TWO WORLDS COLLIDING: NURSING STUDENTS SPEAKING UP FOR PATIENT SAFETY IN RURAL HEALTHCARE SETTINGS

A Thesis submitted by

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ABSTRACT

During clinical placement nursing students may observe clinical practices that breach safety standards. Students are often perceived as inferior and struggle to belong as a health care team member. This creates uncertainty for students about situations where they feel they need to speak up to prevent patient harm. The difficulties are amplified in rural contexts due to the lack of structured support, a lack of education resources, and the absence of the multidisciplinary team at the site. Through an Interpretive Description lens this study aimed to create practice-based solutions that enable students to speak up without fear. This study began with a rigorous review and analysis of the concept of speaking up for students. A two-phased sequential data collection process involved twelve in-depth interviews and six focus groups with students to examine their perceptions, experiences and influences on speaking up during rural placement. The participants were recruited from two universities who completed a placement in rural and regional clinical placement settings. The findings revealed that students encounter a complex alienating culture that undermines their psychological safety and compromises their ability to speak up. Students are conflicted when witnessing breaches in policy and practice and are confused when health care staff justify their unsafe practices. Students speaking up behaviours correlate with experiences they have during placement. Learning to speak up is complex and the trajectory to becoming confident and competent is not clear-cut. The ability and willingness to speak up is influenced by underlying intricacies relating to people and the workplace culture. Students become aware of potential risks associated with speaking up, gaining a sense of agency and developing strategies to mitigate risk. The complex nature of the placement setting and diversity in patient safety curricula creates challenges for students to speak up in practice. Nursing students are the future healthcare workforce who need to be valued and included in the safety culture to feel psychologically safe and have a sense of agency, enabling them to voice their concerns and contribute to preventing patient harm.

CERTIFICATION OF THESIS

I Anthea Kate Fagan declare that the PhD Thesis entitled; Two worlds colliding: nursing students speaking up for patient safety in rural healthcare settings is not more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, and references.

This Thesis is the work of Anthea Kate Fagan except where otherwise acknowledged, with the majority of the contribution to the papers presented as a Thesis by Publication undertaken by the student. The work is original and has not previously been submitted for any other award, except where acknowledged.

Date: 26 October 2022.

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Student and supervisors' signatures of endorsement are held at the University.

STATEMENT OF CONTRIBUTION

I certify that the publications in this thesis do not incorporate, without acknowledgement, any material previously submitted for a degree or diploma at any university. The author concedes that the copyright of published works contained within this thesis (as listed below) resides with the copyright holders (non-open access publications).

Paper 1

Fagan, A., Parker, V., & Jackson, D. (2016). A concept analysis of undergraduate nursing students speaking up for patient safety in the patient care environment. *Journal of Advanced Nursing*, *72*(10), 2346-2357.

Anthea Fagan: 70% Contributed to the study design, undertook the data collection, undertook the data analysis, and wrote the manuscript.

Professor Vicki Parker: 15% Contributed to the study design, assisted with data analysis, and reviewed and provided feedback on the manuscript.

Professor Debra Jackson: 15% Contributed to the study design, assisted with data analysis, and reviewed and provided feedback on the manuscript.

Paper 2

Fagan, A., Lea, J., & Parker, V. (2021). Conflict, confusion and inconsistencies: Pre-registration nursing students' perceptions and experiences of speaking up for patient safety. *Nursing Inquiry*, *28*(1), e12381.

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Paper 3

Fagan, A., Lea, J., & Parker, V. (2021). Student nurses' strategies when speaking up for patient safety: A qualitative study. *Nursing & Health Sciences*, *23*(2), 447-455.

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DEDICATION

I dedicate this thesis to my parents to whom I attribute my strengths and values in everything that I realise in the past, present and in future. My mother beside me, and father looking down on me have given me the values of strength, resilience and determination to instil absolute effort in everything I commit to. I did not envision a PhD as part of my life, and yet the values my parents offered have driven my everyday existence and achievements. I truly realise the values and support that have enabled me to complete this research and thesis.

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GLOSSARY OF TERMS

- The terms *Pre-Registration Nurse* and *Nursing Student* are used interchangeably. The term nursing student is the general phrasing that the wider population use. Pre-registration relates to students who are not yet Registered Nurses (RN) in Australia. However, the international students enrolled in the Master of Nursing Practice students at one of the universities may have been RNs in their home country but considered pre-registration in the Australian context.

- *Clinical placement* refers to the students' practical experience in a variety of diverse settings. In contrast, other terms that are often used include work-integrated learning, clinical praxis and clinical practicum. Clinical placement has been the standardised term for this thesis.

- *Patient safety* is the absence of preventable harm to a patient during health care

- A *just culture* refers to the psychological safety individuals feel within an organisation. A just culture acknowledges there are patient safety risks associated with human error. A just culture allows individuals to take action and reduce risk to patient safety without fear of retribution.

- *Mature-age students* are learners who are independent adult learners who have life experience, previous careers other than nursing, and are returning or commencing a new focus of study.

ABBREVIATIONS

ACSQHC – Australian Commission for Safety and Quality in Healthcare

Ahpra – Australian Health Practitioner Regulation Agency

AIHW – Australian Institute of Health and Welfare

ANMAC – Australian Nursing and Midwifery Accreditation Council

CCA – Clinical Coordination Academic

Gen – Generational

ICN – International Council of Nurses

IPL – Interprofessional learning

JAN – Journal of Advance Nursing

MPS – Multi-Purpose Services

NETNEP – Nurse Education Today/ Nurse Education in Practice

NHMRA – National Health and Medical Research Council

NMBA – Nurses and Midwives Board of Australia

NSQHS – National Safety and Quality Health Service

NSQHSS – National Safety and Quality Health Service Standards

NSW – New South Wales

RN – Registered Nurse

RRH – Rural Referral Hospital

UK – United Kingdom

UNE – University of New England

UoN – University of Newcastle

WAPS – World Alliance for Patient Safety

WHO – World Health Organisation

WIL – Work integrated learning

CHAPTER 1: INTRODUCTION

"Safety has to be everyone's responsibility… everyone needs to know that they are empowered to speak up if there's an issue".

Captain Scott Kelly

1.1 Introduction

This study emerged through my personal experiences of supporting nursing students on clinical placement and significant concerns about students' ability to speak up for patient safety during their clinical placement experience.

The following student story was a critical event that led to the focus of this study;

Late one evening, as the Clinical Coordinator Academic (CCA), I received a call from a distressed nursing student asking for advice about responding to an incident during their placement. This student was distressed and hoping to clarify if their decisions and actions were wrong and asked for advice on how to respond in the future. The first-year student explained that a Registered Nurse (RN) asked the student to help return a patient to bed after an unwitnessed fall to the floor. The student suggested to the RN that a vital sign observation assessment be undertaken, as they had learnt at university. The RN responded to the student, '*No need for that. The patient was fine*', then administered some morphine for pain and left to attend the end-of-shift handover. The student said the RN's actions were confusing, conflicting with what she had learnt at university, so she decided to undertake a vital observation assessment. The RN then yelled at her, telling her she would fail the placement because she could not listen or follow basic instructions.

This story is one of many that students frequently share describing the invidious position in which they find themselves. Students struggle to determine what is the right thing to do when working with health care professionals during placement. Students question themselves and the situation, determining whether they should speak up or remain silent when they are concerned about patient safety. As an educator, I strive to enable students to learn and apply best practice and to maintain patient safety. This thesis explores student stories in order to understand the meaning and challenges of their experiences. This knowledge will inform future nursing education and clinical practice around speaking up for safety to keep patients safe and reduce the risk of harm.

1.2 Problem Statement

Despite a strong and continuing focus on patient safety and patient safety culture in healthcare contexts, nursing students frequently observe practice that compromises patient safety. Patient safety is the absence of preventable harm to a patient during health care. Patient safety has evolved as a discipline in response to a rise in preventable patient harm in health care. It aims to reduce risk and errors that harm patients and provide care through effective implementation of clear policies, effective leadership and skilled health care professionals striving to improve care (WHO, 2022). Adverse events due to unsafe care are one of the ten leading causes of death and disability worldwide (WHO, 2021), almost half of which are preventable (de Vries & Timmins, 2016). Although improving patient safety and patient harm prevention has become a leading concern in healthcare, patient safety risks and breaches continue in practice. Speaking up to voice concerns have been reported as challenging for health professionals across many disciplines (Okuyama, Wagner & Bijnen, 2014; Schwappach & Gehring, 2014; 2014a), and as a consequence, health care professionals often remain silent (Ion, Jones & Craven, 2016; Rainer, 2019). The rural clinical placement setting presents additional challenges for students and their

learning. These challenges relate to staffing and resources, the clinical and community environments, and the support and supervision of students during their placement experience. Speaking up to prevent patient harm is essential to ensure safety. However, there is a gap in the literature that focuses on the propensity for nursing students to speak up in the rural healthcare setting.

Research focused on nursing students' experiences of speaking up in the clinical placement setting has increased in recent years (Bickhoff, Levett-Jones & Sinclair, 2016; Fisher & Kiernan, 2019; Green & Garland, 2018; Ion et al., 2016; Jack et al., 2021). Nursing students consistently report experiencing stressful clinical placements and being negatively impacted by the workplace culture in clinical settings (Bellfontaine, 2009; Courtney-Pratt et al., 2018; Jack et al., 2021). According to Rees et al. (2015), nearly 80% of students have encountered problems related to patient safety violations enacted by health care professionals, such as instances of student abuse and problems with patient consent. Students learn about professional responsibility to speak up if they perceive patient safety is at risk (Bickhoff et al., 2016). Without support, encouragement, and positive role modelling for speaking up in clinical practice, nursing students are left floundering, unsure if, when and how they should speak up (Fisher & Kiernan, 2019).

In Australia, the capability to deliver safe, appropriate and responsive quality nursing practice is Standard 6 of the Registered Nurse Standards for Professional Practice (NMBA, 2016). It is imperative that health professionals, including nursing students, have foundational and indispensable knowledge, skills and attitude that enable them to participate in maintaining safe healthcare environments for patients. Methods of engaging students' learning about patient safety differ significantly among universities (Levett-Jones et al., 2020). There is no consistent framework or approach to teaching students to speak up for safety. It tends to be

integrated within nursing courses rather than learnt in distinct, individual topics (Usher et al., 2018). The lack of structure of safety education negatively impacts students' confidence about responding to safety issues during clinical placement (Hanson et al., 2020).

Nursing students are the future workforce in healthcare who need to be supported and nurtured to develop a strong professional identity (Darbyshire, Thompson & Watson, 2019). Integrity is an aspect of students' identity that will ensure they are responsible, ethical, accountable and honest in practice that aims to maintain patient safety. Students engaging in advocacy increases their identity as professional nurses (Fitzgerald & Clukey, 2021). However, students' identity and integrity are frequently challenged during placement when advocating for patient safety (Bickhoff et al., 2016; Jack et al., 2021). Despite feeling a moral responsibility to take action and prevent patient harm, nursing students experience a deficit in courage and skills to intervene (Hanson & McAllister, 2017). Nursing students' ability to address or raise concerns is influenced by educational, socio-cultural and human factors in the clinical placement setting that obstruct students' decision to speak up (Fisher & Kiernan, 2019).

Examining factors that enable and prevent students from speaking up, understanding the nature of their voice and/or silence(ing), and identifying speaking up strategies will help to improve students' capacity for speaking up. Developing a greater understanding of the factors that enable students to uphold their professional identity with integrity will result in students speaking up as an acceptable and expected behaviour that will reduce future risks to patient safety. Exploring nursing students' perspectives, experiences and responses to events that compromise patient safety during their clinical placement experience will inform patient safety education. Health care staff who support students during placement and education providers will be informed about the students' perceptions and experiences when they speak up.

1.3 Study Aim and Research Questions

AIM: This study aimed to investigate pre-registration nursing students' perceptions, experiences, willingness, and capacity for speaking up for patient safety. It examines students' speaking up attitudes, experiences, behaviours and practices, together with barriers and enablers in rural and regional clinical placement settings.

QUESTION: What are nursing students' perceptions and experiences of patient safety breaches and of speaking up for patient safety during the clinical placement experience in rural and regional settings?

Sub Questions

i. What factors impact nursing students' propensity to 'speak up' when they observe errors in clinical practice?

ii. What strategies or common approaches do students employ to speak up or not speak up when they witness imminent potential harm?

iii. How do student perceptions and experiences of speaking up change over the course of their studies?

1.4 Methodology

1.4.1 Applying Interpretive Description to the study

Interpretive Description is a methodological approach derived from qualitative traditions, informing data collection and analysis methods. Qualitative research methodology is generally concerned with exploring, understanding, and describing personal and social experiences to understand the meanings of a particular phenomenon (Denzin & Lincoln, 2017). Interpretive Description is a qualitative methodology that moves beyond single traditional qualitative approaches such as phenomenology, ethnography, and grounded theory. It aims to generate knowledge related to real-world issues with the desired outcome of creating practical solutions. Interpretive description draws from the philosophical perspectives applied to a discipline, the human experiences within a natural context or setting,

and seeks to expand the disciplines capacity to understand the associated implications. Interpretive Description takes a hermeneutic cycle approach capturing the experiential context and realities through those who experience them (Thorne, 2016). This research focuses on realities, social and cultural forces that shape the context of the clinical setting and influence nursing students' speaking up thoughts and behaviours when observing patient safety risks.

Interpretive Description enables the researcher to develop knowledge and make practical sense of information that generates plausible and functional results for the relevant discipline. This research method aimed for a practice-based goal and an appreciation for what is known and not yet known based on previous knowledge and research (Thorne, 2016). Past research on speaking up has focused on medical staff or RNs' experiences (Garon, 2012; Martinez et al., 2015). Engaging hermeneutic traditions through Interpretive Description gathers lived experiences, giving meaning to patterns and themes the study participants present. Through Interpretive Description this research aimed to understand the students' patient safety perceptions, experiences and interactions in an Australian rural and regional clinical context. Through interviews and focus groups we explored the perspectives and experiences of the socio-cultural challenges that influenced students speaking up behaviours during the placement experience. Thorne's (2016) Interpretive Description methodology provided direction in developing an informative interpretation of students' experiences based on discipline-focused, knowledgeable questioning, reflective practices, and critical examination that will inform the nursing discipline. Understanding nursing students' perceptions and experiences will inform clinicians and educators, creating focused goals directed towards increasing students speaking up skills in a psychologically safe and inclusive healthcare settings that prevents patient harm.

The design of this study and the methods chosen derive logically from what is known about the phenomenon of student experiences, the clinical placement setting and patient safety risks. Interpretive Description required looking beyond the obvious as it is presented in the data. Rather than merely retelling students' experiences of speaking up for patient safety, the stories were deconstructed, and reconsidered to find meaning within the participants' stories. The research questions were designed to explore beyond their experiences by framing their mental attitudes associated with the phenomenon (Thorne, 2016), and examining the barriers and enablers of speaking up. The design and analysis through an Interpretive Description lens gave consideration to the complex social and cultural aspects of the rural healthcare clinical placement experience and their influence on the students speaking up behaviours.

The Interpretive Description analysis focused on development of unique practical solutions that will potentially enable students to speak up and prevent patient harm in the Australian rural and regional clinical placement settings. Findings of the study will add to theoretical understanding of nursing students' behavioural and attitudinal factors that influence how they advocate for patient safety through speaking up.

1.5 Design and Methods

This qualitative study utilised a two-phase sequential design guided by Interpretive Description (Thorne, 2016). Phase One consisted of in-depth individual interviews with twelve nursing students. Phase Two involved six focus group discussions with student year groups, across the three-year program. Together the two phases provided insight into individual and shared experiences and perceptions. The study's first phase was designed to understand students' perceptions and experiences of speaking up and systematically make sense of the common and recurring themes (Thorne, 2016). In the second phase, the focus groups provided a space where individual students became informed about other students'

experiences and perceptions of speaking up. This resulted in a shared perspective of the everyday experiences and perceptions linked back to the participants' relevant year of study and changes as students progressed through their degree (Morse, 2010).

Extensive review of the literature identified a lack of clarity in defining and describing the nature and purpose of speaking up as a nursing student. Therefore, a concept analysis of the students' speaking up' was undertaken, clarifying a working definition of speaking up. For this study the definition of speaking up as initially defined by Premeaux and Bedeian, (2003) and Lyndon et al., (2012), and then further refined by Fagan, Parker & Jackson (2016) will be utilised. That is that 'Speaking up is assertive communication in clinical situations that requires (immediate) action through questions with statements of opinion with appropriate persistence aiming for a resolution' (Fagan, Parker & Jackson, 2016 p.106; Lyndon et al., 2012; Premeaux & Bedeian, 2003; Schwappach & Gehring, 2014). Defining the term speaking up before the data collection phase was important because it assisted with clarity and focus of the conversations with the participants about speaking up.

