo et al., 2016; Shafakhah et al., 2018). The definitions and understanding of professional values were varied in the studies reviewed. Leners et al. (2006) defined professional values as the worth (importance) and quality (value) of beliefs and behaviour within a discipline. They are suggesting

that professional values are concepts that give meaning and assist with the navigation on a professional level in nursing. Therefore, professional values can be viewed as an instrument to define the quality of nursing care. Gallegos and Sortedahl (2015) offer a similar definition of professional values to Leners et al. (2006) as a requirement set by a professional regulatory body that serves as a framework for assessing and measuring behaviour.

Weis and Schank (2009) define professional values as standards for activities that experts and professional groups prefer. The definitions offered by Weis and Schank (2009) and Gallegos and Sortedahl (2015) both adhere to the professional values of a professional group or body. The difference is that Weis and Schank (2009) focus on professional values as the standards of action preferred, whereas Gallegos and Sortedahl (2015) suggest that professional values serve as a framework for assessing behaviour.

Professional values are an essential aspect of the NMC Code. Thus, professional values translate into a commitment to uphold the profession's reputation and act as a role model for others to aspire to; for example, maintaining the professional values of trust and confidence from those receiving care, other professionals, and the public. The NMC offer the following explanation:

> *Uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public (NMC, 2018a, p18).*

After considering the different definitions of professional values, the following definition of professional values is employed throughout this thesis: professional values are standards for behaviour that guide individuals and professional groups.

Examining the complex nature of professional values is vital to ensure that quality care is not compromised within an already challenged NHS. Parvan et al. (2012) and Kim et

al. (2015) report that professional values remain vital in decision-making, the delivery of quality nursing care, and maintaining patient safety. Moyo et al. (2016) advocate that a link exists between an individual's personal and professional values. For example, soon after an individual accepts a professional role, their conduct in the work environment is guided by their personal and professional values. However, their personal values remain important to the individual and influence their professional practice (Moyo et al., 2016). Rassin (2010) supports the notion that professional values are less straightforward, as individuals have personal values while they try to negotiate and make sense of their new professional values. There comes a time when 'value incompatibility' occurs, when the professional values do not connect with the personal values in the CPE. Section 5.8.1.1 demonstrates some of the challenges that the participants in this research experienced when navigating their personal and professional values in the CPE. Rassin (2010) referred to this as 'conflict' between personal and professional values. The extent of this conflict can vary between individuals within the clinical environment to the point where the individual cannot separate their personal and professional values (Rassin, 2010; Sellman, 2011). Schwartz (2012) affirms that, while some individuals can modify their existing personal values to bring them into line with the profession as they take on a new role, other individuals adopt professional values that are aligned with their personal values to make them less tenuous and prevent conflict in the CPE.

The nursing profession demands that individuals reflect on their personal and professional values to ensure that the decision-making and patient care remain in the patient's best interests (Sellman, 2011). However, Sellman and Snelling (2016) suggest that nursing is also charged with ensuring the financial efficiency of care and essentially balancing the cost, quality, and professional values while trying to deliver high-quality care. One might argue that the financial pressure on the nursing profession can only bring about further conflict between quality care and professional values. Nevertheless, Sellman (2011) suggests that professional values can be a problematic area to prove in a busy, challenging CPE because it is open to the individual's interpretation and operationalisation. For example, trust can mean different things to different individuals depending on how it is interpreted and applied. Hence, examining the professional values of student nurses as future registered nurses

can only help to improve patient care, decision-making and patient safety (Donmez, and Ozsoy, 2016; Ayla et al., 2018; Arries, 2019; Çöplü and Kartin, 2019).

So far, I have discussed the nature of personal and professional values. Next, I will examine the professional regulatory values of the Nursing and Midwifery Council (NMC) Code and International Council of Nurses (ICN) Professional Code of ethics and conclude by discussing the NHS's values and the current state of nursing.

2.7 Professional Regulatory Values

Professional Codes of Conduct and Professional Codes of Ethics embrace professional values explicit to the nursing profession (NMC, 2018a and ICN, 2012). The NMC Code is referred to as 'the Code' throughout this thesis. It is a document that contains professional standards for nurses, midwives, and nursing associates to practise in the UK. The Code (NMC, 2018a) serves as a legal, binding document upon entering the nursing profession, that is structured around four principles, which relate to and encapsulate professional values: prioritise people, practise effectively, preserve safety and promote professionalism and trust. The current version of the Code (NMC, 2018a) was developed as a response of the recommendations of the Francis Report. Applying the Code's principles undoubtedly reflects the need for a constant commitment to high-quality care and patient safety, in addition to the readiness to uphold high standards, raise concerns and challenge those responsible for poor practice (NMC, 2018a). Nurses across the profession are required to promote professional values, demonstrate compassion, kindness, knowledge and skills to support the principles of the Code. Nevertheless, despite the strong presence of the Code, there is a need for professional integrity and professional values to take the forefront in all the tasks that nurses are expected to perform.

The International Council of Nurses (ICN) represents nurses worldwide to support and promote the nursing profession. The ICN campaigns for nurses' well-being and endorses health in healthcare policies for all. The ICN (2012) Code of ethics has four principles, similar to the Code: nurses and people, nurses and practice, nurses and the profession, and nurses and co-workers. The ICN Code reported the expectation that "*The nurse is active in developing and sustaining a core of professional values*" (ICN,

2012, p3), while also providing explicit examples of professional nursing values "*such as respectfulness, responsiveness, compassion, trustworthiness and integrity*" (ICN, 2012, p2). In addition, the ICN Code provides helpful examples of how the four principles could be applied and operationalised in the clinical setting (ICN, 2012, p6-9).

Professional values are viewed as a social construct and no doubt mean different things to different nurses because of how they are interpreted and operationalised, especially due to the increased changes in healthcare, the complexity of care, patient safety, and the service users' experiences (Borhani et al., 2010; McKenna et al., 2017). That said, the Code remains a set of principles that promote professional values. On the one hand, the Code is helpful as it provides a standardised set of principles yet, on the other hand, it remains open to interpretation. The onus lies on the individual to understand and operationalise their professional values and remain accountable for their actions or non-actions. Wiechula et al. (2016) argue that nurses' professional values ultimately translate into the experiences to which the patients are exposed in the CPE. Tension may exist between what the Code represents and what student nurses experience on their clinical placements regarding their professional values. The findings from this research presents some of the tensions experienced by the participants in Section 5.7.1.2. The Code may be regarded as unhelpful in resolving the ethical or moral dilemmas faced by student nurses on a daily basis in the CPE. It would undoubtedly be beneficial to have a guide or related text similar to that of the ICN (2012) from the NMC for clinical mentors and student nurse's to draw on when applying professional values. To apply the principles of the Code, it must be understood and applied to the realities experienced on a daily basis. Nevertheless, I believe that the Code demands respect and admiration for those who struggled for nursing to be recognised as a profession.

2.8 The NHS Values

In recent years, the NHS has placed a greater emphasis on professional values. Following the Francis Report (2013), the professional values within nursing were called into question; the NHS was required to respond to the lack of standardised professional values. The NHS Chief Nursing Officer for England, Professor Jane

Cummings, introduced a strategy referred to as the 6C's (Care, Compassion, Courage, Communication, Commitment and Competence) in a document called 'Compassion in Practice' which are the values to be adopted in CPE (DoH, 2012). The 6C's are identified as being the foundation or core of the professional values which are essential in nursing. 'Compassion in Practice' was to be used alongside the existing Code at the time. The existence of two documents would undoubtedly have caused confusion for the nursing profession and possibly rendered the Code of lesser importance (Sellman and Snelling, 2016). However, the 6Cs aimed to create a consensus about professional values across health and social care staff in England, not just for nursing. Nevertheless, it is notable that there was no mention of the Code in the document.

Against the backdrop of the publication of the 6C's, the NMC and General Medical Council (GMC) jointly issued a statement through NHS England in 2012, designed to remind healthcare professionals of their commitment to uphold their professional values constantly. This represents yet another attempt by the profession to address the need for a lack of consistent professional values amongst healthcare professionals. The statement continues that "*healthcare professionals need to demonstrate compassion and kindness as well as knowledge and skills…"* (NMC and GMC, 2012, p2). Before reminding doctors, midwives and nurses that they all share similar professional values, then referring each professional group to their respective professional regulatory Code. The joint statement concludes by acknowledging the challenges faced by "*Doctors, Midwives and Nurses today are very different from those faced by their predecessors but the human values that underpin these professions remain constant…"* (NMC and GMC, 2012, p2).

In 2016, following a meaningful consultation, the Chief Nursing Officer for England introduced yet another strategy to ensure that professional values were part of the NHS culture called 'Leading change, adding value' (NHS, 2016). This strategy was forward-thinking and incorporated leadership into three main sections: health and well-being, care and quality, and funding and efficiency. It is noteworthy that the strategy was presented and referred to as "*the ten commitments that will underpin our leadership today and help us shape the provision in the future*" (NHS, 2016, p7). The

ten commitments have an almost biblical connotation, similar to the ten commandments, demanding respect as the divine law that, therefore, should be accepted. The strategy does not stop there but refers to the 6C's, which purport to support and complement the 'leading change, adding value' strategy. Considerable significance was placed on the 6C's as acceptable professional values within the NHS, which represented "*the foundation of our value base*" (NHS, 2016, p7). Only minor consideration is given to the meaning and operationalisation of professional values and how they can be enacted in the challenging economic and political climate of the NHS. It becomes evident that a single document is required to demonstrate the set of consistent professional values that are applicable to all healthcare professionals.

2.9 Values of the NHS's Constitution

The NHS's Constitution DoH (2013) outlines the NHS's principles and values in England. The Constitution establishes the rights of patients, the public, and staff, as well as the NHS's commitment to these three groups. The values of the NHS Constitution consist of "*Working together for patients*" (patients always come first), "*Respect and dignity*" for all, "*Commitment to quality of care*" (striving to provide quality care), "*Compassion*" (central to all care provided), "*Improving lives*" (striving to improve health and wellbeing) and "*Everyone counts*" (ensuring everyone is included and that no one is discriminated against) (DoH, 2013, p5). These values apply to everyone in the NHS, even those that do not belong to a professional regulatory body, in order to establish a shared vision and common understanding of the type of care delivered within the NHS.

The NHS also employs a values-based recruitment policy HEE (2016) to identify and recognise the values of the registrants during their pre-employment eligibility to ensure compatibility with the values of the NHS organisation. HEI and the NHS must work in partnership to ensure that student nurses' personal and professional values are examined to ensure the sustainability of the nursing profession. Hence, organisations like the NHS and the clinical mentors within the organisation have a responsibility to ensure that their professional values are aligned with the nursing profession to support the next generation of nurses. If the NHS and HEIs fail to recruit student nurses and registered nurses who uphold compatible professional values,

there is a risk that the Mid-Staffordshire hospital incident will be repeated (Francis, 2013).

Nevertheless, despite the 6C's, NMC Code, and the NHS's values and the NHS Constitution the efforts to embrace professional values are only effective if all staff internalise them and have the capacity to enact them in a meaningful way. However, minimal emphasis is placed on understanding the meaning and significance of professional nursing values and how they might be implemented in the difficult current economic environment.

2.10 The Current State of Nursing in Relation to Professional Values

Following on from and as a result of the Francis Report (2013), various initiatives were implemented by the NMC (2018a, 2018b, and 2018c), RCN (2017 and 2020) and NHS (DoH, 2012 and DoH, 2016). This presented opportunities to learn from the CPE and to support the development and implementation of professional values across the healthcare sector. Due to the current shortage of nurses and the recent tumultuous political climate adding to the already overstretched NHS, the nursing profession is in dire straits, struggling to ensure patient safety, safe staffing levels, evidence-based care, and maintain professional values for all patients accessing the NHS—demonstrating the long-standing political resistance towards funding Health and Social Care reforms in the UK, coupled with the pressure created by a global pandemic (Covid 19). This matters because professional values predict the quality of care that patients receive (Riklikiene et al., 2018; Kaya et al., 2017).

We are living in unprecedented times in that the RCN (2022) has called for strike action for the first time in 106 years, where thousands of nurses and midwives took to the picket lines across England, Wales and Northern Ireland because of low pay and staff shortages making patient care unsafe. The current Health and Social Care secretary Steve Barclay expressed his disappointment that union members had chosen to take strike action. While strike action is in no one's best interest, least of all patients, he further urged unions to reconsider the strike action before walkouts had a worse impact on patients (RCN, 2022). This reflects the current political situation and its implications for the ability to deliver safe patient care and operationalise professional

values to a high standard. The NMC (2018a) suggest the need for all registrants to provide leadership in their role, including being able to articulate concerns about service provision and political decisions that may have an adverse impact on care provision. This implies that the NMC supports a pro-activist position, despite the negative political backlash to silence nurses. Nursing remains one of the most trusted professions, equipped with the skills to actively engage locally, nationally, and internationally. Nursing is ideally positioned to influence the future of Health and Social Care globally. If the nursing profession is to make a change and put professional values at the heart of delivering quality care, the time to act is now.

Nevertheless, the NMC (2018c) remains responsive to change. In 2019 the NMC implemented the Standards for Student Supervision and Assessment (SSSA) model. The SSSA model is significant as it offers a new practice support model with a change to the name and role of the clinical mentor, referred to as Practice Assessor (PA) and Practice Supervisor (PS). The roles are separated to ensure students receive high-quality learning, support and supervision during their practice placements. The PA is responsible for assessment decisions informed by feedback sought and received from the PS. While the PS is responsible *"for safe, effective and inclusive practice, enabling students to learn and safely achieve proficiency and autonomy in their professional role*" (NMN, 2018c, p6). There is a crucial distinction in the roles, the PA and PS can take on both roles at any given time, but not simultaneously to assess the same student. Furthermore, there is a third person, known as the Academic Assessor (AA), that is appointed by the HEI and is responsible for working "*in partnership with the nominated academic assessor to evaluate and recommend the student for progression for each part of the programme*" (NMN, 2018c, p9).

The SSSA model is a welcome change to supporting student nurses and midwives in clinical placement; however, as with any practice support model, there are facilitators and inhibitors (Royal-Fern, 2019). The SSSA (2018c) model establish the precise roles and responsibilities of the PA and PS, ensuring transparency, so that student nurses and midwives receive high-quality learning, support and supervision during their clinical placements. In my institution, the placement documentation is online and can be accessed by the relevant PA, PS and AA at any time. Student learning and support

benefit from the PS, who can come from a range of health and social care specialities, thereby providing a robust interdisciplinary approach to learning. This increases the scope of PS and may mean widening the placements offered to provide a variety of learning opportunities for nursing students.

The SSSA model requires the PA and PS to be adequately prepared and supported to effectively carry out their roles in the challenging CPE. It is necessary to ensure these roles are appropriately supported and maintained for consistency and to prevent role strain and burnout. Therefore, it is vital to coordinate the student experiences because of the vast range of PS that a student can be exposed to at any given time.

Ensuring that every clinical placement has a sufficient number of PAs, can be challenging due to the shortage of staff in most clinical areas. In addition, to prevent a 'failing to fail' situation, in which action is taken at the end of the placement, often too late to address concerns when the PA must decide to pass or fail the practice assessment component. Although it will require courage and dedication from individuals in PA roles, AA support may help decrease any risk by stepping in at crucial points during the clinical placement, that is, the middle and just prior to the end of placement. It is key to ensuring the SSSA model is clearly understood by all concerned in supporting the GEN student's learning and professional values in the CPE.

At the time of undertaking this doctorate the NMC (2008) Standards to Support Learning and Assessment in Practice document was in use, in addition to the international context of a mentor. The term "clinical mentor" is used through this thesis.

2.11 Chapter Summary

This chapter provided the background to understand this research, the GEN programme and the nature of values, followed by an exploration of personal and professional value. The professional regulatory Code and the NHS's values in supporting the professional values of healthcare professionals were discussed. The following chapter presents a scoping review of the literature. More specifically,

Chapter 3 provides an overview of the literature surrounding the professional values of student nurses and explores the related themes.

Chapter 3: Review of the Literature

3.0 Introduction

The previous chapter provided the context and background of this research. This chapter establishes a clear understanding of the state of knowledge and the current gaps in the field by identifying, analysing, and critically evaluating the literature associated with student nurses' professional values in the clinical placement environment.

3.1 Scoping Review Approach

The literature review adopted a scoping review approach to identify the themes, clarify the concepts and identify the knowledge gaps (Arksey and O'Malley, 2005). Scoping reviews are beneficial to synthesise knowledge when a body of literature has yet to be comprehensively reviewed (Peters et al., 2015). A scoping review follows an iterative process involving the five steps postulated by (Arksey and O'Malley, 2005).

3.1.1 Identifying Relevant Studies and Study Selection

A range of electronic databases and search engines were consulted to identify relevant studies, including but not limited to Medline (Ovid), the British Nursing Database, Cumulative Index Nursing and Allied Health Literature (CINAHL), Evidence-Based Nursing (EBN), Scopus (Elsevier platform), and Google Scholar (see Appendix 2 for the complete list of Databases searched – the reason and number of hits). As well as searching electronic databases, the bibliography and reference lists were searched to ensure that the relevant published studies were covered. Grey literature was drawn on to provide a complete review of the search process and gather a comprehensive notion of professional values extending beyond the nursing profession.

3.1.2 Inclusion and Exclusion Criteria

The following inclusion and exclusion criteria were adopted to provide a clear remit and focus for the search (see Table 2).

Table 2: Inclusion and Exclusion Criteria

The following inclusion criteria were used:	The following exclusion criteria were used:
• Articles concerned with professional values and/or student nurses. • English language. • Published from 2005-the present. • Peer-reviewed papers. • Primary studies. • Research methodologies including quantitative, qualitative, and mixed method approaches.	• Articles concerned with 'registered or qualified nurses' professional values. • Articles concerned with the development of professional values after qualifying as a nurse. • Articles concerned with an independent variable associated with professional values e.g., motivation, self-directed learning, etc.

Source: (Author, 2022)

3.1.3 Keywords and Samples of the Search Strategy

All the databases discussed were searched independently to identify appropriate literature. The search consisted of two phases, and employed the following search terms: 'graduate entry,' 'accelerated programme,' 'second degree,' 'fast track,' 'non-traditional,' and 'direct entry masters'. Due to the dearth of literature associated with GEN programmes and professional values, the search was widened to include 'BSc nursing,' 'undergraduate nursing,' and 'first degree'. Other search terms included: 'values,' 'professional values', 'student,' 'nursing,' 'practice placement,' 'clinical placement', and 'practicum'. The Boolean operators ('AND' or 'OR') and truncations* were used to combine searches up to theoretical saturation.

3.1.4 Critical Appraisal Techniques

Aveyard (2019, p102) asserts that a "*critical appraisal is the structured assessment of the strengths and weaknesses of a paper*". Indeed, critical appraisal tools aim to ensure that a rigorous, reliable and systematic approach is adopted when appraising literature. There are several documented methods for critically evaluating literature. The Critical Appraisal Skills Programme (CASP) (2013) is one such method, which was

released by the Public Health Resources Unit in the UK and is used to evaluate selected studies based on its methodological and analytical features. As a result of this programme, each methodological design has a distinct appraisal form. As such, this research drew upon the appropriate CASP tool to appraise the quality of the literature critically.

3.2 The Process of Data Charting

The process of data charting produced three hundred and thirty-two articles, of which the titles and abstracts were reviewed to see if they included the terms 'student nurse/s' and 'professional values'. After removing duplication and irrelevant articles, seventy-five articles were critically reviewed. Forty-nine articles were excluded. Six articles were reviewed as having one or more independent variables associated with professional values: for example, professional values and critical thinking. Twenty-five articles were included in the final review. Appendix 3 shows the process of selecting the articles for review. The data extraction and collation process follow this section and can be viewed in Appendix 4. This process required returning to the articles selected and extracting appropriate information to meet the research objective by creating themes. The themes identified in the literature are presented and discussed in Section 3.5. However, before this, Section 3.3 examines the uniqueness of the GEN students and 3.4 considers professional socialisation in nursing to provide context to understanding the GEN student participant's professional values. Cohen (1981) recognises the importance of professional values as being a central concept within the socialisation process.

3.3 The Uniqueness of GEN Students

The Office for Students (OfS, 2019) refers to mature students as anyone over twenty-one years upon entering a pre-registration programme in the UK. While the student profile has changed over time, there has been little difference in the field of nursing, especially for GEN programmes, which attract more mature students into the profession (Neill, 2012; Stacey et al., 2016; Jamieson et al., 2020). Students choose a GEN programme for many reasons, including personal reasons, the location of the Higher Education Institution (HEI), the bursary system support, and a desire to become

a nurse and join the workforce within a shorter time frame (Koch et al., 2011; McKenna and Vanderheide, 2012; Stacey et al., 2015).

The literature suggests that mature students share personal characteristics, such as a desire to take ownership of their learning and apply critical thinking skills to become competent and knowledgeable in their field (Downey and Asselin, 2015; McKenna et al., 2017). Mature students on graduate programmes possess additional levels of education and significant work and personal life experiences. Hence, they are able to perform well academically, remain highly motivated, and draw on skills and knowledge from their previous experiences to support their navigation through the programme (Everett et al., 2013; Jamieson et al., 2020). The GEN student group appears focused on career progression and intends to remain in the profession for the foreseeable future (Everett et al., 2013). GEN students undoubtedly have a level of maturity, real-life experience, and perspectives that can bring about change in healthcare. Graduate Entry students across other disciplines, such as social work, radiography, and medicine, have demonstrated similar characteristics (Williams and Decker, 2009; Adu-Yeboah, 2015; Garrud and McManus, 2018).

More particularly, Graduate Entry Medicine (GEM) programmes have been established in the UK since the 2000s and continue to grow, much the same as the GEN programmes, due to the high calibre of students such programmes attract. The literature surrounding the GEM students' experiences and characteristics is well documented and they share similar characteristics, motivations, and uniqueness to the GEN students. Their previous work and study experiences fosters hard-working, focused and motivated students, which allows them to recognise and find different ways of working to thrive during the intense graduate programmes (Rapport et al., 2009). GEN and GEM students are well known for their ability to communicate, confidence, self-assurance, and determination to succeed in their studies (McKenna et al., 2017). This is because of the advanced skills they bring with them from their prior study and life experience are considerable, making them unique to the healthcare profession. GEN and GEM students can better manage patient contact, the pressures and demands of the accelerated programme, despite their many challenges as students on a healthcare programme. Their characteristics demonstrate the

uniqueness of graduate students with previous work, study and life experiences and the value they add to the health profession.

However, Baglow and Gair (2019) indicate that mature students experience more significant financial difficulties due to personal and family responsibilities. Adu-Yeboah (2015) demonstrates that Graduate-Entry programmes are just one aspect of the widening participation initiatives and are more likely to attract female students. As a result, these students experience additional stress because of trying to balance multiple competing roles. Williams and Decker (2009) assert that, while mature students are motivated during the programme, they need to prepare for the challenges related to the clinical placement areas and the associated workload, consequently experiencing conflict between managing their academic work and clinical placement simultaneously. Despite these challenges, Graduate Entry students remain highly motivated, organised, and determined to complete their programme (Garrud and McManus, 2018; McKenna and Vanderheide, 2012; Stacey et al., 2015).

3.4 Professional Socialisation in Nursing

An essential element of developing professional values occurs as a result of the professional socialisation process, which comes to fruition during clinical placement experiences (Coplu and Kartin, 2019). Socialisation is a process that begins in the early part of life by learning norms, values and roles within families and the subcultures within that particular group (Dinmohammadi, Peyrovi, and Mehrdad, 2013). Professional socialisation in the literature uses surrogate terms such as professional preparation, professional adaptation, acculturation, assimilation, and professional absorption. Sadeghi Avval Shahr et al. (2019, p1) defined professional socialisation as:

> *A nonlinear, continuous, interactive, transformative, personal, psychosocial and self-reinforcing process that is formed through internalisation of the specific culture of a professional community, and can be affected by individual, organisational and interactional factors.*

This definition acknowledges that socialisation is more than just learning the skills and behaviour of a profession; it must also include a specific 'culture' of a professional group, and that values and norms are fundamental to knowing and understanding. Individuals must, therefore, internalise knowledge and skills, and develop a sense of professional and occupational identity, and subsequently, a commitment to the professional field. Perhaps, professional socialisation only begins when an individual joins a profession. The definition offered further suggests that a socially constructive nature is required in a profession, and getting involved in a community of practice is the antecedent of professional socialisation. Therefore, forming a professional identity and professional development become the consequences of professional socialisation.

Dinmohammadi, Peyrovi, and Mehrdad (2013) support this notion and suggest that socialisation in nursing is not linear and that other factors can affect the development of professional values. Such factors include personal characteristics, motivations, sociocultural status, and previous experiences, which all influence its formation (Shafakah, et al., 2018). Therefore, it is argued that some key attributes influence the professional socialisation of student nurses. Indeed, these key attributes contribute to internalising and developing a professional identity and acquiring professional values to develop behaviours that are suggestive of the nursing profession. The nursing profession must, recognise that GEN student nurses possess a strong desire to feel part of and belong to a team. In keeping with GEN literature, Downey and Asselin (2015) and Stacey et al. (2016) purport that GEN students experience complex and challenging situations in the CPE that require an intellectual approach to how they navigate their learning, and ultimately, their socialisation into the nursing profession. GEN students are known to share a standard set of characteristics that set them apart from students in other nursing programmes, including maturity, previous life and work experience, and a commitment to succeed (Jamieson et al., 2020). This has the potential to guide how GEN students make sense of their professional values and how they socialise during their clinical placements. Professional socialisation, therefore, is a crucial element in developing the professional values of student nurses.

Professional socialisation is nursing is complex and diverse. The following authors posit various theories that professional socialisation in nursing is a process that occurs in

phases, with some being circular in nature, Davis (1968); Cohen (1981); Simpson and Back (1979). Davis (1968) introduced the well-known doctrinal conversion model, referring to the conversion from a non-professional to a professional nurse through a six-stage process: initial innocence; recognition of incongruity; psyching out; role simulation; provisional internalisation and stable internalisation. From the initial stage of the innocence process to the final stage of stable internalisation, student nurses experience the values and culture within the clinical environment. It is interesting to note the importance of the role of the mentor in the form of role simulation in the socialisation process, as this point still resonates in the professional socialisation literature today (Gopee, 2016). Nevertheless, this model was condemned in the literature by Du Toit (1995) for not appreciating the pre-existing values and experiences that student nurses bring with them at the beginning of their nursing education. The concluding stages of the model offer an understanding of the socialisation process and the internalisation of the values and attitudes of the student nurses to such an extent that they can distinguish their professional identity from that of the profession.

Cohen (1981) proposed a four-stage model of professional socialisation as: unilateral dependence, negative independence, dependence/mutuality and interdependence. Movement through the four stages culminates with intellectual and emotional comfort at the forefront of the professional role (Cohen, 1981). Cohen's theory asserts that professional socialisation allows an individual to feel intellectually and emotionally at ease in their professional role while going through internal and external changes. Therefore, professional socialisation results when professional ideals and values are internalised. On the other hand, a three-stage model was proposed by Simpson and Back (1979) consisting of: pre-socialisation stage, formal socialisation and post-socialisation. The pre-socialisation stage starts before the student begins their nursing career with preconceived ideas from their social group or community of practice and the influence of public perceptions of nursing. The formal socialisation stage follows in developing student nurses from novice to professional. Students learn the professional code of behaviour of the professional group. The final stage is post-socialisation; the student nurses internalise the values and attitudes required of the role of a professional. The theories presented by Davis (1968), Cohen (1981), and Simpson and

Back (1979) agree that professional socialisation is learned within a group, and a powerful way to develop professional socialisation is to align with an established professional group. The theories discussed provide some insights into the process of professional socialisation in nursing and the impact it can have on developing professional values.

3.5 Summarising and Reporting the Results

The discussion in this section focuses on five main themes that emerged from the scoping review, which were: measuring professional values, student nurses' identification of their professional values, the factors influencing professional values in the clinical placement environments, education and experience related to professional values and, finally, the role of personal characteristics in shaping professional values. Each theme is discussed separately in the following sections.

3.5.1 Measuring Professional Values

Historically, nursing professional values have been measured in various ways, and the tools used to measure values are traditionally developed in the country of use, which is unsurprising, as values are known to be socially and culturally shaped (Rassin, 2010). The elements by which professional values were measured consisted of student nurses' general life values (Garvin, 1976; Garvin and Boyle, 1985; Self, 1987), work values (Ulrich, 1987) and nursing values (Eddy et al., 1994; Schank and Weis, 1990; Weis and Schank, 1997).

The more recent literature available on quantifying and measuring professional values uses a variety of tools such as the Nursing Professional Value Scale (NPVS), Nursing Professional Value Scale-Revised (NPVS-R) or Professional Value Scale (PVS) to measure professional values (Weis and Schank, 1997, 2000, 2009; Leners et al., 2006; LeDuc and Kotzer, 2009; Mazhindu et al., 2016). Weis and Schank (2000) developed the Nursing Professional Values Scale (NPVS), the most widely used tool for measuring nursing professional values, which was developed in conjunction with the American Nurses Association Code using a Likert-scale format containing 44 items. They tested five hundred and ninety-nine participants on two different nursing programs as well as

practising registered nurses. The tool proved to have a high reliability level of .94 within a two-week interval; the test-retest reliability remained .94, indicating a high level of reliability and validity. Due to the success of the NPVS tool, it has been adopted and revised in many countries, such as Turkey (Donmez and Ozsoy, 2016; Ayla et al., 2018; Kavradim et al., 2019), South Korea (Bang et al., 2011; Lee et al., 2020), Iran (Bijani et al., 2019; Poorchangizi et al., 2019a and b) and Spain (Bleda et al., 2020).

Mazhindu et al. (2016) offer a new addition to the tools to measure future nurses' professional values and professional identity within the UK context to ensure the suitability of individuals that enter the nursing profession. The tool offered is referred to as the Nurse Match Instrument and was developed using Identity Structure Analysis to verify an individual's match to the tool. The tool was developed in combination with philosophical and theoretical influences, including a psychodynamic approach, symbolic interactionism, social constructionism, the personal construct approach, reference group theory, and cognitive-affective theory. The Nurse Match Instrument developed by Mazhindu et al. (2016) provides a unique measure for future recruits' professional identity and professional values upon entering the nursing profession. The professional values measured by the tool correspond to the principles of the NHS's Constitution (DoH, 2013) and the Compassion in Care vision capturing the NHS's 6C's (DoH, 2012).

A wider body of literature is available encouraging the measurement of professional values for use in the recruitment and retention of RNs. Indeed, having insight into an individual's appropriateness or suitability for the nursing profession will help to ensure that nurses are adequately equipped to provide quality nursing care. On the other hand, understanding nursing professional values can assist employers to devise measures to promote job satisfaction and nurse retention. Nevertheless, measuring professional values features widely in the literature as a means to understand the professional values of student nurses.

3.5.2 Student Nurses' Identification of their Professional Values

Nine studies identified and introduced one or more professional value(s) identified by student nurses (Parvan et al., 2012; Lin et al., 2016; Nelwati et al., 2019; Kavradim et al., 2019). Student nurses' identification and internalisation of their professional values impacted their care of patients. The general consensus was that students reported nursing was a caring profession and that professional values were important to them. For example, Kaya et al. (2017) reported that human dignity and justice are the components of professional values. Kavradim et al. (2019) identified caring, trust, professionalism, and justice as critical professional values. Nelwati et al. (2019) revealed that care was an essential professional value while activism was the least important aspect to Indonesian student nurses. The professional values of care and human dignity were perceived as necessary for student nurses. The findings from the current research led to a similar conclusion (see Chapter 5).

The importance of professional values to student nurses was context and culturally specific. Riklikiene et al. (2018) undertook a large-scale national study of three universities and six colleges that deliver pre-registration nursing programmes in Lithuania and the USA. The study aimed to explore the personal and professional values of the senior student nurses and faculty members. Self-reporting questionnaires were used to collect the data, which were then analysed using the Statistical Package for Social Sciences (SPSS). The faculty members rated, authority and intellectualism as vital to them in all situations, whereas the student's rated honesty and intellectualism as less important to them, so less significance was placed on their academic qualifications when defining their professional values. Nevertheless, student nurses and faculty members rated altruistic values equally. The findings of Riklikiene et al. (2018) are contrary to those of this research, with regards to the GEN students holding strong views on education and clinical competence and being keen activists for evidence-based care. Riklikiene et al.'s (2018) study have some limitations, and the authors called for further research to examine the acquisition of professional values in nursing. The study used a self-reporting tool to gather the data, which may limit the information that the participants offered. The self-reporting tool was translated from

another language and culture, which may have affected the study's findings, as the initial intent was adapted.

Lin et al. (2016) undertook a cross-sectional study to compare the professional values of Taiwanese and Chinese nursing students. The study had a large sample size of nine hundred and forty-six participants. A Nursing Professional Value Scale–Revised tool was used to collect the data for the study. The findings demonstrated that the five top-scoring professional values that were shared by the participants in both groups were advocacy, privacy, confidentiality, responsibility, accountability and education. The Taiwanese participants attributed greater importance to the professional values of responsibility and accountability than the Chinese participants. This variance could be attributed to the difference between the cultural and political situations in these two countries because Taiwan is known to be a democratic country while China is not. While these findings may be controversial, parallels could be drawn between Taiwan and the UK political systems; this suggests that no one professional value is more significant than another and that culture, context and time are essential variables when identifying professional values. The study by Lin et al. (2016) was confined to one nursing school in Taiwan compared with three in China, which may lead to generalisability concerns. The study acknowledged the highest and lowest order of professional values, but failed to demonstrate how or if any development or change might influence the participants as future nurses.
Lin et al. (2016) emphasised the differences between professional values and culture. The findings, nevertheless, demonstrated a shared understanding of certain professional values and the importance of being a patient advocate. In support of the internationalisation of nursing, it is imperative to develop a shared understanding of professional values if nurses are to deliver quality care. The noteworthy difference identified between Lin et al. (2016) and this research is that the GEN student participants not only identified the professional value of patient advocacy but demonstrated the confidence to enact it in the CPE.

The maintenance of patient confidentiality and safeguarding of patients' rights, with less emphasis on activism, policy decisions, and the distribution of resources, was identified by Poorchangizi et al., (2019b). The study consisted of one hundred participants and relied solely on a Nursing Professional Value Scale-Revised (NPVS-R) to generate the data, thus adding numerical value to the findings. The study concludes that the student nurses' identification and perceptions of professional values varied but mainly focused on providing care and maintaining human dignity and less on activism and policy. This indicates a lack of importance associated with public policy and actions related to campaigns to bring about change; for example, "participating in nursing research and/or implementing research findings appropriate to practice" and "participating in activities of professional nursing associations" were limited (Poorchangizi et al., 2019b, p5). Poorchangizi et al. (2019b) did not examine why student nurses perceive specific professional values as more or less important to them or if any specific placement experiences contributed to those perceptions. As such, the findings have little significance for the context of the current research but are relevant to understanding the identification of student nurses' professional values.

Another layer to identifying professional values was the differences between student nurses and experienced nurses. The following five studies compared the identification and perceptions of professional values between student nurses, nurse academics and registered nurses (LeDuc and Kotzer, 2009; Lin et al., 2016; Riklikiene et al., 2018; Bijani et al., 2019; Poorchangizi et al., 2019a). These studies demonstrated that the student nurses perceived their professional values differently to nurse academics and registered nurses. Nevertheless, this is unsurprising, given each group's different experience levels. The professional value of justice was viewed as the most important, and activism was considered the least important among the groups. The study did consider differences in age, gender and type of academic degree (LeDuc and Kotzer, 2009; Bijani et al., 2019). Identifying professional values provides insight into the professional values with which student nurses align themselves. The next theme (theme 3) describes the factors influencing professional values in the clinical placement environments.

3.5.3 Factors Influencing Professional Values in the Clinical Placement Environments

The role of CPE's are a significant factor in developing and supporting the professional values of student nurses (Shafakhah et al., 2018; Ayla et al., 2018; Ciftci et al., 2020). Shafakhah et al. (2018) undertook a qualitative study in Iran, and the findings reported individual and environmental factors as the two main influences on professional values. The study included eighteen student nurses, five educators, and five qualified nurses. The facilitators of the individual factors influencing professional values were work experiences and personal beliefs, whereas the inhibitors were a lack of motivation and enjoyment, leading to negative emotions. On the other hand, the environmental factors included facilitators, such as co-operation, order, and discipline, whereas the environmental inhibitors included unfavourable work environments and the image of nursing. However, the study had a small sample size and offered no recommendations about how to address the identified individual and environmental inhibitors. These findings are relevant to understanding professional values in the CPE and, no doubt, the individual and environmental factors can be relevant when examining the GEN students' professional values. The study identifies one context of cultural, educational, and healthcare system differences, producing validity issues for other settings.

A study by Ayla et al. (2018), consisting of first and final-year nursing students studying at a university in Turkey, examined professional values. The results indicated that personal and environmental factors can affect professional values. Ayla et al. (2018) reported that personal factors, such as gender, the readiness to be a nurse, and environmental factors, such as the year of study and satisfaction regarding their career choice, influenced the student nurses' professional values. The findings are similar to those of Shafakhah et al. (2018), since both studies identify personal and environmental factors as influencing the student nurses' professional values. In contrast, Ciftci et al. (2020) offer insights into student nurses' experiences during their internship placement. Internship placements are provided to consolidate students' critical reasoning, professional values, and skills before graduating into the nursing profession. The study concluded that nursing internship placements had a positive

relationship with the professional values of student nurses because they could combine and apply their knowledge and skills.

Another element within the role of the CPE in influencing professional values was the association of clinical mentors (Bang et al., 2011; Fisher, 2014; Shafakhah et al., 2018). Shafakhah et al. (2018) built on the work of Sabatino et al. (2015) and identified the factors that facilitate or inhibit the professional values of student nurses. Sabatino et al. (2015) conducted a study in Italy and reported that two main themes enhanced professional values during a clinical placement which involved student nurses identifying positive role models and a supportive working environment. Within the clinical environment, student nurses encounter both positive and negative role models. That said, Sabatino et al. (2015) advocate further research into understanding the influence of social and environmental factors, with a greater focus on how healthcare staff influence the professional development of student nurses.

Nevertheless, many elements of clinical placements can either facilitate or hinder the experiences related to professional values. These findings are relevant to GEN students, all of whom are exposed to clinical mentors during their clinical placement experiences. However, it should be viewed within the broader context of nursing within the UK's current socio-economic and political arena.

Bang et al. (2011) examined the professional values of Korean student nurses and suggested that this group acquires professional values by observing and role-playing behaviour that is consistent with the nursing profession. The same can be said of less consistent or undesirable behaviour, as identified in the Francis and Keogh Reports (Francis, 2013; Keogh, 2013). While this study may be valid for student nurses studying on a pre-registration nursing programme, one might argue that these findings are relevant to GEN students, particularly because they enter the nursing programme with a set of professional values and have a strong desire to learn and use their critical thinking skills. Therefore, clinical mentors need to be aware of the GEN students' experiences and perceptions of professional values if these are to serve as a foundation to facilitate and support them.

So far, I have discussed measuring professional values, student nurses' identification of their professional values and the factors influencing professional values in the clinical

placement environments. The following two sections will discuss how education and experience are related to professional value and personal characteristics shaping professional values before stating the gaps identified in the literature.

3.5.4 Education and Experience Related to Professional Values

Education and learning experiences affected the development of professional values amongst student nurses. Several studies examine education and the development of professional values (Leners et al., 2006; Lin et al., 2010; Hidle, 2011; Fisher, 2014; Kaya et al., 2017; Kavradim et al., 2019).

Three particular studies (LeDuc and Kotzer, 2009; Hidle, 2011; Fisher, 2014) were conducted in the USA, indicating that student nurses' experiences of learning professional values and their educational preparedness have a positive relationship with their professional values. The study sample consisted of junior and senior students on three different nursing programmes, such as the Diploma, Associate Degree, and Bachelor of Sciences programme in nursing. Nursing students' professional values scores significantly increased as they progressed through their nursing programme. Fisher (2014) highlighted that the student nurses perceived differences in professional values on different nursing programmes. The senior participants on the Diploma programme had higher scores for professional values and educational preparedness than the participants on the Associate Degrees. No statistical significance was noted for the BSc nursing students. Learning professional values is a vital part of any nursing programme; however, the time spent, and experience gained during the programme must be considered part of the development process. Further, education supports the application and operationalisation of professional values in clinical placements. Professional values development necessitates the construction of nursing roles alongside actively involved students.

The studies conducted by Hidle (2011) and Fisher (2014) both indicate a significant difference in the development of professional values during the participant's time on a nursing programme, signifying that time and experience are related to the participant's professional values. Professional values such as competence, responsibility, accountability, quality care, protecting patients' rights and patient advocacy were

ranked highly. Identifying these professional values concurs with professional values identified in studies based in Iran, South Korea, and Turkey.

A study by Lee et al. (2020) concurred with the findings of Hidle (2011) and Fisher (2014) and reported that students who perceived satisfaction with their nursing programme related positively to their professional values and academic achievement. The study relies on using the NPVS-R while acknowledging that this as a limitation, and advocating that further research might capture the participants' experiences and perceptions of professional values.

The study by Arries (2019) was particularly noteworthy because it examined nursing students' perceptions of professional values from an idealistic or relativist view. Idealism refers to the degree to which nursing students appreciate and view professional values, and relativism is the degree to which nursing students view moral behaviour as conditional on the nature of a circumstance. An idealist, therefore, evaluates the implications of an activity and its impact on the well-being of others. The study reported a significant difference between the scores for what the participants viewed as idealistic and relativist perceptions of professional values in nursing respectively. There was a positive correlation between the participants' age and year of study related to their professional values. The 'older' and more senior students on the programme demonstrated realistic rather than idealistic perspectives of nursing and professional values. Overall, the findings suggest that professional values were closely related to idealism. This means that students who identified as idealistic were conscious of their actions and the effect of these on others.

A correlational study by Iacobacci et al. (2013) involving forty-seven senior nursing students explored the relationship between professional values, self-esteem, and ethical decision-making. The findings demonstrated that high levels of both professional values and self-esteem existed among the participants; however, there was no significant relationship between the participants' perceptions of ethical decision-making and their professional values. Furthermore, Iacobacci et al. (2013) and Parandeh et al. (2015) identified an educational gap between the professional Code and its operationalisation in clinical practice, which indicates impending concerns for nurses and patients.

Education and experience have been found to play a vital role in altering the professional values of student nurses. A longitudinal study by Kaya et al. (2017) included one hundred and twenty-three student nurses to examine the effect of education on their professional values between starting and graduating from their nursing programme. Although the results demonstrated that a positive relationship existed between education, learning and professional values, the students had different ways of understanding their professional values. The study has a significant limitation because only one university in Turkey was included, and so it lacked generalisability to the broader student nurse population. One can conclude that professional values can be modified by education and the amount of experiences, as suggested by Kaya et al. (2017) and Kantek et al. (2017). From the literature discussed, the attainment of professional values can be viewed on a continuum depending on the year and level of experience coupled with the desire to want to be a nurse. HEIs and clinical placement providers play an equal role in ensuring that nurse education programmes include professional values that bridge the gap between theory and practice and reflect the current society.

3.5.5 The Role of Personal Characteristics in Shaping Professional Values

The subsequent studies demonstrated a link between students' professional values and their personal characteristics, such as self-directed learning, gender, self-esteem and confidence, motivation, professional self-concept and compassion (Iacobucci et al., 2013; Donmez and Ozsoy, 2016; Çöplü and Kartin, 2019; Nelwati et al., 2019; Kavradim et al., 2019; Ciftci et al., 2020; Lee et al., 2020). Donmez and Ozsoy (2016) reported that individual characteristics, such as age, level of experience, education and learner characteristics, contributed to developing professional values. Similar findings were reported by Çöplü and Kartin (2019), suggesting that individual characteristics, such as gender, age, level of experience and learner characteristics, contributed to developing professional values. Çöplü and Kartin (2019) undertook a quantitative study that compared self-concept and professional values using the Nurses Professional Values Scale and Professional Self-Concept Scale. The study included six hundred and nineteen participants and sought to determine their professional self-concept and professional values in their final year on a nursing programme. The findings indicate a

gender difference, as the female nurses assigned greater importance to professional values than the male nurses.

In contrast, Lener et al. (2006) and Parvan et al. (2012) reported no significant differences between the female and male student participants in their study. What remained consistent across these studies was a shared understanding of professional values, which meant respect, human dignity, and privacy.

Lee et al. (2020) reported a positive relation between self-directed learning as an individual participant characteristic and professional values. Lee et al. (2020) examined the relationship between self-directed learning and professional values. The findings suggest that self-directed learning positively related to the professional values of the student nurses. The researcher argues that self-directed learning could be an effective pedagogical method for instilling professional values in future nursing programmes, which would be particularly appropriate for GEN students with previous educational and life experiences. Bang et al. (2011) reported that individual characteristics, such as wanting to be a nurse and seeing nursing as a professional job, led to higher scores compared to students who entered the nursing profession based purely on their exam results. The literature review demonstrated that individual characteristics, such as age, gender, level of experience, and unique learner styles, influenced how professional values were perceived.

Professional values are viewed as a source for promoting quality nursing care and maintaining patient safety. It is essential to acknowledge that, although most of the studies included in this review were quantitative or mixed-method in nature and based in an international context, they provide insight into: how professional values are measured; the professional values that student nurses identify as important to them; the factors influencing professional values in the clinical placement environments; the impact of education and experience; and finally, personal characteristics, in shaping professional values. Nevertheless, all these studies examine the experiences of professional values on clinical placements relating to BSc nursing students rather than GEN students. The themes within this review demonstrate some complex, multifaceted points that are often contradictory, making it hard to draw firm conclusions.

3.6 Gaps in the Literature

The existing literature examined the perceptions and understanding of student nurses' professional values. These extant studies involved the pre-registration nursing students in diverse geographical locations, such as South Korea, Iran, Turkey, Spain, Lithuania, and the USA, identifying cultural influences on their professional values. These studies are pertinent as there are parallels that can be drawn with the UK context (Lin et al., 2010; Bang et al., 2011; Gallegos and Sortedahl, 2015; Donmez and Ozsoy, 2016; Riklikiene et al., 2018; Kaya et al., 2017; Bleda et al., 2020). Many studies embraced using professional values assessment tools or scales to measure or rank professional values according to their identified importance. These studies, however, failed to acknowledge the depth and significance of the experiences, beliefs and perceptions of student nurses' professional values, thereby creating a knowledge gap. This knowledge gap matters because, if the nursing profession is to prevent a repeat of the Mid-Staffordshire hospital incident (Francis, 2013), it is essential to know how student nurses define their professional values and which clinical experiences support or exacerbate specific professional values so that appropriate support can be provided. In addition, there is no indication in the literature of whether or not a relationship exists between clinical placement experiences and professional values or how they are internalised and operationalised (Lin et al., 2016; Kaya et al., 2017; Kavradim et al., 2019; Bijani et al., 2019; Nelwati et al., 2019). Furthermore, it became more evident that the implications of this relationship are less researched and explored.

All nursing programmes in the UK adopt the NMC-accredited standards and guidelines for integrating professional values (NMC, 2018b). Regardless, these standards are subject to interpretation. Not much is known or recognised in the literature about the success of this implementation. The understanding and operationalisation of professional values from a student nurse’s perspective in the UK represent a gap in the research field. While there exist studies on the professional values of student nurses on pre-registration nursing programmes and their clinical placement experiences, there are no studies that combine or include GEN programmes, clinical placement experiences and professional values.

Several existing studies have identified a need for and requested further research into GEN programmes and the experiences of GEN students, such as nurse education and student nurses' professional lives. To date, this gap still exists in the literature (Stacey et al., 2015; Aubeeluck et al., 2016; McKenna et al., 2017; McKenna and Brooks, 2018). Therefore, the current research is timely and essential because it offers insight into the relationship between the clinical placement experiences and professional values of GEN students, that has not been examined before. Hence, there is no better time to gain insights into and a deep understanding of the professional values of student nurses as future registered nurses and leaders of the NHS, given the current and predicted workforce shortages (WHO, 2020). The Francis Report (2013) and Keogh Review (2013) highlight the urgent need for a consistent approach to professional values across healthcare in the UK. It is essential to examine professional values to ensure that quality nursing care is not compromised when addressing the current shortage of nurses.

This research addresses the identified gap in the literature by examining the relationship between the clinical placement experiences and professional values of the GEN student participants. The current research offers a unique perspective to bridge the identified gap in the literature by adopting a Qualitative interview design, a social constructivist lens, identifying and presenting the nuances and shared patterns of meaning that have not been available to date. These unique perspectives reflect the GEN student participants' definitions and understanding of their professional values. The clinical placement experiences that the GEN student participants identify are related to and have implications for their professional values. These insights may further enhance the understanding of the factors that influence and shape the nursing profession for years to come.

Finally, we should consider the reason for the dearth of research on this field of knowledge within the UK. The researcher can only offer assumptions regarding the gap in the literature, which may be related to the small number of GEN programmes offered compared to the BSc programmes (DoH, 2016). The knowledge gap further points to the historically weak engagement with accelerated programmes in the UK HEI system, with programmes spread far and wide geographically (DoH, 2016).

However, this narrative is changing, as GEN programmes are becoming a more attractive option and gaining momentum both across the UK and internationally.

3.7 Inferences from the Scoping Review

Two inferences were identified based on the scoping review. The first inference is that professional values are central to all nursing practices and therefore, all student nurses have them. "*Professional values form the basis for nurse attitudes and behaviour, and are cornerstones to guiding nurses' clinical practice decisions*" (Gallegos and Sortedahl, 2015 p187; see also Weis and Schank, 1997, 2009; Leners et al., 2006; Rassin, 2008, 2010). The second inference is that professional values are learnt in the clinical placement environment; as such, all student nurses encounter clinical placement experiences in much the same way. Kaya et al. (2017, p717) suggests that *"Values are acquired; they can be taught directly or learned indirectly by observing the behaviour of others".*

3.8 Integration of the Literature with the Research Question

Booth et al. (2012) and Moser and Korstjens (2018c) assert that a research question is central to a study. Indeed, the research question in this thesis is the foundation upon which the research is developed. The scoping review was crucial as it facilitated the exploration and understanding of the existing research in the field and identified the gaps in the literature. Furthermore, the integration of literature supported the development of the research question: **What is the relationship between the clinical placement experiences and professional values of Graduate Entry Nursing Student Participants?** This research aims to examine this relationship and critically examine the implications of the clinical placement experiences and professional values of the GEN student participants.

3.9 Chapter Summary

This chapter reviewed the literature related to student nurses' professional values. The scoping review revealed different levels of complexity in the subject matter and a lack of agreement among experts on the understanding and interpretation of professional

values in the clinical placement environment. Notably, the review identified gaps in the empirical research on the professional values of GEN nursing students. Chapter 4 will discuss the methodology and the methods underpinning this research.

Chapter 4: Research Design: Methodology and Methods

4.0 Introduction

Chapter 4 is divided into three sections. Section one explores the rationale for the theoretical and ideological component that forms the foundation of this research. The second section examines the methodological framework utilised; namely, a social constructivist paradigm within a qualitative interview study design (Edwards and Holland, 2013; Brinkman, 2013) and outlines the motivation for using this methodology to answer the research questions. The third section outlines the data collection phase and analytical framework utilised: namely, Thematic Analysis (Braun and Clarke, 2006, 2013).

4.1 Rationale for a Qualitative Research Methodology

My research examines the relationship between the clinical placement experiences and the professional values of GEN students. Research may be considered primary or secondary, and qualitative, quantitative or a combination of qualitative and quantitative, also known as a mixed methodology (Crotty, 2015). A quantitative and mixed methodology is not discussed in detail because it is not applicable and does not necessarily generate an in-depth description of the individual experiences, thoughts, attitudes and values required to answer the research questions.

Denzin and Lincoln (2011, p5) describe qualitative research as "*multimethod in focus, involving an interpretative, naturalistic approach to its subject matter*". A qualitative methodology was most suitable for answering the research question for the following reasons. Qualitative researchers study people in their natural settings, attempting to make sense of or interpret a phenomenon in terms of the meanings people bring to it. Therefore, qualitative research helps to clarify how people experience various aspects of their lives. Qualitative research is aligned with providing descriptions and interpretations of a social phenomenon, extracting the experiences and perceptions from specific social contexts, thereby illustrating how individuals and groups behave, how organisations operate, and how interactions create meaningful relationships. As

such, a qualitative methodology is ideal for illustrating complicated topics in healthcare and nursing (Aveyard, 2019) and includes a particular focus on the richness and depth of real-life experiences. This makes it most appropriate for examining the relationship between the clinical placement experiences and professional values of GEN students.

In addition, a qualitative methodology will enable the research question to be optimally answered and close the knowledge gap regarding the examination of real-life experiences of the GEN student participants, particularly their relationship between clinical placement experiences and professional values within the UK context.

4.2 The Ontological Perspective and Epistemological View

4.2.1 The Ontological Perspective

To ensure high-quality research, it is essential to determine the most appropriate philosophical underpinnings; this can be accomplished by adopting the most suitable ontological and epistemological views. Hence, researchers need to view research within the context of its ontological and epistemological positioning because it reflects how researchers proceed in order to obtain a better understanding of reality (Moser and Korstjens, 2018a)

Ontology is defined as the study of *'being' and is concerned with the nature and the structure of 'reality'* (Crotty, 2015, p11). Ontology, therefore, assists researchers to recognise how certain they can be about the nature and structure of the reality under focus. Accordingly, for research to be acknowledged, researchers need to recognise their ontological stance and demonstrate how their position can influence the chosen methodology, methods, interpretation, and meaning generated from the data (Crotty, 2015). The nature of my reality within this research is grounded on a social constructivist rather than an objectivist view. Herewith, the philosophical position involves the participants' construction of their reality, values, and beliefs about the social world (Bryman, 2014; Gibson, 2017).

Bryman (2014) suggests two ontological realities of the world: the objectivist and relativist realities. The objectivist reality represents objects and facts that are

independent of consciousness. The world is viewed as existing independently of knowledge and perception, implying an apparent reality that is physical and measurable. On the contrary, a relativist reality represents a relationship between two or more entities that can be physical or meta-physical and as such, is firmly grounded in a constructivist paradigm. The world is viewed as something that is experienced, and it is the feelings and beliefs of individuals or groups that shape reality. Reality can be considered a construct of a combination of social, political, economic, and cultural influences (Swain, 2017). As such, within a relativist ontology, multiple realities co-exist, outside which the 'truth' does not exist. It is within the relativist ontology that my perspective is firmly grounded. My positionality in this research is considered that of a co-constructor of knowledge, as further discussed in Section 4.12. My beliefs and views about knowledge undoubtedly informed the research design and methods intended to examine the participant's subjective realities and understand the relationship between the clinical placement experiences and professional values of the GEN Student participants.

4.2.2 The Epistemological View

Epistemology influences how researchers design their research to discover knowledge. Epistemology is defined as the theory of knowledge, *"how we know what we know," and how knowledge is created* (Crotty, 2015, p9). Positivism adheres to the belief that there is one reality in the world, and that the world is independent of those who occupy it. Data are captured and interpreted through mathematical or statistical analysis (Crotty, 2015). At the same time, interpretivism adheres to the belief that reality is shaped by people's experiences, culture, and beliefs (Crotty, 2015). Therefore, research takes place in its natural contexts within real-life situations and is concerned with attitudes, values, and beliefs (Moser and Korstjens, 2018b). Interpretivists assert that individuals create their reality and are concerned with the social world, the meanings constructed, and how individual experiences and perceptions influence reality (Moser and Korstjens, 2018a), indicating that individuals play a vital role in and are the focus of qualitative research. Nevertheless, interpretivism is not without limitations, as it consists of mainly small sample sizes, and the subjective nature of this approach predisposes a wide range of researcher prejudices (Swain, 2017). To

counterbalance this limitation, I maintained a reflexive journal throughout my doctoral journey and acknowledged my views (a discussion is provided in Section 7.1 Reflexivity).

Swain (2017) acknowledges that interpretivism and constructivism are terms drawn upon collectively, and that constructivism is synonymous with an interpretivist research approach, meaning that interpretivists regard knowledge as socially constructed to create new meaning. An interpretivist/constructivist theoretical framework informed my research questions, choice of methodology, and the methods embraced in this research. Therefore, my epistemological view is explained as interpretivism (Crotty, 2015; Swain, 2017).

Nursing as a discipline views knowledge of the human experience as a whole and humans' role in the interactions, be it physical, psychological, or social (McCance et al., 2011). For example, if a patient presents with chest pain, the pain is not viewed in isolation of the individual but rather as a whole, linked to their various physical, psychological, and social aspects. Nursing deals with various interpretations of where the patient comes from, their ideas, and thoughts. Nursing knowledge requires a refined ability to spot differences and commonalities and never assume the end but instead view knowledge as an evolving, flexible process (Holloway and Wheeler, 2010). Nursing, therefore, has a different relationship with knowledge for clinical practice; how to interpret it and what to do with the knowledge is fundamental in nursing. The world of claims to knowledge in nursing is attached to evidence-based practice within a broader context of policy and practice. As such, the nature of clinical knowledge manifests itself in patterns and processes of knowing. Carper's (1978) view of nursing knowledge may seem dated but remains a respected, well-documented form of knowledge-deciphering in nursing and positions four types of nursing knowledge, each of which distinguish its unique character: empirical knowledge, aesthetic knowledge, personal knowledge, and ethical knowledge. The interweaving of the four strands of knowledge does not necessarily occur linearly or logically between theory and clinical practice. As such, each type of knowledge can function independently or in combination. In this view, my teaching adopts an interpretivist/constructivist approach, guided by social constructivist learning theories.

4.3 Rationale for Adopting a Social Constructivist Paradigm

The previous section discussed the rationale for a qualitative methodology and my ontological and epistemological position. I will now discuss my rationale for employing a social constructivist paradigm in this research. Creswell (2014) depicts four research paradigms as choices to inform and guide research inquiries: positivism, constructivism, transformative and pragmatism. A paradigm or "world view" is regarded as the perspective of thinking that guides the research process to generate claims about knowledge, what knowledge is (ontology), how we know what we know (epistemology), and what values are incorporated into it (axiology) (Creswell, 2014: Scaife, 2019). Table 8 (research paradigms' features) demonstrates the elements of constructivism that are relevant to my research.

Table 3: Research Paradigm Features

Positivism	**Constructivism**
Determination	Understanding
Reductionism	Multiple participant meanings
Empirical observation & measurement	Social & historical construction
Theory verification	Theory generation
Transformative	Pragmatism
Political	Consequence of actions
Empowerment orientated	Problem centred
Collaborative	Pluralistic
Change –orientated	Real-world practice

Source: Adapted from Creswell (2014, p36)

Positivism is known to be a deterministic, reductionist paradigm that aims to reduce concepts so that distinct hypotheses can be tested (Creswell, 2014: Scaife, 2019). Positivism was rejected because my research seeks to understand experiences and beliefs that are socially constructed through interacting with others in a social context. In this view, I also did not aim to prove or test a hypothesis. The transformative paradigm is concerned with policy and intertwined with the political agenda to improve the participants' lives (Creswell, 2014). Although health policy and the

political agenda are essential in nursing, that was not the focus of my research and hence rejected. Whereas the pragmatic worldview prioritises the problem and problem-solving, I was seeking a holistic, contextual understanding of the perceptions and experiences through the participants' eyes. On that basis, I rejected pragmatism.

A social constructivist paradigm supports the notion that reality is a construction of the individual's knowledge and experiences while the individual remains an active component of the social process (Vygotsky, 1978). Therefore, it is argued that knowledge is an agreement held by individuals as a principal criterion to validate their experiences rather than an objective reality. Adams (2006, p246) supports the notion that "*social constructivism sees consensus between different subjects as the ultimate criterion to judge knowledge*". Alanazi (2016, p2) posits that "*Constructivists assert that learners construct knowledge rather than acquire new knowledge; therefore, learning is an active process throughout the learners…*". For example, individuals develop knowledge by sharing experiences and interactions with other individuals. However, the reality of these experiences will differ for each individual due to the subjective nature of reality. Crotty (2015) suggests that social constructivism seeks to interpret and understand the cultural and historical influences of the social world through shared interactions. In other words, it is argued that knowledge construction, interpretation and understanding are products of social influences.

Koro-Ljungberg et al. (2009) and Rokeach (2008) suggest that social constructivist theory recognises that values are not stamped on an individual at any particular time in their life. Nonetheless, they develop over time as the individual connects with their social, cultural, and political world. Individuals are viewed as the agents in control of the construction process and the extent to which the construction is a product of social interaction (Burr, 2015). As such, knowledge creation cannot be separated from the social world. By drawing on a social constructivist paradigm, there is an opportunity to examine GEN students' perceptions of how they attach meaning to their experiences in the context of their clinical placement, particularly the relationship between their clinical placement experiences and professional values, either conscious or unconscious, as they seek to make sense of these experiences.

Furthermore, the GEN student participants are not viewed as submissive learners in this research but rather as active contributors to the social construction of their knowledge. As a result, a social constructivist paradigm is essential to interpret and understand the GEN student participants' experiences accurately. By drawing on social constructivism within this research, I felt confident and equipped to infer, recognise, and understand the multiple, varied meanings of the knowledge-making process within the complexities of the clinical placement environment. However, I depended on the GEN student participants' experiences to understand the relationship between their clinical experiences and their professional values. The surreal nature of sharing the participants' experiences is acknowledged, and attempts are made to 'capture' the participants' perceptions by being reflexive throughout the thesis. For example, I found the intricacies of enquiring about and listening to the participants' experiences during and the focus groups and interviews humbling and thought-provoking. There were many experiences I could identify with from my clinical practice experiences.

Cohen et al. (2011) argue that 'new knowledge' is achieved through an awareness and understanding that knowledge creation is viewed on a continuum. Through a constructivist lens, 'new knowledge' is created and approached in this research. Knowledge creation is complicated and relies on the participants' previous knowledge, morals, and beliefs (Creswell and Creswell, 2018). The CPE allows the participants to co-construct new knowledge with others. While acknowledging the very nature of this research, that asks the participants to make meaning of and connect their placement experiences and professional values, I acknowledge that multiple realities do not exist independently of myself and the participants. Accordingly, I draw on my own experiences as a nurse for over 22 years.

To conclude this section, social constructivism as a research paradigm was chosen as appropriate because it is found to be highly effective and powerful in enhancing the comprehension of experiences and perceptions within a social context, as well as producing insights into individuals' motivations and behaviour (Mvududu and Thiel-Burgess, 2012). The following section will discuss the rationale for choosing a qualitative interview study design for this research as well as the strengths and limitations of this approach.

4.4 Rationale for a Qualitative Interview Study Design

Brinkman (2013) suggests that qualitative interview study design is drawn upon to gather in-depth information; the purpose of that information varies according to the research question and the researcher's perspective. Thus, some research is designed to test *a priori* hypotheses, often using a structured interviewing format in which the research questions and analyses are standardised. By contrast, other research seeks to explore meaning and perceptions to better understand and generate theory. This latter research generally requires some form of qualitative inquiry, which encourages the participants to share rich and detailed descriptions of a specific phenomenon while leaving the analysis and interpretation to the researcher. As such, qualitative interview study design is defined as qualitative interviews that contribute to a body of conceptual and theoretical knowledge based on the meanings of life experiences from the participants (Brinkman, 2013). The aim of my research was to identify the relationship between and critically examine the implications of the GEN student participants' clinical placement experiences and professional values. Therefore, a qualitative interview study design was appropriate for my research.

At the same time, I considered which methods to use in collecting qualitative data, such as structured, unstructured, semi-structured, and focus group interviews. Focus group interviews and semi-structured interviews were most appropriate to answer my research questions because the participants are viewed as part of the meaning-making rather than a conduit from which information is retrieved, as in the case of structured interviews (Edwards and Holland, 2013). The focus group interview allowed me to gather a wider range of experiences from a homogenous participant sample sharing their beliefs and experiences about a specific subject whereas the semi-structured interview allowed me to delve deeper into individual and personal matters (Creswell, 2014). Adopting the selected methods further allowed for flexibility and modification of the interview process, as the participants and I co-created knowledge from shared experiences. This was especially important given my position as a nurse and academic; the flexibility allowed authentication checks during the interviewing process to prevent confusion or misrepresentation.

A qualitative research study design is also concerned with establishing answers to the *why* and *how* questions of a phenomenon, unlike a quantitative research design. My ontological and epistemological standpoint lends itself to an interpretivist/ constructivist view. At the heart of this view lies the understanding of individuals' experiences, social interaction and meaning in their social world. As such, a qualitative interview design was adopted in this research because it offers in-depth and detailed data of the *why* and *how* of the participants' experiences. Qualitative interviews usually involve follow-up questions and are conducted in a conversational or discussion format (Edwards and Holland, 2013). My research is grounded in a qualitative inquiry, and as such, drawing on a qualitative interview design within a social constructivist paradigm is best suited for examining the nature of the reality of GEN students in a previously understudied area, as discussed in the literature review (Chapter 3) (Edwards and Holland, 2013).

The previous two sections discussed the rationale for choosing a qualitative research design for this research and its strength and limitations. The following sections will discuss the sampling strategy, and selection of the participants and data collection methods used in this research.

4.5 Sampling Strategy and Selection of the Participants

The technique of purposive sampling is used extensively in qualitative research, especially in instances where the sample is limited (Creswell, 2014). Purposive sampling was drawn upon as a trustworthy design by ensuring that the participants were in their final year of the GEN programme and undertaking their final clinical placement. While purposive sampling is ideal for selecting a targeted sample to examine a phenomenon, there is undoubtedly a loss of representation from the general population. However, this research relies on the strength of purposive sampling to select data-rich sample to examine the relationship between the clinical placement experiences and professional values of the GEN student participants (Creswell, 2014).

Burns and Grove (2011) suggest that inclusion and exclusion criteria should be applied to identify which participants are eligible to take part in the research. The following

inclusion and exclusion criteria were used to select the participants. The inclusion criteria: students currently registered on the GEN (adult field) programme, as other fields of nursing, such as child, mental health, and learning disabilities, are not presently offered on the GEN programme; in their final year and final placement; have all passed the required academic assessments; and students who consented to participate in the study. The exclusion criteria: students on the pre-registration nursing programme; Nursing Associate nursing programme; or MNursing (Master) programme. As such, all nineteen participants from the cohort were invited both verbally and in writing to participate in this research and offered an information sheet at least three weeks in advance to allow for any questions. The information sheet stated the purpose and nature of the research, participants' expectations, and advantages and disadvantages of partaking in the research (see Appendix 7). I provided a consent form to those participants who volunteered to be part of the research (see Appendix 8). The participants were emailed to confirm the date and time of the focus groups and semi-structured interviews, respectively.

4.6 Data Collection

Qualitative data collection can adopt a variety of methods within a qualitative interview study design, such as interviews, observations, focus groups, and documentation (Creswell, 2014; Patton, 2015). The data collection for this research comprised of focus groups and semi-structured interviews. The focus groups were conducted at the beginning of the participants' final placements as they tried to make sense of their clinical placement experiences and professional values. Creswell and Creswell (2018) suggest that focus groups are an excellent method to employ before conducting interviews because the views expressed during the focus group can be followed up in the individual interviews. Based on this, the semi-structured interviews were conducted after the focus groups.

The semi-structured interviews provided in-depth, rich data that captured experiences that may not have been discussed in a group (Creswell, 2014). The semi-structured interviews took place when the participants were on their clinical placement. Table 4

illustrates the number of focus groups and semi-structured interviews used in this research.

Table 4: Research Methods

Method 1 **October**	Focus Groups 1 (n=10) Focus Groups 2 (n=9)
Method 2 **November – February**	Semi-structured interviews Twelve (n=12)

Source: (Author, 2022)

4.6.1 The Focus Groups

A focus group is considered "*a carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment*" (Krueger and Cassey, 2015, p3). Focus groups facilitate an explorative inquiry within a group, such as interactions and shared experiences (Ryan et al., 2014). Depending on the group's purpose, the number of participants of a focus group can range from four to twelve (Krueger and Cassey, 2015). There were nine and ten participants in each respective focus group, and they were all from the same cohort.

Creswell and Creswell (2018) suggest that the interactions within the focus groups involve the participants' feelings, views, and perceptions around shared experiences. As such, focus groups support a social constructivist view and were deemed appropriate for gathering the data for this research. Like other methods adopted in qualitative research, focus groups have their strengths and weaknesses (Rodriguez et al., 2011; Creswell, 2014). Focus groups offer a breadth of understanding related to the experiences of a homogeneous sample. Krueger and Cassey (2015, p7) state that "*focus groups are composed of participants who are similar to each other in a way that is important to the researcher*". For example, all of the participants are from a homogeneous sample, the same nursing programme and in the same stage of the programme (their final placement). Focus groups promote discussion and the sharing of ideas and experiences that can provide in-depth understanding about a specific

phenomenon or topic related to a group or population (Creswell, 2014). Krueger and Cassey (2015, p9) further suggest that "*focus groups presents a more natural environment than that of an interview because participants are influencing and influenced by others – just as they are in life*".

Krueger and Cassey (2015) indicate that researchers serve several purposes in a focus group, such as listener, facilitator, observer and eventually analyst. These varied roles can prove challenging, but I have the advantage of being an experienced nurse who is tasked with being a listener, facilitator, and observer in my everyday activities. Creswell (2014) posits that focus groups can be challenging to control and manage, especially if certain participants dominate the discussion. However, this was not the case; the participants were respectful and keen to share and hear about each other's experiences in the group.

The aim was to generate data with and amongst the participants, the individual interviews promoted an in-depth understanding, with the opportunity to use follow-up questions. The focus groups were conducted in a quiet room at the university as a convenient location for the participants. Before the focus groups started, I used the time to reconnect with the participants, put them at their ease, and create a non-threatening environment. I then checked that each participant had received the information sheet and signed the consent form (see Appendices 7 and 8). The focus groups began with introductions, followed by an outline of the study's aims and the main research question. The participants were asked to identify their personal values at the beginning of the focus group discussions, based on the notion that personal and professional values are closely connected and operate synonymously with each other. Professional and personal values are viewed as a social construct; to understand professional values, it is imperative to understand personal values to provide a complete view of the participants' experiences within their social world (Rassin, 2008; Kaya et al., 2017). The participants were given post-stick notes on which to write down their personal values, which was later followed by a discussion during the semi-structured interviews.

The focus groups were guided by an interview schedule (see Appendix 10) and lasted no more than an hour. The interview schedule was based on evidence collected during

the scoping review, pilot study, and research questions. The pilot study (module 3) was beneficial because the data generated by the research questions were vague and did not provide adequate answers; I used my learning from this to align the focus group and interview questions closely with the main research question. The interview schedule primarily served as a guide rather than being used rigidly to gather information from the participants. Any non-verbal gestures, such as pauses, nods and turns of the head, and smiles, were noted as part of the field notes.

4.6.2 The Semi-structured Interviews

The use of interviews in qualitative research remains the most widely used form of data collection method, and the choice of interview type depends on the purpose of the interview (Creswell, 2014; Patton, 2015). An interview is defined as providing "*in-depth information pertaining to the participants' experiences and viewpoints of a particular topic*" (Turner lll, 2010, p754). More specifically, Moser and Korstjens (2018b, p12) suggest that "*interviews involve interactions between the interviewer(s) and the respondent(s) based on interview questions*".

Semi-structured interviews were adopted to explore and elaborate on the participants' perceptions and experiences regarding specific experiences while maintaining their individuality—for example, the experiences related to how and why the participants felt a certain way and why they chose to discuss a specific experience. Semi-structured interviews are considered appropriate when little is known about a phenomenon or a detailed understanding is required (Moser and Korstjens, 2018b). Some of the participants reported sensitive, private experiences involving their family members, which were not discussed in the focus groups. As such, semi-structured interviews are particularly suitable for examining sensitive information that may not necessarily be discussed in a focus group.

A social constructivist view supports the use of interviews as subjective yet not entirely 'individual' because they are rooted in a social and cultural context (Young and Colin, 2004). While interviews are recognised within a social and cultural context, the reality is considered an interaction between the participant and interviewer. Semi-structured interviews allow the participants to provide comprehensive responses and the

researcher to probe further while gathering more in-depth answers. Semi-structured interviews allow a 'dialogue' to develop between the participant and researcher, thereby creating the best of both worlds by merging the list of prompts with the freedom to ask follow-up questions, which would not have been possible if using either structured or unstructured interviews (Thomas, 2016). The participant is the most crucial source of information when attempting to uncover their perceptions and experiences because they choose to discuss what is important to them. Creswell (2014) suggests that a relationship exists between what the participants share and their perceptions of social constructs while acknowledging that information is exchanged in a social context.

The semi-structured interviews were conducted at a time and location that best suited the participants, as they were on clinical placements at the time. Some of the interviews took place in a quiet room at the location of the clinical placement, while others were conducted at the university. The semi-structured interviews started with introductions, although both parties knew each other, followed by an outline of the study's aims and the main research question. After that, I checked that the consent form had been signed.

Each interview lasted from thirty-five minutes to an hour. An interview schedule guided all of the semi-structured interviews. The prompt questions were designed as open-ended questions to allow the participants to share any experiences they wished to (see Appendix 11). By adopting a flexible interview schedule, I identified areas that needed to be re-addressed, such as why a specific action was carried out and how that made the participant feel. Nevertheless, the semi-structured interviews were unpredictable because the experiences that the participants would bring to the discussion were unknown. As a result, I had to assess the value of the responses and decide whether probing questions were needed.