The semi-structured approach to the interviews and focus groups enabled students to share their thoughts and experiences and raise concerns that mattered to them, while maintaining focus on the aim of the study. This helped to extend the conversations and allowed for probing to gain more in-depth responses, ensuring that all relevant topics were covered (Minichellio, Aroni & Hays, 2008).

The participants shared ideas and reflections by engaging in dialogue with other participants through the researcher's semi-structured approach to asking questions (Roulston & Chio, 2018). Conducting the focus groups after the interviews helped construct meaning and make sense of the nature of shared and disparate experiences when the students shared their stories. The interactive discussion added value from a year perspective as the

group collectively determined why things occur as the participants reacted and built on each other's responses in a more relaxed setting (Morgan & Hoffman, 2018).

The group approach facilitated social interaction and collective contributions between the participants about their perceptions, knowledge and experiences of speaking up. Six focus groups were conducted, two with each year group to understand first, second, and third-year experiences. The focus group participants were asked the same initial questions as the interview participants. However, they were also asked to reflect on their year level within the nursing course program and consider if and how this impacted their experiences, perceptions and behaviours about speaking up to prevent patient harm.

1.5.1 Study setting

This study sought participants from two Australian public universities, the University of New England (UNE) and the University of Newcastle (UoN), both located in New South Wales (NSW), Australia. At the time of the study, UNE had approximately 1200 pre-registration Bachelor of Nursing and Master of Nursing Practice students. Its original and main campus is in the city of Armidale, a rural/regional city in northern New South Wales. The University of Newcastle is situated within the metropolitan city of Newcastle. UoN had approximately 2200 nursing students within its pre-registration nursing program.

There is approximately 500 kilometres of distance between the two universities. Both universities draw students from rural, regional and metropolitan areas within NSW and beyond, including from the eastern states of Queensland, Victoria, and Tasmania. Both Universities deliver their nursing programs through mixed modes of delivery via interactive online and on-campus face-to-face learning. The two universities use common healthcare services for students' clinical placement experiences.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) stipulate that Pre-registration nursing courses require nursing students to undertake a minimum of eight hundred hours of work integrated learning (WIL) (ANMAC, 2019). Both universities included this minimum requirement in their curriculum. As part of the nursing curriculum, students are required to undertake placements across various clinical settings within Australia (ANMAC, 2019). The clinical placements period ranges from a period of two to four weeks in length (80–160hrs).

The study participants experienced a diverse range of clinical placements from small rural healthcare service to larger regional and occasionally tertiary metropolitan services. The focus of care in the clinical placement settings aims to meet the regional, national and global health priorities, including mental health and care of the older person (ANMAC, 2019). Therefore, the participants may have experienced clinical placement in community health, justice health, mental health, aged care, and acute care across regional/ rural, remote and occasionally metropolitan healthcare services.

The settings where the students undertook clinical placement was predominately in rural and regional healthcare organisations. The terms rural and regional are used together to refer to areas of the State outside of metropolitan Sydney, Newcastle and Wollongong, in accordance with NSW Parliament Legislative Council Report 57 (2022).

The healthcare services that host student placements have various classifications. Students were frequently assigned a clinical placement in the smallest rural healthcare services in NSW known as Multi-Purpose Services (MPS). MPSs provide a range of health services, including aged care, emergency care, acute, and sub-acute such as respite and palliative care. They also provide primary, community, and allied healthcare, such as oral services (NSW Ministry of Health, 2022).

The students were often allocated clinical placement at a Rural Referral Hospital (RRH), which is linked with other healthcare services in the area through a formal network and arrangement of its services. A Rural Referral Hospital has a formal agreement and links with a metropolitan hospital that offers education and telehealth assistance. Networking between these healthcare services involves linking health services across various sites and settings, providing appropriate, effective, comprehensive, and well-coordinated responses to healthcare needs (NSW Ministry of Health, 2022). Students occasionally attended clinical placement experience in tertiary level healthcare services. These services were specialised, and patients are often referred from an MPS or RRH to a tertiary health facility for advanced medical investigations and treatment. Such care includes neurosurgery, cardiac and plastic surgery, severe burns, acute spinal injury treatment, and other complex medical and surgical interventions (NSW Ministry of Health, 2022).

Rural healthcare facilities provide different support and learning resources for students during their clinical placement compared with metropolitan placement providers. Many rural facilities only offer placement experiences to nursing students resulting in no other health discipline students at the facility. The lack of students across disciplines leads to a lack of physical resources such as dedicated educators and specialised learning spaces such as tutorial rooms or advanced learning equipment such as simulation suites.

The quality of the clinical placement experience is generally associated with, but not limited to, diverse and appropriate learning opportunities, a safe and supportive environment, excellent communication, and effective supervision (Jansson & Ene, 2016). Choosing

a supervision model for professional practice experiences is key to delivering quality clinical education during the clinical placement experience (ANMAC, 2019). Supervision during clinical placement varied and depended mainly on the size and type of facility. Students undertaking a placement in the tertiary healthcare facilities were mostly supervised, assessed and supported by a university-employed facilitator. Whereas the support and supervision within MPS and RRH and other diverse clinical settings was generally provided by clinicians employed by the health facility and seconded to the role of facilitator. The most common practice for clinical placements within rural settings is to support students utilising a mix of a facilitated and/or a preceptor model; however, there is no standardised approach to supporting the student (Sanderson & Lea, 2012). The participants of this study reported experiencing various approaches to clinical placement supervision and support.

In Australia, the preceptor model is the most common approach to supervision. Students work with a registered nurse who provides supervision and evaluation of the student's care during placement (Health Workforce Australia [HWA], 2014). Through the facilitation model of supervision, the nursing students work alongside an RN, educator or facilitator employed by the University who supervises six to eight students throughout the placement. The facilitator and preceptor models are occasionally merged, incorporating aspects of both models. The least common supervision approach for this study's participants was the mentor model, where there is a long-term relationship between the student and the RN This approach is utilised for more senior students in their final year of the course (McLeod et al., 2021). A recent trend is the development of a collaborative model where the health facility and University agree upon assigning a student to a Dedicated Education Unit (DEU) or health facility for a significant percentage of their total clinical placement allocations. Within this is a combination of the facilitation and preceptor model; additionally, the academic faculty are closely involved in the students'

progression and competence development (Geralish et al., 2018). No participants in this study were assigned a DEU for their clinical placement experience because the universities did not utilise this approach.

Model	Components of the model
Preceptor	The 1:1 model—the most commonly used with clinical supervision—is where a student is assigned to a registered nurse known as the 'preceptor'. The student works alongside the preceptor daily for direct and indirect supervision and undertakes formative and summative assessments.
Facilitation/supervision	A 1:6 or 1:8 model is where a registered nurse directly and indirectly supervises a group of students. Facilitators are University employed or hospital employed staff and undertake summative and formative assessments.
Facilitation/preceptor	A combination of the preceptor and facilitation/supervision models where a student is allocated ('buddied') to a registered nurse for preceptoring and the facilitator undertakes group supervision of 1:8 or more.
Dedicated education unit	A combination of the preceptor and facilitator models with the added component that there is a partnership between the health service and University and a Clinical Liaison Nurse (more commonly called 'Nurse Educator') who provides the link to the University.
Mentor	A model similar to the preceptor model but is less commonly used in undergraduate clinical education as the clinical supervision is more often than not, indirect. The mentor model involves a longer-term relationship between the student and registered nurse.

Table 1: Health Workforce Australia supervision of professional practice experience models (ANMAC, 2017, p.17).

1.5.2 Recruitment

Students enrolled in a pre-registration nursing degree and who had attended at least one clinical placement were invited to participate in the study. Individuals participating in this study were 18 years old or older. They were enrolled in either a Bachelor of Nursing (3 years) or a Master of Nursing Practice (2.25 years) at one of the two universities. Domestic and international students were invited to participate in the study. Students who had not yet attended a clinical placement were excluded from this study. Nursing students from the two universities were invited to participate in the study via notifications posted within their respective universities learning management and student email communications systems. These notifications were posted by an independent person, a university administrative assistant within each of the University's nursing schools. A university administrative assistant distributed participant information sheets to students at the end of classes and following clinical placement debriefing sessions. The information sheet informed students of the aim and purpose of the study and advised that as participants, they could attend an interview, a focus group, or both. All participants who accepted the invitation remained in the study until completion (See Appendix A: Participant Information Sheet).

1.5.3 Participants

Fifty-three participants accepted the invitation to participate in either an individual interview or a focus group discussion. Although it was possible, no participants attended both an interview and a focus group. Twelve students in total were interviewed. Forty-one students participated in the focus groups (eleven 1st-year, fifteen 2nd-year, and fifteen 3rd- year). The ages of the participants ranged from 18 years to 45-50 years old Five of the twelve interview participants were mature-age students, and the focus groups had three mature-age students in the first-year focus group, six in the second year and seven in the third-year focus groups. There were eleven males, and forty-two females who participated in the study. Two male and ten female students were interviewed, while the focus groups had nine males and thirty-two females, reflecting the male-female enrolment

ratio of the student cohorts.

Similarly, mature age students have been proportionally represented in the study. Of the fifty-three participants eight were international students completing the pre-registration Master of Nursing Practice, and the remaining were enrolled in the Bachelor of Nursing. Some are international students with past health care experiences, and cultural diversity is represented across the interviews and focus groups.

1.5.4 Data Collection

The primary researcher, a Registered Nurse who is a university lecturer conducted all the interviews and focus groups. The interviews were conducted between March and September 2017, and the focus groups were undertaken between March and September 2018. The interview length ranged from 30 to 60 minutes, and the focus group discussions ranged between 60 and 90 minutes in length. Six focus groups were conducted with 6-8 participants per session. This number of participants ensured discussion was interactive and inclusive, enabling participants to contribute to a robust conversation. The focus groups and interviews were audio recorded and transcribed verbatim. Interviews were conducted until enough rich stories and data were collected to inform robust data analysis, enabling an all-inclusive understanding of the phenomenon (Bazeley, 2013). Before commencing each of the six-focus group discussions, the facilitator discussed the importance of respectful participation, anonymity, and confidentiality. Throughout the conversations, the interviewer carefully considered individual members and remained mindful of the social dynamics influencing the group's thinking (Thorne, 2016).

1.5.5 Data Analysis

Interpretive Description acknowledges the theoretical and practical knowledge the researcher and participants bring to the study. As a Registered Nurse and researcher, there was consideration and reflection on the responses associated with the contextual and professional influences when collecting and interpreting the data. Therefore, strengthening the credibility of the interpretation as the researcher had extensive knowledge and understanding of the clinical context, nursing discipline, and the sub-discipline of nursing students. Through a reflexive approach, the researcher considered her beliefs, attitudes and biases associated with her professional and practical knowledge (Thorne, 2016).

Data analysis extended beyond qualitative description of the participants' stories to consideration of the social and cultural impact of health professionals' responses and actions associated with the safety culture and, therefore, patient safety (Boysen, 2013). Attention was given to the complexities of student relationships and how other health professionals influence students' responses and behaviours (Levett-Jones & Lathlean, 2009). Careful consideration was given to nursing students' accounts of the actual socio-cultural forces on speaking up for patient safety and the influences shaping this study's findings (Thorne, 2016). The clinical placement setting brings many challenges to nursing students, and the students' actions and responses correlate closely with the social and cultural dynamics of the clinical placement setting (Courtney-Pratt et al., 2018).

The health sectors' socio-cultural traditions need to be recognised when impacting students' perceptions, behaviours, and actions. In particular, student experiences of hierarchy (Fisher & Kiernan, 2019), a sense of belonging in the setting (Levett-Jones & Lathlean, 2009), and perceptions of support (Courtney-Pratt et al., 2018). Through Interpretive Description's inductive process, the researcher, through a multi-faceted

lens, recognised these contextual elements, gaining a greater understanding of the student's inner thoughts, hidden meanings and the essence of students' perceptions influencing their actions and responses (Thorne, 2016).

Constant comparative analysis and a reflexive approach was taken during the data collection and analysis, developing a collective understanding of student speaking up and patient safety perceptions and experiences (Thorne, 2016). Interpreting the students' perspectives developed an understanding of who they are, their interactions and the intrinsic properties associated with students speaking up. When reviewing the themes and patterns, the researcher took an integrative approach, including associated factors such as cultural and historical perspectives of the healthcare setting, the clinical placement experience, the health professional's position and relationships, and the clinical areas' safety culture (Barnsteiner & Disch, 2012; Bickhoff et al., 2016; Courtney-Pratt et al., 2018).

1.5.6 Ethical Considerations

The study was approved by the University of New England's (HE16-293) and the University of Newcastle's (H-2017–0105) Human Research Ethics Committees (See Appendix B: Ethics Approvals). Ethical approval ensured that this study adhered to responsible and accountable research principles. This research met the standards applied by the Ethics committees regarding conflict of interests, participant recruitment, data collection and storage, and publication of the findings. The ethical principles in this study focused on ensuring it presented the truth in the results and upheld standards of trust, respect, fairness and accountability. Also, respecting the participants' moral and social values, welfare and safety (National Health and Medical Research Council, 2018). Key considerations

in this study were the complexities associated with the participant's dependent positions, anonymity, informed consent, the study design and data collection, and presenting the findings.

Consideration was given to the study participants relationship with the researcher. The researcher was a lecturer at one of the universities who had no personal affiliation with the participating individuals. Any risks associated with the possibility of a dependent relationship was mediated by the researcher not interviewing a student who was likely to be in a class the researcher was teaching. This was achieved by undertaking the data collection that occurred during the university lecturers' non-teaching period. The researcher reassured participating students that participation in the study would not negatively impact their progression or results of their degrees. The researcher carefully considered mutual respect, care and interdependence (Moriña, 2021). This included the student's feelings about trust and the teacher-student relationship associated with the interviewer/researcher's professional position. Establishing trust made the participants feel free to talk more openly about their experiences. They were reassured that the researcher would not use the information provided maliciously and not be misused for any purpose as outlined on the participant information letter other than to report the findings of this study. There were no offerings of gifts or aspects of coercion for participation in the study.

The second ethical consideration related to participant anonymity. When reporting the findings of this study, pseudonyms were assigned to the individual interview and focus group participants. Anonymity was important as the participant conversations were about sensitive topics and included conversations that may have repercussions or personal significance when reflecting on situations. During the interview and focus groups, the participants were reminded of the importance of maintaining confidentiality when telling their patient safety stories. The Registered

Nurse Code of Conduct and Standards of Practice require RNs to report notifiable conduct and safety risks where the practice may be below expected standards (NMBA, 2016). Due to the conversations being challenging and potentially stressful in nature, the participants were offered support through counselling services at their respective universities (Flick, 2017) (Appendix A: Participant information sheet).

Informed consent about the study relating to the design, including its purpose, intent, and methods, was achieved through the Participant Information Sheet. Participants signed the consent forms during the interviews and focus groups. In addition, verbal consent was obtained at the commencement of the interviews and focus groups. The participants were informed of their right to withdraw from the study at any point in time. However, they were also informed that the focus group conversations would remain part of the wider conversation, and their contributions could not be removed (Appendix C: Consent Form).

The interviews were conducted in a private room at the students' university campus or a meeting room in a clinical placement facility. The space provided a closed-door space that enabled a private and non-interrupted conversation between the interviewer and interviewee. The timing of the interviews was mutually agreed, and scheduling allowed students not to be rushed or restricted. All participants reviewed the study's information sheet, ensuring they were knowledgeable and informed about the focus of the research and the challenges and opportunities for support if needed. The participants' ability to review the audio recordings and transcriptions demonstrated the researchers' commitment to transparency, honesty, and trust.

Three focus groups were conducted on each university campus grounds in a tutorial room, and three were conducted while the students were on clinical placement. With the assistance of the clinical placement

supervisor, who booked a meeting room at a time convenient to the interviewer and the participants. Both the University and clinical placement focus group sessions were conducted in a space where confidentiality was maintained. The timing of the interviews and focus groups did not interrupt the students' University or clinical placement learning opportunities and experiences.

1.5.7 Data Management

The interviews and focus groups were digitally recorded, transcribed verbatim and stored as required by the National Health and Medical Research Council (2018) guidelines for data storage requirements. The audio recordings, transcriptions, and notations for both the interviews and focus groups were stored in NVivo password-protected software on the researcher's personal computer.

1.5.8 Study Rigour

Rigour was ensured through attention to the fundamental indicators of trustworthiness, credibility, auditability, and transferability. The TACT framework (Daniel, 2018) was used to guide this qualitative study and to ensure a systematic approach to the key dimensions of rigour and reflects the research integrity and authenticity of the research outcomes (Daniel, 2018). This framework is congruent with Koch's (2006) guidelines for evaluating quality and recommended by Morse et al. (2002) as a quality measure for improving research impact and efficacy. The TACT framework demonstrates the researcher's accountability to detailed description and recording of the methodology and establishes a systematic approach to ensuring rigour within this study. The framework assisted the research in being methodical and accountable when conducting the research and in validating decisions throughout data collection, analysis, and presentation of the findings.