As the only researcher in the study, I was the only person who interacted with the participants during the interview process. This allowed me to develop a consistent pattern of interviewing. Further allowing me to build a relationship with all of the participants and construct their realities through the same lens. A consistent approach

is advantageous when analysing and generating data as it strengthens the credibility of the findings (Creswell, 2014).

The previous sections discussed the sampling strategy, participant selection and data collection methods employed in this research. The following sections will discuss the ethical considerations related to this research before outlining the process of data analysis and synthesis.

4.7 Ethical Considerations

Resnik (2011) defines ethics as the rules that differentiate right from wrong and acceptable from unacceptable behaviour when carrying out research. Ethics is based on well-established guidelines for protecting human subjects, the British Educational Research Association Guidelines (BERA, 2020). In keeping with the University's ethical approval procedure, I applied for ethical approval from the Ethics Committee of Sheffield Hallam University and was granted permission to conduct the research (see appendices 5 and 6). This research was conducted at the university where the researcher works; approval was sought and obtained from the Head of Department and the Research Governance Committee. By adhering to the BERA (2020) guidelines, I ensured that my research was carried out responsibly and courteously, with due regard and consideration for the participants. The following key areas were considered; informed consent, the right to withdraw, confidentiality and anonymity, protection from harm and data storage.

Informed Consent and the Right to Withdraw

I provided all of the participants with an information sheet (see Appendix 7) before obtaining their informed consent, giving the participants time to ask questions and clarify any information about the research if they wished. I was mindful that the participants were known to me, and there was an element of convenience to taking part in the research. Once their informed consent had been gained, the participants were informed, that should they wish to withdraw at any stage of the research process, they could do so without any negative impact on themselves or their

programme of study. However, if more than a fortnight had passed since the data had been collected, they would be used in the research.

Confidentiality and Anonymity

I informed the participants that the focus groups and interviews would be recorded and assured them of confidentiality and anonymity when the recording was accessed for transcription purposes. To achieve this, I replaced the names of the participants and clinical placements with aliases. This makes it impossible to identify the participants or clinical placements. I was the only person with access to the original transcripts, which were stored on a secure drive that was password-protected.

Protection from Harm

GEN students are not considered a vulnerable group, although the research questions might provoke negative emotions, causing distress. All of the participants were reassured that, if they experienced any emotions and wanted to discontinue the focus groups or semi-structured interviews, they could do so without any repercussions or recrimination. If the participants disclosed witnessing any unsafe practices or distressing events, I informed that that I would signpost them to the appropriate support services provided by the Department of Health Sciences. In addition, I provided the participants with a list of services and organisations that could provide further support; for example, Samaritans, open-door counselling, etc. (see Appendix 12). Having been a nurse for over 22 years, I believed that I had the skills to deal with distressing situations and offer appropriate support to the participants.

Data Storage

The participants were informed that their data would be stored safely, and that I would follow the Department of Health Sciences data storage guidelines. The data management plan (see Appendix 9) outlines the data storage procedure. All of the data generated for this research is password-protected and stored as per the University's data storage policy, abiding by the General Data Protection Regulation (GDPR, 2018) and (BERA, 2020) guidelines, with only the researcher having access to the data. All data will be securely stored for a maximum of five years, after which they will be destroyed using the University's data disposal procedure.

4.8 Approach to the Data Analysis and Synthesis

The approach to the data analysis that I adopted is consistent with qualitative research and intended to generate knowledge that is grounded in human experiences. TA (Braun and Clarke, 2006) lends itself to my ontological and epistemological stance, enabling me to interpret the vital knowledge about the fundamental nature of the relationship between the clinical placement experiences and professional values of the GEN student participants and, hence, is the most suitable analytical method to employ to answer my research questions. Computer-Assisted Qualitative Data Analysis (CAQDAS) NVivo (version 12) was used to assist the analysis and further serves as an audit trail, allowing transparency and traceability in the research process. Braun and Clarke (2006, 2013) assert that TA intends to capture a level of pattern-matching or themes about research questions.

The approach adopted to analyse the data in my research follows an inductive analysis process. Silverman (2016, p332) defines inductive analysis "*as taking what is said by participants, what you've observed them doing or what you read in a text (the level of description and summary); to exploring and explaining what is 'underlying' or 'broader' … (level of concepts and themes*)". To facilitate an inductive process, Braun and Clarke's six-phase thematic analysis framework was suitable and drawn upon as the analysis framework for my research (Braun and Clarke, 2006).

However, Interpretive Phenomenological Analysis (IPA) (Alase, 2017) and Constructivist Grounded Theory (Charmaz, 2014) were also suitable for my research and could address my research questions. Smith et al. (2009, p6) stated that "*IPA are not trying to operationalise a specific philosophical idea but rather draws widely, selectively, from a range of ideas in philosophy*". That said, IPA is primarily embedded in phenomenology and concerned with the causation and structure of the participants' experiences (Lorelli et al., 2017). IPA is better known as a methodology than an analytical framework. In that sense, IPA draws on using a small participant sample group (4-6) while relying on in-depth interviews as an effective data collection method (Flowers and Larkin, 2009). The epistemological position of IPA is founded on critical realism and contextualism (Alase, 2017). At the same time, a Constructivist Grounded theory is embedded in a pre-existing theory, purporting to generate a hypothesis

supported by the data (Charmaz, 2014). My research did not intend to prove a hypothesis as in Grounded theory, so the literature was critical. From a social constructivist position, the researcher recognises, defines, and categorises the themes and patterns from the entire data set, so TA was the most suitable method for my research (Thomas, 2016).

4.8.1 The Data Corpus

The two focus groups and twelve semi-structured interviews were digitally recorded using an encrypted audio recorder. Two audio recorders were used in the event one failed to work for any reason. The transcriptions and audio recordings were securely stored on the Q drive system provided by the Department of Health Sciences, and password-protected. Upon completing the research, all the electronic transcripts will be stored on a computer (Q drive) for five years, as per the University of York data storage policy. All of the audio recordings were transcribed verbatim. I outsourced some transcriptions to an independent professional transcription service, ensuring that the company observed the General Data Protection Regulation (GDPR, 2018) principles. Bryman (2014) suggest the transcription process is the initial phase in the analysis process, providing the researcher with an opportunity to become familiar with the data.

I transcribed one focus group and three semi-structured interviews. As a novice researcher, the challenge was enormous and slightly frustrating because the process was highly time-consuming. For example, it took two to three days to transcribe each interview and a week to transcribe the focus group consisting of ten participants; however, this process was invaluable. I started the transcription process by repeatedly listening to the full recording to ensure clarity by active listening. The recordings were of high quality and made the listening and transcription process easier. I referred to the field notes in order to connect the non-verbal responses of the participants. In an ideal situation, I would have transcribed the focus groups and semi-structured interviews, but this proved impossible, due to the amount of data involved and the timescale for this thesis.

Shopes (2011) supports the idea that using a transcriber does not undermine the value of the data, as the researcher is required to listen to the recordings several times and

check them against the transcription. The transcription process here involved actively listening to all of the recordings and checking the transcriptions for accuracy with regard to language, punctuation, and the spelling of medical terminology. The transcription also contained (*** ***) for words that could not be deciphered, with phonetic spelling indicated by (ph + timecode) and missed words as (? + time code) (see Table 5). This process served two purposes. It allowed the researcher to become familiar with the data word for word and also ensured that nuances, such as correct punctuation, were used to avoid changing the meaning of the sentences.

Table 5: Excerpt from the Transcript

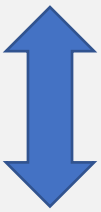
Original transcript
I really, really appreciate that. So, um, why did I come to nursing? Okay, three years ago, um, my son is ****, and then he had, err, an asthma attack And we'd been, err, in hospital for six days So, during that time, um, I just-, I fell in love with the ph + timecode really, seeing that the determination with all the doctors, all the health professionals and it just triggered that, you know, thing in me to do the same thing Because even though I have that, you know, um, that? + timecode in me to help people, stuff like that, but definitely from that time, I knew it's something that, um, I would be passionate about doing Helping people, seeing them from where they were ill and then seeing them going home, just like my son did So, it did really, really impact on my ? + timecode life stuff yes, so.
Transcript after checking
I really, really appreciate that. So, why did I come to nursing? Okay, three years ago, um, my son is **asthmatic** and then he had an asthma attack. And we'd been in hospital for six days. So, during that time, um, I just I fell in love with the **profession** really, seeing the determination with all the doctors, all the health professionals and it just triggered that, you know, thing in me to do the same thing. Because even though I have that, that **spirit** in me to help people, stuff like that, but definitely from that time, I knew it's something that I would be passionate about doing. Helping people, seeing them from when they were ill and then seeing them going home, just like my son did. So, it did really, really impact on my **personal life.**

Source: (Author, 2022)

4.9 Process of Data Analysis

Data from the focus groups and individual interviews were analysed as one data corpus. TA was considered the most appropriate method for capturing the themes across the entire data set, reflecting the GEN students' experiences and perceptions of their professional values while answering the research questions. Meanwhile, the nuances of the individual participants' responses and depth of their experiences were preserved by using excerpts from the semi-structured interviews. As Braun and Clarke (2006) noted, the six TA phases were applied to this research with the use of NVivo, as demonstrated in Table 6: Application of the TA framework with NVivo.

Table 6: Application of the TA Framework with NVivo

Thematic Analysis	Application using NVivo 12	Strategic objective	Iterative process during analysis
Phase 1 **Familiarisation with the data**	Transcription - reading and re-reading of all the transcriptions. In some cases, making several attempts at re-reading to ensure accuracy and understanding of the data.	**Data management** Open coding through NVivo  **Expressive accounts** Coding and annotating through NVivo.  **Explanatory Accounts** Inducing deeper meaning, creating memos through NVivo	**Convey data to refined codes/concepts to represent meaning.**  **Further, refine and extract abstract concepts.**  **Convey data to themes/concepts to represent meaning.**  **Assign meaning**  **Produce themes and sub-themes**
Phase 2 **Generation of the initial codes**	Generate the initial codes, also referred to as broad codes, from the data, to ensure that no ideas or interesting features are missed that are relevant to answering the research question.		
Phase 3 **Searching for themes**	I grouped the initial codes to form board categories that constitute a potential theme.		
Phase 4 **Review of the themes**	I inspected the themes to see if they related to the codes in the abstract by reviewing the entire data corpus. I produced an initial thematic map of the themes.		
Phase 5 **Defining and naming the themes**	Ongoing analysis to classify each theme and sub-themes to be logically and reliably related to the data. During this phase, each of the themes was defined		
Phase 6 **Produce of the report**	The final phase of the analysis. Excerpts were drawn to analyse and answer the research questions.		

Source: (Adopted from Braun and Clarke, 2006, 2013)

4.9.1 Phase 1 –Familiarisation with the Data

Phase 1 entailed carefully listening to all of the audio recordings and then reading the transcripts to verify their accuracy. Any inaccuracies were noted on the paper transcript and then amended on the electronic copy. Notes were made in the margin of the hard copies of the transcripts. Any concepts that were linked with the literature were noted on the transcript. In theory, immersion in the data begins with the data collection stage. Shopes (2011) suggests that immersion in the data is equivalent to the first step of the data analysis. The familiarisation with the data continued with reading and re-reading the transcriptions in some cases, with several attempts made to re-read them to ensure accuracy and understanding of the data. Bryman (2014) argues that familiarising oneself with the data is a crucial phase in the research process, and that this process is iterative. Lorelli et al. (2017) reports that researchers should keep thorough records throughout the analysis process (see Table 7: Excerpt from the Field Notes). Furthermore, if changes are made to the themes, these changes should be included in the reporting phase to ensure transparency. The participants were provided with a copy of the transcript to ensure that it was an accurate account of what was said, in line with good practice and credibility (Braun and Clarke, 2013).

Next, I formatted all of the transcripts before importing each one into the computer software - NVivo 12. At this stage, I anonymised the participants' names by allocating them pseudo-names. In that way, only I was able to identify the participant, should this be required for any reason. After adopting a robust approach to the data transcription and checking, I then felt ready to concentrate on the data and the meanings of what the participants were saying.

Table 7: Excerpt from the Field Notes

Field notes: Lila
Lila discussed her deep appreciation for the NHS and accessible healthcare, where healthcare is not free in her home country – helps to understand Lila's positionality -The comment about free healthcare struck a chord with me coming from South Africa, where healthcare is not free – not directly related to professional values -there was a brief pause, and Lila appeared as if she was gathering her thoughts… Before saying she wanted to understand her patient's experiences, and for her, it was important for patients to feel that she understood them too. -Lila's professional values appear to be leaning toward being a patient advocate (demonstrating sympathy and empathy) and establishing clear communication to understand her patients. Lila appeared slightly emotional (broke eye contact) when discussing the importance of understanding her patient's experiences before sharing her son's personal experience being a hospital patient.

Source: (Author, 2022)

4.9.2 Phase 2 Generate Initial Codes

The next phase of the data analysis process was to generate the initial codes. This process involved line-by-line coding of all of the transcripts to develop the initial codes, also referred to as broad codes, to ensure that no ideas or interesting features were overlooked that were relevant to answering the research question. The field notes that I took included the participants' tone, pauses and body language, together with my immediate thoughts, which informed the initial coding. Braun and Clarke (2006) suggest that the initial codes should be constructed by creating a list of ideas that appear exciting about the data. Therefore, the initial codes identify features from the raw data in a meaningful way related to a specific phenomenon while paying particular attention to repeated patterns. With that in mind, I constantly referred back to my research question: What is the relationship between the clinical placement experiences and professional values of GEN student participants?

The initial coding phase involved me returning to the transcripts several times to ensure that all of the transcripts received equal attention. The data were coded, even those that did not appear to fit into a particular code; for example, the code of 'loneliness'. A code was influential in the data set due to not necessarily the number of its occurrences but to its relevance to answering the research questions. This lengthy process required numerous hours of work and total concentration (see Table 8: Excerpt Demonstrating the Initial Codes). Using the NVivo data software package to

assist with the coding, 112 initial codes were generated during this phase, with some extracts fitting into more than one code on multiple occasions. When a transcript identified something interesting or significant with regard to answering the research question, this was highlighted to facilitate the next phase.

Table 8: Excerpt Demonstrating the Initial Codes

Initial Code: Professional Value of Care	
Um, you know, to be able to provide that care, that compassion for other people as she received, you know. I couldn't think of anything more rewarding than that. And um, so I think this time around, it means a lot more to me. I've got that emotional investment. P3.	Care and compassion Feelings of gratitude Nursing is more than a career

Source: (Author, 2022)

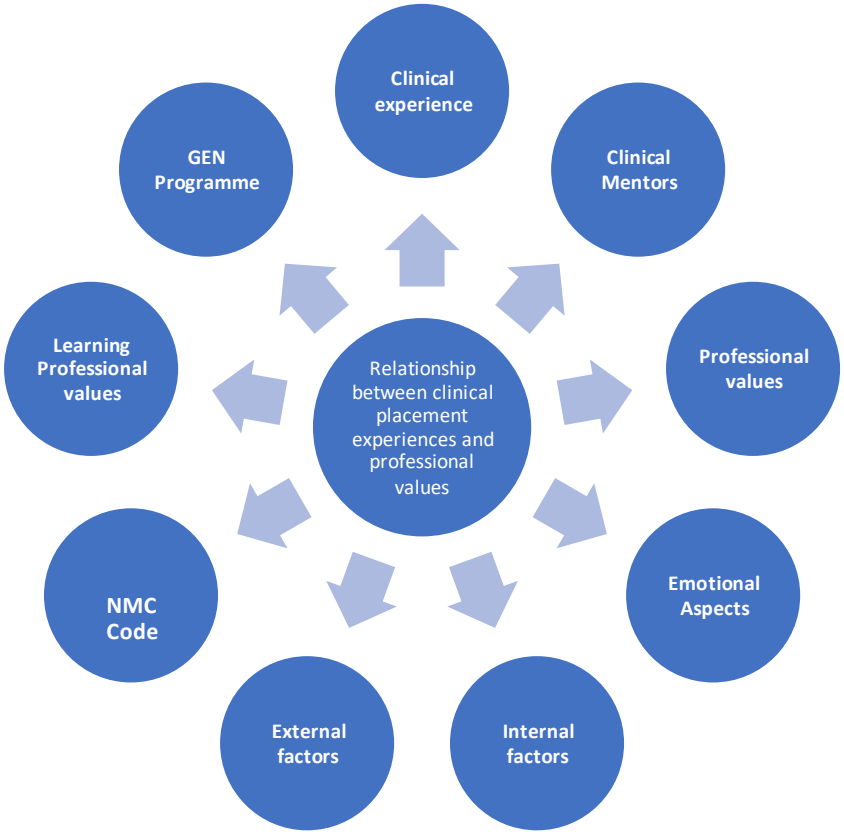
4.9.3 Phase 3 Searching for Themes

After completing the coding process across the data set, the next phase involved searching for the themes. Before searching for the initial themes, it is essential to clarify what constitutes a theme, as a theme forms a considerable part of the data analysis. Braun and Clarke (2006, p86) provide the following definition: "*A theme captures something important about the data in relation to the research questions and represents a patterned response or meaning within the data set*".

Collating the codes into themes is not entirely dependent on numerical measures but on capturing something relevant to the research question (Braun and Clarke, 2006), which means that a theme has a more extensive remit than the initial codes and is often more specific in nature. Braun and Clarke (2006; 2013) suggest two stages of identifying and reviewing themes: 'semantic' and 'latent' themes. Semantic themes are derived from the participant's exact words, identifying explicit meaning, whereas latent themes refer to "underlying intentions, assumptions or ideas" (Braun and Clarke, 2013). At the same time, Boyatzis (1998, p68) refers to these same two types as "*manifest*" and *latent*" themes.

The search for themes phase started by re-visiting the initial 112 codes and combining the initial codes to form semantic and latent themes (Braun and Clarke, 2013). The process continued by creating relationships between the codes and deciding if any of the codes could be grouped to form a theme (Braun and Clarke, 2013). This process produced nine initial themes, such as 'professional values' and 'clinical experience'. All of the themes were important at this stage and relevant to the research questions (see appendices 15a and 15b of the Codebook). Figure 1 below demonstrates the nine initial themes that were later revised in phase 4.

Figure 1: Initial Themes from the Data



Source: (Author, 2022)

4.9.4 Phase 4 Review of the Themes

The next step was to review all of the themes against the coded data. NVivo 12 was extremely useful in facilitating this process because it allowed me to go back and forth through the codes and themes to ensure that they were suitable. I re-read the data set

at this stage to ensure that the themes represented the entire data set. I assessed all of the data under each theme to ensure they were related to my research questions.

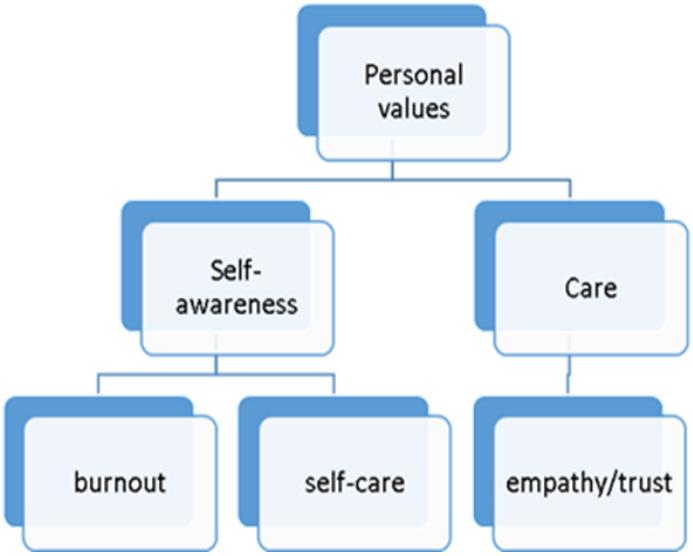
Braun and Clarke (2006) suggest that additional useful data may be identified during the process of reading and re-reading. However, it is essential to remember that data coding is an ongoing process, and the researcher should have clear guidelines on when to stop. Reviewing the themes is a vital stage in the analysis process. Creswell (2014) suggests that reviewing the themes is an iterative process, and that 'letting go' of the initial themes is part of the process. I can identify with the phrase 'letting go' as I had difficulty letting go of some of the themes; I felt that all of the data and hence all the themes were essential and told a story of the participant's experiences. After discussing this with my supervisors, I began to appreciate that not all the data can be included, and that I could still articulate an accurate account of the participants' experiences.

Where data appeared inconsistent or incongruent with other data coded under a particular theme, I considered moving it to another theme or creating a new theme. Some of the original themes lacked sufficient data to constitute a theme or sub-theme and so had to be reconsidered. As a result, some of the themes were expanded on, while others were renamed to reflect the relationship between the data. Through this process, the nine themes were reduced to five, as "external factors" and "internal factors" were combined with "clinical experience" as they appeared to belong to the wider theme, while "GEN programme" was removed from the themes and placed in the section demonstrating the participants' characteristics and their reasons for choosing the GEN programme. After reviewing these five themes (see Appendix 14 - Themes after the initial review), they were then reduced to three key themes with sub-themes to answer the three research questions (see Figure 4 Key themes). The themes were then given labels representing their similarity and accuracy across the data set (Tong et al., 2012). The final themes and sub-themes are discussed further in the findings chapter.

Lorelli et al. (2017, p8) suggest that maps, matrices, and other diagrams may be helpful when exploring and displaying the relationships between themes. A thematic map

provides a visual representation of the themes and sub-themes across the data. Figure 2 demonstrates one of the initial thematic maps.

Figure 2: Initial Thematic Map



Source (Author, 2021)

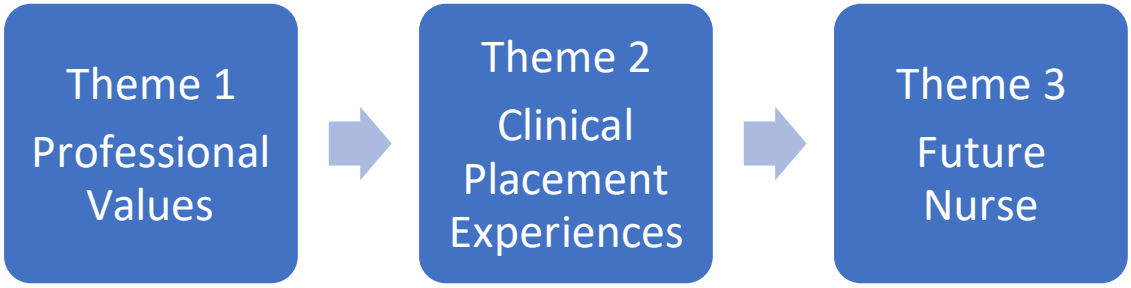
4.9.5 Phase 5 Defining and Naming the Themes

The penultimate data analysis phase was related to defining and naming the themes, which involved linking the final themes and sub-themes to ensure coherence. This phase started by classifying each theme and sub-theme so that they were related to the data logically and reliably. Each theme was defined and re-defined during this phase to articulate the participants' experiences accurately. The themes were arranged to reflect the participants' understanding and perceptions regarding the research question. The final key themes were: ‘Professional Values’, ‘Clinical Placement Experiences’ and the ‘Future Nurse’. Figure 3 demonstrates the final key themes that contributed to the relationship between the GEN student participants’ clinical placement experiences and professional values.

Throughout the data analysis process, I was guided by new readings and continually developed and altered the analysis. The process of comparing the themes and sub-

themes across the data set allowed me to view the links between the themes and subsequently merge or rename some of the themes. For example, the theme of 'Engaging with the Clinical Mentor' was merged into (theme 02) 'Clinical Placement Experiences'. Moreover, the theme of 'Learning Professional Values' was merged with (theme 03) 'Future Nurse', particularly the strategies for maintaining professional values. Finally, theme 05, 'Expectations: realism versus idealism', was renamed as the theme of 'Future Nurse', to be more representative of the data (see Appendix 14 - Themes after initial review).

Figure 3: Key Themes



Source: (Author, 2022)

4.9.6 Phase 6 Production of the Report

Producing the report is the final phase of the analysis. This data analysis phase relates to the interpretive analysis (Braun and Clarke, 2013). The report demonstrates the participant profile and nuances of the complex nature of the relationship between the GEN student participants' clinical placement experiences and their professional values. This is an area that is not represented in the field. To achieve interpretive analysis, excerpts were drawn upon to describe what was crucial in the entire data set and focused on the GEN student participants' clinical placement experiences and their professional values.

4.10 Quality Assurance

Quality assurance within any research study, whether qualitative or quantitative, is essential to maintain quality, trustworthiness, and integrity. I was mindful of my role in the research process and the importance of ensuring research rigour. That said, my research adopted the criteria described by Lincoln and Guba (1985) and more recently Patton (2015) to ensure rigour in the research process. This section demonstrates how I achieved quality assurance in my research.

Bryman (2016) argues that research quality and trustworthiness should be measured against an appropriate criterion for that research. Nowell et al. (2017, p3) suggest utilising the four criteria identified by Lincoln and Guba (1985), "*credibility, transferability, dependability, and confirmability*", when conducting TA to enhance confidence and instil trust in the reader. The step-by-step approach offered by Nowell et al. (2017) is interwoven throughout the process of TA to ensure credibility and trustworthiness, as demonstrated in Section 4.9 (the data analysis process). Table 9 reflects the quality assurance criteria adopted throughout this thesis.

Table 9: Quality Assurance Criteria

Credibility	Member checking Prolonged engagement and observation
Dependability	Audit trail (NVivo 12 - See codebook appendices 15a and 15b). Reflexivity
Confirmability	Audit trail (all documents used). Fieldnotes Reflexivity and positionality
Transferability	Development of thick descriptions Transparency in the research process

Adapted from Lincoln and Guba (1985) and Patton (2015).

4.10.1 Credibility

Credibility refers to ensuring that the research findings are convincing and trustworthy (Creswell, 2014). Within credibility itself, several measures can be carried out, such as member checking, using multiple sources of data, and de-briefing (Denzin and Lincoln, 2011), all of which were undertaken to ensure credibility in the research process.

I used member checking to enhance the credibility of my research, whereby the participants were provided with a copy of their transcript and invited to check the accuracy of the recording and see if they wished to redact any text (Houghton et al., 2013). Only three participants accepted the invitation to check the transcripts, and not all of them were interested in reviewing what they had said. Those participants who reviewed their transcript found what they had said interesting but did not request any changes. Unfortunately, I did not have the opportunity to present the research findings to the participants because they had completed the nursing programme by the time the results had been analysed. I am in contact with some of the participants, who are now qualified nurses, and would be happy to share a copy of my thesis with them. Member checking was used during the pilot study as well, and this measure did not add anything new to the quality assurance process.

Another strategy for ensuring credibility is data triangulation, which involves adopting two or more data collection methods to study a phenomenon (Houghton et al., 2013). While data triangulation is beneficial within a social constructivist paradigm, it is argued that there is no one reality; therefore, in principle, there are no data to verify. However, each data collection method served to strengthen the interpretations of the findings.

Prolonged engagement and observation are the final measures for ensuring credibility in the research process. Lincoln and Guba (1985) emphasise that prolonged engagement and observation can improve the credibility of research and thus produce a more complete understanding of the phenomenon under study. I used observations during the focus groups and semi-structured interviews in an informal way, as I spent a substantial amount of time with the participants during the six-month data collection phase. I took the time to build a rapport and develop a trusting relationship with the

participants through engagement and observation. Hence, I felt a personal responsibility to share the participants' realities as far as I was able.

4.10.2 Dependability

Crotty (2015) suggests that dependability is the ability to demonstrate research reliability and trustworthiness by creating a reliable audit trail and reflexivity. To establish dependability in the current research, an audit trail of the data analysis is available via NVivo 11 (Table 6: Application of the TA Framework with NVivo), (see appendices 15a and 15b) detailing the different phases of the coding and theme development. In addition to the NVivo audit trail, I created an audit trail of all the documents used in the research process, clearly explaining the decisions taken. All of the transcripts, audio files, and field notes are stored observing the data storage regulations, which can be viewed upon request.

Furthermore, copies of all of the forms, such as the consent form, information form, and interview proforma, can be found in the appendix. Concerning the research dependability overall, I believe that I have been transparent and open about my positionality while demonstrating reflexivity and the methodological approaches utilised.

4.10.3 Confirmability

Confirmability is an important criterion that questions the interest and incentive of the researcher (Houghton et al., 2013). The researcher should be mindful of their contribution and personal responses. Reflexivity and reflection are procedures that account for transparency in the research process; by engaging in these, I demonstrate self-awareness.

Due to this, I made explicit my role in the research process as a doctoral researcher and not a nurse lecturer primarily because the participants were known to me. Further details about my positionality and reflexivity can be viewed in Sections 4.11 and 7.2. I also maintained a reflective journal throughout the research process as well as detailed supervision notes.

4.10.4 Transferability

Transferability is the last criterion reported, including thick descriptions and transparency (Denzin and Lincoln, 2011), which means that adequate details of the research process must be included to ensure how far the findings may be transferable to another, similar context. The responsibility of creating a comprehensive account of the processes or context of the research rests with the researcher, by providing 'thick descriptions' and transparency (Lincoln and Guba, 1985). However, there is a balance between the researchers' understanding and interpretation of the participants' perceptions (Patton, 2015). To achieve this balance, I presented the thick descriptions in chapter (5) (Findings) by using extracts from the transcript to generate authenticity. This involved presenting detailed, nuanced accounts of the participants' experiences. From these 'thick descriptions', the reader can infer meaning from the context. Patton (2015) argues that, for transferability to be achieved, a detailed account of the research process must be available, covering aspects such as the findings with developing themes and a discussion of the conclusions of the study and its limitations, to allow the reader to compare and contrast the relevance of the study with other research. I believe that I provided a detailed, transparent account of the research process followed.

4.11 Positionality

Central to qualitative research, and particularly within a qualitative interview study design, the researcher is essential to every phase of the research process (Creswell, 2014). Holmes (2020) refers to positionality as the researcher's position within the research. Acknowledging my place in the social world, this research recognises and acknowledges my positionality in the research process. A problem confronting research of this nature is its potential lack of objectivity, but this does not mean that the research needs to lapse into a state where actions are not accounted for. As such, I have clarified my biography and positionality in the research process and the decisions made.

I was mindful of my intersectional positionality as a South African female, registered nurse, and nurse academic with professional experiences from South Africa, Saudi Arabia, and the UK, all of which factors played an essential role in this research. The critical lens through which the data was collected, interpreted and analysed was inevitability influenced by my experiences and positionality. Palaganas et al. (2017) suggest that self-awareness is critical when an individual is actively involved in research. Self-awareness meant recognising my experiences when working alongside the GEN student group.

Palaganas et al. (2017, p426) suggest that research "*highlights the journey of discovering how we, as researchers, shape and how we were shaped by the research process and outputs*". As a researcher, I possessed knowledge and power, which resulted in me being an 'insider' in this research, and meant I had a responsibility to reflect on my background as a registered nurse and nurse lecturer. I adopted a critical stance and considered the positionality of my role as a researcher (EdD student) and nurse lecturer within this research, particularly with regard to how I shaped the research process.

My prior knowledge and experience enabled me quickly to immerse myself in the research. That said, I did not have any teaching contact with the participants during their five- month clinical placements. From the beginning of the research process, I ensured that my role was made explicit, being a student undertaking a Doctorate in Education rather than a nurse lecturer, to prevent this influencing the participants' participation or responses. I further discussed the research process with the participants (information gathering, analysis, and presentation). The participants were invited to review the transcripts if they wished. Some participants wish to read the thesis on completion, which would be my honour, and I will share the link to it once it is available. That is the least I can offer them in return for their kind contributions.

I was constantly aware of the power imbalance between myself as a researcher and the participants. I reassured the participants of their role in the research process, gave them a choice to share the experiences they wished to share, and assured them that there were no right or wrong answers. These steps help to negate what Thomas (2013, p63) describes as the "*halo effect*", where the participants say what they think the

researcher wants to hear. Nevertheless, some participants might have felt that they 'should' participate in my research, so it is essential to be mindful that a power imbalance can never be entirely eliminated but acknowledged as part of the research process.

During the interview process, there was the potential for conflict between my dual position as a nurse and researcher. As a registered nurse in the adult field of nursing with experience in ITU, I could join in discussions about this area far more than discussions relating to the community placement experiences. The participants' experience also included aspects of mental health and social care issues, areas with which I am relatively unfamiliar, hence my level of participation in the discussions depended on my level of competency within the clinical speciality concerned. As a nurse with professional registration, I am duty-bound by the NMC to work within my level of competency (NMC, 2018a, p5):

> *Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code*.

Another perceived difficulty I experienced related to my positionality was maintaining my professional integrity as a registered nurse and researcher. My role and responsibility as a researcher appeared to oppose my role as a registered nurse. Whilst this research did not aim to identify poor practice or sub-optimal care, in light of the experiences the participants shared with me, I occasionally felt duty-bound as a registrant of the NMC to intervene. For example, the excerpt below shared by Mila indicates various levels of poor practice, whereby a patient who was non-compliant with an artificial airway (tracheostomy) continued to eat and drink, which is counter-advised and can cause aspiration. In this case, the medical team advised the patient to stop eating or their artificial airway would be removed, leading to the patient's death.

> *Oh, big, because he needed it. Um, there's no reason why he shouldn't get better. Um, yes he was very unwell but he you know, he*

wasn't on end-of-life, he wasn't palliated at that time, we were expecting him to recover (Mila, Int. p8).

This example of inadequate practice is worth challenging and questioning by the registered nurse and student nurses, not merely taking the lead from their clinical mentors. I decided not to intervene and felt that, had I intervened during this interview and questioned the clinical practice, it may have caused the participant anxiety and perhaps altered what they shared with me. I followed the participant's lead, as her experiences and views needed to emerge. I did not share with the participant my difficulty with the experience and how strongly I felt that this situation should have been questioned and reported to the nurse in charge for further investigation. This experience demonstrates the complexity of my positionality as a registered nurse and researcher.

Sultana (2007) suggests that recognising and renegotiating the positionality, identity, and power can change the research process, and notes necessity for researchers to be aware that participants may modify their behaviour and alter their dialogue to suit the researcher or audience. During the data collection phase, I was mindful of this and drew on the behaviour management techniques. For example, I ensured that all participants had a fair chance to contribute, which enabled the less vocal participants to share their experiences and avoid being dominated by the loudest voices in the group.

4.12 Chapter Summary

This chapter provided the rationale for the adoption of the methodological approach in this research. This research employed a qualitative interview study design through a social constructivist lens. The chosen methodology is compatible with the research aim and questions and made it possible to explore 'new knowledge' relating to the GEN student participants' experiences and perceptions of their professional values. The research design, sample strategy, recruitment of participants, data collection methods, ethical considerations, analytical framework, quality assurance, and finally, my positionality have all been discussed. The following chapter will present the findings of this research.

Chapter 5: Research Findings Sections 1 and 2

5.0 Introduction

This research aims to critically examine the relationship between the GEN student participants' clinical placement experiences and their professional values. The findings chapter presents two inter-related sections; Section 1 presents the demographic data and participant profiles while identifying and examining their personal values. Section 2 is structured by directly responding to the three research sub-questions presented under the theme's headings and sub-headings to reflect TA, which was drawn upon to analyse the data (Braun and Clarke, 2006, 2013).

The goal in combining sections 1 and 2 of the findings chapter is to provide coherence and a continuation of the participant profiles and personal values with the rest of the findings. There is a deep connection between the participants' profiles and their personal and professional values within a nursing context (Rassin, 2008, 2010). Understanding personal values is linked to the participants' profiles, experiences, backgrounds, and prior learning, that affect how they understand their professional values. As discussed in chapter (4), the data gathered in this research were analysed through a social constructivist lens. Bryman (2014) suggests that no object can be adequately understood in isolation from the context in which it is experienced, nor can any experience be appropriately described in isolation from its circumstances. Therefore, the findings throughout this chapter are validated by using direct quotations from the participants.

Section 1 - Participants' Profile and Personal Values

5.1 Demographic Characteristics

Section 5.1 focuses on the participants' demographic data. Demographic data facilitate a better understanding of the participants' background characteristics, such as their age, gender, reasons for undertaking a GEN programme, and previous degree and work experiences (Creswell and Creswell, 2018), whereas Section 5.2 focuses on a contextual analysis of the individual participants' profiles before discussing their

personal values. The participants are identified by pseudonyms so that no participant can be identified in the process. Each extract has a reference that indicates the participant's name, whether the comment was made during a focus group (FG) or interview (INT) and the page number of the transcript where the quote may be found. Definitions of the terms used in this chapter can be viewed in (see Appendix 1).