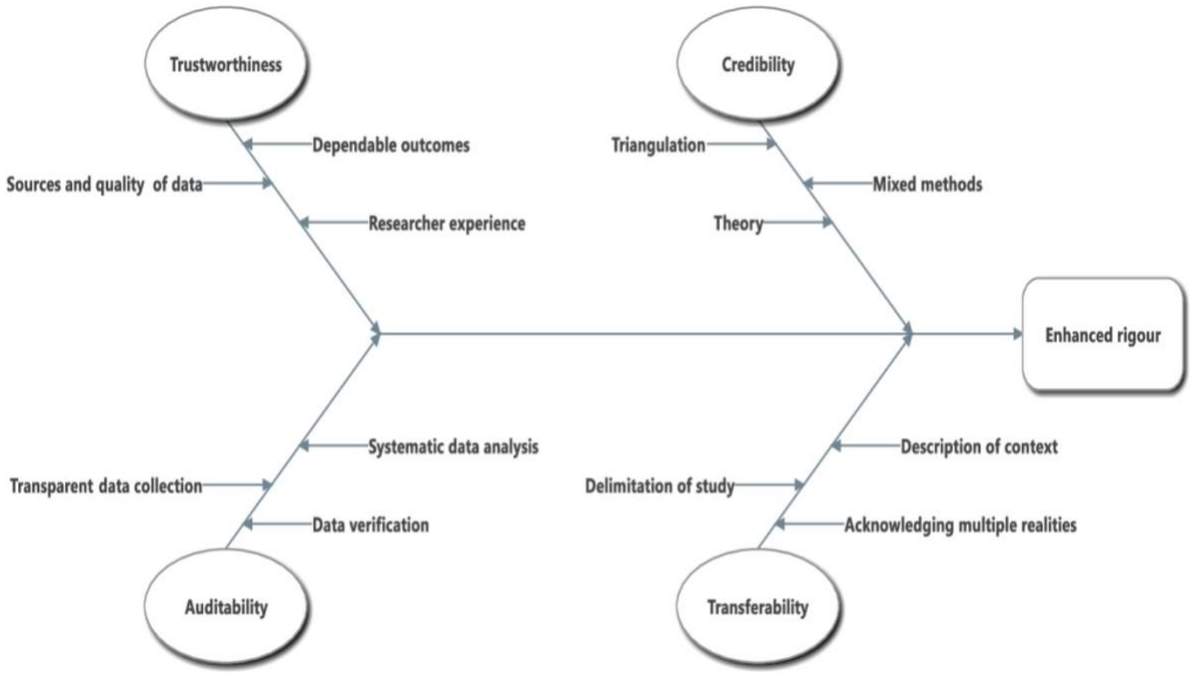

Figure 1: Demonstrating the key dimensions of rigour through the TACT framework as presented by Daniel (2018, p.264).

Trustworthiness is a means by confidence in the quality of an investigation and the outcome of the research is established (Daniel, 2018). Trustworthiness portrays the quality of the research analysis and truth through transparency of how the study was conducted, giving integrity to the findings (Daniel, 2018). Evidence of trustworthiness in this research study was through the focus of the study aligning and supported by previous literature associated with student experiences in the clinical setting. The research question stems from previous knowledge about risks to patient safety and nursing students' experiences during clinical placement. Confidence in the need for the investigation relates to prior reports about students needing moral courage (Bickhoff, et al., 2016) and challenges in placement (Courtney-Pratt et al., 2018). Dependability was achieved by asking all participants in the interview and focus groups the same questions relating to perceptions, experience barriers and enablers. The focus groups were asked the additional question about the impact of the year of study on speaking up.

Throughout the study, there was enhancement of the trustworthiness through the researchers' reflexive approach through notetaking, journaling, and consistently reviewing the data analysis while reflecting on one's own experiences, assumptions, beliefs, experiences, and biases. The researcher maintained neutrality by participating in a systematic approach to reviewing the data, coding categorising themes and findings (Creswell & Miller, 2000; Krefting, 1991). Inter-rater reliability and consistency in coding identified shared themes and overlapping as the research team reviewed the data from the individual interviews and focus groups (Daniel, 2018). The research team consisted of a novice researcher and two experienced researchers who consistently guided the study. The researcher has knowledge and experience in the clinical placement setting and with nursing student education, assisting when the participants used medical jargon and described any nuances of the clinical setting.

The second indicator of rigour under the TACT framework is auditability and the systematic approach that is undertaken when collecting, analysing and interpreting the data (Daniel, 2018). Through Interpretive Description, the data were categorised into themes, and the underlying meanings of the stories were developed. Internal audibility is demonstrated systematically through the methodological approach of aligning the research question with research design, analysis of data, and conclusions drawn (Daniel, 2018). Auditability is the provision of record keeping of all decisions made during the research process (Koch, 2006). The ethics approval ensured each step of the research was transparent and the process was sound and met acceptable human ethics requirements, and a transparent approach of participant inclusion criteria, data collection analysis and reporting of the findings. The participant information sheet outlined the purpose of the study and informed prospective participants of the inclusive and exclusive criteria. The participants' enrolment status, age, and nationality demographics were recorded and stored in the University's

approved password-protected software space. A guideline for the semi-structured individual interviews and focus group questions served to ensure the questions aligned with the overall research question. Response to the questions was transcribed verbatim and recorded electronically. Accuracy of the transcriptions was assured as they were consistently compared with the audio recordings, assuring the accuracy of the direct quotes when reporting the findings. A clear and concise audit trail was kept within NVivo, preserving a record of the decisions made throughout the research process, including data analysis, initial coding, inferences that were drawn, and thematic analysis (Koch, 2006). The NVivo system also enabled accurate date and time-stamped documentation, filing, and storing comments, notations, and decisions.

The third indicator within the TACT framework demonstrating rigour is credibility, determining that the findings are reliable, relevant, and congruent (Daniel, 2018). The strategies within this study that enhance the credibility of the findings include the independent data analysis by each member of the research team and the utilisation of verbatim quotations. Triangulation was achieved through the convergence of the individual perceptions and experience data through the interviews, with the collective and shared perceptions and experience data obtained through the focus groups. This convergence of data corroborated the findings of the individual interviews, which were confirmed by the focus groups (Cope, 2014). Further, the focus groups also determined the different year groups' perceptions and experiences. The participants could review the transcriptions to assess the accuracy of the data and confirm the descriptions and themes presented in the research findings assists credibility, which is termed member checking (Creswell, 2009).

Transferability is the final indicator of the TACT framework (Daniel, 2018), which suggests that the findings from this study can be applied to other settings or groups of people (Lincoln & Guba, 1985). The usual

approach to education for many health care professions requires the student to go into the clinical setting and ascertain knowledge through an integrated learning experience. Therefore, the research adds to the body of knowledge that already exists about other health disciplines students undertaking integrated learning experiences in health.

The contextually sensitive notion of maintaining patient safety suggests relevance and application to other healthcare disciplines. The undertaking of a concept analysis determining the antecedents to speaking up and defining speaking up in the healthcare setting (Fagan et al., 2016) clarified the focus of the study that can then be applied to other health professional students. This study's participants provided data associated with student perceptions and experience across many healthcare settings and specialty clinical areas. Therefore, multisite transferability can be applied by focusing on the attributes of the different clinical settings. Furthermore, it may be suggested that changes may have occurred when a study is completed that renders the findings out of date (Slevin & Sine, 2000). However, the issue of preventing patient harm, promoting patient safety and voicing concerns has been discussed and reported for more than twenty years with the report by Kohn et al. (1999), and continues to be an issue of concern within the healthcare context (Hu & Casey, 2021).

When defining the boundaries of this study, the inquiry was limited to the nursing student perspective rather than extending to other health disciplines' experiences of risks to patient safety. In the clinical setting, students work alongside other health disciplines and experience organisational and cultural dimensions of the clinical setting. However, the extent to which the dimensions impact student experiences and responses cannot be ignored but is challenging to investigate thoroughly. Further, the research student and supervisors discussed including RNs and their perceptions of students speaking up. However, the focus is on the student's perceptions and

experiences rather than others' perceptions of nursing students' speaking up behaviours.

The cohort of students who participated in this study included international students who presented their own challenges during clinical placement experiences. Therefore, while their responses are considered valuable, a focus on international student speaking up experiences is beyond the primary focus of this study. The clinical placement experience allows students to practice skills and demonstrate competence in practice. While students learning about patient safety and speaking up are very relevant to this study, this study did not aim to examine what students are taught about safety. Nor does this study aim to assess students' safety knowledge or assess students' ability to transfer knowledge from the education setting to the clinical placement setting. This study aimed to focus on student perceptions and experiences of speaking up for patient safety and determine if their speaking up behaviours change as they progress through their studies in rural and regional healthcare settings.

Initial planning for this study included only first and final-year nursing students. However, previous studies suggest there might be changes in perceptions or experiences at the second-year level; therefore, exploring the phenomenon from all-year group perspectives was included. Rather than limiting the analysis to participants being from a single university, the invitations to participate were extended to a second university with a similar approach to diversity in the clinical placement component of the nursing curriculum, utilising the same settings and models of student support therein. Universities with only metropolitan clinical placements were not considered because of their limited approach to student supervision was solely facilitation rather than including facilitation, preceptorship, and mentorship during placement. Focusing on rural and regional placements contributes to the findings and considers the

possible impact of supervision and support on students speaking up during clinical placement.

1.5.9 Reflexive approach to the research

Reflexivity is the 'active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation' (Horsburgh, 2003, p.309). As a reflexive researcher, one needs to consciously reveal underlying beliefs and values. The researcher must evaluate and explore their 'biases, beliefs and personal experiences' and how this may impact the research process and results (Berger, 2015, p.220). An epistemological viewpoint considers a reflexive approach, recognises knowledge as constructivist, developed throughout the research process and depends on prevailing understandings and beliefs (Winter, 2013). Exploring how the researchers' altered opinions within various settings gather and interpret data reveals the numerous features and effects of reflexivity. Therefore, it helps deepen the understanding of the different dimensions that can be considered when being reflexive. There is a need to determine if various aspects of the researcher's positionality or knowledge affect the analysis and interpretation of nursing students' perceptions and experiences of speaking up for patient safety.

In my role as the Clinical Coordinator Academic (CCA) I was responsible for supporting students during their clinical placement. It was essential to remain sensitive to competing priorities of gathering information and supporting students when nursing students discussed their ability to speak up for patient safety during their clinical placement experience. Students told stories about observing poor clinical practice and patient safety risks and remaining silent in these situations. Rather than intervening and discussing how to improve the placement experience and prevent patient harm through continual internal dialogue, the researcher

refrained from such discussions that may influence the participants' thoughts and responses.

During the interviews and focus groups, the interviewer recognised that being a university lecturer may affect or impact the nursing student participants. As nursing students, they may have felt the questions being asked may expose their knowledge and communication skills, including deficits in these skills. The researcher situated herself in a non-exploitative and passionate position, helping address the adverse effects of the participants being in a dependent relationship with the researcher. This was done by not judging the students nor holding biases when students identified their inability to speak up for patient safety. This consideration of bias and withholding of judgement continued throughout data analysis. Consideration was also given to the data analysis phase of the study and the decisions about the choice of lens for filtering the information gathered from participants and making meaning of it, and thus helped shape the findings and conclusions of the study (Kacen & Chaitin, 2006).

The reflexive approach of listening to the recordings, reading and re-reading the transcripts, and then referring to notations and reflective journaling and personal experiences impact on the study and its findings. The transcriptions and interpretations were reviewed later with a new lens aimed at identifying where one's own experiences interfered with the accuracy of understanding the participants' dialogue. The research student consulted with the research supervisors, who offered feedback on the analysis and interpretation looking for possible influences of the findings or missed or ignored elements of the dialogue.

1.6 Thesis Structure and Layout

This thesis is structured into five chapters. Chapter One has established the need for the current study. It identifies the issues of patient safety, student experiences and challenges on placement and the challenges of speaking up in healthcare. The study's objectives and research questions were outlined, and the significance of nursing students maintaining patient safety through speaking up during their clinical placement. This chapter has introduced Interpretive Description methodology and its relevance and use in this study. It has highlighted the disciplinary focus and the need for a practical goal or solution to address the issues associated with students speaking up for patient safety.

1.6.1 Chapter Two: Locating the study within the literature

Chapter Two of this thesis presents the theoretical perspectives and underpinnings that relate to students speaking up about patient safety risks during their clinical placement experience. Firstly, this chapter presents the theories associated with speaking up. This discussion defines speaking up and how and when it is enacted in practice. The discussion clarifies how governance informs that speaking up is an obligation of healthcare organisations, health care professionals, nurses and nursing students. This chapter also presents the socio-cultural context in which the participants in this study undertake clinical placement and experience patient safety risks that may require the students to speak up to prevent patient harm. The socio-cultural aspects that relate to or influence student behaviours include leadership and safety culture. The international governance in patient safety curricula and the responsibility of all healthcare organisations and professionals globally clarifying the roles and responsibilities of healthcare organisations, professionals and students to maintain safety. A critique of teaching and learning patient safety and speaking learning initiatives clarifies the effectiveness of different strategies for students speaking up about confidence, behaviours and attitudes. Following this, is an analysis

of literature that has focused on student experiences speaking up in the healthcare setting. The socio-cultural influences on students' clinical placements experiences lead to a focus of discussion on students' psychological safety that is impacted by the professional relationships and the culture of the workplace in the clinical environment.

1.6.2 Chapter Three: Clarifying the concept of nursing students speaking up

Chapter Three of this thesis comprises a published manuscript that analyses the term 'speaking up' through a concept analysis process. While undertaking the literature review at the commencement of the research project, it was identified that there were many terms used to describe the reporting of patient safety errors. The terms whistleblowing, error reporting and speaking up were frequently used. However, other health professionals and RNs have reported and researched speaking up with minimal literature associated with nursing students speaking up. The purpose of the concept analysis was to locate speaking up from a nursing student's perspective, create a concrete definition for moving forward with the study, and to define the concepts being reviewed within this research. The concept analysis consequently clarifies and refines the ideas around student speaking up in practice. It offers thorough theoretical and functional definitions that are in line with the goal of this research.

The findings were published in the Journal of Advanced Nursing which has a Scopus Q1 rating, and in 2021 impact factor of 3.057 and is ranked 21/125 (Nursing and 20/123, and (Nursing (Social Science)) Journals. This publication currently has forty-eight citations (Appendix D: Citations). The Journal of Advanced Nursing is a world-leading international peer-reviewed journal that targets readers committed to advancing practice and professional development based on new knowledge and evidence.

Citation

Fagan, A., Parker, V., & Jackson, D. (2016) A concept analysis of undergraduate nursing students speaking up for patient safety in the patient care environment. *Journal of Advanced Nursing 72*(10), 2346–2357. doi: 10.1111/jan.13028

1.6.4. Chapter Four: Students experiences of speaking up

Chapter Four presents the first of two articles that report the results of this research. The first publication responds to the first study question, which explores how students perceive and engage in speaking up for patient safety. The paper clarified the students' impressions of the opportunities and constraints for speaking up. The results mostly rely on the responses of the students to the specific interview questions and the collective viewpoints presented in the focus groups. This paper is distinctive because it shows how dissonance and bewilderment were expressed by the students as they observed safety concerns and people defending policy violations meant to keep safety practises in place.

It is published in the Nursing Inquiry journal, a Scopus Q1 journal with a 2021 impact factor of 2.65. It is rated 29/125 (Nursing) and 27/123 (Nursing (Social Science)) journals. This publication currently has twelve citations (Appendix D: Citations). Nursing Inquiry is an international peer-reviewed journal of interest to nurses, health care professionals, social scientists and health policymakers on ideas and issues about nursing and health care. This journal was chosen as it is considered vital in informing policymakers associated with the practical goal and the interpretive description methodology. Publishing while undertaking the research enabled the researcher to be informed of other research and literature throughout the candidature.

Citation

Fagan, A., Lea, J., & Parker, V. (2020). Conflict, confusion and inconsistencies: Pre-registration nursing students' perceptions and experiences of speaking up for patient safety. *Nursing Inquiry, 28*(1). 00:e12381. https://doi. org/10.1111/nin.12381

1.6.5 Chapter Five: Students speaking up strategies

The second manuscript in this chapter reports study findings related to the strategies students use when speaking up. The strategies used by the students demonstrate that they understand that they must navigate the complicated social and cultural dynamics of the clinical placement setting. The paper describes how students might reduce risks when speaking up in a challenging clinical setting. The research presented here strengthens the employee voice behaviours model established and published in the concept analysis publication by Morrison (2018).