Eleven of the twelve participants were white middle-class, representing the local area's demographics, while one participant identified as African-other. Two of the participants identified with the male gender, while ten identified as female. It is not uncommon for a nursing programme to attract more female nurses than male nurses; nevertheless, this narrative is changing. The Office for Students (OfS) (2019) suggests that Nursing and Midwifery programmes across the board had a higher number of female than male student nurses, while recognising that 20-35% of the students came from ethnic minority backgrounds. The participants were aged 25 to 43 years, with an average group age of 28.1 years at the time of the research. All of the participants had a previous degree or experience of master's level study. Six of the participants had a degree in a health-related subject, while the other six had an arts or humanities degree. All twelve participants had been attracted to the GEN programme because of its shorter duration and personal/family reasons. Three participants had young families while undertaking the nursing programme. All twelve participants agreed that the bursary offered at the time was a major determining factor in them accessing the GEN programme.

Furthermore, the participants reported that the university's location was relevant to them accessing the GEN programme. Seven of the participants had a final placement in acute areas, such as A&E, ICU, or CCU, and five participants had a placement in community areas, such as a GP practice, district nursing or outpatient services. The participants' characteristics can be viewed in tabular form in (see Appendix 13 Participant Characteristics).

5.2 Individual Participant Profiles

Direct quotations from the individual interview transcripts were used to highlight the personal values that the participants brought to their experiences and learning. Each participant's profile begins with a quotation, that represents their profile and understanding of their personal values.

Lila - "Being in good health is the wealth we can have"

Lila is a 43-year-old female with a young family. Lila had completed two previous degrees, in French literature and Community Development, that involved building local communities based on justice, equality and respect both in the UK and in her home country in Central Africa. Lila chose to become a nurse because of her personal experiences and family influences. Lila was attracted to the GEN programme in particular because of shorter duration, family reasons and the financial support provided by the nursing bursary. Lila had several years of care experience as a healthcare assistant. Her final placement was in a community care setting. Lila identified the following personal values: 'humanism', 'value others' and 'seeing others fulfil their purpose in life'.

Ava - "Respecting everyone"

Ava is a 29-year-old female, with a degree in Geography. Ava wanted to become a nurse because of her experiences while working for a healthcare-related charity. Ava chose the GEN programme because of its shorter duration and to earn a salary sooner than is possible in the case of other nursing programmes. This meant that Ava had to move location to join the GEN programme. She has no healthcare experience apart from volunteering at a healthcare charity prior to the GEN programme. Ava's final placement was in an acute care setting. She prioritised the following personal values: 'respect for people'; 'treating people individually and personally', 'value each individual' and 'empowering individuals' There was a strong connection between Ava's personal values and her Christian faith.

Bella - "Know that the small things make a big difference"

Bella is a 28-year-old female with a young family and a degree in Psychology. Bella chose to become a nurse for personal and family reasons. The GEN programme was a feasible option for Bella because of its shorter duration, which meant she could spend more time with her family. The bursary offered Bella the financial support that enabled her to undertake the GEN programme. Bella has four years of healthcare experience from working in psychiatric hospital before starting the GEN programme. Her final placement was in an acute care setting. Bella's personal values were to 'help others', 'care passionately' and provide 'evidence-based care', as well as to consider all aspects of a patient's lifestyle.

Zara – "To offer care equally and compassionately"

Zara is a 28-year-old female with a degree in Tourism Management. Zara wanted to become a nurse for personal reasons, and enjoys working with different people and dealing with different challenges. Zara chose the GEN programme because of its shorter duration and the financial support provided by the bursary. Zara liked the structure of the GEN programme and the proximity of the university to her home. Zara has several years of healthcare experience of working in a psychiatric hospital prior to commencing the GEN programme. Zara's final placement was in an acute care setting, and her personal values were 'enjoys working with people', 'helping people' and 'care in a non-judgemental way'.

Tim - "Seeing beyond the illness and staying in the moment"

Tim is a 33-year-old male with a degree in Biochemistry and a master's degree in Biotechnology. Tim chose to become a nurse for personal reasons and has a strong parental influence as both his parents are nurses. Tim was attracted to the GEN programme because of its shorter duration and the financial support of the nursing bursary. Moreover, he had student loans from his previous degrees. Tim had no previous direct healthcare experience apart from working as a research technician

doing clinical trials. Tim's final placement was in an acute care setting. His personal values were 'compassion' with an emphasis on the human connection and simple acts of 'kindness'.

Iris - "Hard-working and very organised"

Iris is a 28-year-old female with a degree in Event Management. Iris chose to become a nurse because of her previous experiences and enjoyed working with people. Moreover, Iris wanted to be the best nurse she could be. She chose the GEN programme because of its shorter duration and the financial support of the bursary. Iris had experience of working as a community carer before commencing the GEN programme. Her final placement was in an acute care setting. Iris demonstrated the personal values of 'helping people' and 'person-centred care'.

Evie - "Enthusiastic and compassionate"

Evie is a 27-year-old female with a degree in Sociology. Evie chose to become a nurse because she enjoyed working with people and is a practical person who prefers doing hands-on tasks. The GEN programme was suitable for Evie because of its shorter duration. Evie had several years of experience working as a healthcare assistant prior to commencing the GEN programme. Evie's final placement was in an acute care setting. She recognised 'patient-centred care', 'compassion' and 'being approachable' as her personal values.

Chloe - "Treating people as individuals"

Chloe is a 33-year-old female with a degree in English literature, writing and performance. Chloe chose to become a nurse because of her previous experiences of working alongside children with learning disabilities. Chloe was attracted to the GEN programme for multiple reasons: having a previous degree, the shorter duration and the financial support of the bursary. Chloe has several years of experience of working as a carer with adults and children with learning disabilities prior to commencing the

GEN programme. Chloe's final placement was in an acute care setting. Her personal values were 'treating people as individuals and 'providing care' when people cannot care for themselves.

Jin - "Partnership with patients"

Jin is a 26-year-old male with a degree in Psychology. Jin chose to become a nurse because of working with a positive role model in a previous healthcare setting. Moreover, he enjoyed working in a care setting. Jin chose the GEN programme because of its shorter duration, to earn a salary sooner, and the financial support of the bursary. Jin had experience working as a healthcare assistant for two years before commencing the GEN programme. Jin's final placement was in a community care setting. His personal values consisted of 'partnership with patients' and 'supporting patient autonomy'.

Liv - "Giving patients the same care, dignity and respect I would want to receive"

Liv is a 35-year-old female with a degree in Communication. Liv chose to become a nurse because this had been her ambition since childhood, and she had previous personal experience of being a patient herself. Liv chose the GEN programme because of its shorter duration, family influence and financial support. Liv had several years of experience of working as a healthcare assistant in a hospital prior to commencing the GEN programme. Liv's final placement was in a community care setting. Her personal values were 'care', 'dignity' and 'respect'.

Erin – "Respect, diversity and inclusion"

Erin is a 28-year-old female with a degree in Law and a master's degree in Nutrition. Erin chose to become a nurse because of her long-standing interest in anatomy and physiology and the fact that she enjoys working with people. Erin chose the GEN programme because of its shorter duration and the financial support of the bursary.

Erin does not have any direct healthcare experience but had volunteered at a health-related charity before working as a podiatry assistant prior to commencing this nursing programme. Erin's final placement was in a community care setting. Her personal values encompassed the following: 'respect', 'dignity', 'diversity', 'inclusion' and 'learning'.

Mila - "Free healthcare and Equal healthcare"

Mila is a 25-year-old female with a degree in Music. Mila chose to become a nurse because it was an available option and something she had considered before. Mila chose the GEN programme because of its shorter duration, small cohort size, association with like-minded people and the financial support of the bursary offered. Mila had experience as a healthcare assistant prior to commencing the GEN programme. Mila's final placement was in an acute care setting. She identified her personal values as 'valued as a nurse', 'respect' and 'equal healthcare'.

5.3 The Participants' Perceived Personal Values

The participants listed a range of qualities that represented their personal values. However, many participants had, surprisingly, never consciously considered their personal values until this point in their nursing career. This was slightly concerning as these participants were only two months away from qualifying as RNs. The participants reported a consensus regarding their personal values of care, compassion, respect, empathy, and kindness. However, what became evident when developing the participants' profiles were that most of them wanted to help people, and nursing provides that opportunity. Many of the participants shared personal qualities about themselves while articulating their personal values. Some of the participants focussed on selfless acts of caring for someone in a time of need, followed by the human connection of caring for someone. Tim stated the following about his personal values:

> *"I'll always strive to, you know, demonstrate that ability to understand the human connection and it's how these smallest acts of kindness make the*

unbearable bearable" (Tim, Int. p15).

Jin, meanwhile, thought that offering a patient a cup of tea was simple yet very effective in demonstrating his compassion and the human connection:

> "I ask them if they'd like a cup of tea and a sandwich, you know. Because, it's just simple things like that. It doesn't take long, it's going to a staff room, it takes max a minute to make somebody a cup of tea and just talk to them" (Jin, Int. p7).

Tim and Jin were the only two male participants in the group, and both reported their personal values through social interaction and human connection. The most likely reason for this is that Tim and Jin viewed 'human connection' and the 'simple things' as going beyond treating the physical condition of the patient and connecting with him/her on a deeper level. The 'simple things' do not require much time, money, or resources yet offer invaluable care and compassion to a patient. It is through interactions and connections with the patients that Tim and Jin were able to construct the social meaning of their personal values in a rewarding way.

Bella and Zara identified their personal values as care and compassion. Compassion was recognised as the vulnerability of others and the need to alleviate any suffering by 'helping people'. Bella reported that all nurses need to have care and compassion, and must want to share those values with their patients. Delivering care and compassion for Bella, therefore, meant being aware of the patient's needs before being able to care compassionately:

> *I hope that every nurse that comes into nursing wants to help others. think that caring compassionately is important because it means that you care about the person for every aspect or you consider all their wants and needs at the time to give that better care* (Bella, Int. p1).

Bella may be alluding here to the point that she has come across nurses who fail to display 'care' and 'compassion'. Indeed, it may also be naïve to believe that every nurse has the qualities that Bella had. On the other hand, Zara wanted to deliver

compassionate care in a 'non-judgemental' way. Zara's personal values were related to her perceived experience of witnessing some unprofessional behaviour during her clinical placement, where staff displayed judgemental behaviour towards a patient. Zara felt very strongly about this as it did not align with her personal values:

> *It would be to deliver care compassionately and be non-judgemental. Yeah. I always try to look at it from an aspect of what I would feel like in that instance, or what I would want if it was me or a family member. So, I would rather give them what I would want if it was me* (Zara, Int. p13).

Bella and Zara always wanted to be nurses and to help people, and the fact that they had accumulated several years of healthcare experience prior to commencing the nursing programme may have shaped their personal values and ideas about nursing and the type of nurse they wanted to be. They were sensitive to the needs of the patients and wanted to provide compassionate care as if they were caring for a family member.

Lila, Ava, Evie, Liv and Chloe reported 'respect' for and the human rights of their patients as part of their personal values. All the above participants had previous healthcare experience or had a family member who was/had been a patient. They appreciated that mutual respect was vital. The following excerpts from Lila, Evie and Liv demonstrate their understanding of the personal value of 'respect':

> *Valuing others is really important as well because everybody wants to be valued. When you show respect to people, they feel valued* (Lila, Int. p3).

> *You should respect someone's privacy and maintain dignity* (Evie, Int. p5).

> *In the community it's very much you're in the patient's home so, you know, you respect everything that's going on for them* (Liv, Int. p2).

In addition, Lila, Evie and Liv are older than the other participants, which might indicate that a generational difference was associated with respect, and respect was important to them when caring for their patients.

Notably, Ava was the only participant who reported a strong connection between her personal values and her religion (the Christian faith). Religion was the focal point in Ava's life, and therefore she viewed everyone as equal and important when delivering care:

> *I suppose um-, respect I'm a Christian, so, that is quite central to my life and my values. I see everybody as people and just everyone's as important as each other* (Ava, Int. p2).

Liv, Lila and Ava reported that the values of having 'empathy' and 'humility' motivated them to become a nurse, indicating that they may have already had these personal values before starting the nursing programme. Liv shared her experience of being a patient herself, undergoing controversial surgery for weight loss, so she could empathise with her patients first-hand. Liv demonstrated a sense of duty to reflect on her positive experience with her patients.

Furthermore, Liv's experiences in the hospital as a patient were co-constructed between the healthcare staff and herself, which created her reality of the social experience:

> *So, I've been a patient as well in the hospital and everyone was, they were lovely. I had surgery, it's quite a controversial thing and I know what it's like working with larger patients, and it can be quite strenuous, hard, you know, hard work. So, I just wanted to give back but at the same time make sure that the patients received the same care that I received* (Liv, Int. p2).

Conversely, Zara, Erin, Iris and Mila did not consider that their personal values influenced their decision to become a nurse. However, they attributed their experiences to a family member being a patient, that co-constructed the development of their personal values:

> *Um, to be completely honest. It was never something throughout any part of my life that said 'Oh, you know, I really want to be a nurse.' Nursing was really, really recent* (Mila, Int. p1).

Later, during the semi-structured interview, Mila shared her personal experience of her father being admitted to hospital for surgery. Due to the pressures of the NHS her father was put on a long waiting list which resulted in him paying to have surgery privately. It may be this experience that helped to shape Mila's personal values, giving her a strong desire to ensure equal and free healthcare for all.

5.4 Common Threads when Examining Personal Values

All the participants were able to identify and report their personal values, which ranged from 'care', 'compassion', 'dignity', 'respect', and 'empathy' to kindness. Personal values form an extension of one's professional values, and several participants indicated that managing both in clinical placement can prove challenging, further discussion is provided in section 2. The participants demonstrated a link between their personal values and nursing. However, this integration concerned their personal and professional values and how they present themselves and navigate the CPE. A discussion of the divergence and convergence between the participants' personal and professional values is reported in Section 5.8.1.

Although the participants enter nursing with a set of personal and professional values, there is an awareness that these values may change in order to enable them to reflect and uphold the professional standards of the nursing profession. The participants provided the following reasons for becoming a nurse, some of which were not directly related to their personal values but essential to understanding their social context—ranging from personal issues, family-related factors, the shorter programme and the bursary as having motivated them to embark on a career in nursing. Their personal reasons ranged from being a patient themselves to having a family member or close friend in hospital. Ava, Tim, and Erin had no previous direct healthcare experience

when they started the GEN programme, unlike all of the other participants. However, they shared similar sentiments of wanting to help and make a difference to people's lives.

5.5 Summary of Section 1

Section 1 provided an overview of the participants' demographic characteristics and profiles and identified their personal values. The research suggests GEN student participants had a set of personal values acquired from their families, society and life experiences. Personal values ranged from care, compassion, dignity, respect, and empathy. These values remained relatively constant and guided their professional values when faced with professional dilemmas. Nevertheless, the aim of this research is to examine the professional values of the participants, which cannot be achieved without examining their personal values also. Section 1 makes it possible to gain a sense of whom each participant is based on their profile and understanding of their personal values when answering the three research sub-questions in Section 2. Next, Section 2 of the findings will be discussed, which is structured according to the main themes to answer the three research sub-questions.

Section 2 Findings Related to the Research Questions

5.6 Summary of the Answers to the Research Questions

There is a complex interdependent relationship between professional values and the clinical placement experiences. The latter shape the participants' understanding, development, and operationalisation of their professional values as future nurses. The findings demonstrate that professional values are essential in providing quality nursing care. The GEN student participants defined their professional values in relation to maintaining quality nursing care, patient safety, and patient advocacy. At the same time, the operationalisation of professional values is governed by the participants' understanding of their professional values and interpretation of the NMC Code. The findings further illustrated that the clinical placement experiences related to nursing care and engaging with the clinical mentor had an overall positive relationship with the participants' professional values. The NHS's social and organisational pressures had implications regarding the awareness and management of the participants' emotions related to their professional values. The participants creatively developed strategies to maintain their professional values as future nurses.

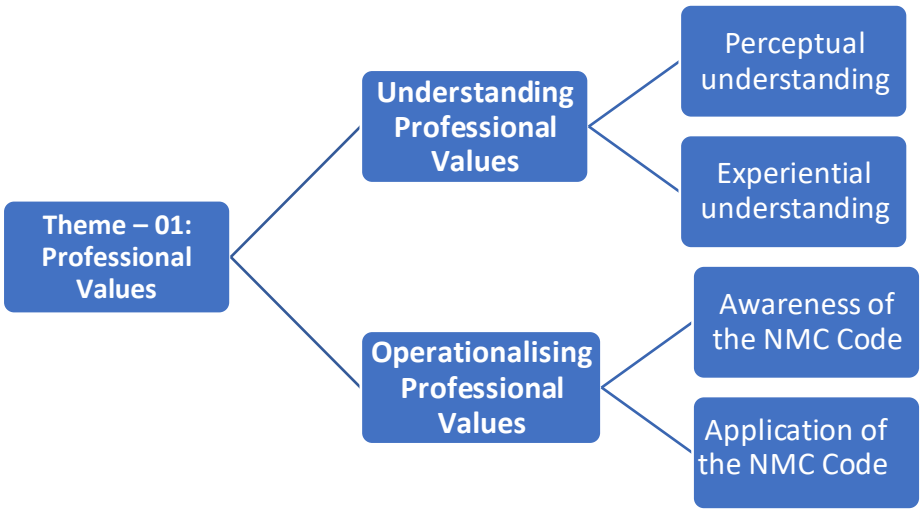
5.7 Research Sub-question – 1

What are the definitions of professional values as understood by the GEN student participants?

The objective was to identify how the GEN student participants define their professional values. The justification for this sub-question can be found in chapter 1, section 1.5. Figure 4 below presents theme 01 – Professional Values.

5.7.1 Theme – 01: Professional Values

Figure 4: Professional Values



Source: (Author, 2022)

Theme (01) Professional values consisted of the following sub-themes: 'understanding professional values' and 'operationalising professional values'. Each sub-theme will be discussed separately in this section. The participants identified their professional values in terms of: 'respect', 'promoting independence', 'empowering patients', 'patient advocate, 'education', 'honesty', 'care', 'compassion', 'respect' and 'patient safety'.

5.7.1.1 Understanding Professional Values

The participants' definition of their professional values varied and was related to their nursing practice, the type of clinical placement and their past healthcare experiences. Nevertheless, the common thread throughout the participants' understanding and definitions of professional values is maintaining quality nursing care, patient safety and patient advocacy.

The following extract is from Lila, who has significant experience of healthcare. Lila defined her professional values as:

> *Valuing others is really important. When you show respect to people, they feel valued. Um, it is the same for any other areas, like, if I talk about person-centred care for instance, we value the patient when*

we give them a choice. When we ask them (patients) about their opinion about the care that they receive, they feel valued, you know. So, I think, valuing the patient is very important as well (Lila, Int. p3).

Lila's understanding of her professional values was related to valuing patients' input into their care. Lila draws on the explicit connection between giving the patient choices, which implies respecting and valuing the patient. Lila further discussed the importance of the patient being involved in their care and feeling valued. Valuing patients may indicate Lila's own desire to feel valued and respected in the clinical placement environment. Indeed, mutual respect creates an atmosphere of positive relationships.

In comparison, Jin, one of the two male participants in the group, had studied psychology before starting the GEN programme. Jin described his professional value as encouraging patient independence. From a psychological perspective, promoting patient independence is viewed as a process that promotes a partnership when dealing with patients. As such, Jin suggests that independence requires focus and commitment. Jin's perception of his professional value may be related to his previous degree in psychology; therefore, promoting independence is important to him and viewed as a task that he focuses on while interacting and caring for his patients:

I think independence is something that's hugely important, and so it's something that you've got to focus on when you're dealing with people (Jin, Int. p3).

Meanwhile, Ava's definition of professional values focused on empowering patients, which may support Jin's definition of promoting patient independence. Both Jin and Ava focus on giving control back to the patient, and the patient therefore becomes the central focus of their care which in turn allows the patients to take ownership of the decisions related to their healthcare:

Yeah, empowering the patients is really important. I think it is good to give people the opportunity just to do what they can, especially, if

> *someone has a condition that is going to affect them for the rest of their life* (Ava, Int. p3).

In an ICU setting, empowering patients to take control of their recovery and rehabilitation is strongly promoted. For Ava, her professional value of empowering patients meant seeing beyond the immediate situation and empowering patients for the future so that they can be better prepared to manage their long-term condition. Ava's professional values of 'empowering patients' might have been influenced by the nature of her placement.

Zara had a diverse understanding of her professional value of being a patient advocate, yet acknowledged that it can be challenging to uphold advocacy within the NHS's hierarchical structures. From the following extract, Zara refers to the importance of having the confidence and courage to speak up if concerned about any aspect of patient care:

> *Stand up for what you believe in, I guess and sometimes it's really difficult, depending on who's above you or power and that. But if it's something you're really concerned about or believe in, having a voice to bring it up* (Zara, FG1. p2).

Yes. Absolutely. (Group agreement)

Zara has several years of healthcare-related experience and clearly understands how the healthcare system works. Therefore, Zara appreciates being heard and feels that representing the patient's voice is important when providing quality care. There was group agreement when Zara shared her experiences, possibly because the participants have experienced similar situations themselves and fully support the promotion of patient advocacy.

Chloe, Erin and Evie shared a similar understanding of their professional values that were linked to learning and education in supporting the development of their professional values. They believed that learning and education were significant to their development, enabling them to keep up-to-date with nursing knowledge and deliver evidence-based care. Neill (2011, 2012) and Jamieson et al. (2020) support the idea

that the GEN student group demonstrates an ability to be fast learners and critical thinkers, and seek opportunities to learn. The following extracts indicate the GEN student participants' desire to learn and be the best nurse they can be to deliver quality nursing care, and thus, learning and education are a means of achieving that:

> *I really enjoy learning and always have done. I was looking for a role that would encourage me to enhance my skills and to develop and to learn more about the world. And that is exactly what nursing is about and how nursing came to me* (Chloe, Int. p2).

> *I really like nursing because I think it's professional, you're constantly having to learn, and I like thinking that I'm never going to know it all because I'll have to keep on learning. I like that sort of excitement of constantly learning* (Erin, Int. p2).

> *As well as the personal stuff, I think a nurse has an interesting role in that we kind of have to know our stuff, we have to know what's going on with the patient, and the anatomy and physiology….* (Evie, FG1. p3).

On the other hand, Tim described his professional value as honesty. Tim was the other male participant in the group who had a degree in biochemistry but no direct healthcare-related experience, having worked as a research assistant:

> *It's this idea of the duty of candour and being open, honest, you know. We're all human, we do all make mistakes. The worst thing you can do is to deny that happening and to lie about it. It's so important to be open and honest* (Tim, Int. p6).

From the above extract, Tim is referring to the context of witnessing an incident involving repeated attempts to undertake specific invasive clinical procedures to a patient, such as catheterisation, nasogastric tube insertion or cannulation. Tim

referred to the legal duty to be open and honest with patients and carers when something goes wrong. Through this, Tim demonstrated an awareness of his professional and statutory commitment to uphold his 'Duty of candour' in nursing. There is also an element of acknowledging the personal limitations of the self and others when Tim said, "*We're all human, we do all make mistakes*". These limitations can occur within or without a challenged healthcare system, leading many to re-assess the situation.

Bella's understanding that professional values are related to compassion was crucial to her when delivering quality nursing care. While also demonstrating her awareness of a lack of compassionate care and the implications, she referred to the Francis report as follows:

> *I just think compassionate care, really. I'm focused on compassionate care and I've, discussed the fact that it's part of our 6Cs of nursing. That it came following a real you know, failing of care, and so that is really important. I could talk you through the Francis report?* (Bella, Int. p6).

Whilst Bella expressed her commitment to compassionate care, she also referred to compassionate care as part of the 6C's of nursing. Bella was one of three participants with a young family at home, for whom she cared when not at work. Bella's understanding of what it means to provide compassionate care for her patients may be related to her provision of care and compassion to her family. Bella demonstrated a heightened awareness of the implications of poor care due to a lack of professional values and what that meant for patient care.

Several participants shared the view that delivering person-centred care was an aspect of their professional values. Person-centred care is a model of care related to creating equal partnerships to ensure that all health and social care needs are met:

> *Person-centred because they (patients) are in a complicated environment, the NHS and all the pressures that come with that, but*

> *at the end of the day, it's a person who is the centre of that, and they are the centre of their lives, and we need to support them* (Ava, Int. p3).
>
> *I think person-centred, that's the first that comes to mind. We're in a privileged position performing lots of clinical interventions you know. Moving away from this idea of paternalism and more towards shared decision-making, yeah* (Tim, Int. p6).
>
> *I think holistic care suits. Yeah, just looking after the whole person rather than just the problem that they have medically* (Liv, Int. p4).
>
> *Person centred care always focuses on the needs of the person because everyone's individual, what one person might like another person might not. You need to kind of be mindful of what other people are going through and what kind of care, basically individualised care* (Evie, Int. p3).

Ava, Tim, Liv and Evie made sense of their professional values based on a similar understanding of person-centred care, according to the above extracts. Person-centred care meant putting the needs and care of patients first and providing them with an opportunity to be part of their care. In order to deliver person-centred care, the participants suggested that it is vital to get to know the patient; hence, person-centred care can be viewed as a way of thinking and acting, in which the patients who use the health services are considered equal participants. Both Tim and Liv agree that person-centred care is neither paternalistic nor driven by a medical model of care, but forward thinking and the patient remains the centre of all care.

Care and compassion were other ways in which the participants defined their professional values. That said, care and compassion including privacy, dignity, and respect also appeared as part of the participants personal values, highlighting the importance of understanding both personal and professional values in nursing. These findings support the notion of Rassin (2010) that personal values extend to professional values and should not be viewed in isolation. It is encouraging to see this

overlap and the favourable implications for the nursing profession, which requires such perceptive views.

The following extracts demonstrate the participants' understanding of the professional values of care and compassion:

> *I feel it's important to be enthusiastic and compassionate because people are at a very vulnerable stage of their life, so it's important to have someone there who's going to make them feel that they can talk to and listen to* (Evie, Int. p2).
>
> *Empathy is really important, as well. It does establish that caring relationship between you and the patient* (Lila, FG1. p2).
>
> *I'm focused on compassionate care and I've, sort of, discussed the fact that it's part of our 6Cs of nursing* (Bella, Int. p6).
>
> *I think it's always; I think a fine balance of being able to be compassionate, and show empathy* (Erin, Int. p4).

The above extracts demonstrate that care and compassion are essential for delivering quality care, and consideration must be paid to empathy and humility. Moreover, care and compassion are recognised as alleviating suffering when a patient is vulnerable, as illustrated by Evie, whilst empathy was regarded as the ability to view oneself in the patient's situation and understand things from their point of view. A delicate balance is needed to deliver the best care. Bella referred to the NHS's 6C's again: care, compassion, communication, commitment, competence, and courage (NHS, 2014), which demonstrated Bella's commitment to implementing the national guidelines and, importantly, the link between these and her professional values.

Several participants identified 'respect', as their professional value suggesting a desire to respect individuals at a deeper level that being, as human beings rather than patients in need of care. Respect was also identified as a personal value. Tim's perception of respect as his professional value seemed to transcend merely maintaining patient privacy and dignity to incorporate a connection between two human beings:

> *I wanted to give something back to other people you know, be able to establish positive nurse-patient relationships based on respect and dignity and trust and being able to connect with somebody on a human level* (Tim, Int. p3).

Liv's experience of respect related to respecting patients' rights, including their right to refuse treatment or reject the advice of healthcare professionals. Liv referred to an experience where a patient refused the treatment or advice offered, even though it was in their best interests. Liv appeared perplexed by this experience but recognised the need to respect the patient's wishes, which is linked to her professional value of person-centred care:

> *It's quite frustrating really, it's just ignoring the advice, but at the same time it's their choice to, so you've got to respect their, their autonomy* (Liv, FG2. p5).

Erin had a different understanding of respect, which appears twofold: firstly, to her, having respect meant not having a prejudiced view of patients and thus demonstrating respect. Secondly, being part of the nursing profession meant that everyone respected each other because they were like-minded. Erin appeared to demonstrate a degree of naivety by expecting to find the same understanding of respect amongst all nurses:

> *I do see nursing as an area where you have to show respect to other people, I think if you have any prejudice you can't really use that. You shouldn't really be going into it (nursing). I thought I have those values and maybe if I go into an environment other people will also have those values as well, so they'll want to respect other people* (Erin, Int. p2).

The participants' perceptions of respect as a professional value demonstrated that professional values mean different things to different people because of their varied life and work experiences and, furthermore, emphasising that professional values are viewed as a social construct. Nevertheless, the responses and perceptions gathered might have differed had this same question been asked at a different stage of the

participants' nursing programme or perhaps if the participants were on a different nursing programme. The GEN student participants brought with them different experiences from their prior learning, work experiences and life experiences and therefore, respect is viewed in a far deeper and broader context than the nursing field.

5.7.1.2 Operationalising Professional Values

The participants were not provided with any information regarding the NMC Code prior to the focus groups and semi-structured interviews. They were asked if they thought that the Code influenced how they operationalised their professional values, to explore their awareness and application of the Code while drawing on their own professional values.

All of the participants were mindful of the Code concerning their professional values, particularly now that they were final year students compared to when they embarked on their nursing programme. It became evident that, when the participant's operationalised their professional values, that there was a link to the principles of the Code. There exists an implicit connection between the participants' professional values and the NMC Code because the GEN student group is viewed as unique due to their prior learning, previous healthcare experiences and life experiences. Accordingly, they respect and understand the standing of the Code as future nurses:

> *I think it's important regardless of whether it's necessary for me, it might be necessary for others, because it governs us and it's really useful in those situations to bring people back down to basic. 'This is nursing at the basic level and this is what we want of you* (Bella, Int. p12).

> *I think it's quite clear and specific and it does guide you in the right direction. It gives you enough room to be your own kind of nurse and bring your own kind of quality to your role with the proper professional values and guidance that you need…It just brings a better all-round good care to a placement really* (Zara, Int. p15).

These extracts demonstrate that Bella and Zara viewed the Code as a benchmark for providing care. The discussion indicated that the Code was the minimum standard to achieve when providing nursing care: "*bring people back down to basics*". However, Zara acknowledges that the Code allows room for initiative, which may suggest that nurses can go above and beyond the realms of the Code or that the Code is open to interpretation by individuals.

There is an assumption that the participants had already aligned their nursing practice with the principles of the Code and *vice versa*. Evie, Erin, Chloe and Jin suggest, in the following extracts, that the Code simply complemented or confirmed their pre-existing professional values. As such, the Code served as a reminder of what is expected of a nurse, which they already possess and know:

> *I think I already had these values in me anyway. I think the code had just strengthened mine. This is what it should be, you should be caring and compassionate, you should respect someone's privacy and maintain dignity, and all that. I think that's already in me anyway, but the code is like a good guideline, just as a legal document to say this is what you should be following and not to forget it* (Evie, Int. p5).

> *Absolutely yeah. When reading through it a lot of the values such as openness, honesty or treating people as individuals and providing the best care that you can when you can. Lots of those values are things that I feel that match my values anyway. And there aren't very many, I can't think of a single one that doesn't match how I would want to be treated and how I would want to treat people. So, I think that they imprinted my professional values but also, I feel like they come from a place where I recognise and understand* (Chloe, Int. p4).

> *I think my professional values have, sort of, been there for the last six, seven years, in terms of empathy, kindness, wanting people to be independent, and I think it's just maybe the Code has acted as maybe a reference point* (Erin, Int. p6).

> *I'm may be influenced in the sense that it provides a validation for the values that I hold. I find that my values line-up with the values of the NMC. Not necessarily that they've influenced them* (Jin, Int. p10).

On the other hand, Ava reported feeling unsure if the Code directly related to her professional values or nursing practice but believed that it is required to convey her "*professional responsibilities*. Ava understood her professional values as her professional responsibility while demonstrating a degree of honesty by saying that she did not look at the Code every day but understands the responsibility. I suspect that this is the case for many student nurses:

> *I don't know if it might, I think they're already there, but I think that it has broadly helped to articulate them better, because I can't say I look at them every day. You know, you don't look at them that regularly, but, you still know what, you know it's needed to articulate what the professional responsibilities…* (Ava, Int. p8).

Mila shared a similar view to Ava, believing that the Code had not directly influenced her professional values or nursing practice. Mila compared the Code to *common sense*, somewhat reducing the value and purpose of the Code to what is known by all instinctively:

> *I don't, I don't think it's (the NMC code) really influenced, it's very much almost a common sense, isn't it? It's, like, you've got to be honest, you've got to do the right thing. You've got to make sure you know your stuff* (Mila, Int. p9).

The Code served as a point of reference or a guide, according to the above extracts, especially when things go wrong during a clinical placement. The Code is drawn on to refocus or calibrate care needs and the purpose of being a nurse.

Learning in the clinical placement environment makes up more than fifty percent of the participant's educational experiences while studying on the GEN programme. Therefore, applying the principles of the Code is essential in order to maintain

professional values. Iris reported an experience of applying the professional values that she had learnt in the clinical environment:

> *And it's so busy I'd get like a bit stressed; I'd just think back to what my mentor would do in this situation and it's just stay calm* (Iris, Int. p9).

Iris applied the professional values she observed in her clinical mentor, which was to remain calm when the ward was busy, whereas Mila reported consciously or unconsciously adapting her behaviour while applying the principles of the Code to her professional values:

> *Um, because when you're at work you're also consciously or unconsciously adapting your personality and your habits to the people around you. I think it's almost as a collective, really, that you act. If somebody does something one way, it's, you know, it's going to snowball and spread throughout* (Mila, Int. p11).

Mila provided an alternative yet interesting interpretation of the application of the Code by relating it to an 'act'. The abstracts from Iris and Mila implied that they were constantly observing and applying the principles of the Code in the CPE, indicating that the participants are putting on a performance while applying the Code rather than embodying its principles:

> *I've obviously been doing this course for almost two years now. I've done a lot of placements, and independently I've organised a lot of bespoke placements as well. So, I've come across a lot of different nurses and a lot of different nursing styles. And it can be quite difficult to adjust to people's nursing styles* (Tim, Int. p11).

In the above extract, Tim raises a similar point of linking the application of the Code to an 'act' when working with different nurses and each having a different nursing style. The extract highlights the challenges that the GEN student participants face related to applying the Code when working with clinical mentors with different nursing styles. The different clinical mentors' styles might lead to the GEN student participants'

adoption of different professional values because the clinical mentor is central to all clinical placement experiences. Their positive or negative influences have a strong relationship with how the GEN student participants formulate and operationalise their professional values (see Section 5.8.1.2. Experiences of engaging with clinical mentors).

GEN student participants' ability to adapt to their clinical mentor's style, rather than *vice versa*, is thought-provoking and demonstrates some of the difficulties that student nurses experience while on their clinical placements. Nevertheless, the extract may also suggest that the application of the Code may influence the participant's behaviour, which could potentially influence the types of professional values that they adopt.

Applying the professional values of empathy and compassion can be a delicate, complicated task. Erin admired her clinical mentors' ability to apply empathy and compassion while remaining professional:

> *I think with empathy, my mentor is quite inspiring in the sense that she, Um, she's still very professional* (Erin, Int. p4).

Erin implied that the ability to differentiate between compassion and empathy indicates the successful application of the Code. This extract indicates that exposure to positive experiences when applying the Code could positively shape the participants' professional values.

Conversely, the participants discussed perceived experiences that compromised the application of the Code, creating a conflict between their professional values and their clinical experiences:

> *It's not all about task-oriented, is it. The thing with confidentiality people just shout people's details across. Like, I'm sure people don't mean to do that, but it's just when you've not got time, you're just, like, rushing* (Tim, FG2. p9).
>
> *Or like, there's, like, folders left open* (Iris, FG2. p9).

> *Oh yeah. I've seen visitors looking at the screens, you know, in the corridor. You can see everyone's names, what bed number, you know. People just stand there and stare at them, and that's not okay* (Chloe, FG2. p9).

Exposing confidential patient information is unacceptable, even when rushed or busy. The above extracts demonstrate that a breach of confidentiality when delivering patient care was recognised as conflicting with the participant's professional value of maintaining confidentiality. These experiences suggest that exposure to different practices may influence how students learn and apply professional values to their nursing practice.

5.7.1.3 Common Threads in Defining Professional Values

Professional values can mean different things to different people; however, the participants demonstrated consistency and shared meaning in their definitions of their professional values. The participants' perceptions of their professional values positively influenced their patient care and maintained patient safety. Despite witnessing perceived unprofessional behaviour, the participants had a strong desire to maintain their professional values and deliver high-quality care. The Code was considered necessary to the participants when operationalising their professional values and they aligned their definitions of professional values with providing care, compassion, collaboration, patient safety, respect, and learning.

5.7.1.4 Summary

In summary, professional values are essential to all healthcare professionals including student nurses navigating the field. The GEN student participants had a unique combination of professional values centred around delivering quality nursing care, patient safety, and advocacy. Thus, the GEN student participants' definitions of professional values are firmly rooted in their desire to deliver and maintain quality patient care. The participants' understanding of professional values reflects their reality of constructing their knowledge and experiences while remaining an active part of the social process—the participants' professional values are related to their

perceptions and the operationalisation of the principles of the NMC Code. However, there was an implicit connection between the participants' professional values and the NMC Code, as they recognised when a conflict arose between their professional values and specific clinical placement experiences that they encountered. In conclusion, the participants' professional values were their personal values playing out in a professional context, and that context mediated their professional values creating an interdependent relationship.

This section discussed and presented theme 01, Professional Values, to answer research sub-question 1. The following two sections will discuss theme 02, Clinical Placement Experiences, to answer research sub-question 2, followed by theme 03, Future Nurse, to answer research sub-question 3.

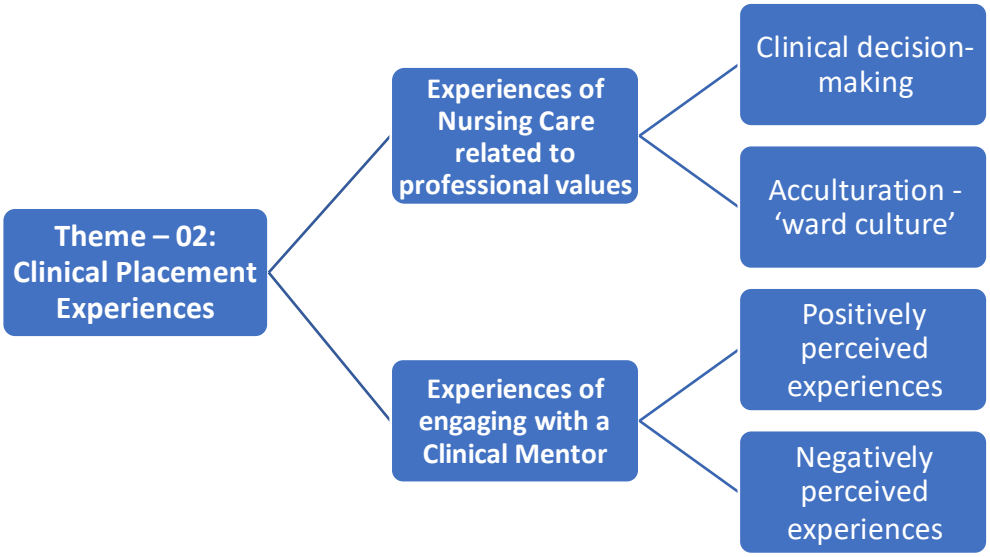
5.8 Research Sub-question – 2

What experiences do the GEN students identify in their clinical placements that relate to their professional values?

The objective was to understand the identified clinical placement experiences that change or shape the professional values of the GEN student participants. The justification for this sub-question can be found in chapter 1, section 1.5. Figure 5 below presents theme 02 – Clinical Placement Experiences.

5.8.1 Theme – 02: Clinical Placement Experiences

Figure 5: Clinical Placement Experiences



Source: (Author, 2022)

Theme (02) identified the two most significant clinical placement experiences related to the participants' professional values; experiences of nursing care related to professional values and experiences of engaging with the clinical mentor. The following professional values were identified within those experiences: patient autonomy, patient advocate, patient's rights, patient safety, knowledge, compassion, and kindness.

5.8.1.1 Experiences of Nursing Care Related to Professional Values

The category of clinical decision-making refers to the decisions made by registered nurses, doctors and patients related to the GEN student participants' professional values. Clinical decision-making was context- and time-specific in each experience reported. In contrast, the acculturation of professional values was multi-layered and related to the social and organisational elements linked to the participants' professional values. Clinical decision-making and acculturation will be discussed separately.

- **Clinical Decision-making**

Clinical decision-making is an evolving process related to a sense of balance between the patients' experiences, awareness and knowledge concerning the information

available at the time to achieve the desired outcome. It is the process of clinical decision-making, that challenged the participants' professional values.

Evie's extract refers to the clinical decisions taken regarding end-of-life care for a patient. A Do Not Resuscitate (DNR) order was in place, and the minimal treatment provided was intended to ensure that the patient was comfortable. Evie appeared to have experienced a conflict between her professional value of person-centred care and the clinical decision taken, which may seem contradictory because person-centred care places the patient at the centre of their care. Evie had a strong connection with her professional value and felt that withdrawing treatment was not the 'right' thing to do for her but the best choice for the patient:

> *So, I did not feel like it was right to carry on, but I know some people would say it is right to carry on because it could reverse the effects of what happened. Looking at the scenario and how many interventions she had and her age and everything* (Evie, Int. p3).

Mila shared a similar experience to Evie regarding the clinical decision to perform cardio-pulmonary resuscitate (CPR) on a 99-year-old patient with multiple co-morbidities, at the family's request. Mila demonstrated a conflict between the clinical decision taken and the best outcome for the patient, as she could not see any benefit in performing CPR on the patient purely due to the family's request. Mila may have been closed off to the family's feelings at the time:

> *I mean, mine is almost on the other end of the scale to that, when you've got somebody who's extremely frail, extremely poorly, and yet, family are insisting, 'No, we (family) want you to do everything possible,' and we're just thinking, 'Why?* (Mila, FG1. p9).

Zara's experience appears to be more focused on the clinical decision taken, which was the early discharge of patients due to a shortage of beds and the fast turnaround. Zara grappled with the clinical decision to discharge clinically unfit patients to a less acute ward or even home, only to have them return later. Zara identified the root cause of

the problem as being the lack of staff and unless we are given "*more staff*" the problem remains, emphasising the current situation in the NHS:

> *We can't do any more, unless you give us more staff. Like, we are going to be sending patients back out who are poorly and then they'll bounce back again. Like there just isn't anything we can do…* (Zara, FG1. p5).

Mila shared her experience involving a patient who was non-compliant with an artificial airway (tracheostomy) as they continued to eat and drink, which is counter-advised and can cause aspiration. The conflict arose when the medical team advised the patient to stop eating or their artificial airway would be removed. Whether said in jest or as a threat to encourage the patient to comply, Mila felt distraught by this experience and the explicit link to her professional values:

> *Oh, big, because he needed it. Um, there's no reason why he shouldn't get better. Um, yes he was very unwell but you know, he wasn't on end-of-life, he wasn't palliated at that time, he was, we were expecting him to recover* (Mila, Int. p8).

This clinical decision profoundly affected Mila, sparking disbelief and challenging her professional values of person-centred care and patient autonomy. Mila reported that the patient had the mental capacity and ability to recover, so removing his artificial airway would end his life. From the extract, Mila recognised the ongoing nature of clinical decision-making and its influence on the type of nursing care she delivered to her patients. Therefore, indicating the patient's recovery was important to Mila as much as operationalising her professional values.

The extracts shared by Tim and Jin suggest that they both had great difficulty with the process and outcomes of some of the clinical decisions that were related to their professional values. Tim found it difficult to watch the procedure of inserting a naso-gastric tube but realised the importance of addressing the patient's nutritional needs. At the same time, Jin grappled with the idea of amputating a patient's leg versus their quality of life. The extracts shared demonstrate powerful iterations of some of the

challenges faced by healthcare staff in the CPE, and Tim and Jin question the reality versus the idealism of nursing:

> *I found it really difficult watching people get naso-gastric tubes, it's very unpleasant, anyway, and then people are not very well, or they don't realise what's happening. I suppose my values is patient autonomy, and if someone's fighting, I guess that means they don't want some kind of intervention and whereas that was in conflict with needing to keep someone alive by feeding them, so, yeah* (Tim, FG2. p14).

> *There was an older gentleman with dementia, the treatment for him was, like, he had to have his leg amputated, and the doctors were, well, the healthcare staff who were looking after him, basically recommended against it because it wasn't going to improve his quality of life in any way* (Jin, FG2. p15).

The above extracts demonstrate that the clinical decision-making challenged some of the participants' professional values of dignity, respect, care, compassion, autonomy, and person-centred care. The key areas identified in the relationship between the participants' professional values and clinical decision-making are, firstly, how clinical decisions are made and the motivation behind the decisions and, secondly, the organisation's role in providing support when protocols and procedures are implemented regarding the clinical decisions taken. Nevertheless, all clinical decision-making experiences were emotive and demanded social interactions between the participant, nursing and medical staff and the patient.

- **Acculturation - 'ward culture'**

The clinical placement culture refers to the shared values, belief systems, attitudes and the set of assumptions shared by those accessing the CPE.

The findings demonstrated that the ward culture significantly shaped the participants' professional values of providing compassion, kindness, respect, and person-centred care. The findings demonstrated the subtle differences between how the participants

perceived and operationalised their professional values within different 'ward cultures'.

An established 'ward culture' can be challenging for student nurses to enter and operationalise their professional values. Mila, for example, reported that feeling like an 'outsider' entering an established group of people on the ward was so difficult that she considered leaving the nursing profession. (Mila completed the nursing programme despite the challenges she reported).

> *Apart from the first week, it was cliquey, and everybody was very, you know, kind of, stuck together like, 'Oh, yes, that's my friend.' And then, coming into that from the outside was really difficult, and throughout the entire placement, it just got worse, and worse and I hated it. I wanted to quit, and I didn't want to go back again, and it was really, really awful* (Mila, FG1. p6).

The above extract suggests that this negative experience impacted Mila's formulation of her professional values and that feeling accepted on the ward was important in allowing her to operationalise her professional values. Mila was fortunate in being able to draw on her previous work and life experiences in this situation. This experience demonstrates the significance of the ward culture and how it can lead to student nurses wanting to leave the nursing profession.

Evie reported that the high staff turnaround on the ward meant that the capacity to support student nurses was affected. The staff shortage and feeling of being unwelcomed contributed to a negative ward culture that impacted on how Evie operationalised her professional values. Staff shortages impact the ward culture, particularly when the participants are trying to learn and deliver quality nursing care:

> *One of the things in my placement is staff turnaround, at the moment. So, apparently, they have told the uni, before my placement, that they didn't really have the capacity for a student, because they have a massive amount of new staff nurses* (Evie, FG1. p7).

Erin highlighted the difference between working in a hospital setting with a specific ward culture to working in a community setting. A community setting means working within an unfamiliar environment such as the patient's home rather that in a familiar ward setting in a hospital. Erin suggests that nurses feel more comfortable about exercising control and power in a familiar environment and thus have the freedom to exercise their professional values more easily than in a patient's home, which is unfamiliar to them:

> *I think as well, in a hospital setting, because nurses view it as their environment, they're in control, that they don't give patients enough freedom to express themselves to be comfortable, and you notice the difference in the community where you go to people's homes* (Erin, FG2 p8).

Jin, Ava, Evie, Mila, and Iris perceived a positive ward culture as involving supportive ward sisters or senior team members. The following extract from Jin suggests that teamwork is undoubtedly part of a supportive ward culture. Irrespective of the hierarchy, teamwork is a necessary skill in the CPE and can have a massive impact on the staff's morale and general well-being during a long shift. This, in turn, impacts how professional values are viewed and operationalised:

> *Well, maybe not my values but certainly my professional values in nursing, working with a mentor. The way she (senior sister) is kind, so thoroughly did her job, the example that she set. It was quite impressive because it's quite easy to maybe consider things to be less worthy of your time and therefore, either put them off or not do them with any enthusiasm, which is difficult and not good when you're working with people* (Jin, Int. p3).

Tim and Chloe's final placement was in A&E, and they discussed the shortage of staff and busyness of the environment, suggesting that this impacted patient care and, no doubt, their professional values:

> *Nurses that are not really willing to engage the patients because they're upset about the workload that's been given to them because somebody hasn't turned up into work and you can see that it's their attitude then, which they then transmit onto the patient is not very good* (Tim, Int. p10).

> *So, yeah, it's both the time and a workforce aspect, you know, the NHS, the long-term plan is recognising that staff are feeling the strain and that it needs to recruit more staff to the NHS. And retain the staff that are in the NHS by making working environments more rewarding and providing a more positive culture* (Tim, Int. p11).

> *It's a challenge sometimes, in that environment when it's so acute and so busy to provide care. To find, I'm sure that's the same in any ward situation where you're understaffed, and you don't have the time to provide the kind of care that you'd like to anyway* (Chloe, Int. p3).

These extracts further demonstrate that the ward culture is closely related to how Tim and Chloe perceived operationalising their professional values. There appeared to be a degree of frustration expressed because they were aware of the outside challenges and had no control over them or ability to change the situation (nurse shortages and a lack of resources). The issue identified was the shortage of nurses and recruitment/retention, which poses challenges for the participants as future RNs. The participants were acutely aware that they were two months away from qualifying as RNs. They would be faced with these challenges as newly qualified nurses when operationalising their professional values.

Liv shared a contrasting view of the 'culture' in the community setting compared to Tim and Chloe, however, suggesting that holistic care is more readily delivered in a community setting because of the ability to refer a patient to other health and social care services. However, that in itself does not mean holistic care. Liv may be suggesting that a nurse in the community setting can assess the physical, mental, and social needs of patients more readily than in the hospital setting and make appropriate referrals

independently, thus providing holistic care. Liv's professional value firmly supports holistic patient care:

> *I suppose in the community where I am at the minute, the patients are looked after holistically you know, 'cause we don't just deal with the issue that they've got medically. They need any social help we instigate or refer them on to other services. I like the fact that everybody's treated like a whole rather than just, it's different, but in the community it's very much you're in the patient's home so you respect everything that's going on for them* (Liv, Int. p2).

Liv, Zara, and Bella perceived that the lack of funding and clinical resources negatively affected both the ward culture and their professional values:

> *When people need extra help, they're at crisis point, that's where it becomes a struggle. The rapid response team, it's not particularly rapid and people end up struggling on. The carers get carers' fatigue and you know that's when it becomes more frustrating. I imagine its finances and staffing levels* (Liv, Int. p3).

> *The team, which is in an area that there's not much you can put in there really. You can only help so much and then the funding as well and bed space. It's kind of, all comes into one, doesn't it?* (Zara, Int. p11).

> *And maybe that might change when, if things become better or more funding is put into nursing, then I could maybe reconsider what area that I work in. But at the moment, I feel like I need to be somewhere where I can actually give the time to the patient, which is quite sad, but it's been a huge consideration for me* (Bella, Int. p8).

Time, bed and resource pressure is not a unique experience in the NHS. All of the participants agreed that they had experienced either time or bed pressure at some point and that this had challenged their professional values. Bella and Zara shared their experiences as follows:

> *I had a particular example, where the hospital that I'm working in, the need for beds is high, so I've had it before where someone's passed, and we're contacting the family, and then we're constantly asked, 'Is the bed free? Is the bed free?' And you're just trying to remain calm and compassionate, and it's really hard, because you're fighting against this ongoing force of, you know, the needs of the hospital, and people who aren't necessarily as compassionate and are more target-driven than you are, perhaps* (Bella, Int. p5).

> *When I was on my placements, we were in the morning handover, someone from management came in and was like, 'You've breached x number, and that's too many. You need to improve on your times* (Zara, Int. p5).

These comments by Bella and Zara indicate that the culture of their placement was mainly task-driven, thereby ensuring that all targets are met, and boxes ticked at the expense of patient care and safety. Bella appeared to grapple with the idea of demonstrating a lack of compassionate care when someone has died, which she found a challenging experience.

The above extracts demonstrate that the participants had different experiences related to the 'ward culture' and the relationship with their professional values. However, all of the discussed experiences are strongly related to the participants' professional values.

5.8.1.2 Experiences of Engaging with a Clinical Mentor

The findings revealed both positively and negatively perceived mentor experiences related to the participants' professional values. Positively and negatively perceived mentor experiences will be discussed separately.

- **Positively Perceived Experiences**

The positively perceived experiences were related to the clinical mentor's competence, knowledge, approachableness, kindness, confidence, communication

skills, passion for teaching and mentoring. The role and qualities of a clinical mentor became essential to the participants and a central focus of their learning and emulating their professional values. The participants were asked if any specific values of a registered nurse related to their professional values?

The extracts below from Ava, Erin and Tim demonstrated that knowledge in a particular area of nursing was recognised as an essential professional value associated with clinical competence. The participants' desire to learn and acquire knowledge was something they looked for in their clinical mentors. Erin, in particular, reported, *my mentor is knowledgeable, and it links in with my values, what I see in her*. Another element of knowledge identified was linking theoretical knowledge with clinical practice knowledge through the support of the clinical mentor as a role model.

> *I feel like sometimes it's hard to pinpoint exactly what somebody does, but it's the knowledge, and the work with patients, and also the ability to, kind of, stand up for herself, in a way* (Ava, Int. p5).
>
> *I think maybe that's why I admire her, because my mentor is knowledgeable and it links in with my values, what I see in her. I think also the stereotype sometimes with nursing that it's not as much theory, when you're explaining to patients why, if you don't know the theory, you don't know why, so you can't explain* (Erin, Int. p5).
>
> *This nurse, she's taken the time to understand things really well, and be able to explain that to people at different levels, you know? So, to me, as a student, or to a patient or another newly qualified nurse, I think that's really important, just to know as much as you can about the area that you're working in* (Ava, Int. p6).
>
> *She was absolutely fantastic. Her knowledge base was amazing, she knew everything. She helped me organise (spoke) placements. She explained concepts that I hadn't come across before* (Tim, Int. p11).

Jin and Lila valued a clinical mentor that was approachable and kind to them and their patients, and thus, an approachable and kind mentor was associated with positively perceived experiences. Iris associated a calm mentor with being approachable and kind, a quality that showed on the outside.

> *Um the way she is kind, so thoroughly did her job* (Jin, Int. p3).
>
> *Yes. I've worked with somebody who's just completely instinctive. Just instinct. They just knew exactly everything* (Lila, Int. p11).
>
> *Even if they're not feeling relaxed inside, on the outside they're just so calm and it soothes others. It really tested me when I was on an elderly ward* (Iris, Int. p9).

Evie, Zara and Ava had great admiration for their clinical mentors and viewed them as role models, one day wanting to be like them. Interestingly these participants identified similar professional values of being a patient advocate, open and honest and knowledgeable to that demonstrated by their clinical mentors. Hence, these experiences were positively associated with their mentors. However, Ava acknowledges her level of knowledge and skill by saying, "*they're all so much more knowledgeable, and skilled, and experienced than us*", suggesting the admiration for her clinical mentor or Ava could be implying that with experience, she would achieve the same level of knowledge and skill as her clinical mentor.

> *They were speaking up for the patient's rights because they couldn't do it for themselves. So, they're a voice and always thinking about the patient's needs* (Evie, Int. p4).
>
> *I appreciate the fact that she (clinical mentor) was happy to put her hands up when she didn't know the answer, as well, and she was like, we will go and find it or this is what we'll do instead and I just appreciated that* (Zara, FG1, p9).
>
> *I think it's just like, no matter who we're working with, they're all so much more knowledgeable, and skilled, and experienced than us, so I think it's just that admiration of thinking one day we might*

> *understand it as well as they do, or we might get it as quick as they did* (Ava, FG1. p13).

The participants associated the professional value of confidence with being a patient advocate. Being the patient's voice when they cannot speak up for themselves was appreciated and inspiring for Evie and Ava, which is not surprising as they acknowledged being a patient advocate as one of their professional values.

> *Oh yes, for sure. It takes a lot of confidence I think to kind of speak up because when you've got lots of people around you are kind of telling you one thing, yes, you have to be quite confident. If it's what you believe in, I think it's the right thing to do, but I can see why it's hard* (Evie, Int. p5).

> *Um, I suppose it's also confidence in the role of a nurse. You're playing an important role in the care of a patient* (Ava, Int. p6).

> *They were just, yes, speaking up for the patient's rights because they couldn't do it for themselves because they couldn't stick up for themselves. So, they're (mentor) a voice, and yes, always thinking about the patient's needs* (Evie, Int. p4).

Teaching on clinical placements is a large part of the mentoring process, and the clinical mentor is central to enabling this process, as the participants spend a large part of their nursing programme on clinical placements. Tim and Liv associated clinical mentors who created the time to teach and encourage student nurses as positively perceived experiences because they felt valued.

> *But the best nurses I've found, from a student nurse point of view, are those who invest time in you. Again, just as I would like to invest time in my patients, my mentors investing time in me and my personal and professional development, has meant an awful lot to me* (Tim, Int. p13).

> *Just taking the time to explain things to you, as well, you know, when you get a quiet moment. Actually, sort of, facilitating your learning*

process, rather than just telling you to do, you know, your 100th set of obs (vital signs) for the day. Explaining the reasons for something, and why things are done, and, you know, yeah. Just thinking more about your progression as a nurse (Liv, FG2. p19).

- **Negatively Perceived Experiences**

The negatively perceived experiences were related to a lack of professional values, and included poor communication, a lack of professionalism and a dislike for mentoring. The participants disagreed with this type of behaviour and did not wish to emulate it themselves as future RNs.

Jin, Zara and Evie reported negative experiences of poor communication when engaging with the clinical mentor. Jin discussed an experience that he perceived to represent poor communication and a lack of professional values demonstrated by his clinical mentor when carrying out his nursing duties. This experience was out of line with Jin's professional value of empowerment, and he appeared to be disappointed by the response of his clinical mentor, by whom he expected to feel empowered and supported:

I said to him (clinical mentor) it's okay I've been taking charge of some patients, so I'll, kind of, run everything there and you can do the rest if that's alright,' and he says, 'You can do whatever you want.' Not, like, 'Yes, that's a good idea,' or anything, he just said, 'You can do whatever you want (Jin, Int. p11).

Evie shared similar sentiments to Zara, who valued respect and communication when dealing with people. Zara referred to an experience with a clinical mentor, who appeared to be task-orientated, with little time to communicate with her or the patients. Zara's professional values of respect and communication were challenged because her clinical mentor focused on the tasks rather than the patients. Hence, Zara perceived this as a lack of respect and communication, which she consequently associated as a negatively perceived experience:

> *Yeah, there were a few (clinical mentors) that are very specific like that, very task orientated. So, I've worked with a few task-orientated nurses that like to just get given the tasks, what needs done during the day, and tick them off as they go* (Zara, Int. p12).

> *I think that's quite important, as well. Speaking to people like a person* (Evie, FG1. p3).

> *You know, the patient's picked up on it and they've had complaints as well. I'd never want the patients to know that I'm in a rubbish mood or-, you know? I just don't want my attitude to come across to the patients if I'm feeling rubbish* (Liv, Int. p4).

The above extracts demonstrate that the participants experienced a perceived lack of communication or poor communication. Some clinical mentors were perceived as very task orientated and, therefore, not providing the support required by the participants. Liv and Zara may have picked up on the non-verbal communication from their clinical mentors, which may have given them the impression that their mentor was too busy to offer any support.

A perceived lack of professionalism was a negatively associated experience when engaging with the clinical mentor and hence conflicted with the professional values held by Zara, Evie and Liv. A lack of professionalism consisted of being judgemental, breaching confidentiality and having an unkind attitude toward patients and other healthcare providers, including student nurses. Tim further suggested that some clinical mentors may feel threatened by GEN students because of the difference in the nursing programme and experiences. GEN students can be perceived as different from other students in the CPE because they are studying at a higher academic level, have previous life and work experiences. Tim felt confident enough to confront his clinical mentor; the confidence could be a result of his prior learning and previous experiences.

> *Maybe they just, like I say, maybe there's insecurities there. Maybe they don't like the fact that nurses are becoming more academic and it's slightly threatening for them. And, yeah, there's been times when*

> *I've actually, not pulled a nurse up on something she's done, but I've said, isn't this how, how it's done you know. So, I think there is that level of intimidate, especially for the sort of academic and studious students, who are engaged with learning and want to improve their knowledge-base quickly* (Tim, Int. p13).

Zara's placement was in an acute setting that saw patients with drug and alcohol misuse. Zara's experience questions the nature of the multidisciplinary team in providing quality care for the patient and questions if they share the same professional values or have a shared patient care perspective. Zara held the professional value of being non-judgemental, and her experience left her feeling uneasy. The experience also indicates a breach of confidentiality regarding the patients' personal information.

> *I think I wasn't that comfortable with the way people (clinical mentors) spoke about him. I know yeah, he wasn't being spoken about in a kind or respectful way. I think people had found out what he'd done, and then were sharing it. I didn't want to know what he had done but knowing that people were treating him differently because of that was quite uncomfortable* (Zara, Int. p3).

Liv was based on a community placement and witnessed what she perceived as a lack of professionalism from her clinical mentor. Liv was able to identify a lack of professionalism demonstrated by her clinical mentor but appeared constrained to say anything because she was mindful of her position as a student nurse and had to continue working with the same clinical mentor for the duration of the placement. As explained in the discussion chapter Stacey et al. (2016) noted that GEN students understand the rules of the game; as a result, they pre-empt and strategically position themselves to navigate their clinical placements successfully. This may be the case for Liv and how she navigated her clinical placement experiences. Tim also describes the difficulty of reporting a lack of professionalism as a student nurse.

> *It's, like, you don't really know whether you're, obviously if this nurse is giving the patient a really bad attitude and you can clearly see that this is not right but you don't want to overstep the boundaries*

because obviously you've gone there with your mentor (Liv, FG2. p10).

I suppose we are supposed to call out stuff when we see it, we're responsible, that's part of promoting professionalism. It's not just yourself, it's also everyone else but it is extraordinarily hard, it is really difficult (Tim, FG2. p11).

The above extracts imply that the GEN student participants were confident with their professional values and, therefore, able to identify a perceived lack of professional values in certain situations that they witnessed. Many student nurses may find it difficult to report a lack of professionalism due to the implications of this with regard to having their clinical competencies signed off.

Ava, Tim, Liv and Mila reported that knowledge and learning were professional values that were extremely important to them. Therefore, the perceived lack of mentoring in the form of teaching was viewed as out of line with their professional values. Some of the participants perceived that their clinical mentors disliked teaching them and therefore negatively associated these experiences with the clinical mentor:

I had the least natural teacher for a mentor. I mean no disrespect, because she's probably a great nurse. She's band 6, but I just felt like I was stalking her around the ward, and she didn't want me there, and she had no teaching qualities (Ava, FG1. p8).

Just making you feel like you're not a burden, cause there are some mentors that just make me feel like, 'Oh my God, do I really want to do nursing? I've come across nurses who, you know, they begrudge having students. Um, you know, have to explain things that we just, to be frank, can't be bothered to explain (Tim, Int. p19).

Yeah, and other people, they make you feel like you're asking a stupid question (Liv, FG2. p11).

> *It makes you remember what I've always told myself. If I'm a mentor, please remember what it's like, because this is why. So many mentors don't, and they don't get it* (Mila, FG1. p9).

The above extracts suggest that the participants' negatively perceived experiences could even cause them to feel that their clinical mentors disliked them personally. At the same time, Tim reported feeling like a burden and even a threat to his clinical mentors because they were too busy to teach and mentor him. These experiences led to the participants disliking their clinical placements, which affected their clinical experiences and significantly impacted how they internalised and operationalised their professional values.

5.8.1.3 Common Threads in the Participants' Clinical Placement Experiences

The findings suggest that a strong relationship exists between the participants' clinical placement experiences and their professional values. The scope of clinical decision-making had a broad remit, from decisions involving end-of-life care to the question of whether or not to perform resuscitation. The participants appreciated and understood the importance of being open and honest and respecting patient autonomy and maintaining patient safety. Some of them experienced a conflict between their professional values and how they operationalised them. Spending insufficient time with patients was viewed as a barrier to providing care and building therapeutic relationships; however, this was not the only perceived barrier. Some of the participants shared similar upsetting and challenging experiences related to the pressures arising from the understaffing and lack of resources in the CPE. These challenges appeared to compromise the participants learning and operationalisation of their professional values.

The clinical mentor is central to all clinical placements and played a crucial role in the relationship between the GEN student participants' professional values and their clinical placement experiences. The findings illustrate an overall positive relationship between the clinical mentors' professional values and the professional values of the participants. The participants associated their own professional values with those of their clinical mentors, which deepened and reinforced their pre-existing values. The

shared professional values were admired in most cases, and thus the experiences of engaging with the clinical mentor were positively perceived. Hence, the participants perceived their clinical mentors as role models if they shared similar professional values.

5.8.1.4 Summary

In summary, operationalising professional values remained essential to the participants when providing quality nursing care. The experiences challenged or affirmed their professional values when they experienced fluctuating tensions between their clinical placement experiences and professional values. Their professional values alignment kept participants focused on delivering quality nursing care and their commitment to the nursing profession, regardless of context or circumstances. All of the participants' experiences demonstrated the ability to socially construct meaning from their interactions with other healthcare professionals.

The clinical mentors had a crucial relationship with the participants' experiences and professional values. The positive experiences outweighed the negative experiences that the participants reported. A minority of the participants perceived their clinical mentor experiences as being negatively related to and consequently challenging their professional values. The participants' negatively perceived experiences made them feel determined to change the narrative as future RNs and clinical mentors. There was a strong commitment among the participants to uphold their professional values despite the challenges they experienced.

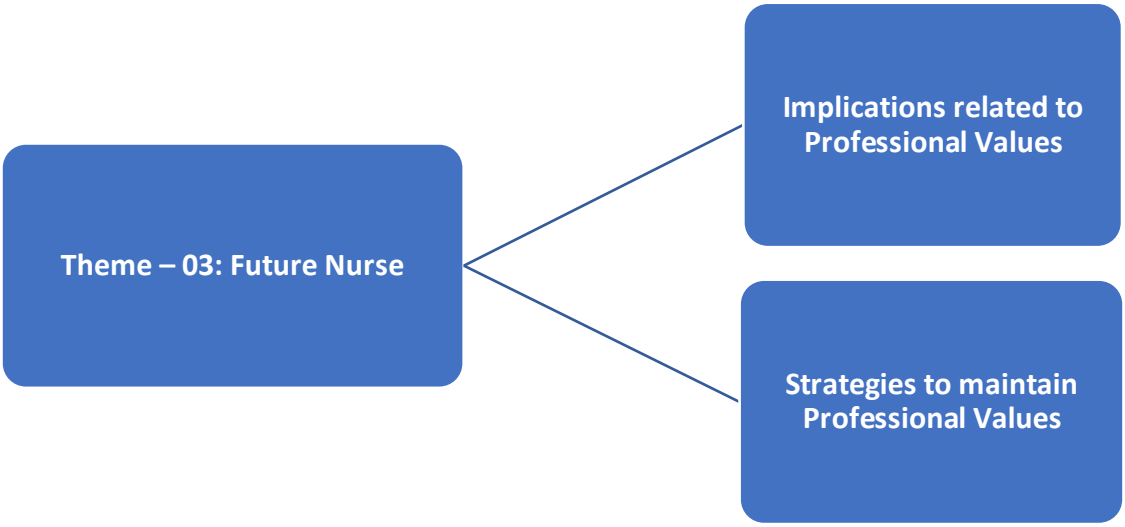
5.9 Research Sub-question – 3

What are the implications of the identified clinical placement experiences for the GEN student participants' professional values?

The objective here was to analyse the implications of the clinical placement experiences for the professional values of the GEN student participants. The justification for this sub-question can be found in chapter 1, section 1.5. Figure 6 - below presents theme 03 – Future Nurse.

5.9.1 Theme – 03: Future Nurse

Figure 6: Future Nurse



Source: (Author, 2022)

Theme (03) identified the emotional implications and the strategies that the participants used to navigate their experiences related to their professional values as future nurses. The following professional values were identified within those experiences: care and compassion, clinical decision-making and being a patient advocate.

5.9.1.1 Implications Related to Professional Values

The implications of the identified clinical placement experiences for the GEN student participants' professional values were demonstrated by their ability to identify and acknowledge their emotions while operationalising their professional values.

- **Emotion Awareness Related to Professional Values**

The participants recognised emotionally taxing experiences and the implications of those experiences on the operationalising of their professional values in the CPE. The extracts from Zara and Lila suggest that they could identify emotional experiences that

could lead to compromised professional values. Further identifying that repeated exposure to such experiences may lead to desensitisation when delivering quality nursing care. The implications of such experiences can result in a lack of care and compassion fatigue.

> *You know, if they see the same kind of case, similar cases, over and over, and I know they have in my placement recently, it's like burnout. They've just, kind of, lost their tolerance in that sense* (Zara, Int. p6).

> *I felt that patients were not looked after properly, just because of the shortage of staff. I think it's not that I'm used to it. Then our values, the NHS values are compromised* (Lila, Int. p7).

Chloe reported that it was important to be aware of professional values and prejudices, and that, more importantly, an awareness of professional values helps to operationalise them and distinguish between care that may negatively affect patients. There is also an element of being realistic in applying the Code when delivering care, especially in daily activities:

> *Um, I think that just being aware of what your values are. Because nobody has professional values that match the NMC values to the T. Like, everybody has their own prejudices and their own ideas of what should be done and what shouldn't be done. You wouldn't be human if you were, if you were just like the NMC. So, as long as you're aware of it and aware of how that may affect your care for people and you check yourself regularly and just find a way of dealing with, you know* (Chloe, Int. p9).

Bella and Tim further affirmed Chloe's point regarding emotion awareness and knowing how to manage one's professional values within specific clinical placement experiences. Wilson (2014) strongly supports that student nurses need emotional awareness if they are to deliver competent nursing care and develop the emotional intelligence that will enable them to manage the tumultuous clinical environment:

> *That's the difficult thing, because, like, you're constantly aware of what's happening around you on a greater level and sometimes you need to switch off to that. So, I suppose that, um, if I could change something, it would be that I would be better at turning off to the fact that, that there is so much going on, you know* (Bella, Int. p13).

> *Yeah, but it's not just the clinical side of it, it's the emotional side of it. So, I did three days in ICU and I was with the same patient and his wife, throughout those three long days. And by the end of it, when they decided to take him off his ventilator, um, because it was causing him discomfort and let nature take its course, it really had an impact on me. Yeah. More so than any other patient throughout my training. It stuck with me for the weekend after, it was really, yeah, really quite emotional* (Tim, Int. p14).

Evie, meanwhile, discussed the conflicting emotions that she experienced when caring for a patient with confirmed brain stem death, whose healthy organs were to be harvested later for another patient. Evie's professional value was focused on person-centred care; with that in mind, she struggled with the clinical decision to keep the patient alive for their organs instead of stopping all treatment. After discussing this with her clinical mentor, Evie accepted the idea that the decision to donate the patient's organs was in keeping with the patient's wishes. Nevertheless, her emotional awareness of the situation and its relationship with Evie's professional values was exhausting.

> *I came across a patient who's older and was like a real conflict of emotions. But yes, just keeping a patient alive when they're brain-dead, to keep their organs healthy, and ready* (Evie, FG1 p8).

For Evie, being emotionally aware meant avoiding becoming emotionally involved when building a rapport with patients, as this could cloud her professional values and, ultimately, the care the patients received. A clear boundary was required between personal and professional life to manage her emotions:

> *It's very, yes, that's hard to do because, especially if you get emotionally involved, you've got to try and not get too involved in the situation. You've got to take a step back and look at the whole picture because sometimes, you can build a rapport with patients but if you get too involved maybe your emotions will take over the actual scenario of what's going on if that makes sense* (Evie, Int. p5).

In the following extract, Erin identified the emotional element of trying to 'fit in' while on a clinical placement, which was not directly related to a patient care experience but to how she operationalised her professional values. This meant engaging in conversations of which she would not usually be a part. Erin and Tim shared similar views regarding their emotional awareness of "*fitting in"* and "*feeling settled*" before operationalising their professional values, suggesting that belonging and being part of a team was crucial when operationalising professional values:

> *I think sometimes I struggle when I think in order to feel like you fit in on a ward, sometimes you have to join in in conversations that I don't think nurses should be having such conversations when they're talking about patient's relatives or about patients maybe in a disrespectful way that they really shouldn't be. I feel like, it goes back to, like, you're there for thirteen hours, so I want to, sort of, just fit in and get on with it* (Erin, FG2. p17).

> *You're moving from one placement to the next, um, you finally feel sort of settled and comfortable in a clinical placement area, and you feel like you're getting to know the people before having to move again* (Tim, Int. p5).

While the participants were aware of their interpersonal encounters and their relationship with their professional values, Tim suggests that he felt lonely on clinical placements and having to restart his interactions because of moving from one placement to another. A new CPE may require abandoning familiar networks and exerting a great effort to seek and build new relationships, which may lead to the experience of loneliness.

GEN students are different because of their previous learning/work/life experiences, that may predispose them to feel unsettled and failing to 'fit in', which in turn may affect how they internalise and operationalise their professional values. GEN students operate on a different foundation compared to students on other nursing programmes and hence may have a higher emotional awareness and greater determination to stay the course of their journey (Jamieson et al., 2020).

Iris's emotional awareness involved wanting to make friends but was mindful of looking at the bigger picture of operationalising her professional values while still adhering to the ward's "*politics*". Stacey et al. (2015) suggest that GEN students may downplay their disposition to navigate the clinical placement environment, which may be the route that Iris chose as a means to fit in:

> *I think sometimes it's easy to get caught up with like the politics. And getting caught up with the wards. I just want to make friends, but then it's important to step back and just think. You've got to look at the bigger picture here* (Iris, Int. p17).