This article has been published in the Journal of Nursing and Health Sciences, a Scopus Q2 journal with an Impact factor of 1.89 (2019) and a ranking of 72/123 (Nursing) and 70/120 (Nursing (Social Sciences)) journals. Nursing and Health Sciences is a leading international peer-reviewed journal focusing on the global exchange of knowledge in nursing and health science and advancing research and practice across health disciplines. This journal informs practice beyond the nursing discipline. The practical nature of this publication hopes to inform the nursing discipline and beyond, assisting other health professionals in understanding students' strategies for speaking up. This publication currently has three citations (Appendix D: Citations)

Citation

Fagan, A., Lea, J., & Parker, V. (2021). Student nurses' strategies when speaking up for patient safety; A qualitative study. *Nursing and Health Sciences. 23* (2), 447-455 https://doi.org/10.1111/nhs.12831

All the journals were selected because they are well respected by researchers, clinicians, and education providers because of their global reach disseminating new knowledge about students' experiences informing all entities of the nursing discipline. The disciplinary focus aligns with the Interpretive Description methods and aims to inform the relevant elements of the Nursing profession. This helped develop professional alliances of other researchers and health professionals, focusing on patient safety, patient safety curriculum, and nursing researchers examining speaking up practices in the healthcare setting.

1.6.5 Chapter Six: Discussion and conclusion

This chapter proposes four premise statements that derive from the body of knowledge presented in previous chapters, these premise statements exemplify the major findings from the study, which are discussed in light of inferences drawn from the relevant literature and the concept analysis and the findings of this study. Recommendations for practice, policy, education, and future research are also discussed, followed by identification and discussion of the study limitations.

1.7 Conclusion

Chapter One has provided an introduction and background to the study. Past research on nursing students speaking up for patient safety and past and present approaches to patient safety education were discussed. An overview of the research aims and questions was provided. The application of analysis through the Interpretive Description lens was described, along with how Interpretive Description aims to inform practical solutions derived from the findings of this study. Critical discussion has highlighted how rigour was ensured throughout the research process, reflecting the research integrity and authenticity of the research outcomes utilising Daniel's (2018) "TACT" framework to ensure a systematic approach to the key dimensions of rigour. The chapter concludes by

describing the thesis structure and the published papers presented in each chapter, and clarification of key terms.

CHAPTER 2: LOCATING THE STUDY WITHIN THE LITERATURE

2.1 Introduction

This chapter provides a detailed narrative description of the background literature associated with nursing students speaking up for patient safety. The nature of speaking up and its importance for safe health care will be addressed, along with examination of the context, conditions and culture which enable or dissuade students from speaking up. The notions of speaking up and employee voice will be explored and explained in the first instance. The nature of patient safety from a legal, ethical and regulatory perspective is presented and then followed by a dialogue about the phenomenon associated with health professionals, nurses and nursing students' obligations, experiences, barriers and enablers of speaking up for patient safety. To conclude associations between the socio-cultural contexts of the healthcare setting and nursing students' perspectives, behaviours, psychological safety and impacts on their learning in the clinical setting will be discussed.

2.2 Speaking up for patient safety

2.2.1 Defining speaking up

Speaking up in the healthcare setting is an important concept associated with maintaining patient safety and preventing harm in the healthcare setting. Speaking up has been defined as assertive communication in clinical situations that requires (immediate) action through questions, statements of opinion or information with appropriate persistence aiming for resolution (Fagan, Parker & Jackson, 2016 p.106; Lyndon et al., 2012; Premeaux & Bedeian, 2003; Schwappach & Gehring, 2014). Speaking up has also been described as discretionary, change-orientated and assertive communication using questioning or statements

with information, concerns, or opinions about safety-related issues (Noort et al., 2019; Schwappach & Gehring, 2014). More precisely, speaking up has been defined as seeking clarification or explicitly challenging or correcting task-relevant decisions or procedures (Kolbe et al., 2012).

Speaking up relates to health professionals acting autonomously and advocating for patient safety by using their voice to raise concerns (Ahern & McDonald, 2002). Advocating for patient safety is the responsibility of all health professionals. Nurses who embrace the advocacy role endorse, guard and advocate for patients' interests and rights with a determination to make them whole and well again (Bandman & Bandman, 2002). Advocacy with a focus on patient safety describes the health professional as a counsellor, watchdog, or whistle-blower (Baldwin, 2003; Gadow, 1980; Konke, 1982). Effective advocacy is evident when communication successfully addresses safety issues, and the patient's safety is preserved (Garon, 2012). However, several factors influence health professionals' decision to advocate and speak up about patient safety concerns.

Speaking up behaviour is a complex phenomenon influenced by individual, legal, ethical, and socio-cultural factors in healthcare. Speaking up is assertive communication when individuals respectfully express their opinions and concerns about patient care to other health professionals, including those in authority (Omura et al., 2017). Assertive communication in the form of speaking up aims to communicate observations, seek clarification or challenge other health professionals, including others in a position of power or authority. Assertiveness is an essential skill for positive and productive interprofessional relationships. However, assertive communication can be mistaken for aggravation or aggression (Omura et al., 2016). When health care professionals speak up about patient safety concerns, they demonstrate their knowledge about the care being provided and appropriate communication practices in the healthcare setting (Omura et al., 2017).

Speaking up and whistleblowing have similarities as both are influenced by socio-cultural factors such as organisational culture, authority and power gradients. Both actions are associated with health care workers being aware of and voicing concerns about wrongdoing by individuals, but not having the authority to make changes. Speaking up and whistleblowing are actions where individuals voice their concerns to one another, aiming to bring about change (Gagnon & Perron, 2020; Ion et al., 2015). Both speaking up and whistleblowing are associated with taking a risk (Brous & Olsen, 2017; Jack et al., 2021), addressing ethical dilemmas (Jackson et al., 2014; Rees, Monrouxe & McDonald, 2015) and are closely associated with an individuals' professional identity (Bickhoff et al., 2016; Milligan et al., 2017), and organisational culture (Ion et al., 2016; Jones & Kelly, 2014b). While there are similarities, a key difference is that speaking up is action or disclosure, primarily an internal disclosure looking to prevent patient harm in the immediate sense. In contrast, whistleblowing aims to address the healthcare issue after the incident to an entity external to the organisation (Gagnon & Perron, 2020).

2.2.2. How speaking up is enacted

Voicing concerns is more than just communication or employees talking about issues. When individuals engage in voice, they intentionally communicate about safety concerns and aim to improve or change the workspace (Morrison, 2014). The intention of utilising voice is to convey information or deliver a message that requires underpinning knowledge, a skilled position, experience in communication and personal attributes to speak up effectively (Mannion & Davis, 2015; Morrison, 2011). However, effective communication delivery also requires an appropriate response from the receiver that will demonstrate if the message has been heard. The use of phrasing, tone and emotion when voicing concerns and speaking up influences others' response to the information presented during the interaction (Garon, 2012).

Safety voice is a concept that is associated with individual behaviours and actions when speaking up to prevent patient harm. Safety voice describes the behaviour where individuals communicate a concern to another to change a situation or provide relevant information. The nature of the communication may be discretionary, constructive, and proactive. Discretionary voice involves the choice to engage in voice or not. Constructive communication aims to alter and challenge the status quo. A proactive voice is directed towards improvement and is positive in its intent; therefore, it is constructive rather than merely complaining or venting (Morrison, 2011). Characteristics of a constructive and challenging safety voice aim to improve patient safety and prevent emergency situations that may harm patients (Noort et al., 2019). Safety voice remains a challenge for some health care employees, and the issue remains that when safety concerns are observed, individuals may remain silent (Fisher & Kiernan, 2019). Safety voice may be difficult to practice due to associated psychosocial risks, perceptions of moral obligations and the potential impact or outcome. Safety voice appears to be prohibitive; while it aims to prevent harmful consequences, it is associated with practices in an organisation that may have detrimental outcomes. The issue of risk perception correlates with individuals' perception of the safety problem and the recognition and acknowledgement that the problem needs to be addressed. Health professionals voicing concern is influenced by attitudes, team dynamics, safety knowledge and workplace culture (Noort et al., 2019).

Health care professionals who feel psychologically safe are able to engage in interpersonally risky behaviour such as speaking up or seeking feedback. Speaking up requires individuals to feel a sense of shared values and trust between multidisciplinary health care team members who are responsible for maintaining patient safety. When there is doubt and individuals do not feel safe, they withhold voicing concerns and remain silent. Therefore, not voicing patient safety concerns has been viewed as

intentional behaviour (O'Donovan, De Brún & McAuliffe, 2021). An absence of voice can lead to severe consequences for health care professionals and the public. A consequence of the silence can lead to unfavourable outcomes, and the patient may remain at risk of harm. The distinction between voice and silence is associated with the perceived impact of speaking up. An anticipated positive impact will lead to individuals deciding to speak up. Whereas a perception that speaking up is futile or a risk that individuals' psychological safety is threatened results in intentional silence (Sherf, Parke & Isaakyan, 2021).

2.2.3. Global principles and directive to prevent patient harm

'Patient safety' is a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in healthcare that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make errors less likely and reduce the impact of harm when it does occur (World Health Organisation [WHO], 2021). The World Health Organisation (2019) reports that adverse events are among the ten leading causes of death and disability globally, and there is a 1 in 300 chance that a patient will be harmed while receiving health care. International Classification for Patient Safety is a consistent set of concepts and terms structured into a conceptual framework to support the coherent organisation of the key events related to patient safety. The WHO Patient Safety Framework provides a method of organising patient safety information for aggregation, analysis and interpretation into operational knowledge, as well as the direction of patient safety research (McElroy et al., 2016). The Framework incorporates activities that consider cultures, processes, procedures, behaviours, technologies, and environments in healthcare. Therefore, aiming to consistently and sustainably lower risks, reduce avoidable harm, make errors less likely to occur and have less impact on patients' welfare (WHO, 2021, p.6). The World Health Organisation standards, national regulatory bodies and interdisciplinary regulatory bodies require individuals to be

accountable and maintain standards that protect patients from harm. While regulatory bodies set expectations and standards that require health professionals to maintain safety and speak up, patients continue to experience risks to their safety and incidents of harm continues to occur.

The World Health Assembly implemented the Global Patient Safety Action Plan 2021-2030, which recognises safety issues, and prioritises the reduction of the burden of patient harm due to unsafe healthcare. The plan evaluates healthcare structure, design, and operations aiming to improve health performance globally. The action plan identifies that instilling a safety culture in healthcare is an essential underlying guiding principle when planning to eliminate avoidable harm (WHO, 2021). A safety culture develops strategies that prevent patient harm and focuses on analysing errors or a breach in safety, striving to reduce the occurrence of errors in practice. These actions include speaking up about initiatives that need to be respected by all health professionals (Garling, 2008). Speaking up for patient safety is impacted by organisational influences that affect how individuals respond to patient safety risks and their decisions to speak up or remain silent.

A review of preventable patient harm literature identified that around one in twenty patients are exposed to preventable harm during their medical care (Panagioti et al., 2019). The development of patient safety principles encourages all health care professionals to strive to prevent patient harm. Under these patient safety principles, the WHO Action Plan has seven strategic objectives that strive for zero patient harm. It aims to develop a state of mind and rules of engagement for health care professionals when planning, delivering and speaking up about safety risks in healthcare. The principles that were developed relate to common errors that require individuals to speak up including infection control, medication management, safe equipment and environment, patient education, pressure ulcer prevention and person-centred care (WHO, 2021).

The WHO strategies aim to reduce patient harm globally while national bodies govern healthcare organisations, ensuring healthcare follows these directives and enforces patient safety policies. National patient safety bodies that uphold the WHO Action Plan objectives are more likely to eliminate avoidable harm and support a no-blame culture through good governance and leadership. Adherence to the principles is a positive organisational standpoint of risk prevention, management and reporting errors in practice. Within an organisation, the management and reporting are influenced by leadership, teamwork, and the health care team's responsibility and accountability (Vasimoradi et al., 2020). Education and training within an organisation promote adherence to patient safety policies and behaviours as the WHO patient safety becomes a regulatory requirement that is recognised globally. The global objectives and initiatives that maintain patient safety are already in place, requiring health care professionals to speak up and maintain patient safety.

2.2.4 Australian healthcare organisations' obligation to maintain patient safety

Patient safety in Australia is controlled by governing regulatory bodies responsible for keeping the public safe through stringent accreditation processes. The Australian Health Practitioner Regulation Agency (Ahpra) and the Australian Commission for Safety and Quality in Healthcare (ACSQHC) work collaboratively to identify common and consistent issues impacting public safety. The primary role of these regulatory bodies is to protect the public by ensuring that standards and policies are adhered to by all healthcare organisations and registered health practitioners (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2019; Australian Health Practitioners Regulation Agency [Ahpra], 2022). The professional regulatory bodies must understand and respond to safety issues/concerns and consider the context of the situation and leadership within an organisation. Healthcare governance ensures

transparency with the people affected, including patients and practitioners, is maintained consistently (Biggar, 2021).

The Australian Commission for Safety and Quality in Healthcare (ACSQHC) developed the Australian Safety and Quality Framework for Healthcare. The framework promotes discussion with consumers, clinicians, managers, researchers, and policymakers about how they might best form partnerships to improve safety and quality (ACSQHC, 2010). The ACSQHC developed and implemented eight National Safety and Quality Health Service (NSQHS) Standards to provide a nationally consistent level of health service across Australia. The NSQHS standards address events with high safety risk occurrences in healthcare and aim to improve the quality of health service provisions and protect the public from harm (ACSQHC, 2019). There is an expectation that healthcare organisations and practitioners who breach safety standards are reported to regulatory bodies, such as the Healthcare Complaints Commission and the Australian Health Practitioner Regulation Agency (Ahpra). Despite these standards, nursing students continue to witness risks to patient safety during their clinical placement experience (Fisher & Kiernan, 2019; Ion, Smith & Dickens, 2017; Jack et al., 2021).

NSQHS Standards identify communication as a crucial safety and quality issue incorporated across all standards. The NSQHS Standard focuses on communication and aims to ensure timely, motivated and effective communication and documentation supporting continuous, coordinated and safe patient care (ACSQHC, 2019, p.48). Communication about risks is embedded throughout the standards and provides direction associated with high-risk clinical actions such as, blood transfusion, medication management, and recognising and responding to an acutely deteriorating patient. Despite substantial attention to improving patient safety, such as developing communication standards that encourage speaking up, Australian quality and safety reports suggest that 10–25% of

hospitalised patients will experience an adverse outcome during their care (ACSQHC, 2019).

The Australian Commission on Safety and Quality in Health Care stipulates that all hospitals must be accredited in line with the National Safety and Quality Health Service (NSQHS) Standards as part of the Australian Health Service Safety and Quality Accreditation Scheme (Quality Innovation Performance, 2022). Australia mandates that health organisations adhere to the terms and conditions of their accreditation, practice legally, and abide by all relevant laws. Health organisations work under clear and defined expectations relating to accountability and professional conduct that promotes safety and minimises and prevents patient harm. Primarily the obligation aligns with the public's trust in healthcare organisations and expectations they are acting in the public best interest to protect them from harm (Topazian, Hook & Mueller, 2013). However, there are frequent safety incidents reported to Ahpra that may have been prevented if an individual spoke up (Australian Health Practitioner Regulation Agency [Ahpra], 2021).

Australian regulatory bodies are responsible for sanctioning poor practice and developing insight into the associated safety issues, whether organisational, system or individual errors in practice. It is the professional regulators' responsibility to address issues such as the adherence to principles and policies, the culture of safety in healthcare and the reality of the nuances that impact patient safety. However, the combination of organisational governance and systems collaborative approach, or lack of collaboration, impacts the patient journey and the likelihood of risk and harm. Governance in healthcare focuses on delivering care and considering the safety culture and environment in which patients and families receive care. Meeting these responsibilities will improve the public's trust in the regulatory body and their responsibility to keep the public safe.

2.2.5 Registered Nurses' obligation to speak up

Registered Nurses are accountable to the Australian Health Practitioner Regulation Agency (Ahpra) and the Nurses and Midwives Board of Australia (NMBA) via the Registered Nurse Standards of Practice (NMBA, 2016). The Standards of Practice are for all RNs and students across all practice areas and must be adhered to in conjunction with the Code of Conduct (NMBA, 2018) and the Code of Ethics for Nurses (International Council of Nurses, 2021). Within the professional standards and codes, there are many references to nurses' responsibilities to practice legally and ethically maintain patient safety and ensure best care practices are prioritised to prevent patient harm by taking action and speaking up (NMBA, 2016).