The constant pressures and harsh reality within the NHS strengthened Lila and Evie's emotional awareness of the relationship between their clinical placement experiences and their professional values. The shortage of staff and lack of resources in the NHS, with extended waiting times for routine operations, became all too familiar to the participants, leading them to question the nature of nursing and the emotional burden that accompanies it:

> *I always questioned that but then there were days where I get home, in the toilet and cry, because for me, it, it's not nursing at all. It's not. It's too harsh* (Lila, Int. p4).

> *You can get emotional burnout where you just feel so drained and that, yes, because some people then start feeling like, 'Oh, I don't want to go into work because I feel drained,' but yes, you have to-, most of the time it's okay, so it's fine* (Evie, Int. p7).

The following comment from Evie further emphasises her frustration at wanting to provide good quality care but being constrained by the lack of resources that were

beyond her control, which ultimately impacted the type of care delivered and how she operationalised her professional values:

> *That's what's quite frustrating though isn't it? You want to do your best job and then find there's an issue of we don't have enough staff or you feel like you've got a lot to do, you feel a bit more pressured and I think if you're under pressure that's going to have an impact on how you are as a person and how you interact with other people* (Evie, Int. p7).

Bella's comment that "*This is not nursing to me, at all*" implies a disconnection between her professional values and nursing, so Evie and Bella share a similar awareness of the emotional experiences relating to their professional values. Their priority is to provide good quality care with the patient at its heart. The challenges identified by Bella in the following extract extend beyond the shortage of staff and resources, leading to frustration and despair:

> *This placement has made me realise what I don't want to do, which is not only care about paperwork, breached times and what's on the computer screen. This is not nursing to me, at all, so it's really frustrating to see. All I've been used to doing is make sure I'm keeping up with those tasks. It's more about getting them in and out and it's not nice to see* (Bella, FG1. p4).

While Jin perceived his personal and professional values to be aligned, he was emotionally aware that he struggled with prioritising tasks, such as giving a patient water or applying a wound dressing, due to the constraints caused by the time pressure. It is not uncommon to be required to prioritise nursing care in the CPE:

> *Um, they tend to line up pretty well. So, the biggest conflict I have is, um, I tend to think that there's no kind of request too small in terms of a patients, asking me for a glass of water or something. Or anything you know, if I'm free I'd always do that regardless, if I've got the time for it, but I'd, I'd often struggle effectively, like, saying no to*

a small request in order to pursue something of more value (Jin, Int. p12).

Jin highlighted the influence of organisational pressure on the effective operationalisation of his professional values and the emotional burden of making difficult decisions at the patient's expense. After being a nurse for many years, I can personally identify with some of the challenging experiences reported by the participants. Indeed, it feels reassuring for the future of the nursing profession that the GEN student participants could demonstrate their emotional awareness as future RNs while simultaneously operationalising their professional values. However, many of these challenges remain at an organisational level, with socio-economic and political influences. Next, I will discuss the participants' strategies for maintaining and operationalising their professional values.

5.9.1.2 Strategies for Maintaining Professional Values

The participants discussed their strategies for maintaining and operationalising their professional values while managing their emotions in the CPE. These were essential for the participants, after viewing staff and patients facing stress and distress while experiencing healthcare services that are not ideal. Emotions of frustration and even anger were experienced. Professional values are about being caring, compassionate, clinically competent and doing an excellent job. It is imperative that healthcare professionals manage their emotions in order to do their job well.

- **Emotion Management Related to Professional Values**

Tim reported his involvement in Schwartz Rounds to understand and make sense of his emotions, experiences, and interactions, with a particular emphasis on maintaining his professional values:

> *It's dedicated towards strengthening the human connection at the heart of healthcare and providing more rewarding jobs and a more supportive culture. I think we need, in modern healthcare, to retain nurses in the NHS. We have a workforce crisis, so by creating nicer environments for staff, it's going to keep them, and it can only benefit the NHS* (Tim, Int. p4).

Tim spent a long time discussing his experience of being involved in Schwartz Rounds while on his clinical placement as a means of sharing, reflecting and managing his emotions. Tim's comment illustrates the importance to him of sharing and dealing with his emotional experiences. The purpose of the Schwartz Rounds is to create a reflective environment in which staff may share their clinical experiences to reduce their work stress and emotional fatigue. The Schwartz Rounds allow all staff to discuss their clinical experiences and related professional values so that improvements may be made in the future.

All of the participants discussed their ability and confidence to manage the emotions related to their professional values, which is unsurprising given that they had previous healthcare-related experiences and significant life experiences. These qualities will stand them in good stead as future RNs. Bella and Zara reported sharing their placement experiences with other student nurses as a strategy for managing their professional values. Social media platforms seem to provide an effective way for them to share their experiences with other students:

> *I mean, it definitely helped that Jane was going through the same thing at the time, so we shared that experience* (Bella, FG1. p10).
>
> *Thank God for Instagram chat* (Zara, FG1. p10).

Liv had the confidence and preferred to ask questions when she encountered a disconnection between her placement experiences and professional values, which enabled her to manage her emotions in a far more effective way, that suited her. This suggests that confident students can manage these disconnections and thus maintain their professional values more effectively than less confident students:

> *I talk a lot. You know? I ask questions. I ask questions, I do read if I need to. Yeah, just finding the support where necessary* (Liv, Int. p7).

Mila, Evie, Chloe and Tim drew on the following creative strategies to maintain their professional values: using aliases for patients, stepping back from the situation, talking to someone and accepting the human side of being a nurse:

> *If I've had a bad day, I tell people about it. I've got a thing where every patient is called Bob or Doris. So, Bob or Doris did this today. Bob or Doris said that today. There are never any further details given, I have a very dry sense of humour in that way* (Mila, Int. p12).

> *Yes, it is hard because obviously, we're all human, it's a person-centred job. I think it's important to take a step back, but it's easier said than done. I think it's important to have a team around you that you can talk to if you've got any problems* (Evie, Int. p5).

> *Like, you have your sounding board that you have at home or that you speak to regularly. And make sure you check in with them and, you know, do what you need to do. Sound off and then you can go into your workplace and be professional and deliver care in that way* (Chloe, Int. p9).

> *Obviously, whilst respecting boundaries. You know, it just shows that you are a human at the end of the day. Nurses are humans and they're vulnerable like everybody else. They have that human side. They have their own families, their own children you know, they can relate to the patients* (Tim, Int. p14).

Despite the challenges experienced in the CPE, Mila, Evie, Ava, and Tim reported that they did not wish to leave the nursing profession even when they experienced a disconnection between their clinical placement experiences and their professional values. The qualities displayed by the participants could be related to the unique characteristics that the GEN student group is known to have and demonstrate, coupled with a strong desire to become nurses, and make a difference (McKenna and Vanderheide, 2012; Jamieson et al., 2020).

The participants offered a unique layer of emotion management that is not part of their everyday experiences, regarding a lack of staffing and/or organisational resources. It entails working with healthcare services that are not ideal yet still demonstrating an ability to be professional and maintain one's professional values. Thus, managing their emotions kept them from leaving the nursing profession:

I only need to remember why I wanted to be a nurse in the first place. Yes, and remembering why you came into nursing (Evie, FG1. p7).

The positive experiences, and the overall initial reason to go into nursing keeps you doing it. Yes. It's that spark for doing it (Ava, FG1. p7).

Yes. (Group agreement)

I just, I felt like I wanted to make more of a difference, really. I'd done a lot of office jobs that, yes, paid very well, but I didn't get any sort of job satisfaction from them, any reward (Tim, Int. p1).

The above extracts indicated the participants' capacity and ability to achieve practice resilience while maintaining their professional values. A close connection is demonstrated between the participants' expectations and their desire to become an excellent nurse while making a difference in people's lives. These extracts further support the findings from the literature (Stacey et al., 2016; Jamieson et al., 2020) regarding GEN students being hardworking, motivated, determined and wanting to be the difference in nursing.

Much of the discussion focused on the end of the placement and the programme; however, having emotional awareness provided some participants with a clear perspective of the clinical area in which they wanted to work once qualified. A clinical area that shared and supported their professional values was an important factor in taking that decision. The participants also had a clear idea and confidence in the type of nurse they wished to become and the professional values that they wanted to emulate in the future:

You try your best in nursing to do everything that person needs. To be happy with that, without constantly thinking about the great and good, I suppose (Bella, Int. p14).

As long as you're aware of it (emotions) and aware of how that may affect your care for people (Chloe, Int. p9).

You know, we need to look after ourselves and each other as well as our patients. So, yes looking at where I want to work in the future, I'm going to be looking at, you know, what that trust (NHS) offers for its staff. What services are there to promote, good mental health and wellbeing in its staff members (Tim, Int. p5).

You have to think about the end, and that you will be back in that place (clinical area) where you want to be, and then, you can do the job that you want to do. But you have to have the resilience, don't you, to get through it (SH, FG1. p7).

5.9.1.3 Common Threads within the Implications for Future Nurses

The participants demonstrated maturity and resilience in their emotional awareness and management related to maintaining their professional values. The extracts demonstrated astonishing levels of practice resilience and emotional intelligence and realising that others in the group had been exposed to the same or similar experience appeared comforting to them. At the same time, this suggests that the issues discussed were far more widespread than indicated during the focus groups and interviews. The participants demonstrated that they had developed creative strategies for maintaining their professional values as they embark on the next phase of their journey to become a RN. Unfortunately, due to the limited space, this thesis cannot consider practice resilience or emotional intelligence in any detail. Nevertheless, emotional intelligence (Wilson, 2014) and resilience (Grant and Kinman, 2013; HEE, 2019a) form part of the wider debate about student nurses' experiences and further research focused on the GEN student group might prove helpful in this regard.

5.9.1.4 Summary

In summary, the findings demonstrate that the participants had personal integrity and self-awareness and wanted to be part of the CPE, where they could internalise and operationalise their professional values. The participants are agents of change who were able to socially construct learning and be transformative in their actions while being true to their professional values. In that, the participants demonstrated a unique, yet strong and highly emotional relationship between their clinical placement

experiences and the professional values to which they will adhere as future RNs. The participants offered a unique view into their emotional awareness and management while working under the pressures arising from the current NHS constraints. The participants had a strong sense of the need to operationalise their professional values, which need to be matched by investment, practical and emotional support to ensure that healthcare professionals, especially student nurses, stay in touch with their humanity as future leaders.

5.10 Overall Findings through Analysis

There were three main themes: Professional values, Clinical Placement Experiences and the Future Nurse. All three of the themes were complex, multifaceted, and interlinked with each other.

The key findings are as follows:

- A complex interdependent relationship exists between the clinical placement experiences and professional values of the participants. The participants found that their clinical placement experiences allowed them to put into practice their professional values. In turn, their professional values allowed them to approach and understand their clinical placement experiences.
- Personal values and beliefs were connected to professional values concerning nursing care and clinical decision-making.
- Clinical mentors were identified as facilitators and inhibitors of developing the professional values of the GEN students during their placement experiences.
- The process and implications of operationalising professional values are complex and can be very stressful but strengthen the participant's emotional awareness and emotion management.

5.11 Chapter Summary

The overall findings demonstrated the GEN student participants' definitions of their professional values and insight into their personal values. The participants' provided detailed, complex and often multi-layered accounts of their clinical experiences, that were open to various interpretations. The findings indicated that professional values had an interdependent relationship with and was influenced by the nature of the clinical placement experiences and clinical mentors. The power of emotional awareness and management should not be underestimated. Professional values are more about individuals and the clinical context in which they work than about organisational relationships. Nevertheless, their professional values remain extremely valuable and vital as they embark on their journey to becoming future RNs. It can thus be concluded that clinical placement experiences had a strong relationship with the GEN student participants' professional values.

This chapter examined the findings from this research in two sections. The next chapter will discuss the findings in relation to the research questions and the relevant literature.

Chapter 6: Discussion of the Findings

6.0 Introduction

This research critically examined the relationship between the GEN student participants' clinical placement experiences and their professional values. This is the penultimate chapter, built on the findings outlined in the previous chapter 5. This chapter is divided into four key sections based on the findings of this research: defining professional values, clinical placement experiences, mentor relationship and emotional implications for future nurses. These key sections are discussed in conjunction with the literature and the three research sub-questions.

6.1 Key Findings and Discussion

This thesis set out to answer the main research question: **What is the relationship between the clinical placement experiences and professional values of the GEN Student Participants?**

GEN students are a group of mature nursing students with prior life and work experiences, and knowledge gained from previous studies. As a result of this, their attitudes, education, and life experiences contribute to the construction of their professional values. GEN student participants therefore, occupy a unique position in nursing, and so offer different perspectives on defining their professional values, which were central to interpreting the findings of this research. The findings indicate a strong link between personal and professional values when faced with experiences in the CPE. In addition, their engagement with their clinical placement experiences and clinical mentors is viewed as refining and strengthening their professional values. Finally, GEN students demonstrate emotional awareness and an ability to successfully manage the implications of their clinical placement experiences related to their professional values.

6.2 Defining Professional Values

The first research sub-question examines the definitions of professional values as understood by the GEN student participants.

The discussion in this section offers a critique of the traditional definitions of professional values versus the GEN student participants' definitions of professional values in terms of quality nursing care, patient safety and patient advocacy. Alongside defining professional values, the participants demonstrated a strong connection with their personal values and a predominant shift towards understanding personal and professional values to operationalise quality nursing care. A discussion on personal values is provided to strengthen the definition of their professional values. Each finding will be discussed separately in this section.

Quality Nursing Care:

Nurses are deeply bound by their yearning to help others; care and compassion arguably form the foundation of quality nursing care. The findings demonstrated that the participants had a range of perceptions based on what defined their professional values within nursing. This is because GEN student participants possess a variety of previous healthcare experiences, life experiences and education. Quality nursing care encompasses delivering care and compassion when dealing with patients and recognising when a patient is vulnerable. The definitions offered by the participants extend beyond professional regulations and theoretical frameworks and translate into hands-on patient care with the patient as their primary focus. It was evident that the GEN student participants wanted to become nurses because they desired to 'help people', and moreover, make 'a difference' within nursing, which demonstrated an established purpose and intention to realise their vision. Sellman (2011) and Snelling and Sellman (2016) suggest that wanting to 'help people' and make 'a difference' is not a new concept in the nursing literature and is recognised as 'giving something back'. It was evident that making 'a difference' was essential to the GEN student participants and meant delivering care and compassion at the highest level as a means of giving something back, because some of the participants had personal experiences of being a patient or having a family member who was a patient. The GEN student participants' definitions of professional values are contrasted with how professional values are defined in the literature. For example, Leners et al. (2006) define professional values as the importance and quality of the concepts and behaviour existing within a discipline. Gallegos and Sortedahl (2015), meanwhile, define professional values as a framework

for assessing the actions set by a professional regulatory body. The definitions offered by Leners et al. (2006) and Gallegos and Sortedahl (2015) appear relatively abstract and are limited to a set of actions within a framework, whereas the descriptions offered by the GEN student participants are deeply rooted in patient care, with the patient at the centre of delivering quality care. However, it quickly became apparent that the GEN student participants were acutely aware of the wider implications of operationalising their professional values. That being the policies and healthcare initiatives at the time from the regulatory body and political arena that contributed to the additional pressure within the NHS (for example, the four-hour turnaround time in A&E). Moreover, they had difficulty accepting these initiatives while responding to the pressures in a meaningful way, which ultimately impacted how their professional values were operationalised. These findings are unsurprising, as care and compassion are synonymous with a caring profession and highly regarded in the Code (2018a) and DoH (2012) document regarding the delivery of compassion care in practice. However, the GEN student participants identified professional values that extend beyond care, compassion, empathy and dignity as identified in the literature. This may be due to the unique position they hold as GEN students.

Delivering quality nursing care was considered part of a nurse's "common sense" by Mila, whereas Bella deemed quality nursing care as "nursing at the basic level". They suggest that nurses should have those qualities to be a nurse, yet this is not always the case, as identified by the Frances Report (2013). Mila and Bella equated "common sense" to critical thinking skills and upheld this view with everyday experiences, which were important for delivering quality nursing care and directing their nursing practice. The "common sense" approach proposes the basics for providing nursing care lie in collective understanding. While some differences were noted between what the GEN student participants expressed as defining their professional values, most of the participants focused on the caring element, as such professional values were ultimately viewed as providing quality patient care.

Consequently, the GEN student participants expressed patient safety and patient advocacy as professional values that embody the nursing profession and their definition of professional values. The GEN student participants' definition of professional values aligns with the theory of social constructivism, as the participants constructed their meaning of professional values in line with their experiences and interactions which were context-dependent and based on their perceptions.

The following section discusses the findings related to maintaining patient safety and the GEN student group desire to learn and keep up-to-date with current research in order to provide evidence-based care. This was presented in the form of maintaining patient safety.

Patient Safety:

All nurses and student nurses are obligated to ensure the safety and protection of the patient and the public (NMC, 2018a). Delivering high quality and safe care that patients deserve and expect of healthcare staff should be the main priority of all healthcare professionals. Indeed, there are a minority of instances where the standards fail to provide quality patient care or patient safety, as identified by the Francis Report (2013). Nevertheless, such instances call for a robust commitment to supporting and maintaining the professional values of the GEN students as future RNs.

The GEN students identified several elements of patient safety, ranging from being honest, preventing injury and harm, effective communication, clinical competence and teamwork. As a result, they were predominantly concerned with maintaining patient safety, which extended to ensuring that the correct processes and procedures were followed when delivering care for them to operationalise their professional values. For example, the number of attempts at and the quality of some patients' clinical procedures raised concerns about patient safety. Such experiences caused some GEN student participants to feel anxious and conflicted with their professional values. However, the GEN student participants demonstrated a readiness to accept their professional responsibility by ensuring patient safety was observed through

attentiveness to their Duty of Candour. As a result of their attributes and ability to be independent, critical thinkers, GEN student participants could more effectively conceptualise the skills and knowledge of their nursing role beyond their bedside responsibilities.

The NMC (2018) states that:

> *You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk (NMC, 2018a, p13).*

The professional responsibility related to their Duty of Candour that the GEN student participants so readily referred to. A Duty of Candour means that healthcare professionals must be transparent in the event things go wrong within the organisation. As discussed in Section 2.8, one of the four principles of the NMC Code (2018a) includes 'preserve safety'. Preserving safety consists of conducting regular risk assessments and audits to keep the patients safe, such as maintaining accurate record-keeping, undertaking risk of falls and nutritional assessments. Reporting untoward or near-miss incidents, promoting transparency so lessons are learnt, and recurrences avoided. Nevertheless, it was apparent that a more significant concern highlighted by the GEN student participants regarding the delivery and maintenance of patient safety was the shortage of staff and lack of resources, which are not unique to the local Trust but a national and global problem. The impact meant fundamental changes in the way patients were cared for in the CPE, and the extent to which the participants had the freedom to operationalise their professional values.

The findings further demonstrate that a CPE is a complex, challenging environment on both a personal and professional level, and the challenges identified within the clinical environments include a lack of funding, limited bed availability, and a shortage of nurses coupled with an ageing population with complex health conditions. This research provides context by emphasising the challenges that GEN students face in the

contemporary healthcare system and the constant need for sound professional values to underpin all patient care and preserve patient safety.

The GEN student participants identified that ensuring patient safety does not rely exclusively on the clinical competence of healthcare professionals, but encompasses a myriad of values, such as honesty, patient protection, teamwork and communication, in a supportive culture. DoH (2013) supports these findings; anyone accessing healthcare services can expect to receive care with dignity and humility in a safe environment. Undoubtedly, a standard set of professional values can help to promote a shared understanding of professional values among all healthcare staff, as recommended by Francis (2013). This is not to dismiss the current professional values available within the NHS. Traynor (2013) asserts that nursing is the largest workforce in the NHS and depends on managers' planning of how nursing activities are delivered. Traynor terms this activity ‘managerialism’; although managerialism can be beneficial when working with large groups of people, it is accompanied by its own bureaucracy. Indeed, managerialism affects how professional values are operationalised on both a macro and micro level in the NHS, and so student nurses need to be prepared to face the reality of these challenges in the clinical environment.

The GEN student participants bring a wide range of attributes and experiences. Thus, learning and education was also viewed as a way to achieve patient safety. Neill (2012) and Jamieson et al. (2020) support the notion that the GEN student group demonstrates the ability to be fast learners and critical thinkers; therefore, learning and education are important to them. The participants appreciated the integration of the best available research evidence with clinical expertise and patient values to support decision-making and provide and maintain patient safety. The attributes the participants bring with them provide an opportunity to recognise and build upon their prior skills and attributes as fast learners.

The previous two sections discussed the participants' definitions of professional values in terms of quality patient care and patient safety. The following section will discuss patient advocacy and the strong connection with their personal values in understanding their definition of professional values.

Patient Advocates:

The GEN student participants regarded patient advocacy as an essential professional value for maintaining patient safety and providing quality patient care. GEN students are often described as confident, inquisitive, capable and highly motivated students with a broad range of experiences (McKenna and Vanderheide, 2012). This research corroborated those descriptions of the participants as they demonstrated an increased awareness of the critical role patient advocacy presents, along with their self-confidence of wanting to be the patients' voice. The GEN student participants found meaning and purpose through being patient advocates and a way of enacting their professional values.

Patient advocacy as a professional value was not straightforward and was further related to privacy, dignity, responsibility and accountability. There was a strong consensus amongst the GEN student participants that they needed to be the patients' voice when the patients were unable to voice their needs themselves. Being a patient advocate also included respecting the patients' rights. Unsurprisingly, the GEN student participants held strong views about protecting patients' rights and had the confidence to challenge poor practice. Displaying high confidence levels in the CPE can be daunting for student nurses, but the participants were confident enough to stick their heads above the parapet. Indeed, these characteristics are undoubtedly attributed to their life and previous healthcare experiences as well as education (Jamieson et al., 2020).

Patient advocacy is reported in the Code to "*act as an advocate for the vulnerable, challenging poor practise and discriminatory attitudes and behaviour relating to their care*" (NMC, 2018a, p7). This means that nurses have a responsibility to act as the patient's voice when the patients cannot speak for themselves. The GEN student participants demonstrated no concerns about being patient advocates, demonstrating their self-belief and confidence in providing the best care possible. Patient advocacy allowed the GEN student participants to defend and promote patients' rights and interests when they could not do so for themselves. The participants believed that patient advocacy empowers patients, promotes positive health outcomes and preserves and protects patient's rights and safety. Therefore, advocating for the patient meant protecting them from present and anticipated harm and empowering them to take ownership of their health. The finding implies that the nurses' role in patient advocacy is crucial to minimising harm, enhancing safety and delivering optimal care for patients and their family members.

The participants were aware that the absence of patient advocacy meant the patient's voice would most likely not be heard and patient needs might not be met; if they were not met, this could result in sub-optimal care. The GEN student participants affirmed that patient advocating was to ensure quality care. Hence, patient advocacy was linked to providing quality nursing care.

A further description of patient advocacy by the participants included 'promoting independence' by empowering patients. The participant's understanding of patient advocating was not exclusively focused on physical needs; patients were valued and respected as individuals with unique biopsychosocial needs. Moreover, the participants believed that patients must be allowed to participate in the decision-making process by speaking up and advocating for themselves if they could do so. The participants referred to the patient advocacy process as an interpersonal relationship of establishing rapport with patients, getting to know them and their needs and involving them in the decision-making. Therefore, in a therapeutic relationship, patient involvement in decision-making effectively promotes patient advocacy. Finally, the

need for patient advocacy will continue to increase as the quest for patient safety and quality nursing care of patients continues.

6.2.1 Personal Values

Life, as human beings, is fundamentally based on personal values. Personal values influence and direct priorities, define who we are in the world, and are expressed when decisions and actions are taken (Kaya et al., 2017). The GEN student participants had various personal values which reflected their beliefs about themselves, their communities and society. The participants had preferred visions for themselves as future nurses and wanted to make a difference in their patient's lives. Their personal values guided their significant decisions and actions, which were underpinned by their experiences with their families and communities. For example, participant Tim had a family who valued having a strong work ethic, caring, and giving something back to the community. Tim's personal values mainly originated from the experiences of his parent's whose professional background was also as nurses. For Tim, this meant putting all his effort into achieving his goal of being the best nurse he could be and giving something back to the community.

Ava's source of personal values came from her family's religious background. Ava's catholic values that guided her decisions, priorities, and goals. This meant that Ava had to manage her personal values in a specific way that reflected her religious beliefs by seeking support from family and like-minded communities. Many of the GEN student participants identified personal values that motivated them to join the nursing profession. They revealed personal values of providing care, compassion, respect, empathy, and kindness. Preserving human privacy and dignity, all had a sense of integrity and justice towards the patients and patient care.

The GEN student participants developed their personal values from their early life experiences. They were encouraged to think and behave in a supportive and trusting manner when interacting with people. As a result, the participant's understanding of

their personal values remain socially constructed by the very nature of their experiences.

The findings from this research also highlighted that 'being a nurse' requires the integration of personal and professional values, and ongoing professional development is imperative to ensure that future nurses have the professional values to practice in today's healthcare environment. The GEN student participants identified an overlap between some of their personal and professional values and a strong relationship existed between the two. This overlap revealed that personal and professional values underpin the participant's professional relationships with their clinical mentors, learning, clinical decision-making and delivering quality nursing care in the CPE. The participant's personal values were shaped by their experiences in critical interaction with themselves, their families and communities to develop their sense of purpose, awareness and resilience in nursing.

The CPE allowed the participants to practise their personal values while acquiring professional values that aligned with each other. The findings further identified how structures and hierarchy within the organisation can conflict or align with personal and professional values, impacting on the GEN student participants commitment to the profession as future nurses. These findings offer new insight into viewing the GEN student participants' relationship with their clinical placement experiences and professional values.

The discussion so far has focused on the GEN student participants' definition of their professional values and the close link with their personal values. The discussion of personal values adds new insights to the understanding of professional values that has not been discussed in the literature. The following section discusses the experiences of nursing care related to professional values under 'clinical decision-making' and 'ward culture'. Followed by the experiences of engaging with their clinical mentor under 'positively' and 'negatively' perceived experiences related to professional values.

6.3 Clinical Placement Experiences

The second research sub-question examines which experiences the GEN students identify in their clinical placements that relate to their professional values.

The role of the CPE was identified as complex and multi-layered in this research. It is within the socially constructed interactions in the clinical placement experiences that 'clinical decision-making', and 'ward culture' are discussed, both of which had a relationship with the participants' professional values. The participants identified experiences of nursing care related to their professional values and experiences of engaging with their clinical mentors as the two most significant clinical placement experiences which had an interdependent relationship with their professional values. In some cases, these experiences challenged the participants' professional values.

Clinical Decision-Making:

The participants in this research demonstrated that the process and outcome of clinical decision-making was closely related to their professional values. For example, GEN student participants who prioritised the professional values of delivering person-centred care, promoting patient autonomy and maintaining patient safety experienced a conflict between the process and outcome of clinical decision-making. These participants were concerned about patient care-related factors, such as ensuring that the patient was the priority and that no harm came to them because of the outcome of the clinical decision-making. In this sense, they were less concerned about the context or situation in which the clinical decision-making occurred and more about the actions that followed it; for example, supporting a patient to stay alive to save someone else's life through organ donation. The participants were hyper-aware of and believed very strongly in their professional values when caring for patients, so that they questioned the decisions made by the healthcare professionals, at times experiencing a sense of shock and dismay. Providing high quality care remained at the forefront for the GEN student participants. This research resonates with the work of Ciftci et al. (2020), which suggests that student nurses with an awareness of their

professional values provide high-quality nursing care, and thus their patients' satisfaction level increases.

There appeared to be a deeper conflict related to clinical decision-making, and patient and family outcomes. These experiences led the GEN student participants to reflect and question their role in the process and the organisation's policies related to clinical decision-making. This deeper level of conflict was experienced because the GEN student participants consistently applied their critical thinking skills and analysed the situation to determine what they believed to be the best outcome for the patients concerned. The following professional values guided the GEN student participants' clinical decision-making: patient advocacy, honesty, privacy, confidentiality, and respect. Ciftci et al. (2020) support the view that clinical decision-making is more than providing care and understanding of a patient's condition and includes understanding the family's biopsychosocial dynamics.

As identified from the findings, the GEN student participants identified the complex process concerning shared clinical decision-making around end-of-life care, DNR and CPR and the ongoing tensions and alignments between the GEN student participants' professional values and their capacity to enact them in the CPE. Given that GEN student participants are viewed as highly critical and analytical, they expect to be given information regarding a patient's condition and treatment options and be involved in the decision-making process with the MDT to support the patient's preferences. This means that the participants expected to contribute to clinical decision-making and their learning in the CPE, to be given agency to explore their professional values and to have clinical mentors who modelled professional values, that support shared clinical decision-making.

The GEN student participants were aware that clinical decision-making brings up informed consent, capacity and communication issues. For example, some patients may wish to be actively involved in the decision-making process, making the decisions with their personal interests considered. This was evident when Mila reported having to continue CPR on a 99-year-old patient because of the family's wish but to the detriment of the patient. Mila felt uncomfortable and this situation challenged her

professional values because the patient was not involved in the decision-making. It was important to the participants to hear the patient's voice and respect their role in managing their healthcare needs.

Clinical decision-making in nursing is becoming increasingly fashionable as nurses assume higher levels of autonomy, and some become advanced clinical practitioners (Ciftci et al., 2020). As such, clinical decision-making demands a high level of clinical competency and critical thinking skills to make informed clinical decisions when caring for patients. Several studies focus on the purpose and expansion of clinical decision-making as a professional value within an inter-professional environment (Iacobucci et al., 2013; Moyo et al., 2016; Moyo et al., 2019; Ciftci et al., 2020).

The professional value of authority or professional power, as suggested in the literature, was not explicitly linked to clinical decision-making but proved to be an essential element in the clinical decision-making process (Aydin Er et al., 2017). Professional power is gained from knowledge, skills, education and working within interprofessional teams. Nevertheless, nurses are expected to merge their clinical decision-making skills with their professional power when working with other healthcare professionals to support a person-centred care approach when delivering quality patient care. The Code does not explicitly regard authority as a professional value but refers to the significance of leadership, delegation, and supervision as qualities nurses should aspire to. The Code recognises that it is important to "*Provide leadership to make sure people's wellbeing is protected and improve their experiences of the health and care system*" (NMC, 2018a, p21). This demonstrates the inherent professional power within leadership and the relation to maintaining professional values to protect patients within the organisation.

The GEN student participants demonstrated the ability to apply their knowledge and critical thinking skills to clinical decision-making. In addition, they demonstrated their confidence in applying their professional values to the clinical decision-making process.

Overall, the participants demonstrated that professional values are the foundation of everyday clinical decision-making, care planning and resolving ethical dilemmas.

Ward Culture – Working under Fire

This section discuses the ward culture that encapsulates a sense of working under fire with no time for the little things. Having applied a social constructivist approach to viewing the nature of professional values, the participants draw on their pre-existing ways of thinking and talking about their experiences and socially constructed meaning from these experiences in the CPE. The clinical placement environment was identified as a catalyst for different 'ward cultures', which was unhelpful and challenging for the participants professional values. The 'ward culture' fundamentally influenced how the participants viewed and operationalised their professional values. The GEN student participants identified different factors that jointly created the 'ward culture', such as the type of clinical placement, hierarchical structure and an acute care culture versus a community care culture. Unprofessional behaviour was also identified as part of the ward culture, such as being judgemental towards long-stay patients and the pressure to ensure the quick turnover of short-stay patients, reducing the time to create therapeutic relationships. The 'ward culture' affected the nurse-patient relationship, contributing to how the GEN student participants navigated their professional values. The participants demonstrated a strong commitment to ensuring quality patient care by creatively using their critical thinking skills, collaborating with the Multi-Disciplinary Team (MDT), and using reflection to manage and operationalise their professional values. These findings resonate with the view that GEN students tend to have a strong desire to learn, are high achievers and can apply critical thinking skills in the CPE (Stacey, 2014; Downey and Asselin, 2015 and McKenna et al., 2017). As a result, GEN students have higher expectations regarding learning and operationalising their professional values in the CPE.

A supportive 'ward culture' was central to the GEN student participants feeling supported and inspired to learn and develop into professionals representing the nursing profession. The findings demonstrated that GEN student participants who perceived a supportive 'ward culture' had positive experiences and perceived that

more learning had occurred. On the contrary, participants who perceived the 'ward culture' as less supportive felt frustrated, unwelcomed and perceived their learning as less meaningful. In challenging situations, the GEN student participants reported that the 'ward culture' impeded them operationalising their professional values. For example, the staff shortage affected the nurses on the ward, creating stress, fatigue, and low morale, resulting in less time spent with the patients. Shafakhah et al. (2018) support these findings and suggest that unfavourable work environments and negative attitudes can inhibit student nurses' development of professional values.

The GEN student participants demonstrated an expectation that the CPE would 'teach' them; therefore, they expected to be constantly learning in the CPE. Thus, influencing how they related to and the types of social interactions they engaged with in the CPE. Contrary to this view, tensions were caused by the higher academic level of the GEN students compared to some RNs in the CPE. It became apparent that some of the GEN student participants experienced prejudice towards them for being GEN students, and as a result, were viewed and perceived differently because of their higher degree. Tim particularly, was aware of being perceived as a threat to some of the RNs because he was on the GEN programme. As a result, tended to tone down his 'graduateness' attributes to navigate the CPE. Some participants have assumed a passive disposition as a way to 'fit in' and be accepted within a specific 'ward culture' due to the differences between their level of education compared to the RNs they worked with. These findings are in agreement with the work of Aubeeluck et al. (2016). Such dispositions may negatively affect GEN students by making it challenging for them to apply critical thinking and professional values when delivering care to patients.

The GEN student participants demonstrated their desire for friendly relationships and an atmosphere where they could feel welcome on the ward. Working within a team was an important element of the 'ward culture'. A welcoming environment is something the participants felt supported by and thus perceived the 'ward culture' positively. These findings concur with the work of Courtney-Pratt and Fitzgerald (2015), who suggest that a supportive environment nurtures the development of professional values, knowledge and skills development. The 'ward culture' is fundamental in student nurses acquiring professional values. Being in a familiar

environment meant the GEN student participants could operationalise their professional values freely compared to being in someone's home. They highlighted several subtle differences in the power relations affecting the ward culture when working in a community setting compared to an acute ward setting. Irrespective of the type of clinical placement model adopted, working closely with their clinical mentors afforded them a greater degree of support despite the change in mentorship on each shift. For professional values to thrive in the CPE Francis (2013, p80) recommended a culture of caring by suggesting:

> *Ward managers should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team and ensuring that the caring culture expected of professional staff is being consistently maintained and upheld.*

'Busyness' was another element encapsulated in the 'ward culture' and was all too familiar for the GEN student participants in this research, as they reported having no time for the little things, such as talking or even making a cup of tea for their patients. In addition, the staff shortages meant that there was a lack of mentors, and they were often counted in the staff numbers, which predisposed them to perceive the behaviour of the RNs as uncaring, unprofessional, and at times hostile. Creating disconnections between delivering quality nursing care and operationalising their professional values. Experiencing 'busyness' in the clinical placement environment led to frustration because the participants could not operationalise their professional values and deliver the type of care they wanted to. However, a culture of busyness is widespread in healthcare and nursing.

Indeed, 'busyness' creates a philosophical and moral divide between what the GEN student participants could do and what they should do when caring for patients. 'Busyness' was viewed as a barrier to operationalising their professional values. It created a conflict between professional values they could and could not operationalise, leaving them feeling incompetent at times. Professional values should not be taken for granted when prioritising nursing care. Chan et al. (2013) assert that 'busyness' on the ward can increase stress and put pressure on nursing staff,

compelling them to choose between routine care or task-oriented care and neglect emotional engagement with patients. The 'ward culture' is an evoking finding, especially when autonomous practice is actively encouraged, and clinical competency is a contested area for nursing students.

This section discussed 'clinical decision-making' and the 'ward culture' as clinical placement experiences that had a relationship with the GEN student participants' professional values. The following section discusses the relationship between the clinical mentors and the GEN student participants' professional values.

6.4 Mentor Relationship

Professional values in the CPE are developed and internalised through the process of professional socialisation (Rassin, 2010). The current research considered the professional values of GEN students as a hitherto unexplored area concerning the changes to supervision and assessment in the UK (NMC, 2018c). As discussed in Chapter 2, the new practice support model (SSSA) for supervision and assessment is intended to transform nurse education and ensure that future nurses are prepared to manage increasingly complex CPEs. These changes should empower student nurses to access a range of learning opportunities through the support of the clinical mentor. However, the findings demonstrated that mentoring is not a simple activity; it includes building professional relationships, nurturing, being knowledgeable, providing opportunities for learning and reflection. Student nurses can practise honestly, effectively, compassionately and safely through positive learning cultures. When considering the position of the clinical mentor, it is essential to remember that student nurses are exposed to a variety of healthcare professionals in the CPE. Hence, the factors that are related to their professional values are complex. Alongside the growing pressure caused by a lack of resources, clinical mentors must skilfully equip themselves and student nurses to operationalise their professional values in a busy CPE.

Positively Perceived Experiences:

Overall, the GEN student participants were very positive about their experiences of engaging with their clinical mentors. Many participants felt well-supported by their clinical mentors. The participants understood the roles and responsibilities of their

clinical mentor, which correlated with what they expected of their mentor. Student nurses must have realistic expectations of the support available to them in the CPE, reducing misunderstandings and disappointments.

The GEN student participants perceived their clinical mentors as being kind, approachable, able to teach, and simply giving them time and attention, which strengthened the mentor-student relationship. The participants also identified similar professional values to their clinical mentors, such as confidence, knowledge, and patient advocacy. The participants sought a close alignment between their professional values and their clinical mentor's professional values. Once an alignment had been established, they developed an admiration for and viewed their clinical mentors as knowledgeable and confident. Thus, they identified positively with those clinical mentors who shared similar or the same professional values and less so with clinical mentors who had different professional values from theirs. The alignment of professional values allowed the participants to socially construct the realities of their experiences with their clinical mentor and build a therapeutic mentor-student relationship. The mentor-student relationship was important to the participants because it shaped how they viewed their clinical placement experiences and the extent to which their professional values were operationalised. This research demonstrated the effectiveness and application of shared professional values and their beneficial impact on the GEN student participants' experiences. Professional support, guidance, and nurturing offered by a therapeutic mentor-student relationship increased a sense of belonging and the type of care the GEN student participants delivered.

In keeping with the GEN student participants' characteristics of being fast learners, highly critical and analytical in their approach to nursing (McKenna, and Brooks, 2018), the GEN student participants appreciated and had an affinity for clinical mentors who demonstrated sound theoretical knowledge and clinical skills. Being knowledgeable meant keeping up-to-date with the current research and clinical practices translated to delivering evidence-based nursing care. Clinical competence meant that the participants emphasised the knowledge and skills required for a clinical mentor to deliver quality care. The GEN student participants reported that clinical competence

was associated with clinical mentors demonstrating knowledge and skills, which positively correlated with their professional values. The Code defines clinical competency as:

> *Keeping your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance (NMC, 2018a, p20).*

Hence, nurses must recognise and work within their level of clinical competence to maintain patient safety. As a result, nurses must ensure that their knowledge and skills are updated regularly. In addition, clinical mentors must ensure that any task delegated to a student nurse is within their level of clinical competence. Therefore, maintaining clinical competence is vital in order to promote professional values and the longevity of the nursing profession.

Delivering quality care stands at the forefront of the nursing profession and is constantly observed and scrutinised by the public, service users and student nurses. Ensuring that clinical mentors as role models display professional values that are in line with the nursing profession is essential for student nurses' professional development. The participants agreed that a friendly, hospitable CPE was central to developing and operationalising their professional values and contributed to them positively perceiving their experiences. The participants viewed their clinical mentors as role models promoting a supportive environment which was conducive to learning. The participants described a role model as someone who displays positive qualities that are congruent with the nursing profession. The RCN (2017) defines a role model as someone with whom student nurses can identify and who influences their professional development. Indeed, the social process of aligning the participants' professional values to their role models was identified by sorting and judging their clinical placement experiences. However, the role of clinical mentors as role models remains a crucial part of nurse education programmes in the UK through providing teaching, supervision and assessment for future nurses (RCN, 2017; NMC, 2018c). The findings indicate that positive role models in the CPE were powerful in assisting the participants

in deciding the type of clinical mentor they envisage when they qualify as RNs. The GEN student participants felt welcomed and respected when they received feedback from their mentor, which gave them the confidence to seek help when they needed it. Hence, positive role models were viewed as a supportive and a valuable part of the learning experience. In comparison, negative role models were viewed as having the opposite effect on their learning, leading to negative feelings about their career as future nurses. Despite identifying positive role models, this did not distract from the current staff shortage, relentless pressures and continuous changes in the CPE that the clinical mentors and student nurses faced daily.

Negatively Perceived Experiences:

The GEN student participants viewed a lack of professionalism, poor communication skills, and a dislike for teaching and mentoring as negatively perceived experiences related to their professional values. Although negatively perceived clinical mentor experiences were relatively few, the GEN student participants could identify a lack of professional values or professional values unaligned with their own because of their maturity, previous experience and sound definitions of their professional values. A negatively perceived mentor-student relationship caused adverse effects and disappointment in the participants. For example, feelings of being disempowered, ignored, and unsupported. Despite these negative experiences, the participants were determined to change the narrative when they became clinical mentors themselves.

Some participants reported their clinical mentors were disinterested in them and their learning in the CPE or had a personal vendetta against them. Taking on the role of a clinical mentor is not compulsory for RNs in the UK, although the Code (2018a p12) suggests nurses and midwives should "*support students' and colleagues' learning to help them develop their professional competence and confidence*." Even though the use of the Code may ensure continuous numbers of mentors to support student nurses, it does not necessarily result in mentors who are interested in the role. It may lead RNs to view mentorship as a necessity for promotion and not a role they are willingly taking on. This experience was echoed by the GEN student participants, who in some instances, felt like a burden to their mentors. These clinical mentors may have been required by their organisation to take on the role of clinical mentor rather than

this being an individual choice, which resulted in the experiences the participants perceived as negative.

There may be challenges in achieving the high expectations the GEN student participants bring with them due to their previous work and life experiences. It was evident from the findings that the GEN student participants expressed a change in their mentorship needs as they progressed through their final clinical placement. Although the participants viewed their clinical mentors as vital to their learning, they were less reliant on them and wanted to plan and lead the nursing care as time went on. However, this was met with some resistance from their clinical mentors because they could not find appropriate times and locations for mentoring and supporting the participants in the busy CPE without impacting patient care. The lack of time spent with their clinical mentors was viewed by some participants as an inhibitor and contributed to what the participants referred to as poor communication, consequently contributing to negatively perceived experiences. Nevertheless, other participants felt their learning needs were not being met because their clinical mentors were unaware of the learning objectives of students of different nursing programmes. There was a sense that achieving transparency for both parties may have been beneficial, especially for student nurses undertaking the GEN programme.

The participants also viewed a lack of learning opportunities caused by demands on their clinical mentors and the shortage of resources. The impact of this meant that their clinical mentors appeared to be unprofessional or presented poor communication skills. A lack of time and the busyness of the CPE meant putting patient care needs before student mentoring needs was an important finding to understand the barrier to effective mentorship. The participants were well aware of the role of their clinical mentors, and facilitating learning in the CPE is not always recognised as important where the priorities are focused on health care provision. RNs have a duty to care for patients first and foremost (NMC, 2018a). However, changing the status and role of the clinical mentor to PA/PS may enhance mentorship responsibilities. Some participants viewed a perceived lack of professionalism as poor mentoring, which led them to consider leaving the nursing profession or even choosing a speciality with a higher patient-staff ratio. Although they were tempted to leave, the participants

wanted to complete their nursing programme and remembered the reasons they wanted to be nurses. Thus, negatively perceived experiences only fuelled their passion and a recognition of the type of mentor they did not want to become in the future.

For clinical mentors, there should be a constant obligation to be aware of their role and responsibilities to student nurses. As identified in this research, clinical mentors can display both positive and negative qualities. The GEN student participants were able to identify learning from both these positive and negative experiences, which helped them develop their professional values. Gopee (2015) suggests that clinical mentors with negative qualities can damage student nurses' learning and compared them to an absent role model. Gopee also identified the qualities of a positive role model as being inspiring, motivating, knowledgeable, confident, self-caring, empowering and diverse thinkers, all of which attract student nurses to join the nursing profession. It was these qualities that the GEN student participants admired and wished to emulate when they qualified as RNs. Similarly, they were adamant about the negatively perceived professional values they did not wish to adopt when they became clinical mentors.

The clinical mentor relationship is crucial if student nurses are to learn, internalise and operationalise their professional values in the CPE. The findings suggest that the GEN student participants were exposed to positively perceived and negatively perceived clinical mentors. The participants had the confidence to choose which professional values to adopt in the CPE and tended to adopt professional values that they perceived as benefitting the patient by showing respect, care and compassion. While there is literature available on the benefits of having a supportive mentor, the participants highlighted that their needs are different to other student nurses, this is because they bring previous experiences with them.

The previous section discussed positively, and negatively perceived experiences related to the participants' professional values. The following section discusses the emotional implications for the GEN student participants that were related to their professional values under emotion awareness and emotion management.

6.5 Implications for Future Nurses

The final research sub-question identified the implications of the identified clinical placement experiences on the GEN students' professional values.

The GEN student participants had clinical placement experiences that they found emotionally challenging and tested their professional values. The experiences concerned confronting dilemmas regarding clinical decision-making, repeated exposure to similar clinical situations, unprofessional behaviour among healthcare professionals, fitting in and belonging. The implications of these experiences were significant for the relationship between the participants' clinical placement experiences and their professional values. These experiences concerned both the formal and the hidden nursing curriculum. For example, student nurses are formally taught about belonging to the nursing profession, but not how to fit in on a ward; about ethics and clinical decision-making, but not the impact or consequences of those decisions; about ill health and various diseases, but not the unprofessional behaviour resulting from staff and resource shortages. The hidden curriculum is discussed later in this section. The following section will discuss the GEN student participants' awareness of their experiences, which is related to their professional values, before discussing the strategies they employed to manage those emotions.

Emotion Awareness:

Learning to become a nurse and operationalising professional values involved a variety of emotions, and as a result, presented the participants with experiences that caused strong emotional reactions. These experiences involved the participants engaging with each other and other healthcare professionals to construct their realities. The experience of being confronted by end-of-life care, organ donation and performing CPR on patients with poor morbidity for the sake of family or merely following protocol evoked strong emotions about the quality of life for their patients. The findings suggest the participants felt unprepared to deal with dilemmas regarding clinical decision-

making because it challenged their professional values, and they felt unease, sorrow and empathy.

Other experiences concerned, repeated exposure to similar patient conditions, leading to desensitisation and emotional burnout. The discussions described the more stressful, chaotic experiences for their patients. For example, experiences in which difficult choices had to be made between the treatment choice or following protocols and procedures for patients. This was particularly poignant when Tim and Jin discussed their experiences of repeated attempts to undertake specific invasive clinical procedures on a patient, such as catheterisation, nasogastric tube insertion or cannulation. These experiences were challenging for the participants' professional values and left them perplexed about the priorities chosen and why certain procedures were undertaken in the first place. There were times when the participants could not see the benefits of certain procedures for a patient, and therefore questioned the decisions taken. The GEN student participants wanted what was best for the patient, and when other healthcare professionals treated the patient or acted in a way that challenged their professional values and they felt frustrated.

The participants witnessed perceived unprofessional behaviour, such as being judgemental towards patients, poor communication and poor mentoring. In some experiences, unprofessional behaviour was directed towards the participants and the patients in their clinical placements. The participants expressed feelings of unease and sometimes guilt because the unprofessional behaviour conflicted with their professional values. More particularly, the participants felt this type of unprofessional behaviour demonstrated a lack of empathy. The essence of the perceived unprofessional behaviour was that clinical mentors sometimes did not meet the patient's needs. For example, talking or behaving negatively about a patient, which was thought of as humiliating for the patient. In these cases, the participants reported failing to meet their learning needs because of the lack of professional received by the patient. It was interesting to note that some participants stepped in and tried to compensate for the unprofessional behaviour they witnessed, being concerned for the patient's well-being.

Belonging is a vital part of any social group and a basic human need (Levett-Jones et al., 2009). Not fitting in and belonging is closely related to the social construct of professional values; the participants' mature outlook, and previous work and life experiences stood them in a strong position to be emotionally aware. In more detail, the participants provided rich examples of the importance of feeling welcomed and safe by unknown healthcare staff in an environment they only temporarily occupied. The GEN student participants demonstrated a strong emotional awareness of their need to 'belong' while on clinical placements, creating tension between their professional values and their capacity to endorse them. They expected to contribute to the CPE and explore and develop their professional values while feeling welcome. Unsurprisingly, in the current climate of nurse shortages and the limited availability of clinical placements, the participants were prepared to embrace the CPE and 'fit in'. However, 'fitting in' and becoming a part of a team posed challenges for the GEN student participants as their clinical placements were temporary, and they had to move from one placement to another within a few months. Within that time, they get used to the ward routine, healthcare staff and patients and start feeling settled before having to move again. The clinical practice culture may operate under different professional values to those that the GEN student participants bring with them. This finding is supported by the work of Karimi et al. (2014) and Hunter and Cook (2018), who suggest acculturation of student nurses into the CPE is significantly influenced by the 'culture' and 'value' of a particular environment.

The emotional awareness of not fitting in and belonging demonstrated that the participants faced challenges in optimising their clinical placement experiences and hence their professional values. This meant the participants focused more on trying to 'fit in' and be accepted. They could identify and understand the relationship between their clinical placements, belonging and professional values. Tim eloquently reported, "Sometimes as a student nurse, it can be quite lonely, you know. You're moving from one placement to the next, you finally feel sort of settled and comfortable in a clinical placement area and then you got to move again" (Tim, Int. p5). A noteworthy finding in this research is that the participants modified their behaviour in the CPE, using techniques such as avoidance, avoiding challenging practises and adopting the ward's cultural values to 'fit in'. The GEN student participants' emotional awareness

demonstrates their wider construction of work readiness, to embrace not only the knowledge and clinical skills, but also the soft skills referred to in the literature as non-technical skills. The modification of behaviour by GEN students to fit in and be accepted in the CPE reflects their capacity to comprehend and regulate emotions and cope effectively with the emotional situation, which was also noted by Levett-Jones et al. (2009) and Stacey et al. (2016).

The GEN student participants' experiences were based on receptiveness, recognition and appreciation, had the greatest influence on their sense of belonging and learning. A sense of belonging was viewed as personal involvement and was associated with feeling acknowledged, accepted and appreciated by the other group members. The GEN student participants in this research recognised experiences that had emotional implications when operationalising their professional values in the CPE, such as multitasking on a busy ward, being organised and independent, learning from experience, and getting the most out by overcoming challenges. However, some of the experiences reminded them of their own personal experiences, and handling both the patient's and their emotions was difficult. Nevertheless, their mature outlook supported the GEN student participants' independence, confidence, learning and being able to manage their own emotions because of their previous education and life and work experiences. These findings align with the work of Stacey et al. (2016) in viewing GEN students as independent, critical and highly capable individuals who can swiftly navigate the CPE.

The Hidden Curriculum:

The hidden curriculum in nursing is defined by MacMillan (2016) as the subconscious or subliminal messages that are culturally attained and culturally communicated. The literature describes the hidden curriculum as the 'para-curriculum' or 'unofficial curriculum' through which student nurses learn professional values and behaviour that are not explicitly communicated in the formal curriculum. The hidden curriculum provides learning opportunities that are not deliberately intended, such as transmitting knowledge and behaviours from an impromptu clinical situation. As such, any learning experience may teach unintended lessons in the CPE.

The GEN student participants in this research developed some of their professional values as a result of the hidden curriculum. Several professional values were learnt through observation in the CPE, from the clinical mentors' role and qualities, particularly their attitudes and behaviour when delivering care. The ward culture is another example of how things are done in the CPE as opposed to what the students are taught in the classroom. The GEN student participants witnessed unplanned activities as part of the hidden curriculum, such as performing CPR and clinical decision-making by healthcare professionals. How GEN students and their clinical mentors recognise and manage their emotions becomes a vital component of the hidden curriculum, forming the inherent notions underlying their professional values and behaviour.

The GEN student participants were able to recognise the elements of the hidden curriculum and the implicit learning of professional values that arose from the unplanned nature of activities in the CPE, which affected how they responded to it. It is argued that the hidden curriculum is as important as the formal curriculum, if not more so, to student nurses trying to navigate their professional values in the CPE. Aubeeluck et al. (2016) suggest it is important to “learn the rules of the game's” to navigate nurse education. To successfully play the game in the CPE, student nurses must know the rules, including the hidden ones. GEN students find creative ways to negotiate and learn while on their clinical placement to meet their expectations and the reality of the CPE (Stacey, et al., 2016).

The hidden curriculum also exposed the hierarchical structures within the CPE as part of the ‘ward culture’. The GEN student participants in this research recognised and understood the hierarchical structure in the CPE, which helped them to draw on their professional values when they were challenged to make clinical decisions about patient care. There was no indication that their work ethos was inhibited in any way. Nursing must embrace the hidden curriculum to support GEN studnets entering the nursing profession to consistently develop professional values that reflect and promote care, compassion, patient autonomy, patient safety, and competence.

Emotion Management:

This research identified the CPE is an inevitable part of experiencing and witnessing strong emotions for the GEN student participants when operationalising their professional values. The CPE challenged the operationalising of professional values creating conflict between how the participants 'wanted' to practice and the reality of how they 'had' to practice. The conflict arises because of systems and organisational pressures that harness a culture of exhaustion, fatigue and burnout due to a lack of resources (Kim et al., 2015). It is crucial for student nurses to learn how to manage their reactions in emotionally challenging situations. This research suggests that the GEN student participants were aware of their own and patients' emotions; more so, they demonstrated creative cognitive and interpersonal strategies to manage and navigate the CPE. These findings demonstrate that the GEN students' ability and characteristics of self-sufficiency and self-efficacy are outstanding, supported by the literature (Neill, 2012; Stacey, 2016 and Jamieson et al., 2020).

Cognitive strategies drawn upon included: asking questions, using aliases when discussing patients' experiences, emotional detachment, compartmentalising home and work life, using reflective practice, stepping back from situations and positive self-talk by simply remembering why they started the nursing programme. Whereas, the interpersonal strategies included: peer debriefing, conforming by wanting to become friends, joining in discussions they would not usually engage in, talking with family and friends, and avoiding confrontation to maintain positive relationships. The cognitive and interpersonal strategies are discussed below.

Cognitive Strategies

The participants' emotion management during their clinical placement forms an extension of their interpretation of their professional values within a highly charged and dynamic environment. Despite the challenges that they experienced; the participants demonstrated a sensitive, measured approach to managing their emotions by using various strategies. Cognitive strategies consisted of using critical thinking and reasoning to manage challenges in the CPE. Several participants took themselves out of their comfort zone, questioned situations, and evaluated treatment options that

were out of line with their professional values to manage their emotions. For example, Evie grappled with the idea of keeping a patient alive for organ donation after they had been confirmed with brain stem death (Evie, FG1 p8). Mila used their creative, humorous side by assigning aliases to maintain confidentiality when discussing patients in order to manage the experiences they encountered. This strategy allowed the participant to reflect on their experiences, seek support, and maintain patient confidentiality.

By contrast, several participants used 'emotional detachment' to separate and suppress their emotions and become detached from the experiences to protect them from emotional fatigue. At the same time, another challenging aspect was balancing closeness and distance when providing patient care while being overwhelmed by emotions. The participants admired their clinical mentors, who successfully managed their personal and professional values to avoid becoming emotionally overwhelmed. Clinical mentors were central to how the participants experienced, managed, and aligned their emotion management when operationalising their professional values. For example, when a participant was experiencing a stressful situation, they recalled what their clinical mentor would do in a similar situation.

Engaging in reflective practice was a strategy used by the participants; the Schwartz Rounds offered in the local NHS Trust provided opportunities for all healthcare and non-healthcare staff to share their emotional experiences within a safe environment. The Schwartz Rounds aim to offer an opportunity to appreciate the challenges and incentives when providing patient care rather than necessarily finding solutions or focusing on the clinical elements of patient care. Schwartz Rounds are known to assist staff in feeling encouraged and supported while providing them with the time and space to reflect on practice experiences (The Point of Care Foundation, 2009 - Schwartz Rounds). However, reflection through the Schwartz Rounds provides support through informal discussions with healthcare and non-healthcare staff. It serves different purposes regarding the participants' learning and well-being. Thus, the findings from this research and the literature suggest that student nurses need support and opportunities to talk to someone they trust and reflect on their experiences when they find themselves in situations that affect them emotionally (Felstead, 2013).

Positive self-talk was another strategy used for managing complex emotional experiences. Positive self-talk reminded the participants of their reasons for entering the nursing programme and wanting to be a nurse, and the difference they wanted to make to patient care. As such, quitting was not an option. Positive self-talk also served to boost their confidence and offered reassurance when in doubt. At the same time, they reminded themselves that "nurses are human and they're vulnerable like everybody else" (Tim, Int. p14). Taking a step back from the situation also proved helpful in enabling them to see the whole picture. Indeed, taking a step back could also mean that the participants felt reluctant to appear troublesome or feel like a 'burden' for sharing their emotional experiences. Dealing with emotionally charged situations independently was best achieved by taking a step back for some participants. The strategy of positive self-talk and taking a step back during emotionally challenging situations occurred due to participants taking control to manage those challenging experiences. Alternatively, perhaps there was a shift in focus from the overwhelming emotional experience to learning how to regulate their emotional experiences.

Interpersonal Strategies

Interpersonal strategies include interaction and communication to build and maintain therapeutic relationships in the CPE. The participants articulated their desire to develop comradely relationships in order to manage their emotions. In doing so, some participants "just wanted to make friends" (Iris, Int. p17). Building such relationships was thought to be advantageous and allow them to gain the trust and confidence of the staff on the ward which may have offered emotional immunity because the participants would be seen as one of them. Several participants used a similar strategy to join in judgemental, unprofessional discussions regarding patients on the ward. They felt deeply uncomfortable and guilty about doing this, but engaged anyway to ease the sense of confrontation and thus reduce any emotional stress. "I want to, sort of, just fit in and get on with it" (Erin, FG2. p17). Despite wanting to uphold their professional values, several of the participants were partial to bending their professional values to manage their emotions, as shown by the quote from Erin.

Other interpersonal strategies which were drawn upon to manage challenging situations included debriefing with peers, family and friends. For example, a private

social media group on Instagram was set up amongst the GEN student participants so that they could remain in contact with each and offer support, providing a valuable way to contact their peers and share experiences during clinical placements. Several participants were surprised to find that others were going through similar experiences to themselves, making it easier to support each other. Meanwhile, some participants turned to family and friends to talk about their experiences, which played an essential part in assisting the participants in navigating challenging emotional experiences. However, these sharing experiences were informal and happened close to the time of the CPE experience. These findings point to the need for additional formal support in the CPE. Formal debriefing or clinical supervision provided by experienced clinical mentors supervising the GEN student participants may offer a safe and structured way to support and develop emotion management. Thes formal support strategies can provide integrated learning for the GEN student participants with opportunities to engage with context-specific emotional knowledge and regulation in a complex CPE.

Throughout these experiences, the GEN student participants demonstrated emotional intelligence when operationalising their professional values. These findings are supported by Culha and Acaroglu (2019), who reported that professional values, emotional intelligence level, and perceptions of care were closely linked and had a positive relation to patient care. Moreover, nurses who demonstrated high levels of emotional intelligence could provide individualised patient care because of their self-awareness and awareness of others' feelings. These findings are particularly beneficial in progressing the GEN student participants' professional values and emotional intelligence to support patient-centred care.

Nevertheless, there are some formal support structures embedded within the GEN nursing programme, such as the clinical mentor. This is the first point of contact in the clinical placement environment, but only two participants accessed them for support. This could be because the participants were mindful of how they would approach their clinical mentors and wanted to maintain positive clinical placement assessments without jeopardy (Felstead, 2013). The experiences the participants shared demonstrated that they felt secure and confident, knew what to expect, and could handle emotionally challenging situations probably better than they expected.

All of the GEN student participants in this research recognised the connection between their professional values, clinical placement experiences and the emotional implications of those experiences. They were able to construct and understand these realities through social interactions, while remaining determined to become excellent nurses, and not losing sight of their commitment to the nursing profession as future nurses.

6.6 Overall Discussion

The answer to the main research question in Section 6.1 is that the key findings confirm that the participants' definitions of professional values were related to delivering quality nursing care, maintaining patient safety and being a patient advocate and is contrary to the definitions offered in the literature. Personal values were intrinsically linked to professional values. The participants identified the two most significant clinical placement experiences which were related to their professional values. The clinical placement experiences had far wider implications, including emotion awareness and emotion management related to their professional values as future nurses. Overall, the relationship between the GEN student participants' clinical placement experiences and professional values was complex and interdependent in nature.

The discussion in this chapter emphasised several key areas concerning the relationship between the GEN student participants' clinical placement experiences and their professional values, such as the definition of professional values, the nature of clinical placement experiences, the role and qualities of the clinical mentor and the emotional implications of professional values for future nurses. The GEN student participants' experiences were led by their professional values, personal values and alignment with the NMC Code in the CPE. There were instances where the GEN student participants experienced frustration when their professional values did not match their clinical placement experiences, creating a value conflict. In such instances, the GEN student participants demonstrated strategies that they could draw on to manage their emotions.

6.7 Limitations of this Research

All research has drawbacks, and this research is no exception. The main limitation of this research is that the sample population was drawn from one university in the north of England and one GEN student group, thereby limiting the generalisability of the findings to other universities and other GEN programmes. The sample size was relatively small and specific to the final clinical placement. The reason for employing small-scale research was the specific timescale of this doctorate. Therefore, this research focused on the relationship between clinical placement experiences and professional values of the GEN student participants. In this sense, student nurses on other nursing programmes, such as the BSc, Nursing Associate, and MNursing programmes, were excluded. Additionally, this research's limited nature and scope meant that it did not include the views of any clinical mentors or nurse lecturers. Had more time been available, this research could have benefitted by being a longitudinal study that tracked the professional values of GEN students from the beginning of their programme. Finally, there was a noticeable lack of diversity amongst the study participants, with only one participant identifying as an ethnic minority and two identifying as male gender. Therefore, the findings should be viewed within these constraints.

6.8 Chapter Summary

In conclusion, professional values cannot be experienced without clinical placement experiences and the clinical mentor's role is critical in shaping the GEN student participants professional values. Hence, care must be taken to understand and support GEN students as they navigate this complex journey. The next chapter is the final chapter of this thesis and offers a conclusion and recommendations.

Chapter 7: Conclusion and Recommendations

7.0 Introduction

Chapter 6 discussed the findings from this research. This chapter synthesises the key findings from the research and draws conclusions to answer the main research question and research sub-questions. In doing so, presents a review of the findings, my reflexivity, original contribution to knowledge, implications and recommendations arising from this research.

7.1 Review of the Key Findings

This research focused on a phenomenon that forms the bedrock of the nursing profession, the personal and professional values of GEN student nurses. The findings indicate a complex, interdependent relationship exists between the GEN student participants' clinical placement experiences and their professional values. The GEN students are different and occupy a unique position in nursing, offering different perspectives when defining their professional values, which were central to understanding their experiences in the CPE. Due to their uniqueness, they provide an alternative definition of professional values compared to the traditional definitions in the literature. The GEN student participants define professional values in terms of quality nursing care, patient safety and patient advocacy. The findings indicate a strong link between personal and professional values when faced with experiences in the CPE.

More specifically, the research identified positive and negative experiences, which depending on their nature (positive or negative), were associated with the promotion of or challenges to the GEN student participants' professional values (e.g. care, compassion, safety, advocacy, learning, respect, dignity, confidentiality and privacy). All experiences reported by the participants were a valuable source of knowledge and understanding in developing and operationalising professional values in the CPE. Both positive and negative experiences helped shape and provide the participants with valuable insights into their development process in the CPE context.

The findings suggest that understanding professional values is essential for delivering quality nursing care.

Furthermore, the findings demonstrate that professional values are not simply theoretical and abstract ideas, but core concepts that take on concrete meaning and are activated by/in the CPE. The GEN student participants' development and operationalisation of professional values depended on various individual and situational factors. The impact of the ward culture was powerful and viewed as a determinant of how GEN students operationalised their professional values in the CPE. Clinical mentors were viewed as role models in transmitting professional values to the GEN students during their placement experiences. In doing so, they created and sustained a learning environment conducive to operationalising professional values. The research indicated that positively perceived experiences were decisive motivational factors for using and expanding the development of professional values and developing their identities as future nurses. Negatively perceived experiences were good examples for the participants of what not to do in their future careers as RNs.

The participant's reported the situation-specificity of understanding and operationalising professional values in the CPE. The implications of experiencing professional values were far more complex than providing patient care. The findings demonstrated the participants' integrity, self-efficacy, and self-awareness which harnessed their creative strategies to manage emotions and moral integrity. Lastly, this research offers a unique view into the GEN students' emotional awareness and management when working with the challenges of the current NHS.

7.2 Reflexivity

Etherington (2004, p19) defines reflexivity as the "*need to be aware of the personal, social and cultural contexts in which we live and work and to understand how these impact on the way we interpret our world*". Indeed, reflexivity operates on multiple levels, based on an awareness of who you are as a researcher, as your values and beliefs will inevitably influence how you engage with and present your research.

As discussed in Section 1.1, Researcher's Biography and Section 4.11, positionality affected how I analysed and interpreted the data. Unsurprisingly, my positionality was influenced by my experiences as a South African female, a registered nurse, and an academic with professional experience working in SA, KSA, and the UK. It was vital for me to be mindful of my personal and professional values during the research process. With this in mind, I maintained a reflexive journal (see Appendix 16) which extended throughout my research journey. Reflexivity encouraged me to view myself and the social world as deeply-rooted in my cultural and historical beliefs, values and knowledge (Crotty, 2015). Etherington (2004, p128) recommends that:

> *Keeping a reflexive journal can develop the researcher's self-awareness by providing a platform for reflecting and processing our internal and external responses and behaviours.*

Moreover, Crotty (2015) also advocates journal writing as a form of record-keeping during any part of the research process. I deliberately wrote my journal in order to be transparent about my feeling, beliefs, and assumptions. Hence, the reflexive journal I maintained acted as an *aide-memoire* when conceptualising the themes and sub-themes. In addition, it could be used as a tool during the audit process to establish transparency.

My reflexivity consisted of being empathetic towards the participants, appreciating the experiences they shared with me, and collectively making sense of those experiences. The participants shared many experiences from their clinical placements that I could identify with as a nurse, such as the busyness of the CPE and a strong desire to do an excellent job, despite the challenges. As a result, I felt an immense sense of responsibility to articulate the experiences the participants so generously shared. Being reflexive did not mean abandoning my pre-conceived ideas about GEN students, but rather it served to illuminate my ideas and ensure that I kept an open mind. I found myself so deeply immersed in the research process that, at times, I struggled to remove my thoughts from the experiences that the participants shared with me. Moreover, this encouraged me to adopt a critical stance and consider the ethical issues associated with my dual role as a researcher (EdD student) and nurse lecturer in this research. Whilst I held a position of knowledge and power as an 'insider', this meant

that I had to reflect on my position as a nurse and nurse lecturer (Cronin, 2014). I acknowledged my role in the research process as a student undertaking a doctorate in education rather than a nurse lecturer to prevent any influence or power arising over the participants' responses. As a result, reflexivity permitted me to become acquainted with how I situated myself in the research process. So far, I have presented my reflexivity. The following two sections will discuss the original contribution to knowledge and the implications of this research.

7.3 Original Contribution to Knowledge

The GEN student group are unique since they are mature and have previous education, life and healthcare experiences. Whilst data do exist that examine the professional values of pre-registration nursing students, no studies to date have explored the relationship between GEN students' clinical placement experiences and professional values. Moreover, there are no studies, to the researcher's knowledge, that examine the professional values of the GEN student group.

The findings from this research make a number of original contributions by extending the literature and knowledge of the relationship between clinical placement experiences and the professional values of GEN students, within the UK context. The contributions are as follows:

- The GEN students' offer an alternative definition of professional values to what is presented in the literature (Sections 5.3 and 5.7)
- The two significant clinical placement experiences were identified that had a relationship with participants professional values (Section 5.8)
- The implications of the identified experiences for GEN student participants' professional values were emotion awareness and emotion management (Section 5.9)

7.3 Implications of the Research

The implications of this research are significant in supporting GEN students' professional values within the CPE, particularly because this group enters the nursing profession with professional values obtained from their previous experiences. They

undertake a shorter nursing programme while completing extended clinical placements. There are also broader implications for supporting the professional values of student nurses on other nursing programmes and healthcare-related programmes with a placement element attached. Consideration should be given to their definitions of professional values, as these are internalised and operationalised differently by different people. Due to the close connection between GEN student participants' personal and professional values, support should be provided to encourage their development in the CPE. The challenges remain concerning how the CPE can support GEN student's professional values within the challenges of the NHS. As such, the findings have significant implications in three key areas:

Education: The findings suggests that personal and professional values were related and should be considered important elements in the planning and development of further nurse education programmes.

Clinical placements: Special attention should be given to the attributes that shape the quality of the GEN student participants' learning experiences of professional values: the type of clinical placement, ward culture, psychosocial factors, teaching and learning elements.

Policy: There is a need to develop consistent policies and Codes of professional conduct to include personal and professional values across all levels of nursing.

7.4 Recommendations and the Way Forward

Throughout the development of this thesis, I have sought to unearth new knowledge and understand the relationship between clinical placement experiences and the professional values of the GEN student participants as future nurses and leaders of the NHS.

There are several recommendations arising from this research to support the development and maintenance of professional values in the CPE:

- CPE must recognise the duality of personal and professional values as a dispositional measure to a) provide quality patient care; and b) recognise the social cognition and emotional intelligence of the GEN student's ability to self-manage.
- CPE should support 'time out' for debriefing or clinical supervision as an opportunity for reflection and learning to support the development of professional values.
- CPE and HEIs should enable open and transparent communication through the current SSSA practice model to ensure opportunities to operationalise professional values are at the forefront.
- HEIs could use role-play or case studies to introduce students to the realities of nursing, similar to the complexities arising from everyday clinical placement experiences.
- Advocate for further research to examine the relationship between personal and professional values over the duration of the GEN programme.

7.5 Conclusion

This thesis examined the relationship between the clinical placement experiences and professional values of GEN student participants. The findings suggest that a complex interdependent relationship exists between clinical placement experiences and the professional values of the participants. Professional values influenced how the GEN student participants delivered patient care and maintained patient safety, and clinical placement experiences changed professional values. The findings identified the existence of an alternative, unique layer to emotional awareness and management that is closely connected to operationalising professional values. Moreover, nursing care experiences and clinical mentors are essential in supporting professional values. Furthermore, this research demonstrates how resilient the GEN student participants are in reading the CPE and creatively responding to their experiences while maintaining their professional values.

Ubuntu - "I am because you are; we are because you are".

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Appendices

Appendix 1 Definition of Terms

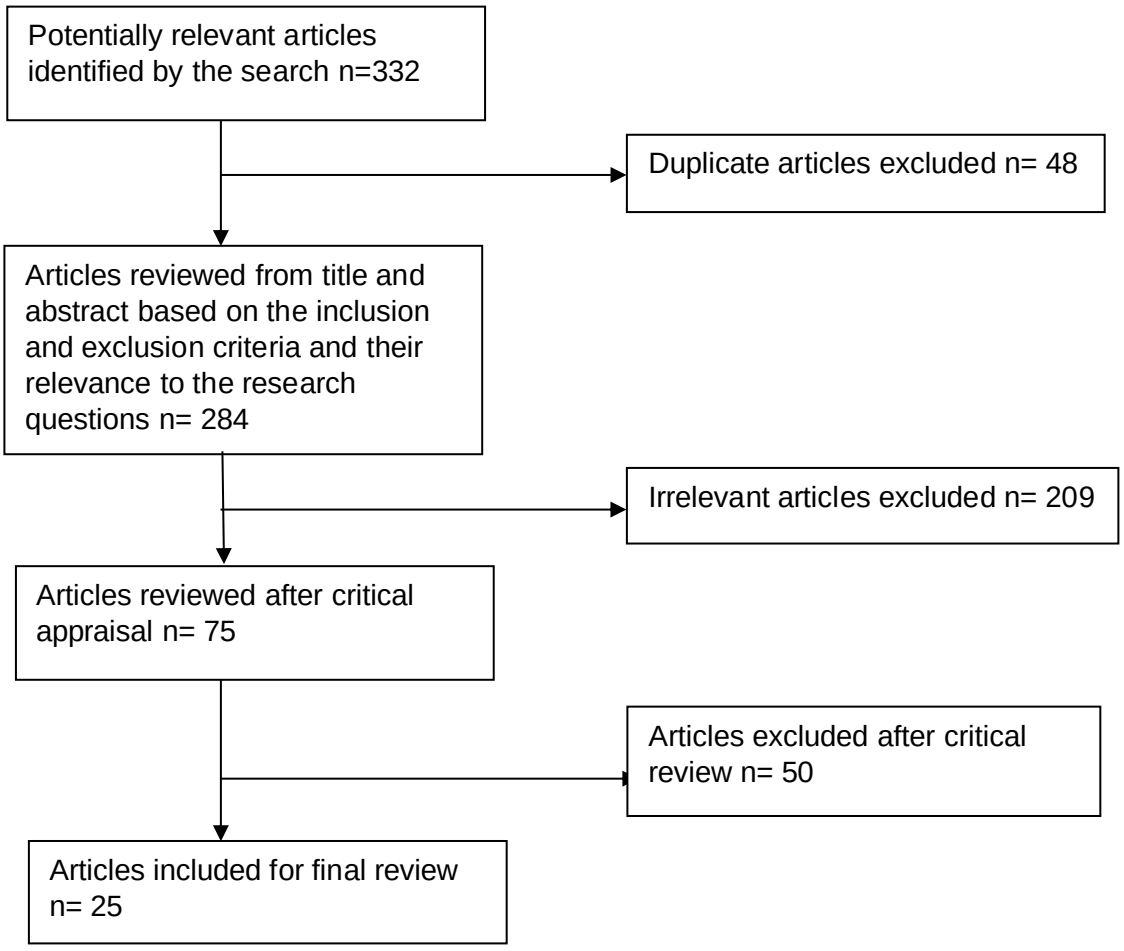
Definitions	
Values	Values guide an individual's behaviour and choices in their lives as individuals (Rokeach, 1973).
Personal values	Rassin (2008) describes personal values as what is right, good or desirable and motivates both social and professional values. Personal values are the things that are important to an individual, the characteristics and behaviours that motivate and guide decisions. Personal values are influenced by culture, ethnic background, religious background, society, and family (Blais and Hayes, 2016).
Professional values	Professional values are standards for action that are preferred by experts and professional groups (Weis and Schank, 2009). Professional values are a requirement set by the professional regulatory body and serves as a framework for assessing behaviours (Gallegos and Sortedahl, 2015).
Professional socialisation	Professional socialisation is a process where an individual learns the roles, statuses, and values necessary for the engagement in a profession (Dinmohammadi et al., 2013). The method of developing the values, beliefs, and behaviours of a profession (Blais and Hayes, 2016).
***Registered nurse* (RN)**	Is an individual who has completed a nursing programme and met all the requirements of the Nursing and Midwifery Council (NMC, 2010)
Profession	A profession is referred to in functional terms but is also associated with accountability and responsibility and therefore allows for professional autonomy (Wilson et al., 2013).
Professionalism	"Professionalism is characterised by the autonomous evidence-based decision making by members of an occupation who share the same values and education" (NMC, 2018a, p15).
Graduate Entry Nursing Programme	Refers to a post-graduate diploma programme in adult nursing designed for students with a previous degree in a health-related subject.
Graduate Nurse	Graduate Nurse is a nurse who has completed their academic studies but not completed the requirements to become a Registered Nurse. (NMC, 2010)
Clinical placement environment (CPE)	A clinical placement environment can be defined as an environment that provides healthcare or related services to patients or the public (GMC, 2009).