The Code of Conduct sets out the legal requirements, professional behaviour regulations and expectations of professional conduct for RNs in all healthcare settings including practising honestly and ethically. Nurses are required to adopt the values outlined in the Code of Conduct, despite their personal beliefs and values (NMBA, 2018). Under these Codes, nurses are obligated to and accountable for providing safe and competent care. As a Code requirement, RNs are to follow laws relevant to the profession when witnessing unlawful conduct, nurses are expected to intervene and aim to prevent or resolve a safety issue (NMBA, 2008). Specific thresholds trigger mandatory notification of health professionals to the regulator who are not adhering to acceptable practice guidelines, including breaches of National Law (Ahpra, 2020). Registered nurses under the standards and Codes are required to speak up about breaches in practice, such as drifts from adhering to local organisational policies or protocols that risk patient safety. In the healthcare workplace, colleagues are often in the best position to recognise misconduct, non-adherence or drift from the Standards of professional practice. Many remain silent despite the legal requirements for RNs to speak up (Gamble & Ion, 2017).

Failure to report unsafe or unethical practices to meet these standards is a failure in itself, which may constitute professional misconduct (Leslie et al., 2021). Registered Nurses have a duty of care to maintain patient safety, always act in the best interest of individuals and others, and not fail to act in any way that risks patient harm (International Council of Nurses [ICN], 2021; NMBA, 2016). Registered nurses' duty of care is to speak up and encourage others to speak up (Topazian et al., 2013). The public has a universal understanding that RNs have a moral and ethical obligation of nonmaleficence and to promote patient safety in everyday practice minimising adverse events. The principles informing RNs on patient safety practice is to be responsible, accountable and report errors in practice (NMBA, 2016; Vaismoradi et al., 2020).

Autonomy enables nurses to make decisions, and demonstrate accountability in practice, advocate and raise concerns about patient safety (Ahern & McDonald, 2002). Speaking up originates from the concept of undertaking the role as a human advocate. As an advocate, when speaking up nurses draw on their personal and professional identity, security and accountability in the clinical setting (Snowball, 1996). This autonomous role allows nurses to have the freedom to make decisions about patient care according to their professional knowledge (Oshodi et al., 2019). Voicing concerns correlates with nurses' perception and knowledge and confidence in themselves within the healthcare environment and the organisation's culture. Registered nurses experience challenges fulfilling the moral obligation to advocate for the patients, to speak up to prevent patient harm (Rainer, 2019). The discussion later in this chapter will address the factors that enable or create barriers to speaking up including confidence, courage, knowledge and support, which are dependent on organisational factors such as the safety culture, peer support and leadership (Kim et al., 2020).

2.2.6 Nursing students' obligation to speak up

Nursing students are also obligated to meet the basic requirements of the NMBA Registered Nurse Standards of Practice, Codes of Conduct and Code of Ethics during their clinical placement experience (ICN, 2012; NMBA, 2021). In Australia, national law states that students undertaking clinical placements in a health profession must be registered with Ahpra to protect the public's safety in much the same way that other health care professionals must be registered. During clinical placement, students have direct care for patients and may encounter experiences where they observe poor care or be asked to participate in actions that may risk patient harm (Fisher & Kiernan, 2019). Thus, students working under the expectations of the standards of practice and codes of conduct are required to speak up and advocate for patient safety (ICN, 2021; NMBA, 2021).

Factors influencing students' obligation to speak up for patient safety are associated with self-reflection and developing an understanding of an inner compass that guides students' clinical and professional practice (Lindh, Severinsson & Berg, 2008). Lindh et al. (2008) highlight that students are concerned about the patients' safety, well-being, and vulnerability. Students recognise essential values and moral responsibilities, the importance of being thoughtful, and that effort must be made to protect patient safety. The overarching themes of these moral responsibilities for students is being available to the patient and shielding the patient from harm. Students reflect on their inner compass and professional responsibilities, enabling them to acknowledge their obligation to act and protect patients from the risk of harm (Darbyshire & Thompson, 2018). Students who are unable to recognise this obligation fail to position patient safety as a priority and potentially prioritise themselves over the patient's needs (Ion et al., 2019).

Nursing students' knowledge and self-awareness about their obligations to professional practice expectations are developed

incrementally throughout their studies (Jack et al., 2021). Reflective practice on clinical placement experiences assists students to gain insight into their values in practice, such as helping others, humaneness, and benevolence. Students reflect on personal attributes they bring to practice, citing ambition and determination as necessary to achieve in their professional nurse roles. These values are associated with their upbringing and past experiences providing a foundation for their obligation to prevent patient harm (Garon, 2012). Students who speak up are inclined to respond to internal factors associated with their personal beliefs and attributes, including their moral strength and commitment to being professional nursing students adhering to standards and codes (Ion et al., 2019). Students identify that they have no choice but to speak up to prevent patient harm (Ion et al., 2015). However, to meet their obligation, they need the confidence to realize their objectives and act on their beliefs and ambitions (Ion et al., 2016).

Students' personal stance is driven by moral, ethical and professional accountability to professional practice. Students clearly understand their role as patient advocates and are genuinely concerned for the patient's wellbeing and safety (Fitzgerald & Clukey, 2021). They know that other health professionals and education providers have professional, moral and ethical expectations that students should and will speak up to prevent patient harm (Fisher & Kiernan, 2019). Students speaking up for patient safety has been described as a challenging decision and action that requires inner strength and determination, described as moral courage (Bickhoff et al., 2016). Not reporting patient safety issues can result in a deficit in the ethics of caring, increasing the likelihood of patients being harmed. This may cause the student stress and damage relationships with other health care professionals (Palese et al., 2018). Legal, ethical and professional guidance gives a clear direction of the expectations of nursing students' responsibility and duty to take action to maintain patient safety (Ion et al., 2019).

Students believe that speaking up to maintain patient safety is the responsibility of all health professionals. They acknowledge that as registered health practitioners, all must adhere to the associated standards of practice and codes of conduct. Reflective practice enables students to consider their inner compass and moral and ethical responsibilities to prevent patients from experiencing harm. These factors are the core elements that influence students' obligation to speak up. However, their speaking behaviours are not only influenced by these core elements; students are also influenced by the healthcare context and the socio-cultural aspects within that context where they undertake a clinical placement.

2.3 The socio-cultural context in which health care professionals maintain safety

2.3.1 The healthcare setting

The healthcare setting is complex, with many elements that influence the interactions between health professionals, within and across various disciplines, and the people receiving care. Providing safe care and speaking up within these organisations are influenced by several factors, including the systems in place, the organisational governance and structure, safety culture, the health care teams, and professional relationships across teams. A safety culture in the healthcare setting prioritises patient safety and is associated with and influenced by the organisation's governance. Governance influences interdisciplinary professional relationships through leadership, hierarchy and support, affecting patient safety and speaking up behaviours amongst health care professionals and nursing students (Fisher & Kiernan, 2018; Jack et al., 2021). A *Safety Culture* is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of an organisation's health and safety governance and management (Hodgen et

al., 2017; O'Donovan et al., 2019). It looks at peoples' establishment, actions and responses to goals that are associated with maintaining safety.

Two theoretical positions define a safety culture: the interpretivist and the functionalist. Safety culture within the interpretative approach considers safety as a complex and developing phenomenon that is sometimes resistant to interventions and training (McDonald & Waring, 2018). Whereas the functionalist perspective considers that a safety culture is something an organisation entertains, which can be improved by changing individual behaviours, attitudes and beliefs. The two opinions, interpretivist and the functionalist, while having limitations, contribute to the discussion and understanding of a safety culture and influence the interventions to improve it to decrease the risk of harm to patients (O'Donovan et al., 2019). A safety culture comprises safety systems, management behaviours, and employee perceptions that aim to prevent patient harm without concern or consequence. However, the barriers or inhibitors to a safety culture include blame, distrust, fear of recrimination, and disciplinary action (Murray, Sundin & Cope, 2017). These feelings contribute to health care professionals' psychological safety, impacting their speaking up behaviours and how they respond when observing patient safety risks (Shef, Parke & Isaakyan, 2021). A lack of social support in the workspace leads to stress-related functional impairment, increasing the risks of errors or near misses and patient harm in practice (O'Donovan et al., 2019).

A collaborative approach is essential to developing and maintaining a safety culture. Individuals and systems within an organisation cultivate a safety culture by distinguishing safety responsibilities and accountability in practice (Murray, et al., 2017). It has been argued that a systems approach is a misguided and risky line of demonstrating accountability in maintaining patient safety, resulting in reduced transparency (Aveling, Parker & Dixon-Woods, 2016). Individuals who embrace a safety culture focus on

prioritising safety and being accountable, responsible, and vigilant in maintaining patient safety. Individuals' attentiveness towards others' practices may lead to the detection of unsafe practices and reduce the risk of patient harm. However, the concern remains that identifying and alerting these risks may damage professional relationships, respect and trust within the health care team (O'Donovan et al., 2019). The student's disconnection from the team removes them from the safety culture and impacts their ability to be collaborative and contribute to the safety culture (Bickhoff et al., 2016; Courtney-Pratt et al., 2018; Levett-Jones et al., 2009).

In a 'just culture' people are encouraged to provide information that is essential to maintaining safety and essentially draws a line between acceptable and unacceptable behaviours. A just culture recognises that all humans can make mistakes and 'to err is human' (Kohn et al., 1999). A just culture allows individuals to feel psychologically safe and to take action to reduce patient safety risks without fear of retribution (Walker et al., 2021). It contributes to a safety culture by providing a critical approach to learning from incidences and preventing reoccurrence. A just culture presents a balance between the system and individual accountability which are influenced by the organisations' culture. Furthermore, a just culture acknowledges the nature of healthcare and the associated high risk of potential human error and patient harm while valuing transparency, trust, respect, and accountability. A just culture relies on the evidence associated with patient safety events (Barnsteiner & Disch, 2017).

2.3.2 Leadership influences and safety culture

Healthcare leadership can be categorised under two categories: transformational and transactional. Each leadership style has different focuses and different outcomes. However, both are very relevant to patient safety and patient safety culture in healthcare. Transformational leadership focuses on developing and maintaining standards of excellence in patient safety and patient outcomes associated with a blameless safety culture

(Merrill, 2015). The characteristics of transformative leadership include engaging, inspiring, empowering, and motivating health professionals and other employees to extend beyond primary care with a shared goal of a safety culture. This approach to leadership is visible with clear and robust expectations that promote open communication across health care workers and aim to improve patient safety (Murray et al., 2018). Essential to patient safety is leadership that requires and supports effective teamwork, communication, situation awareness, decision making, error response and management (Murray & Cope, 2021).

Transactional leadership takes a different approach focusing on a task-oriented approach that utilises motivators and rewards to engage others to focus on change and desired safety goals (Ledlow & Coppola, 2014). Motivating followers for change creates satisfaction in the workspace and is effective with prompt decision-making about patient safety. However, patient outcomes may not always be positive due to the decisions and actions of individuals. Actions may take a task-orientated approach that does not place the patient at the centre of the decisions and actions and contrasts with a holistic, person-centred approach to maintain safety throughout care delivery (Murray et al., 2018).

Leadership within an organisation can positively and negatively influence the environment's safety culture. The leader within an organisation does not need to be a person of power or in a position of hierarchy, but rather a collaborative, empowering person who contributes to positive safety culture (Daly et al., 2014). Strong leadership leads to staff satisfaction and a multidisciplinary collaborative approach to patient safety policy development that focuses on crucial safety issues such as medication errors, hospital-acquired infections, falls, and complaints associated with care (Murray et al., 2018). Leaders who encourage and support are more likely to openly address safety issues rather than criticising and presenting indirect negative commentary behaviours

(O'Connor & Carlson, 2016). When comparing localised versus centralised leadership, a robust yet centralised hierarchy can delay speaking up behaviours. Localised leadership directly impacts patient care, including maintaining and improving patient safety to prevent patient harm (Krenz et al., 2020).

Leadership that focuses on compliance with patient safety principles encourages all team members to participate in best practice. A team with positive attitudes demonstrates common safety practices such as infection control and safe medication administration. When more than one team member takes a coordinated or collaborative approach to safe practice, patient safety compliance is enhanced across the team. That leader in safety does not need to be in a hierarchical position to encourage patient safety and speaking up behaviours (Vasimordi et al., 2020). However, collaboration does not always result in health care workers addressing safety issues. In some clinical settings, the occurrence of health care workers recognising their colleagues making potentially harmful actions that place patient safety at risk has been reported by more than fifty per cent of staff (Schwappach & Gehring, 2014). When observing safety risks, health care professionals choose not to express their concerns for patient safety. Organisational governance and poor leadership influence RNs' psychological safety associated with speaking up. This, together with the lack of training about how to speak up, means that nurses frequently remain silent about risks to patient safety (Jones et al., 2021; Kim et al., 2020).

2.3.3 Interpersonal relationships influence speaking up

Effective health care teams require positive interpersonal relations across the health team characterised by effective communication, mutual respect and trust between all members. However, psychological barriers such as professional silos, hierarchy, and organisational barriers can lead to a lack of understanding of professional positions that cause

communication failures, including remaining silent (Weller, Boyd & Cummin, 2014). Health care teams require many disciplines to work collaboratively and communicate effectively. However, distinctions between disciplines can lead to an imbalance in patient safety perceptions and expectations about how things should be undertaken and who is responsible for safety actions (Lee & Doran, 2017). Research on other professions' hierarchical structure influences, such as junior pilots failing to challenge their superiors, has proven to have disastrous consequences, such as plane crashes and death (Gladwell, 2008).

Interpersonal factors that affect a person's position within a health care team include discipline, sex, cultural distinction, education and personality traits such as introvert or extrovert, passive or aggressive (Green et al., 2017). Understanding interpersonal factors are essential for all health care professionals when considering the importance of maintaining patient safety. The quality of relationships between health care providers and patients affects patient safety outcomes, especially regarding decision making, treatment and adherence to best practices (Lee & Doran, 2017). Positive relationships across teams improve employees' attitudes to their job, improving communication between team members and leading to individuals speaking up when necessary. Hostile interpersonal relations affect communication between nurses and other health disciplines, potentially impacting individuals' actions and increasing the risk of patient harm. Furthermore, health care teams do not consider all team members equal, and a dominant hierarchal structure negatively impacts collaboration and communication, including speaking up to prevent patient harm (Baker et al., 2011).

Speaking up is associated with professional relationships in the work environment. Health care professionals' feelings of fear, power dynamics and authority gradients can have negative patient safety behaviours across the team (Morrow, Gustavson & Jones, 2016). Hierarchical gradients vary

across clinical areas, and doctors, when compared with nurses, are often considered to be positioned at a higher level in the health care team. Sometimes, health care staff identify the highest ranked staff member as the most responsible professional to ensure patient safety is maintained (Schwappach & Gehring, 2015). One of the greatest challenges associated with hierarchy is the impact on communication across the health care team.

Health care professionals from different disciplines need to communicate respectfully and avoid negative behaviours that damage respectful communication. Hierarchical positioning of health professionals leads to perceptions of elitism and disrespect, which may be demonstrated by non-adherence to guidelines and protocols that may increase the risk of harm. This elitism of health care professionals also causes individuals to not listen to or acknowledge others when speaking up and advocating for patient safety (Morrow et al., 2016). Speaking up in a healthcare setting with significant hierarchical differentiation and across disciplines has been described as futile because individuals' concerns are being ignored or disregarded (Garon, 2012). Interprofessional respect and an environment free from blame and fear of consequences or ramifications increase the likelihood of individuals speaking up to maintain patient safety (Murray et al., 2017). Speaking up is more likely to occur when professionals across disciplines value how other professionals contribute to patient care and hence nurses are more likely to speak up when physicians value and encourage their input (Jones et al., 2021).

2.3.4 Student perceptions of the socio-cultural context

Students experience challenges in the clinical setting relating to their position and the socio-cultural context. Experiences are influenced by the workplace culture, safety culture, professional relationships, and clinical practices conflicting with what students learn at university. Students' adjustment to the clinical learning environment is determined by the attitudes of the staff they work alongside during the placement, impacting

the immersive learning experience positively and negatively. Students identify that leadership in the clinical setting influences the staff's attitudes and behaviours, including attitudes towards students. Furthermore, students report that the culture of the clinical setting can influence positive engagement in the placement and challenges to professional relationships and the placement learning experience (Panda et al., 2021).

Leadership in the clinical setting influences students' clinical placement experience and speaking up behaviours. Students consider a good leader in the clinical placement setting is a person who encourages, embraces and supports students in the clinical environment. Students prefer a transformational approach to leadership as they recognise that nursing leaders need to adapt to individual situations and learning needs and demonstrate behaviours that aim to develop interpersonal relationships with students that build rapport and trust (Zilembo & Monterosso, 2008). Students value being welcomed to the clinical setting and a leader that provides direction and encouragement. However, students identify that clinical staff, instructors, and significant others, such as leaders, significantly influence the student experience (Panda et al., 2021). The safety culture and leadership during clinical placement impact the students' psychological safety in the healthcare setting, influencing their speaking up behaviours (O'Donovan, Van Dun & McAuliffe, 2020).