	The clinical placements environment can take place within a hospital, community or social care settings. This research only considers the real-life experiences in the CPE.
Clinical mentor/Practice Assessor/Supervisor	A clinical mentor (also referred to as practice assessor/practice supervisor) is someone who represents the knowledge, skills and professional qualities expected of a registered nurse (NMC, 2010; NMC, 2018c).
Acculturation	Acculturation is defined as a process of attitudinal and behavioural change that takes place between an individual or groups with a different culture (Sam and Berry, 2010).
NMC Code	"The NMC Code presents the professional standards that nurses, midwives and nursing associates must uphold in order to be registered to practise in the UK". (NMC, 2018a, p3).
Schwartz rounds	Schwartz rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. (The Point of Care Foundation, 2009).
Patient safety	Patient safety is the avoidance of harm and the right to be treated in a safe environment (Author, 2021).
Urinary catheterisation	Catheterisation is described as a procedure where a tube is inserted into the urethra for the drainage of urine (Dougherty et al., 2015).
Intravenous cannulation	Intravenous cannulation which is a procedure where a tube is inserted into the vein for the delivery of fluids (Dougherty et al., 2015).
Clinical mentor qualities	Clinical mentor qualities are referred to as elements the participants would like to emulate and not as opposed to emulating an individual (Author, 2021).
Person centred care	Person centred care as a process to nursing practise that recognises the patient's individual needs and building a relationship between all involved in the care. (McCormack et al., 2011).
Clinical placement culture	The clinical placement culture refers to the shared values, belief systems, attitudes and the set of assumptions shared by the participants in each workplace (Author, 2021).
Clinical competence	Clinical competence is a 'a mix of skills, knowledge, attitudes and abilities that each nurse must possess to perform acceptably those duties directly related to patient care, in a specific clinical context and in given circumstances to promote, maintain and restore the health of patients' (Notarnicola et al., 2016, p174).

Appendix 2 Databases Used, reason and the number of hits for student nurse* professional values* and clinical placement experience *

Database Since 2005 – 2022 English language	Subject area	Students, Nursing/ or Student nurse professional values	Clinical placement experience	Students, Nursing/ or Student nurse professional values and Clinical placement experience
Medline (Ovid)	Medical and biomedical literature	27323	43	0
British Nursing Index Database	Research for nursing and midwifery	14,033	10,337	2,538
PUBMED	Biomedical and life sciences literature	998	408	35
Allied Health Literature (CINAHL)	Nursing and allied health literature	28	389	0
Wiley	Multidisciplinary Journals in physical, medical, technical and social sciences	113,255	527,735	84,232
Scopus (Elsevier platform)	Multidisciplinary journals in medicine, social sciences, arts and humanities.	975	817	103
Cochrane Library	Best evidence on the effects/interventions of health care -	70	0	0
Science Direct	Literature on life, physical, medical, technical and social sciences.	28,269	18,033	3,812
Google Scholar	Database of scholarly literature	16,900	19,200	18,400

Appendix 3 The Process of Selecting Articles



Appendix 4 Data Collation

No.	Key Author(s)/ Year	Research aims	Sample size	Design	Key points	Country
1.	Arries (2019)	To examine nursing students' perceptions of professional values & ethical positions.	N= 89 student nurses (respondence) to on-line survey	Quantitative – cross sectional study Questionnaires & Nursing Professional Values Scale (NPVS)	Nursing students scored high on professional values and ethical idealism and significantly lower on ethical relativism.	Canada
2.	Ayla et al., (2018)	To determine the professional values of nursing students & factors that affect them.	N= 104 First grade N=84 Fourth grade	Quantitative study – NPVS	The highest mean scores were in caregiving followed by justice, activism, loyalty & professionalism. Personal and environment factors can affect professional values.	Turkey
3.	Bang et al., (2011)	Explored nursing students' perception of professional values compared to participant demographic characteristics.	N= 529 nursing students from 6 Universities	Quantitative Cross sectional study using NPVS	Higher scores for students who entered nursing via an attitude test, seeking a professional job. Then those who entered based on their exam scores.	South Korea
4.	Bijani et al., (2019)	To compare nurses, nursing students & nursing instructor	N= 299 nurses	Quantitative – cross site study	The mean score of the three groups was considered as relatively important. All three	Iran

		perceptions of professional values.	N= 341 students nurses N=100 nursing instructors	NPVS -R Revised	groups found justice to be ranked highly less so is activism.	
5.	Bleda et al., (2020)	The perceptions of professional values among students at a Spanish Nursing School.	N=315 student nurses	Quantitative Cross-sectional study. NPVS -R	Students' perceptions of professional values were significantly correlated with their academic year. Highest scores in 'maintain patient confidentiality and patients' right to privacy'.	Spain
6.	Çöplü & Kartin (2019)	To determine professional self-concept & professional values in nursing students.	N= 619 student nurses	Quantitative Used NPVS & Professional Self-Concept Scale	Woman scored higher than men in the professional values while also maintaining a positive perception & image of nursing.	Turkey
7.	Donmez, & Ozsoy (2016)	Factors influencing development of professional values among Turkish nursing students.	N=416 Nursing students	Quantitative NPVS -R	NPVS -R score was significantly higher in female students who chose their profession willingly, had information about values & were members of a professional organisation.	Turkey
8.	Fisher (2014)	A comparison of professional value development among pre-licensure nursing students in associate degree, diploma, and	N= 69 ADA N= 97 Diploma N= 39 BSN	Quantitative NPVS -R	Differences between professional values scores and levels within each program revealed significance for the diploma students ($p < 0.0001$).	USA

		Bachelor of Science in nursing programs.			Secondary sub-analysis of the NPVS-R factors among levels and between educational preparation again revealed significance.	
9.	Hidle (2011)	The role of professional values in motivating Associate Degree Nursing students to pursue higher nursing education.	N=62 Nursing students	Quantitative NPVS -R + Academic motivational scale	AD nursing students with higher intrinsic motivation and professional values were self-determined to continue their nurse education to a higher level.	USA
10.	Kavradim et al., (2019)	To determine the relationship between compassion and professional values of student nurses.	N= 141first year nursing students & N= 185 third year nursing students	Quantitative Compassion scale & NPVS-R	There was a significant correlation between the student's professional values and education level. I.E. as the education level increased so did the professional values. The level of compassion did not rise with education level.	Turkey
11.	Kaya et al., (2017)	To examine changes in nursing students personal and professional values from entering to graduating.	N= 143 student nurses	Quantitative Value preference scale, Professional Values Scale & NPVS.	Majority of the students ranked human dignity first and justice second. Nurse education is vital in acquiring and maintaining professional values.	Turkey
12.	Ciftci et al., (2020)	The Effect of Internships on Clinical Decision-making and Professional Values of Nursing Students.	N=100 nursing students	Quantitative – NPVS	It was concluded that nursing internships positively affected nursing students' professional values but did not affect their clinical decision-making skills.	Turkey

13.	LeDuc and Kotzer (2009)	To explore professional values held by student nurses, new graduates & seasoned practitioners.	N= 97 student nurses N= 46 new graduates N=84 practitioners	Quantitative – NPVS	Nurses hold high levels of professional values. There were greater similarities than differences noted between the three groups. The study did not validate the idea that experience as a RN is necessary to develop professional values.	USA
14.	Lee et al., (2020)	Self-directed learning and professional values of nursing students.	N= 800 Student nurses	Quantitative - NPVS-R + Self-Rating Scale of Self-Directed Learning	Self-directed learning had significantly positive effects on professional nursing values.	South Korea
15.	Leners et al., (2006)	To track professional values over time.	N= 159 student nurses	Quantitative - NPVS	Patient advocacy was high in the pre & post-test. No significance between the pre and post test scores.	USA
16.	Lin et al., (2010)	Examined changes in professional values of nursing students from entrance to graduation.	N=94 student nurses	Quantitative- pre- and post-test survey design	Professional values changed in a positive direction between the beginning of the student nurses' educational experience and their graduation. The results supported the premise that education had a positive effect on these students' professional values, but causality could not be assumed.	Taiwan

17.	Lin et al., (2016)	To examine professional values on nursing students in Taiwan & China.	N= 292 Taiwanese student nurses N= 654 Chinese student nurses	Quantitative NPVS R	There were significant differences between the two groups reflecting the differences in perceived importance of professional values.	Taiwan & China
18.	Nelwati et al., (2019)	To determine professional values among student nurses & examine the relationship between demographic factors & professional values.	N=391 Indonesian student nurses	Quantitative Cross sectional study NPVS-R	The total score of professional values were high and had a significant with the length of clinical placement. Caring was noted as the most important professional value while activism was least important.	Malaysia
19.	Parvan et al., (2012)	To compare the perspectives of nursing students from type I and III universities of medical science regarding professional values of nursing.	N=240 student nurses	Quantitative- cross-sectional study NPVS	The most important and least important items identified by the participants of type I universities were the “maintain competency in area of practice “and “participate in peer review”, respectively. The most important and least important items identified by the participants of type III universities were the “maintain confidentiality of patient” and “participate in public policy decisions affecting distribution of resources”, respectively. The study did not show any significant difference between the student group.	Iran
20.	Parandeh et al., 2015	Factors Influencing Development of Professional Values	22 articles were assessed for review	A Systematic Review	Four main themes were extracted: “education and achieving professional experiences”, “Students and instructors’ perspectives on	Iran

		Among Nursing Students and Instructors.			professional values", "the role of culture in considering and developing professional values" and "the effect of learners' individual characteristics".	
21.	Poorchangizi et al., (2019a)	Professional values of Nurses & Nursing students: a comparative study.	N=250 qualified nurses N=100 Student nurses	Quantitative- NPVS-R	The student's perspective towards professional values was significantly higher than those of the nurses. The professional values identified were directly related to the nursing care and profession were more important, and both groups considered activism & professionalism as least important.	Iran
22.	Poorchangizi et al., (2019b)	The importance of professional values from nursing students' perspective.	N=100	Quantitative- NPVS-R	Professional values were of a high level of importance to the students. The most important values were "maintaining confidentiality of patients" and "safeguarding patients right to privacy". The less important values were policy decisions and distribution of resources.	Iran
23.	Iacobucci et al., (2013).	Professional values, self-esteem, and ethical confidence of baccalaureate nursing students.	N-47 nursing students	Quantitative – PNVS- R + Rosenberg's Self-Esteem Scale	The participants had high professional value internalization and high levels of self-esteem, there was no significant relationship found with their perception of confidence in ethical decision-making.	USA

24.	Riklikiene et al., (2018)	To explore and compare self-reported general values and professional values.	N= 316 students nurses & 92 nurse educators	Quantitative – Using a 57-item questionnaire	Altruism was equally valued by both groups of participants. The professional values of honesty, intellectualism, and authority was ranked higher in the nurse educators.	Lithuania
25.	Shafakhah et al., (2018)	To describe the facilitators & inhibitors of professional values based on experiences from students, nursing instructors & RN's.	N=18 student nurses N= 5 nursing instruction & N=5 RN's	Qualitative – focus groups & semi-structured interviews Content analysis	Two main factors were identified: Personal & Environmental. Personal stimuli -Work experiences, past relationships, inner beliefs – belief in God Personal inhibitors- Lack of professional motivation, enthusiasms & negative emotions. Environmental stimuli- cooperation, order & discipline. Environmental inhibitors – unfavourable work environment, society's negative attitude towards nursing.	Iran

Appendix 5 Ethical Approval

Dear Devi

Title of Ethics Review: THE IMPACT OF PLACEMENT EXPERIENCES IN INFLUENCING PROFESSIONAL VALUES OF NURSING STUDENTS

Ethic Review ID: ER7565989

The University has reviewed your ethics application named above and can confirm that the project has been approved.

You are expected to deliver the project in accordance with the University's research ethics and integrity policies and procedures: https://www.shu.ac.uk/research/ethics-integrity-and-practice.

As the Principal Investigator you are responsible for monitoring the project on an ongoing basis and ensuring that the approved documentation is used. The project may be audited by the University during or after its lifetime.

Should any changes to the delivery of the project be required, you are required to submit an amendment for review.

Wishing you success you with your study

Kind regards,

Ethics Research Support

Appendix 6 Request and Reply from HoD Health Sciences

Professor Karl Atkin,

Head of Department

Department of Health Sciences

Faculty of Sciences

University of York

01.07.2019

REQUEST FOR PERMISSION TO CONDUCT A DOCTORAL STUDY RESEARCH

Dear Prof Atkin,

I am currently undertaking a Doctorate in Education at Sheffield Hallam University. As part of my Doctorate, I am required to conduct research in my thesis phase. The research will involve the student nurses on the current Post Graduate Diploma programme. The working title of my studying is: The Impact of Placement Experiences in Influencing Professional Values of Nursing Students.

I am hereby seeking your permission to approach the students on the PG Diploma programme to undertake my research. I am in the process of applying for ethical approval from Sheffield Hallam University. As soon as I receive the Ethical Approval from Sheffield Hallam, I will be applying for ethical approval from the Research Governance Committee (RGC) of the Department of Health Sciences.

If you require any further information, please do not hesitate to contact me.

Thank you for your time and consideration of this matter.

Yours sincerely,

Devi Nannen

On Mon, 1 Jul 2019 at 17:51, Karl Atkin <karl.atkin@york.ac.uk> wrote:

Hello Devi

I am happy to approve a prima facie case, particularly since we like to support colleagues, undertaking doctoral studies. Once you have obtained ethical and governance approvals, I suggest you talk with Paul.

Many thanks,

Karl

Appendix 7 Information Sheet

Participant Information Sheet

Title of Project: The Impact of Placement Experiences in influencing Professional Values of Nursing Students

Legal basis for research for studies. Example statement: The University undertakes research as part of its function for the community under its legal status. Data protection allows us to use personal data for research with appropriate safeguards in place under the legal basis of public tasks that are in the public interest. A full statement of your rights can be found at https://www.shu.ac.uk/about-this-website/privacy-policy/privacy-notices/privacy-notice-for-research. However, all University research is reviewed to ensure that participants are treated appropriately and their rights respected. This study was approved by UREC with Converis number ER*7565989*. Further information at https://www.shu.ac.uk/research/ethics-integrity-and-practice

What is the purpose of this study?

I am looking at exploring the impact of placement experiences in influencing professional values of nursing students. This will involve your group of Graduate Entry Nursing (GEN) students in your final placement.

Do I have to take part?

It is up to you to decide if you want to take part. A copy of the information provided here is yours to keep, along with the consent form if you do decide to take part. You can still decide to withdraw at any time without giving a reason, or you can decide not to answer a particular question.

What will I be required to do?

Participating in the study will involve two parts – the first one will require you to take part in two focus groups that will take approximately 60 minutes. The focus group will involve a discussion of your experiences. The second one will involve individual interviews with every participant of the focus group. It is anticipated that the interview will take approximately 45 - 60 minutes to complete. Both the interview and the focus group will be audio recorded.

Where will this take place?

The study will take place at the University of York, in the Department of Health Sciences. Once a room is booked you will be notified.

How often will I have to take part, and for how long?

It is intended that one focus group will take place at the beginning and the other at the end of your placement. While the individual interviews will take place over a week halfway through your placement. Participation is optional and you could withdraw at any time without providing any explanation. However, the data may be used anonymously if you withdrew two weeks after the focus groups or interviews.

Are there any possible risks or disadvantages in taking part?

There are no disadvantages or risks in taking part. However, the study has the potential to elicit emotions that could give rise to the feeling of being upset or stressed by a situation. The group will be assured that if they do experience any upset and would like to discontinue with the focus group or interview, they can do so at any time without repercussion or recrimination. The researcher will sign post the participants to the appropriate support services provided by the University of York.

What are the possible benefits of taking part?

There are no material benefits of taking part in the study. You may benefit from participating in the study by sharing your experiences and perceptions with your colleagues. Your contribution will benefit future curriculum development.

Will anyone be able to connect me with what is recorded and reported?

All responses will be anonymised so you will not be identifiable by name. In addition to distinctive issues or details will be changed in order to preserve anonymity if

necessary. Both the focus groups and the interviews will be transcribed verbatim and access to the computer drive where all the data will be stored will be password protected and only accessible by the researcher. Data management will be compliant with the General Data Protection Regulation (GDPR) (2018) and the Data Protection Act, (DPA) (2018) and the Department of Health Sciences' data management policies. All participants will receive a paper copy and have the right to validate or refute the transcription (i.e. the student will be able to make sure that the transcription adequately reflects what they said).

Who will be responsible for all of the information when this study is over?

The data will belong to the Department of Health Sciences because the participants are students on the current Graduate Entry Nursing programme within the Department.

What will happen to the information when this study is over?

Results may be discussed with future cohorts of the Postgraduate Diploma with Professional Registration in Adult Nursing students to help them plan their studies. However, all responses will be anonymised so you will not be identifiable by name. All data will be stored on a secured and encrypted data drive provided by the University.

How will you use what you find out? [Report, publications, presentations]

The analysed data from the research will be presented in journal articles, policy and practice conferences, possible engagement with Nursing and Midwifery Council (NMC) and the World Health Organisation (WHO).

Details of who to contact if you have any concerns or if adverse effects occur after the study are given below.

Researcher:

Devi Nannen

University of York

Department of Health Sciences

Seebohm Rowntree Building Area 3

Heslington

York YO10 5DD

Director of Studies:

Dr. Fufy Demissie

Sheffield Hallam University

City Campus,

Howard Street

Sheffield

S1 1WB, UK

Tel: 01904 321367

Email: devi.nannen@york.ac.uk

Tel: 0114 2255555

Email:f.a.demissie@shu.ac.uk

You should contact the Data Protection Officer if:	**You should contact the Head of Research Ethics (Professor Ann Macaskill) if:**
• **you have a query about how your data is used by the University** • **you would like to report a data security breach (e.g. if you think your personal data has been lost or disclosed inappropriately)** • **you would like to complain about how the University has used your personal data**	• **you have concerns with how the research was undertaken or how you were treated**
DPO@shu.ac.uk	**a.macaskill@shu.ac.uk**

Postal address: Sheffield Hallam University, Howard Street, Sheffield S1 1WBT
Telephone: 0114 225 5555

Appendix 8 Consent Form

Sheffield Hallam University

UNIVERSITY of York
The Department of Health Sciences

Participant Consent Form

TITLE OF RESEARCH STUDY: THE IMPACT OF CLINICAL PLACEMENT EXPERIENCES IN FACILITATING PROFESSIONAL VALUES AND BEHAVIOURS OF GRADUATE ENTRY NURSING STUDENTS

Please answer the following questions by ticking the response that applies

	YES	NO
1. I have read the Information Sheet for this study and have had details of the study explained to me.	☐	☐
0. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any point.	☐	☐
0. I understand that I am free to withdraw from the study within the time limits outlined in the Information Sheet, without giving a reason for my withdrawal or to decline to answer any particular questions in the study without any consequences to my future treatment by the researcher.	☐	☐
0. I agree to provide information to the researchers under the conditions of confidentiality set out in the Information Sheet.	☐	☐
0. I wish to participate in the study under the conditions set out in the Information Sheet.	☐	☐
0. I consent to the information collected for the purposes of this research study, once anonymised (so that I cannot be identified), to be used for any other research purposes.	☐	☐

Participant's Signature: _____ Date: _____

Participant's Name (Printed): _____

Contact details:

_____

Researcher's Name (Printed): _____

Researcher's Signature: _____

Researcher's contact details:

Devi Nannen

Seebohm Rowntree Building,

Department of Health Sciences,

Heslington, York

TO10 5DD

Tel: 01904 321367

Please keep your copy of the consent form and the information sheet together.

Appendix 9 Data Support Plan

Sheffield Hallam University

University of York
The Department of Health Sciences

Devi Nannen

Doctorate in Education EdD

Cohort 9

Data Management Plan

Question 1

What data will you collect or create?

The raw data will be in the form of an audio recording acquired by means of two Focus Groups (FGs) followed by semi-structured interviews that would take place at the University of York (venue TBC) at a mutually convenient time and lasting about 45 – 60 minutes. After the FDGs and interviews are recorded via a Dictaphone (audio recording only) it will then be transcribed. All participants will receive a paper copy and have the right to validate or refute the transcription (i.e. the student will be able to make sure that the transcription adequately reflects what they said). The verification process can make the analysis more rigorous and reduce any element of bias. The transcription and audio recordings will be securely stored on the Q drive system provided by the University. Once the study is written up electronic copies of the transcripts will be kept on a password secure computer (Q drive) for five years as per the University of York data storage policy. Students will remain totally anonymous throughout this process by being provided with pseudonym names. Throughout the interview process the researcher will be the only member of staff present in the room.

Question 2

How will your data be documented and described?

Data from the audio recordings will be transcribed verbatim for both the FDGs and semi-structured interviews. Thereafter, students will receive a paper copy and will have the opportunity to verify the transcription (i.e. they will be able to make sure that it adequately reflects what they said). The data will be described and analysed using thematic analysis.

Question 3

How will you deal with any ethical and copyright issues?

Data collection will only take place once ethical approval has been granted from the Sheffield Hallam University and the University of York to ensure the research is ethically sound and meets the necessary requirements.

A written consent form explaining the nature of the study and the participants' involvement as well as a guarantee of anonymity. Students will remain totally anonymous and will be referred to by a pseudonym name and that information provided during the interview will be treated in the strictest confidence.

Based on the researcher's positionality (South African female, registered nurse and academic) the care of the participants will be ensured. The researcher will practice emotional sensitivity and in the highly unlikely situation where the participants are disturbed, they will be referred to the University of York's Open-Door Team (ODT).

Question 4

How will your data be structured, stored and backed up?

Data management will be compliant with the General Data Protection Regulation (GDPR) (2018) and the Data Protection Act, (DPA) (2018) and the University of York's Department of Health Sciences' data security policies. After the transcription, the audio recording will be securely stored on the Q drive system provided by the University. Once the study is written up electronic copies of the transcripts will be kept in an encrypted file that is password protected with retrieval impossible without the password. Students will remain totally anonymous throughout this process by being provided with pseudonyms. In addition, the researcher completed and passed the University Information Security Training Course.

The Department of Health Sciences of University of York server is backed up on the daily basis as per the University policy i.e. full AES-256bit encrypted data backups for the Departmental servers are performed nightly, using separate rotational Monday to Thursday tapes, and five rotational Friday tapes. The tapes are stored in a fireproof safe in a separate fire zone and alarmed area. Data backups are retained for a period of 12 months. Old tapes are securely destroyed using a physical destruction process. The data will remain the property of the University of York because the research permission has been granted to access the Department of Health Sciences students. The data will be held on a departmental database kept with the departmental Data Protection Officer.

Question 5

What are your plans for long term preservation of data supporting your research?

Data management will be compliant with the General Data Protection Regulation (GDPR) (2018) and the Data Protection Act, (DPA) (2018). The Department of Health Sciences' data management policies for long term preservation of data will be adhered too. Raw data in the form of the transcriptions will be preserved in the Department of Health Sciences archive for five years.

When data is no longer needed it should be disposed of using the data shredder software program Eraser (http://eraser.heidi.ie/) to securely delete the data from the network storage area. Any backup copies of the data will be securely wiped once the backup disks are renewed or replaced.

Question 6

What are your plans for data sharing after submission of your thesis?

Data will be available upon request by the data protection officer. Results may be discussed with future cohorts of the Postgraduate Diploma with Professional Registration in Adult Nursing students to help them plan their studies. The analysed data from the research will be presented in journal articles, policy and practice conferences, possible engagement with Nursing and Midwifery Council (NMC) and the World Health Organisation (WHO).

Appendix 10 Focus Group Prompts

Focus group prompts: Approximately 45 – 60 minutes

- Introduction to the researcher and participants.
- Check consent form✓
- Purpose of the research
- Group introductions

Group Set ground rules = an hour or less for the focus group

- Respect for each other and information that will be emerging from the Focus Group Discussion.
- Not to make personal comments on others.
- Apply the Chatham House Rule (anyone is not allowed to identify the person that made comments outside the discussion). This will increase openness of discussion.

Start with personal values on sticky notes (use flip chart paper):

- Please write done what you think are your personal values are.

1. What comes to mind when you think about professional values

2. What experiences influence your professional values and behaviours during their clinical practice placement?

- Probe further

3. Did these experiences facilitate or hinder your professional values and behaviours?

- Probe further

4. Use sticky notes (personal values)

- How did (person values) complement or conflict with your professional values?

5. What characteristics of professional values and behaviours of a registered nurse did you observe and why?

6. Anything else to add-

Debrief – summarise

Thank you

Appendix 11 Semi-structured Interview Prompts

Semi-structured Interview prompts: Approximately 45 – 60 minutes

- Thank you for reading the participant information sheet and agreeing to participate in the interview today – check consent form✓

Start with:

1. Why did you come into nursing and has your personal values influenced that decision?

- Probe further

2. Can you tell me about your personal values you wrote done on the post stick

- Probe further

3. Was there a situation that complimented or challenged your professional values?

- What were they and how did you use it in the situation?
- Probe further

4. Was there any specific values and behaviours of the registered nurse that influenced your professional values?

- What professional values would you say are important to you and why?
- Probe further

5. Do you feel the NMC Code has influenced your professional values?

- Probe further - How and why

6. Anything else to add-

Debrief – summarise

Thank you

Appendix 12 Participant Advice Sheet

Anxiety and Depression

Anxiety UK (formerly National Phobic Society): 08444 775774 774. Helps all those suffering with anxiety disorders. Self-help leaflets and contact lists. Self-help groups, counselling, phone self-help groups, email support.

www.anxietynomore.co.uk: Information and advice on all aspects of anxiety and panic.

www.bigwhitewall.com: Improving mental health and emotional well-being.

Bereavement

Bereavement Trust Helpline: 0800 435 455 (6pm-10pm every evening).

www.bereavement-trust.org.uk: Support for anyone who has been bereaved.

Domestic Violence and Abuse

Support Line: 01708 765200. Telephone Helpline providing confidential emotional support to Children, Young People and Adults on any issue including domestic violence. Keeps details of other agencies, support groups and counsellors throughout the UK.

Email info@supportline.org.uk

Gender and Sexuality

LGBT Foundation: 0345 330 3030. www.lgbt.foundation. Wide range of services to lesbian, gay, bisexual and Trans (LGBT) communities.

FFLAG 0845 652 0311, www.fflag.org.uk: National voluntary organisation, which supports lesbians and gay men and their families. Helplines throughout UK and parents' groups. Run by parents of gays and lesbians.

Suicide

Support Line Telephone Helpline: 01708 765200 (Helpline). Confidential emotional support to Children Young People and Adults. Provides emotional support and details of agencies, counsellors,

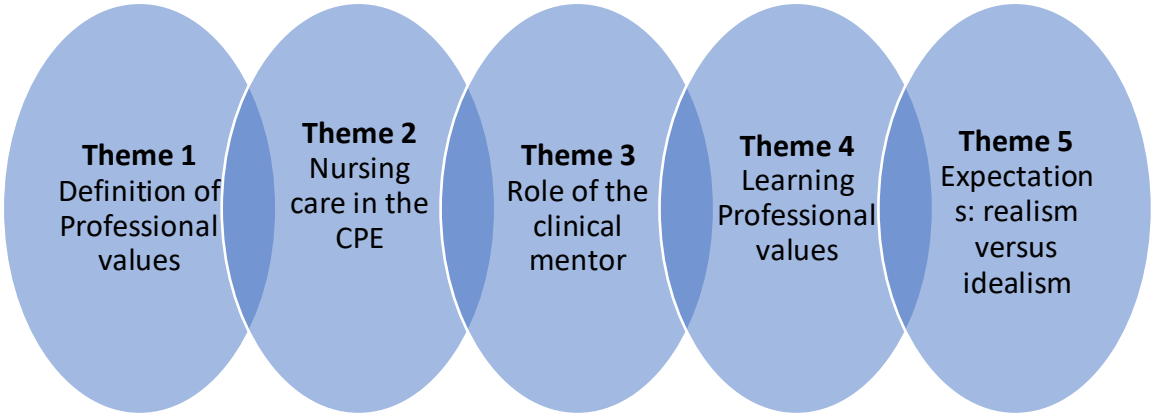
helplines, and support groups across the UK.

Email info@supportline.org.uk:

Appendix 13 Participant Characteristics

Name	Gender Age	Previous Degree	Previous Healthcare experience	Current placement	Reason for doing nursing	Why the GEN programme
Mila	Female 25	Music	Yes	Acute setting (ICU)	Personal reasons	Shorter programme, smaller cohort & the bursary
Ava	Female 29	Geography	No	Acute setting (CCU)	Personal reasons	Shorter programme, earn a salary sooner
Bella	Female 28	*Psychology	Yes	Acute setting (CCU)	Personal reasons and family reasons	Shorter programme
Zara	Female 28	Tourism Management	Yes	Acute setting (ICU)	Personal reasons	Shorter programme
Tim	Male 33	*Biochemistry	No	Acute setting (A&E)	Personal reasons -parents are nurses	Family influence, shorter programme & bursary
Iris	Female 28	Event Management	Yes	Acute setting (PACU)	Previous work experience	Shorter programme and the bursary
Chloe	Female 36	Literature, writing & performance	Yes	Acute setting (A&E)	Personal reasons	Shorter programme & bursary
Evie	Female 27	*Sociology	Yes	Non-acute ward	Personal reasons	Shorter programme
Lila	Female 43	*Community Development	Yes	Community	Personal and Family reasons	Shorter programme, family influence & bursary
Jin	Male 26	*Psychology	Yes	Community	Personal reasons	Shorter programme, bursary and a salary sooner
Liv	Female 35	Communications	Yes	Community	Personal reasons and family reasons	Family influence, shorter programme & bursary
Erin	Female 28	Law	No	Community	Personal reasons	Shorter programme & the bursary

Appendix 14 Themes after the Initial Review



Source: (Author, 2021)

Appendix 15a Codebook\\Phase 3 - Searching for Themes (Developing Categories)

Phase 3 - Searching for Themes (9 initial themes identified amongst 104 initial codes)	Interviews Coded	Units of Meaning Coded
Clinical experience	13	222
Clinical Mentors	13	114
Defining Professional values	10	15
Emotional Aspects	10	60
External factors	12	96
GEN Programme	12	61
Learning professional Values	14	202
NMC Code	12	140
Personal Values	14	310

Appendix 15b Codebook\\Phase 4 - Reviewing Themes (Drilling Down)

Phase 4 - Reviewing Themes (9 initial themes reduced to 6 at phase 4)	Interviews Coded	Units of Meaning Coded
Clinical Mentors	**14**	**121**
mentor advocate	3	3
mentor as a role model	7	12
mentor attitude	2	5
mentor communication	5	6
mentor knowledge	4	6
mentor qualities	13	74

Phase 4 - Reviewing Themes (9 initial themes reduced to 6 at phase 4)	Interviews Coded	Units of Meaning Coded
mentor relationships	7	13
SSSA -Standards for student supervision	1	2
Clinical Placement Environment	**14**	**237**
acute setting	4	4
attitude	2	2
autonomy	1	3
communication	3	8
difficult patient	1	2
diversity-inclusion	1	3
evidenced based care	2	4
favourite patient	1	1
Hierarchy	7	15
honesty	1	2
human rights	2	2
judgemental	5	9
lack of person-centred care	2	3
negative practice experience	3	20
patient care	2	7
patient care ratio	1	1
patient dignity	1	4
patient ownership-independence	6	8
patient safety	2	12
Person centred care	12	24
positive practice experience	2	7
practice challenge	12	57
practice experience	13	25
preferred patient	1	1

Phase 4 - Reviewing Themes (9 initial themes reduced to 6 at phase 4)	Interviews Coded	Units of Meaning Coded
prioritising care	1	2
spare pair of hands	1	2
team working	2	3
workload	3	5
Emotional Aspects	**14**	**169**
burn out	4	10
compassion	5	12
Empathy	2	5
emotions	2	2
empathy	5	14
External factors	13	101
fitting in	1	1
job satisfaction	2	3
little things	5	6
self-care	3	13
Trust	1	2
Learning in CPE	**14**	**216**
Being an advocate	3	7
Code benchmark to care	4	7
Code public awareness	1	2
confidentiality	1	2
duty of candour	1	2
duty of care	2	4
education	2	2
Knowledgeable	1	1
learning-education	1	2
NMC Code Influence	12	37
NMC Code	11	41

Phase 4 - Reviewing Themes (9 initial themes reduced to 6 at phase 4)	Interviews Coded	Units of Meaning Coded
nursing profession	1	2
patient advocate	4	10
patient safety	1	11
professionalism	5	5
purpose of the Code	1	1
right to healthcare	2	2
NMC Code	**13**	**141**
Personal and Professional Values	**14**	**381**
care	10	40
compassion	6	13
empathy	5	13
future career	3	3
GEN Programme	12	58
Manage personal & professional values	14	75
nursing career	4	10
Participant Characteristics	10	19
personal reasons	10	31
personal values	12	44
philosophy	13	30
Prior Experience	9	20
religion	1	3
resilience	1	5
respect	2	3
Self-care	3	13

May 2018 - Thinking ahead

-Oh my goodness, I feel that I need to refocus my research questions to establish the students' understanding of their professional values before identifying and examining the relationship with their clinical placement experiences.
Because the students had some idea regarding their personal and professional values from the pilot study, this needs to be established before moving forward. I am not sure I would have a clear idea of my personal or professional values when I was a student nurse. However, there was no emphasis on professional values when I was a student nurse, this student group is doing rather well.

October 2019

Data collection started yay 😀
I feel ready to start collecting data and to see where that phase takes me. although a bit apprehensive because there is always the possibility, I may not collect enough data.
I was reassured during my supervision meeting that two focus groups alone can produce sufficient data, it's how the data is viewed and used.
I think it's a confidence thing, I need to stop thinking that way and get stuck in.

July 2017

Feeling positive

I have faith in the participants and believe that they are very savvy and have a mature outlook of nursing and their future careers in nursing.
Now that I think about my own experiences as a student nurse or newly qualified nurse. I tend to judge myself harshly when I do not apply my professional values, so I need not judge students because the pressures are different to mine from 24 years ago,

December 2019
Interviewing

Lila discussed the NHS and the free healthcare for all quite a few times and how the health services in the UK are different to her home country. I found myself daydreaming for a brief moment about my experiences of working in the government hospitals in SA as a student nurse and qualified nurse. And yes, I could identify with what Lila was saying because I had experienced similar. I got to focus on what Lila is saying.

February 2020
Transcript reading

Ok Tim has provided so much information during his interview. I am struggling to fitting the various parts of the transcript into my coding! I am getting a bit frustrated with myself because the process is taking so long. I need to take a break, eat cake or go for a walk.