Hierarchical influences in the healthcare setting affect the safety culture and student encounters with other health professionals. Poor hierarchical management negatively affects workplace culture, leading to greater patient safety risks that can cause bullying behaviours in practice. Observing negative professional relationships makes students unwilling to ask questions and remaining silenced (King-Jones, 2011). Students' perception of hierarchy in the healthcare setting has proven to be a constant challenge during the clinical placement experience. They recognise there is more likely to be a positive learning experience when

they have good leadership and direction during the placement. However, students have reported confronting and intimidating experiences and describe being exposed to incivilities such as being yelled at, ignored, and intimidated (Courtney-Pratt et al., 2018).

The culture of the clinical placement setting can negatively impact the students' confidence and ability to interpret what transpires during placement, leading to anxiety, doubt and fear when performing skills (Panda et al., 2021). The culture of the clinical setting, the students' subservient position and the hierarchy negatively influence students' position in the health care team. Student's report feeling they are not considered part of the team and feel unwelcome in the healthcare setting. For example, suppose students choose to rock the boat and address safety concerns. In that case, they fear it will result in adverse consequences, including negative effects on professional relationships and the risk of poor placement results (Bickhoff et al., 2016; Courtney-Pratt et al., 2018).

Positive interpersonal relations often correlate with better health care team performance and improved patient safety through a coordinated approach to engaging in positive professional relationships that are inclusive across the health care team (Lee & Doran, 2017). However, students are frequently not embraced, and often, they feel excluded, ostracised and disconnected from the team (Bradbury-Jones, Sambrooke & Irvine, 2011). Nursing students are identified as subservient; therefore, hierarchical perspectives across the team will significantly negatively impact students' experience in the clinical setting.

2.4. Learning to speak up

2.4.1 International perspective on safety curricula

International and national guidelines drive patient safety curricula across all aspects of health care education. Education providers utilise

theoretical underpinnings and global and national directives when developing curricula that shape the delivery of patient safety education. Nursing education on patient safety issues uses different teaching methods, yet there is a need for greater integration of the concept of patient safety in nursing curricula (Tella et al., 2014). Students are exposed to patient safety curricula through theoretical content, immersive simulation delivered by the tertiary education provider, and experiential learning through learning during the clinical placement experience. Patient safety curricula aim to prepare students to transition with skills such as effective communication and critical thinking necessary in everyday registered nursing practice (Bruce, Levett-Jones & Courtney-Pratt, 2019).

The World Health Organisation (WHO) provides guiding principles that lead to the future healthcare workforce knowledge, skills, and attitudes development to prevent patient harm. The World Alliance for Patient Safety (WAPS), established in 2004, connected the WHO with external experts, health leaders and professional bodies. WAPS then developed a range of initiatives and resources, including the Patient Safety Curriculum Guide for medical schools, and then modified to a multi-professional edition to assist patient safety education across health disciplines (WHO & WHO Patient Safety, 2011). The curricula guide aimed to provide a standardised approach to learning about patient safety globally and assisted universities and schools of health sciences build, integrate and improve patient safety content within curricula.

The WHO curricula provide direction on the importance of managing, responding and effectively communicating about patient safety, including developing and sustaining a culture that enables all health care professionals to speak up and prevent patient harm (WHO & WHO Patient Safety, 2011). The curricula guide utilised the Australian and Canadian Patient Safety Frameworks to demonstrate foundational patient safety principles and competencies that enable health care professionals to reduce

and prevent patient harm. Australia was the global leader in developing the National Patient Safety Education Framework in 2005 (Walton et al., 2006), that draws on adult learning principles and provides international patient safety and quality initiatives in healthcare education globally. The Framework is patient-centred and determines knowledge and performance and is a standard requirement that all health care workers should undertake to maintain patient safety. It is designed to provide a simple, flexible and accessible framework that identifies knowledge, skills, behaviours, attitudes and performance to help health care professionals maintain safety knowledge and skills that prevent patient harm (ACSQHC, 2005).

The Australian and Canadian competencies that informed the WHO Multi-Professional Patient Safety Curriculum Guide (2011) include components of the eleven patient safety themes (See Table 2). The guide confirmed there is a need to have these topics in nursing curricula; however, within the guide, there is little information about the approach to teaching and the evaluation of curricula (Mansour et al., 2018).

World Health Organisation Patient Safety Curriculum Guide: Multi-profession Edition 2011.
1. What is patient safety?
2. Why applying human factors is important for patient safety.
3. Understanding systems and the effect of complexity on patient care.
4. Being an effective team player
5. Learning from errors to prevent harm
6. Understanding and managing clinical risk
7. Using quality improvement methods to improve care
8. Engaging with patients and carers
9. Infection prevention and control
10. Patient safety and invasive procedures
11. Improving medication safety

Table 2: Patient safety themes; Patient Safety Curriculum Guide (2011).

Despite implementing national and transnational policy interventions such as regulatory guidance and legislation informing and influencing curricula aiming to protect the public, there is a limited effect on employees speaking up to prevent patient harm. This issue correlates with the curricula guide focusing on knowledge and skills without consideration of the socio-cultural nuances and diversity across healthcare settings. Patient safety education needs to consider the potential dynamics and interaction between the wider-socio-economic-political system and the local setting (Jones et al., 2021).

2.4.2 Australian perspective on safety curricula

Nursing education providers in Australia are required to provide information and evidence that all nursing curricula meet the required Australian Nursing and Midwifery Accreditation Council (ANMAC) standards (2019). The Registered Nurse Accreditation Standards are designed to provide direction for education providers to demonstrate that their nursing courses develop individuals' knowledge, skills, and attitude for entry-level RNs to practice safely. Public safety is at the forefront of nursing courses accreditation standards. Course accreditation requires the education provider to demonstrate evidence that the curricula have a clear and detailed explanation of public safety principles within a programme's conceptual framework. The curricula must demonstrate evidence that the National Quality and Safety Health Service Standards, Aged Care Quality Standards, and the Nursing and Midwifery Board of Australia Registered Nursing Standards are mapped throughout nursing courses (ANMAC, 2019). Demonstrating these standards within nursing curricula provides evidence there is an aim to enable students to have the knowledge and skills required to prevent patient harm.

National Patient Safety Education Framework provides a template for education providers to construct undergraduate nursing curricula, educational programs and training packages that will assist in

developing the knowledge, skills and behaviours necessary to maintain patient safety (ACSQHC, 2005). The framework has seven patient safety categories that need to be incorporated to provide direction about speaking up and preventing patient harm. Category 1 Communicating Effectively, which focuses on including the patient in decisions associated with care, concentrating on consent, disclosure, and cultural respect rather than speaking up and preventing safety risks. Category 2 Identify, prevent, and manage adverse events focuses on determining risks of adverse events, facilitates an understanding of the reasons that adverse events occur, and reports a safety risk after the event rather than intervening, speaking up, and stopping adverse events from occurring. The remaining categories include utilising evidence and information, working safely, being ethical, continual learning and specific issues such as incorrect site or wrong procedure and medication safety (ACSQHC, 2005).

The National Safety and Quality Health Service Standards (NSQHSS) inform nursing curricula in Australia. A key NSQHSS purpose is to mitigate the risk of patient harm rather than inform education and nursing content. In 2016-2017 an expert panel of academics participated in a study developing the Patient Safety Competency Framework for Nursing students. The Framework aimed to articulate a set of patient safety competencies for Australian nursing curricula to guide teaching and student assessment (Levett-Jones et al., 2017). ANMAC requires nursing curricula to demonstrate that it meets the standards. Standards such as number 6 of the NMBA Registered Nurse Standards for Practice, 'providing safe, appropriate and responsive quality nursing practice' is essential to both registered and nursing students' responsibility in maintaining patient safety (NMBA, 2016). However, there are no direct guidelines on how students learn about patient safety and speaking up content in curricula or how learning and competence is assessed or evaluated (Jones et al., 2021; Mansour et al., 2018).

There has been an ongoing debate about how students learning about patient safety is integrated into the nursing curricula (Jones et al., 2021; Tella et al., 2014; Usher et al., 2018). Unlike other countries such as the United States, Australia has no final examination or benchmark to determine that graduates meet a specific level or standard of practice. Instead, the education provider determines the level students are required to meet as a baseline or an expected standard across the course. The education provider then declares this to the Nursing and Midwifery Board of Australia who assesses and determines if the standard education is being met (Australian Institute of Health and Welfare [AIHW], 2016). Furthermore, Australian nursing education providers do not have a standardised approach to delivery, and there are limited courses that focus the content on patient safety in curricula.

Integrating patient safety across the nursing curricula rather than in a distinct unit of study suggests that focus on patient safety becomes absorbed and, therefore, invisible or not learnt comprehensively (Kirwan et al., 2019; Tella et al., 2014). Leotsakos et al. (2014) from the WHO Patient Safety Programme argued that patient safety is not another subject to add to an already over-packed curriculum. Still, serious thought is required regarding how health professional educators can integrate patient safety competencies into their clinical teaching and learning. Therefore, a standalone patient safety subject in the curriculum would seem inappropriate considering the multiple contexts where students learn about patient safety (Mansour et al., 2018). However, some education providers who have developed a standalone patient safety program in their courses have reported improving students' patient safety competence and confidence (Gleason et al., 2019; Kim et al., 2020).

A collaborative approach to patient safety by undergraduate nursing education providers is thought to result in a standardised approach to safety education. Moving patient safety education beyond traditional

didactic learning to modern methods of education, such as inquiry-based learning increases student engagement. There is consensus that prioritising the components of patient safety and speaking up that are incorporated in curricula, including knowledge skills and attitudes, will result in a shift that improves patient safety outcomes (Mansour et al., 2018). Therefore, strengthening the focus on education about the core safety issues will improve nursing students' capacity to maintain patient safety.

A recurring theme in the delivery of patient safety education in the undergraduate nursing curriculum is the quintessence of authenticity in the delivery and student experience. It is strongly suggested that the authenticity in the learning experience increases the student's perspective that the content is valid and relevant to real-world practice (Hanson et al., 2020; Tregunno et al., 2014). Authentic content delivery impacts the outcome of the students' learning and requires the context and mechanism of delivery to be accurate concerning the socio-cultural and psychosocial factors. The context and delivery need to be authentic learning relevant to real-life experiences that encapsulates students doing clinical nursing and students learning to be a nurse in the healthcare context. The learning design and structure aim to maintain student engagement while focusing on the desired learning outcomes (Hanson et al., 2020). However, patient safety learning has been described as de-contextualised as learnt in the academic setting, where practices and attitudes may differ from the clinical setting (Steven et al., 2014).

The real-world clinical setting is complex and delivering authentic learning experiences through simulation is challenging as it requires interdisciplinary teams, power differentials, hierarchy, teamwork and conflict. Learning about patient safety in the clinical placement setting is essential to offer these complexities and real work safety challenges (Mansour et al., 2018). The focus of patient safety content may include clinical safety issues such as poor infection control due to inadequate hand

hygiene, patient identification errors, and medication administration errors, mainly categorised as near-miss incidents (Tella et al., 2014). Aiming for authentic learning experiences, education providers have embraced simulation throughout nursing courses.

Patient safety learning addresses interpersonal relations through graded assertiveness in practice role-play, interprofessional education, and human factors (Tregunno et al., 2014). However, simulation for content delivery is challenged by increased student enrolment, limited educational resources, and faculty not specialising in simulation or patient safety (Lee, Jang & Park., 2016; Tregunno et al., 2014). Patient safety content that focuses on person-centred care is also addressed in academic assessments, focusing on culture and language (Hanson et al., 2020; Steven et al., 2014). The approach to patient safety education can be superficial and theoretical, lack depth about the underlying principles, concepts and theories associated with speaking up and assertive communication (Mansour et al., 2020).

2.4.3 Clinical placement; an integral aspect learning

The clinical placement is essential to student learning in the undergraduate nursing curriculum. Clinical placements enable students to demonstrate their academic knowledge, practice patient safety skills, and develop work readiness through experiential learning in the clinical environment (Berndtsson, Dahlborg & Pennbrant, 2020). Students learning extends beyond the basics of practising clinical skills and developing clinical competency increasing their awareness and understanding of specified practice areas. The outcome of the placement aims to develop students' theoretical and practical knowledge, skills and attitudes necessary to meet the eligibility requirements to become a registered nurse.

The clinical placement experience is valuable in enabling students to develop a professional identity and facilitate their learning allowing them to

gain clinical and professional judgement. Furthermore, students develop essential characteristics such as social intelligence, organisational intelligence and personal characteristics (Fowler, Knowlton & Putnam, 2018). The ideal learning environment will provide students with professional opportunities and experiences, demonstrate best practice, and focuses on maintaining patient safety (Panda et al., 2021).

Students transfer patient safety theoretical concepts from the classroom to the clinical placement. These include non-technical social knowledge, intelligence and cognitive skills, including effective communication, teamwork, and conflict management during placement. Knowledge and experience develop particularly in decision-making, situational awareness, and what influences practice errors that impact patient outcomes (Hurley et al., 2020; O'Connor, 2015). Furthermore, developing non-technical skills enable students to cope with associated clinical environment stressors, such as communicating effectively (McCloughen & Foster, 2018). However, nursing graduates identify that they lack the skills in managing interpersonal conflict (Walker et al., 2013), and they may not achieve competence in these skills during the placement. However, there is a resounding theme that the theory-practice gap remains a concern when student transition from education to the clinical placement setting. This gap risks students' ability to contribute to or maintain patient safety in the rural setting (Hanson et al., 2020; Salifu et al., 2018).

Developing organisational intelligence during the placement experience develops students understanding of the complexities of the workplace such as the impact of patient load, time constraints and inadequate staffing on the risk of patient harm (McCloughen et al., 2020). The clinical setting exposes students to hospital policies and procedures, where they gain knowledge about current evidence-based practice. While there is value in the diversity of the clinical placement experience of students across many different healthcare organisations and settings, the

diversity can also lead to a deficit in organisational intelligence (Walker et al., 2013). Contact with social and organisational elements develops students' personal characteristics, in particular resilience, managing stress and work-life balance (Cusack et al., 2016).

A resilient student tolerates negative affect and positively adapts to change with tolerance and tenancy (Connor & Davidson, 2003). However, resilience is a personal characteristic that cannot be simply taught or learnt, instead, resilience is developed over time through real-life experiences and strategies to cope with those experiences (Walker et al., 2013). Through the placement experience, nursing curricula aim to prepare students for workplace adversity. Professional socialisation during placement is valuable as it raises students' awareness about the potentially idealised view of nursing and the possible dissonance associated with the realities of practice (Hanson & McAllister, 2017).

Rural placement settings utilise various approaches to support and supervision, including a health facility-appointed preceptor model for placement support that impacts the student learning experience during placement. One approach is a whole community facilitator who supports preceptors to build placement capabilities and promote workforce development that will assist student support. Research related to the allocation of clinical facilitators in other rural areas highlighted the challenges and benefits of this model of support (Smith et al., 2015). Usually, large-scale healthcare services have access to clinical facilitators with a ratio of approximately one facilitator to eight students, which is comparatively unfeasible for most smaller rural services (Zournazis, Marlow & Mather, 2018). The placement facility's supervisor is responsible to arrange student support and supervision that ensures a safe learning environment (Cant et al., 2021). However, in the rural setting, there are challenges associated with staffing and external organisational management that may risk student support and supervision organisation.

The placement setting can impact the students learning experience in the clinical setting. Rural and regional clinical placement settings have been renowned for experiencing ongoing staffing resourcing crises, which affects the structure and model of supervision and the approach to orientation (NSW Parliament Legislative Council, 2022). Preparation for clinical placement by the education providers and leaders in the clinical placement setting significantly impacts the student's capabilities to grow and develop. Students are further challenged when the clinical practice differs from what was learnt and observed in practice. Education providers aim to prepare students for the socio-cultural elements of the clinical setting through experiential learning through simulation. However, due to the interprofessional relationships, the nuances of the clinical context are difficult to simulate (Sevenhuysen et al., 2021).

2.4.4 Strategies in learning patient safety and speak up

Patient safety knowledge is a critical component of learning to become a registered nurse. There are challenges associated with embedding patient safety into the curriculum. The approach to delivery often takes a formal and informal stance whereby focused safety education occurs, such as medication errors and patient identification errors, and interpersonal relationships and an understanding of the socio-cultural aspects of the clinical setting (Sevenhuysen et al., 2021). Education providers, clinical nursing staff, and students consider patient safety as an underpinning concept that is integrated throughout nursing education (Kirwan et al., 2019; Steven et al., 2014).

Evaluating patient safety education through various delivery modes, including didactic lecture, role-play, simulation, debriefing and interprofessional education, examining the effectiveness or impact of patient safety teaching and learning in nursing curricula, present mixed results. Hémon et al.’s (2020) study focused on final-year French nursing students’ development of interpersonal communication examining

students’ assertive communication and speaking up behaviours. The study assessed students' responses to poor compliance of routine hand hygiene standards through high-fidelity immersive simulation and analysis of debriefing sessions. The study found that students utilise strategies including asking naïve questions when speaking up (Hémon et al., 2020). This study demonstrate how vital authenticity is when learning about safety. Including a simulated patient in the scenario demonstrated that students considered the patient impact when speaking up during a clinical procedure. The authenticity and comparative reality within this approach to simulation and the actual healthcare setting is increased by having the simulated patient as an actor rather than a static mannequin.

In contrast to Hémon et al.’s high fidelity simulation study, education providers in the United States, House and colleagues (2016) implemented a timed low-fidelity simulation experience. The simulation provided learning whereby nursing students rotated through four stations exposing students to several patient safety issues on a static mannequin. The study reported the students’ self-perceptions of their ability to identify patient safety issues. The outcome resulted in students having overestimated their ability to identify safety risks. While the students believed they successfully identified the risks at each station, eight per cent or less identified all the possible safety risks. To aid the development of an authentic learning experience, the faculty based the simulation scenarios on their personal experiences of nursing in the clinical setting (House et al., 2016). The study did not explore students’ thoughts or responses to identifying or the number of safety risks they missed. The debriefing session was delayed until one week after the simulation to ensure all students had first-hand experiences. This delay reduced the authenticity of students’ emotional responses and in identifying or missing risks to patient safety. The students’ overestimated self-confidence about their ability to identify issues in simulation could be considered an issue when they

transition to the clinical setting, confirming there is a risk of students' inability to identify patient safety issues during clinical placement.

Sato et al. (2017) also studied students' ability to identify risks after implementing hazard detection education sessions by two different teaching modes to second-year nursing students in Japan. This study compared patient safety content delivery teaching methods by facilitated role-play versus a two-dimensional illustration on A4 paper. Sato et al. (2017 p.2) developed an original measurement tool evaluating the students' "ability to execute safety acts", "ability to use risk experiences", "ability to acquire risk information", "risk avoidance preparedness", "risk response preparedness", and "risk detecting and monitoring ability". The results indicated that students who undertook the role play had a significantly higher ability to identify risk. However, there were no differences between the illustration and role-play concerning students' ability to execute safety acts such as speaking up. What is most evident in this study is that exposing students to safety risks increases their awareness of possible risks, it does not change the ability to respond, act or communicate to reduce those safety risks.

Hanson et al. (2020) undertook a study at an Australian university where first-year nursing students were provided with an assertiveness-based communication activity before attending their first clinical placement experience. They took a practical approach to teach assertiveness, introducing structured communication frameworks that were practiced through role-playing between students and clinical tutors. During the role-play, the students were asked to work outside their scope of practice. The debriefing session evaluated the students' ability, self-confidence, and concerns about addressing safety issues in practice. The findings indicate that teaching assertiveness skills established a framework for speaking up for safety at the commencement of the course and has positive psychological implications associated with students' confidence,

empowerment, and success. The participants acknowledged that the degree of authenticity of the scenario and the relevance of the intervention to speaking up improved their confidence before attending their first clinical placement (Hanson et al., 2020). Several studies recognise the importance of commencing patient safety learning to students early in their nursing program (Fisher & Kiernan, 2019; Hanson et al., 2020; Tregunno et al., 2014). Moreover, Gleeson et al. (2019) argue that students speaking up confidence declines as they progress through their course and clinical placement experiences and that speaking up education needs to be integrated throughout all years of nursing programs. However, it has also been confirmed that final-year students are more aware of what they say and how they say it than first-year students (Hénmon et al., 2020).

Omura, Stone, and Levett-Jones (2018a) undertook a comparative study assessing the effectiveness of assertive communication training with third-year nursing students delivered by two education providers in Japan. The students attended an assertive communication workshop, one group completing a questionnaire before and the other after the training session. The workshop consisted of various modes of delivery, including pre-reading, PowerPoint presentation, videos, group discussion and role-play and reviewed the key elements of effective communication. While the results of the evaluation of the interventions found that students indicated they would speak up when concerned about patient safety, the findings were not statistically significant. However, this learning intervention resulted in students identifying other factors influencing their speaking up behaviours, including psychosocial aspects observed in the clinical setting such as cultural norms, hierarchy, professional status and gender imbalance (Omura et al., 2018a).

Another Australian study implemented an innovative approach to simulation that enhances nursing students' knowledge and skills in engaging in critical conversations that enhanced students' resilience and

capacity to speak up for patient safety (Guinea et al., 2019). The eight National Safety and Quality Health Service Standards underpinned the themes of the learning experience. This simulation focused on facilitating nursing students' understanding and applying the principles of safe care. It aimed to develop students' resilience and confidence to advocate for patient safety by speaking up when patients are at risk of harm. The delivery utilised cue cards that focused the observers of a simulation on a critical patient safety issue and presented antagonist cards. What-if questions were presented to the students, resulting in students engaging in critical conversations about patient safety. Authenticity was assisted by utilising commonly reported safety issues that students reported as the basis for the simulation storyline. This simulation considers the challenges of high student enrolment numbers as it caters for large numbers of students and gives observers a purpose through cue cards (Guinea et al., 2019). However, the learning experience does not allow students to explore or practise speaking up. Furthermore, determining when such conversations need to occur in the curriculum would require further exploration, and how this learning experience translates to the clinical setting is unknown.

Implementation of leadership, effective communication skill development, and conflict resolution courses with nursing students in the United States assessed students' confidence in speaking up after the clinical placement experience. A modified version of the Health Professional Education in Patient Safety Survey (H-HPEPSS) (Ginsberg, Tregunno & Norton, 2010) assessed two safety dimensions, including confidence in what they learned and comfort in speaking up for patient safety. A statistically significant improvement in confidence in speaking up was evident when comparing the beginning to the completion of the clinical placement (Kent et al., 2015). However, evaluation of interventions' impact on speaking up behaviours primarily consisted of self-reported perceptions of teamwork and safety culture in a classroom or simulated environment

rather than focusing on speaking up in the clinical setting (Jones et al., 2021).

An interdisciplinary undergraduate education intervention focused on psychological safety and speaking up required students from twelve different nursing programs in the United States to disclose failures in safety by asking for help or admitting their errors. The education experience resulted in students describing negative impacts on interprofessional relationships (Lyman & Mendon, 2021). Delisle et al.'s (2016) Canadian study evaluates interprofessional learning (IPL) opportunity for pre-licensure senior health care students as a way to foster interprofessional collaboration and empower students to vocalise their concerns. However, results aimed to empower crucial conversations to then empower students to vocalise their concerns led to the participants experiencing negative interactions associated with stereotyping, perceived interdisciplinary hierarchical structures in healthcare and a lack of previous interprofessional education experiences. Similarly, in the United States, Kent et al. (2015) examined the effects of a final year clinical placement and leadership course on nursing students' confidence in speaking up for patient safety. They reported that while some students felt they had increased confidence to speak up to peers, confidence continued to be lacking when speaking up to other health professionals with an associated more significant hierarchical position.

Speaking up education in nursing curricula is delivered in many forms including role-play, immersive simulation that includes the patient in the scenario and static non-immersive simulation. The approach to patient safety and speaking up education in nursing curricula remains diverse in its delivery and many of the approaches do not necessarily translate to the clinical practice setting. Integration of patient safety curricula occurs at the commencement and towards the conclusions of nursing courses. However, there is little evidence that patient safety and speaking up curricula is

integrated and delivered consistently throughout courses. Studies have focused on students' confidence in patient safety competence often evaluated, yet translation of competence to clinical practice has had minimal review or evaluation. Most evident is there is no standardised approach to patient safety education, speaking up, or assertive communication content delivery throughout nursing programs internationally.

2.5. Experiences of speaking up for patient safety

2.5.1 Health professionals' experiences

Effective health care delivery requires a multidisciplinary team that works collaboratively with a common goal to deliver quality and safe care to the public. However, it has been reported that the public has and continues to experience safety risks that may result in harm (Francis, 2013; Garling, 2008; WHO, 2021). Teams rather than individuals deliver modern health care and therefore require a collaborative approach to provide quality and safe care. However, failures in health care teamwork and interprofessional communication are contributing factors that compromise patient safety (Weller et al., 2014). Individuals in health care teams have experienced various responses to speaking up, including being yelled at and ignored.

Factors associated with communication that negatively impact patient safety include unequal power relationships among team members in organisations that are fraught with occupational hierarchy and disrespect within and across health disciplines (Okyuyama et al., 2014; Stevens et al., 2021). Motivators for health care workers to voice concerns about patient safety include communicating with an aim for change when working conditions are unsafe. Communication and collaborative decision-making across the team occurs through formal or informal channels and can be directed toward managers, co-workers, the organisations' management or

other officials. Health professionals voicing about patient safety are constructive and challenging in nature and aim to improve safety (Noort, et al., 2019, Steven et al., 2021).

Pattni et al.'s (2019) review of speaking up in the operating room environment determined the three factors that affect registered health care workers voicing concern in the operating room, including the organisation's culture, dysfunctional interprofessional communication, and power differentiations where interdisciplinary communication is affected by hierarchical gradients (Pattni et al., 2019). To effectively protect a patient from harm, speaking up within an organisation requires transparency, open communication by employees, and positive responses to those who have spoken up. Senior or more experienced staff encouraging and valuing the action of junior staff voicing concerns impacts junior staff speaking up or remaining silent. Interprofessional communication that is disruptive and intimidating results in nurses feeling disrespected and even abused as a response to them speaking up about patient safety.

Registered nurses have described experiences of physicians yelling and screaming, causing anxiety and stress in the workspace that results in them remaining silent when observing patient safety risks (Todorova et al., 2014). Registered nurses change their voice behaviours when there is strong hierarchical positioning in the team. The perception of a lack of support and personal risks results in a pervasive hesitance to directly voice their concerns. Rather, they manipulate their speech, including quiet speech, asking questions or total avoidance, and remaining silent (Lee et al., 2021).

Variations across cultures have been reported to influence speaking up behaviours. Hierarchical relationships, including aged-based seniority, significantly impact junior nurses speaking up behaviours in East Asian healthcare regions, often leading younger health care professionals to

remain silent (Lee et al., 2021). However, American and Japanese trainees or junior health care workers' decision or willingness to speak up for a second time is influenced by the senior staff's initial response to the junior staff voicing concern (Kobayashi et al., 2006). Similarly, in Asian cultures, gender norms impact speaking up behaviours. Female nurses are discouraged from being assertive and speaking up in the presence of male health care workers (Lee et al., 2021). Fear is a well-recognised feeling associated with hierarchy and speaking up. However, clarification of the components of fear is often associated with consequences imposed by the people in senior hierarchical positions. An Australian study confirmed that the ability for junior medical staff to speak up is impacted by the hierarchy, which leads to them feeling embarrassment and exposure to the senior health care team members (Peadon, Hurley & Hutchinson, 2020).

Speaking up across professions influences the teams' overall technical performance by increasing interactions across disciplines, improving the teams' focus on maintaining safe patient care and patient outcomes (Kolb et al., 2012). Nurses speaking up to doctors has associated risks, and the decision to speak up is generally only made under certain circumstances, such as when the hospital policy supports the nurse's position in voicing concerns (Churchman & Doherty, 2010). Most medical and nursing professionals, irrespective of their position and specialty experience, demonstrate some hesitancy in speaking up about risks to patient safety (Okuyama et al., 2014). Health care employees continue to express concerns about the consequences of speaking up, often, they are unable to speak up at the time of the event, and even when they do, their concerns may be ignored (Jones et al., 2021).

The attitudes and values of health care workers contribute to patient safety through voicing concerns and is considered valuable across healthcare systems internationally. Health care workers recognise patient safety, and speaking up requires a collaborative approach to prevent

patients from the risk of harm. However, it has been identified that cultural influences internationally and hierarchical differentials commonly influence individuals' decisions and responses to speaking up in the healthcare setting. Speaking up often results in health care professionals feeling threatened and vulnerable. Speaking up across various disciplines is considered futile, and junior staff's patient safety concerns are simply ignored.

2.5.2 Health care professionals speaking up experiences

It has been widely recognised that human error in health care is complex and often associated with a combination of factors that lead to patient harm. Unsafe practices in the clinical setting that require health care professionals to speak up include violations of protocols and divergence from best practice, most frequently associated with medication administration, hygiene standards and patient management decisions or communication regarding patient care (Schwappach & Richard, 2018). Within these approaches to communication, adherence to rules, policies, and processes across the team determine if the safety issue is addressed or left unresolved (WHO, 2021).

Speaking up is influenced by elements across various levels, including organisational, interdisciplinary, and individual components. The safety governance structure, culture, and leadership characteristics within a healthcare organisation can positively or negatively impact health care professionals speaking up behaviours. Interdisciplinary relationships such as leadership, hierarchy, power, and dynamics of an organisation's safety culture, support and supervision across health professional disciplines have been reported to impact patient safety and speaking up behaviours of health care teams (Lee et al., 2021; Morrow et al., 2016). Individual factors influencing individuals voicing safety concerns include one's sense of agency, confidence and professional relationships in the healthcare setting (Morrison, 2011). Engaging in voice behaviour is not a simple action where

individuals speak up; it has been viewed as risky, unsupported, and an action that causes stress and anxiety in the workplace (Todorova et al., 2014).

2.5.2.a Communicating in a just safety culture

Health care aims to promote and advocate for the patient by adhering to professional standards in everyday practice. These standards set the expectation that employees will speak up about suboptimal health care delivery. However, despite this expectation, some employees remain silent, communication breakdowns are common, and mistakes occur in health care (Morrow et al., 2016). There are perceived risks associated with health professionals speaking up that derive from an individual's perception of psychological safety and the organisation's safety culture.

Health professionals are less likely to speak up about safety concerns if the safety culture lacks insight and focus on the safety of the patients and the health care staff. As a result, health care professionals fear repercussions when speaking up and are concerned about a lack of team support and mutual respect. This inhibits individuals' perception of psychological safety in the work environment. A 'just safety culture' upholds ideas, customs and social behaviours that enable individuals to communicate effectively across health disciplines and encourages individual accountability to improve and maintain a supportive and safe environment without fear of negative consequences (O'Donovan et al., 2019). The fear of negative consequences creates perceptions of risk that result in communication barriers and inhibits a safety culture, inhibiting individuals from speaking up and communicating about patient safety risks.

Organisational interventions can promote an inclusive culture that improves communication by utilising structured multidisciplinary activities. These include interdisciplinary rounds, learning activities and education, and structured communication tools that lead to individuals feeling included

and supported in the team. These inclusive activities initiate patient safety conversations and encourage speaking up when a patient is at risk of harm (Verbakel et al., 2014). Health care professionals' previous experiences, responses and outcomes of speaking up determine if the individual will engage in voicing concerns in the future. Registered nurses have reported overwhelming feelings of futility, resignation and powerlessness when the problems they raise are ignored or responded to inappropriately (Garon, 2012; Jones et al., 2021). When speaking up, a registered nurse reflects on their inner self, their moral and ethical position as a nurse, and the strength and courage needed to speak up (Martinez et al., 2017). However, while nurses may have moral courage, they do not always speak up. Those that do not speak up perceive the action is futile because it frequently falls on deaf ears, and the safety issues continue in healthcare organisations (Jones et al., 2021; Law & Chan, 2015: Schwappach & Gehring, 2014).

2.5.2.b Professional expectations and accountability

Nurses' knowledge, perceptions and attitudes influence their adherence to maintaining patient safety principles in practice. When observing patient safety risks, individual values and attitudes correlate with their actions and responses. Voicing concerns is associated with individuals' interpersonal relationships, communication, coping skills and the role of advocating for the patient. Ion et al., (2019) focus on health care professionals' legal, moral and ethical responsibilities when witnessing poor care. However, if they are unaware or unable to identify poor care, the professional expectation for them to respond would be considered unreasonable. Nurses aware of situations requiring them to speak up experience moral distress when they feel powerless and unsupported (Rainer, 2019).

Health care professionals strongly perceive that it is their duty to uphold patient safety principles and insist on compliance with safety

measures in practice (Schwappach & Gehring, 2014). There is a perception that balancing responsibility to the patient with professional and organisational accountabilities is challenging for health care providers. Common challenges include defensive behaviour, such as verbal abuse. It is also considered that there is no excuse for failing to raise patient safety concerns. While it remains a personal choice to speak up, health care professionals put aside self-interest and self-doubt and prioritise the patient's needs. Speaking up about safety issues and professional accountability is at risk of failing. Patients may be at risk of harm if the health care professional puts their own interests above that of the patient (Gamble & Ion, 2017).

2.5.2.c. Leadership in the clinical setting

Professional mentors and positive leadership that encourages and maintains an authentically safe, open, supportive and respectful work environment positively influences team members to voice concerns about patient safety (Morrow et al., 2016). Trust across the health care team improves professional relationships and members of the team's confidence and a sense of feeling valued. These positive relationships foster a sense of belonging across the team where inclusive team members value and believe all have an expectation and responsibility to the team and contribute to maintaining patient safety by speaking up (Lee et al., 2021).

Positive role modelling increases the incidence of junior nurses engaging in speaking up behaviours (Lee et al., 2021). Registered nurses' stages of professional experience, knowledge and practice influence their responses to safety issues demonstrating that more experienced nurses are more likely to address safety issues (Murray et al., 2018). Newly graduated nurses confirm that some components of undergraduate education that focus on safety issues such as effective communication do transfer to practice, they also confirm some aspects of the theory-practice gap also

remain when they transition from being a student to an autonomous health care professional (Bruce et al., 2019). As RNs transition from novice to expert levels of expertise, they experience role adaptation and the development of an understanding of the roles and responsibilities of other health care professionals. Newly graduated nurses with positive mentor relationships and influential role models who demonstrate assertive behaviours develop a sense of ease and increase the incidence of speaking up (Lee et al., 2021).

2.5.3 Nursing students' experiences of speaking up

Nursing students have been described as visionaries and advocates in health care and have the potential to maintain patient safety and prevent patient harm through their much-needed fresh pair of eyes (Francis, 2013). Nursing students' experiences of speaking up have been studied in both academic and clinical placement settings. There has been growing interest in health care professionals who are willing to speak up in clinical settings to improve the quality of care, enhance patient safety and prevent patient harm (Schwappach & Richard, 2018). Studies that focus on students speaking up about experiences are frequently through a lens of simulation, role play and interprofessional learning, which do not reflect experiences in the clinical placement setting. Rather than focusing on students speaking up, research has reported students' clinical placement experience challenges, including belonging or fitting in, difficulty establishing professional relationships, and perceptions and dilemmas associated with the theory-practice gap and professional practice issues. However, frequently these studies include discussion about students' experiences in speaking up and clinical practice issues, including moral courage and responding to poor clinical practice, which may involve speaking up.

It is estimated that in a nursing programme with one hundred students, approximately 3.8 nursing students are likely to witness patient safety incidents within ten days (Stevanin et al., 2018). Student responses

to observing poor practice or unprofessional conduct during the clinical placement experience are associated with their previous experiences, perceptions and reactions to patient safety risks. Rees, Monrouxe & McDonald (2015) conducted a study in the United Kingdom (UK) of almost three hundred (294) nursing students' most memorable professional dilemmas in practice. Rees et al. (2015) identified that almost 80% of students experienced dilemmas associated with patient safety misdemeanours committed by health care professionals including incidences of student abuse, and patient consent issues. Furthermore, nurses were the perpetrators in more than half of the occurrences, and a majority occurred in the hospital setting.

Published research regarding students' responsibility to reporting issues in practice has been growing over the past 15 years. International studies focusing on nursing students disclosing poor practice, speaking up and, or reporting poor practice are from the UK (Brown, Jones & Davis, 2020; Fisher & Kiernan, 2019; Green & Garland, 2015; Ion et al., 2015; Ion et al., 2016; Morey et al., 2021; Monrouxe et al., 2014; Rees et al., 2015), the UK and Australia (Jack et al., 2021), France (Hémon et al., 2020), Italy (Palese et al., 2018; Stevanin et al., 2018), Israel (Mansbach, Ziedenberg & Bachner, 2013, Mansbach et al., 2014) and Japan (Omura et al., 2018a; 2018b). The research on the nursing students' clinical placement experiences also reports an association with students' responses to poor clinical and professional practice. This research informs the literature associated with student responses to issues in practice, including fitting into the clinical placement setting in Australia (Bickhoff et al., 2016; Courtney-Pratt et al., 2018), the UK and Australia (Levett-Jones & Lathean, 2009), the UK and Japan (Bradbury-Jones et al., 2011), Canada (O'Mara et al., 2014). Much of this research, while not focusing on speaking up, discusses students' responses and experiences of patient safety issues and moral dilemmas during their clinical placement.

Studies on nursing students and patient safety experiences in health care have risen in interest in the past five years. In a most recent study across nations of UK and Australia, Jack et al. (2021) examined nursing students' experiences and perceptions of reporting poor care and the process by which they raised concerns. The outcome determined that both clinical placement settings and education providers are responsible for supporting students' professional development, particularly in ethical knowledge and students' development to become courageous practitioners. This includes developing students' skills to recognise when the care is below acceptable standards.

An early study by Bellefontaine (2009) explored UK Nursing students' experiences of reporting poor practice or delivery of potentially unsafe care during their clinical placement. The results indicated that support during placement is crucial in determining if students speak up when observing poor care. A lack of support leads students not to report potentially unsafe practices they witnessed. The perception of support included the student and mentor (RN) relationship, the support provided by the clinical placement setting and the university, the students' personal confidence and knowledge, and associated reporting risks, including failing the clinical placement (Bellefontaine, 2009). A key finding of this study identified that the organisational culture of the clinical placement setting influences students reporting behaviours making recommendations to improve support and mentorship during the clinical placements. Despite these recommendations, most recently, students continue to describe feeling unsupported and vulnerable during the clinical placement experience (Jack, Hamshire & Chambers, 2017; Jack et al., 2018).

Morey, Magnusson and Steven, (2021) explored nursing students' experiences of patient safety risks to the patient. The participants were directly or indirectly involved in a safety breach. The study focuses on the patient's perception of reporting or not reporting the safety events. It

determined the benefits and barriers of including the patients in the discussion and reporting of safety issues. The students in this study recognised the importance of doing the right thing and valued being supported during the placement. However, concerns remain about the consequences of speaking up for patient safety, particularly when there was a perception of a culture of blame and support is limited (Morey et al., 2021).

The findings of several studies identified common risks to patient safety described by students, including incorrect procedures, poor interpersonal communication and poor interprofessional attitudes in practice (Fisher & Kiernan, 2018). Of these issues, medication administration errors and blood transfusions were the highest risks to patient safety. More specifically, medication errors were associated with missed and close call events relating to wrong dose, route and patient. Incorrect patient identification errors were also common and were associated with incorrect blood sample labelling, an x-ray of the wrong patient and mother-baby mismatch (Stevanin et al., 2018). The Stevanin et al. (2018) study identified students' most frequently observed patient safety issues that occur in practice. However, it does not clarify how the students responded to the errors or safety risks, or if the issues were resolved. This study does not discuss students' speaking up behaviour, nor increases in awareness of reportable patient safety issues that students observe. Discussion and reflection of students' commonly experienced patient safety issues inform the knowledge and potentially reduce the gap between the clinical setting and education providers.

The issues in clinical practice that students experience include deviations from current evidence-based practice by the clinicians they were working with during the placement. Students encountered routine clinical practices that were carried out differently from what they learnt at university. The differences included shortcuts that did not adhere to policies

and procedures they had learnt or different approaches to the same process. Students considered the clinical placement setting an environment where they can learn by observing experienced clinicians' role-model best practices. However, as students described these divergences from current evidence-based practice, they questioned but, were unsure if these were events that required speaking up in the interest of patient safety (Sevenhuysen et al., 2021).

Palese et al. (2018) conducted a national survey in Italy, asking nursing students to describe the clinical issues they observed in practice that allowed reporting, including errors, near misses and patient safety issues during the clinical placement experience. Inconsistencies between what is learnt at university and the reality of what transpires in clinical practice challenge students as they try to rationalise the theory behind the practice, they observe by health care professionals (Panda et al., 2021). These negative learning experiences and conflicting educational and clinical experiences continue as students remain unsure what safety issues are and when speaking up is necessary during the clinical placement experience.

Findings from Rees et al.'s (2015) UK study across several health districts indicated the presence of differences in health districts' reporting where students are more likely to report in some regions than others. Rees et al. identified the student's clinical placement allocation varied; some students are affiliated with one healthcare organisation and opportunity to build knowledge and understanding of that organisation's approach to safety culture. Whereas some of the study participants were allocated placement across many organisations and health districts. Therefore, the outcome of the research does not clarify if the regional difference in reporting is related to the organisations culture or the inconsistent allocation of the placement location. The rationale for the differentials in reporting safety issues are not presented in Rees et al. findings, however

it has been identified the incidence or frequency of reporting is associated with the organisation's safety culture (Palese et al., 2018).

Palese et al. (2018) also identified a variance in students reporting safety issues associated with the level of their nursing course. While they did not specify which year group were more or less likely to report, rather that student's likelihood to report safety issues was associated with their recent education and knowledge development of current evidence-based practice. Gropelli and Shanty (2018) differentiated, finding that first-year students are more likely to report than in their final year, suggesting this was associated with learning more about patient safety in the early years of the course. Stevanin et al.'s (2018) longitudinal study conveyed that across all year levels of Italian students, the likelihood of reporting patient safety issues fell across second-year students, with the highest reporting to occur by final year students correlating with Palese et al. (2018) and safety knowledge development. Furthermore, it was noted that males are less likely to report than females, and there are generational influences where older nurses are less likely to report poor clinical practice. However, generation influences most likely depend on the generation's level of risk-taking, as Generation (Gen) X are considered risk takers compared with Gen Z, who are averse to risk (Shorey et al., 2021). The results also indicated that one-third of students did not witness or report any patient safety incidents, and two-thirds had experienced or observed patient safety risks in practice (Palese et al., 2018). The variance in these findings confirms that speaking up for patient safety is an issue across all year levels of study. Students observing patient issues in practice are common occurrences that students, clinicians and education providers need to acknowledge, support and address in the education and clinical contexts.

Further to the generational factors that influence students speaking up behaviours, consideration of individuals' culture and beliefs also influences their speaking up behaviours. Health care professionals and

nursing students in Australia come from many different cultural backgrounds. The diversity of cultural backgrounds can result in individuals not wanting to disrupt the harmony of the health care team by speaking up, especially if the person is in a hierarchical position (Omura et al., 2018a; 2018b). This cultural perspective is particularly relevant for international students as they work in an environment where they may not know or understand the cultural norms and the cultures influence their speaking up behaviours.

Nursing students observe safety issues in practice regularly. These issues are often associated with direct patient care and are commonly related to medication administration, patient identification and consent. The incidence of safety issues experienced by students occurs across various clinical settings with greater frequency in the hospital setting. Reporting of these issues varies and is inconsistent across health districts. The organisation's governance impacts the student experience and perception of safety during the placement. Student's placement experience and perceptions associated with speaking up are influenced by the approach to support, mentorship and professional role modelling. Students' likelihood to report varies across the year groups and is associated with experience and safety knowledge.

2.5.4 Students' speaking up barriers and enablers

Nursing students speaking up to prevent patient harm is a multidimensional action influenced by individual and organisational factors. Some students speak up when observing risks to patient safety or actual patient harm, while others remain silent. Students' decision to voice or remain silent stems from an individual's perception of the associated risks and circumstances that create barriers or enable them to use their voice. Factors influencing these actions include students' level of knowledge and experience, behaviours modelled by other health care professionals,

potential consequences of speaking up, and an organisation's structure, hierarchy, culture, and professional relationships.

Recognition of patient safety issues requires students to know and understand a broad range of clinical and professional issues, associated policies and procedures, legal and ethical professional expectations, and the roles and responsibilities of many disciplines in health care. Students build their professional practice knowledge through professional socialisation during the clinical placement experience. Students in the early years of their studies may not recognise patient safety incidents in practice due to a lack of knowledge and skills, particularly during the first year, therefore creating a barrier to speaking up when compared with final year students (Garon, 2012; Gropelli, 2018; Stevanin et al., 2018). As the student progresses through their course, they develop knowledge about their professional expectations, including speaking up. Therefore, final-year students with more clinical experience can respond to safety issues and are more able to speak up (Fisher & Kiernan, 2019).

Students learn by observing other health professionals' and RNs' responses and actions to patient safety issues. Remodeling in practice can negatively and positively impact nursing students' speaking up behaviours. When students observe health professionals cover up of safety incidents and remain silent, this creates a barrier as students perceive speaking up as an undesirable undertaking (Sevanin et al., 2019). Speaking up is easier for students when positive professional relationships and mentoring enable individuals to speak up and prevent patient harm (Lee et al., 2021; Murray & Cope, 2021). Students view health care professionals as role models in practice and learn by observing their behaviours in practice. Positive placement settings where RNs role model best practices, including speaking up, will encourage students to respond similarly. Whereas, when health care professionals perceive that speaking up is futile and role-modelled this

perception to students, it will lead students to have similar perceptions, actions and responses to patient safety risks (Jack et al., 2017).

Students observing registered practitioners remaining silent confirms to the student that there are risks associated with speaking up. Students assess the context of the clinical placement setting and identify that effective and collegial student mentor relationships promote open communication enabling students to raise patient safety concerns. Mentors who set the standard at the commencement of the placement that students should speak up creates an environment that is safe and conducive for students to voicing concerns (Brown et al., 2020). While students confirm they experience barriers to speaking up, in a study on student mentors in practice, the mentors believe that students should be encouraged to speak up despite immediate interpersonal concerns (Bellefontaine, 2009). Further confirming this, mentors have described disappointment when hearing those students remain silent, as mentors ascertain speaking up as a student's duty and responsibility in practice (Brown et al., 2020).

Senior nurses and leaders at the clinical unit level have the potential to empower, motivate and enable nursing students to speak up when observing good practices and quality patient care at the bedside. Nursing leaders enable speaking up by engaging all staff in an open communication environment at the bedside. This environment, in turn, has significant positive effects on empowering students in speaking up behaviours (Murray et al., 2018). However, Hensel and Laux's study confirms that student confidence in responsible leadership in the clinical setting remains low (Hensel & Laux, 2014). Students' confidence in leadership has been associated their lack of understanding of an organisation's governance and leadership, together with the absence of good role models (Francis-Sharam, 2016).

Belonging has been described as a central, universal social need, posing a sense of well-being, or understanding, of association with others, being a respected team affiliate and being accepted by the nursing profession (Levett-Jones et al., 2009). Effective mentorship and a supportive environment give students a sense of belonging and team participation. However, students frequently describe not feeling part of the team. Their professional identity relates to their sense of belonging or fitting in, which diminishes as they progress through the course and clinical placement experiences (Bickhoff et al., 2016; Courtney-Pratt et al., 2018; Levett-Jones et al., 2009). This sense of not belonging correlates with not being valued, creating further barriers to voicing concerns (Levett-Jones et al., 2009).

Professional relationships positively and negatively impact students' speaking up behaviours in practice. The placement experience is an interactive process whereby students can reflect on and internalise their values, knowledge, skills and beliefs about the profession and develop their professional identity and position to maintain patient safety (Dinmohammadi, Peyrovi, & Mehrdad, 2013). Empowerment is something that students have described as a factor that is significantly lacking in clinical placement settings. When students feel valued as learners and team members, there are positive engagement experiences in the clinical setting (Bradbury-Jones et al., 2011). Feeling devalued is commonly described by nursing students, which creates a barrier to students speaking up as they perceive the action as futile or pointless (Ion et al., 2015).

Students are concerned by the hierarchical gradient between the student and qualified health professionals, which impacts their speaking up behaviours. Students perceive the power imbalance creates barriers to speaking up about patient safety (Hémon et al., 2020). While power and hierarchy influence student behaviours, individual personalities and traits are also noted to influence students speaking up behaviours, with

extroverts being more enabled and likely to speak up when compared with introverts (Mansour et al., 2020). Also noted, in many instances is a need to reflect on their personality as the students may require moral courage to speak up because of the fear that may have personal and professional consequences for them (Bickhoff et al., 2016; Gibson, 2018).

Nursing students are challenged by the action of speaking up due to the perceived associated risks that may transpire as a response to voicing concerns. Students consider that speaking up risks include failing the clinical placement (Bickhoff et al., 2016; Rees et al., 2015), being ostracised, and being yelled at should they voice their patient safety concerns (Courtney-Pratt et al., 2018; Levett-Jones et al., 2009). The student's professional identity relates to how they perceive themselves within the nursing profession and becoming a nurse (Öhlén & Segesten, 1998). Students' identity is associated with understanding the meaning of patient safety, associated safety activities, and correlating behaviours (Fitzgerald, 2020). Students determine if the risk of harm to the patient is greater than the risk to themselves, which creates a barrier if they decide the personal risk is too significant (Ion et al., 2016). While this assessment occurs, it has been greatly criticised and described as self-preservation being a priority above prioritising patient safety (Paley, 2015). Connecting with other health care professionals and communicating and engaging in collaborative practice is essential to students' professional identities. Students acknowledge they need to care for themselves to effectively undertake the role of a professional nurse and maintain a positive professional identity (Browne et al., 2018). Students' concern with their identity creates a barrier to voicing concern as students fear being perceived as troublemakers trying to create conflict (Hémon et al., 2020; Levett-Jones et al., 2009).

The clinical placement setting and the safety culture influence students speaking up behaviours. In the simplest form, culture is '*the way*

things are done around here' (Milligan et al., 2017, p.29). The culture influences staff and students' ability to raise concerns about the quality of care. Students' relationship with the team and perception that others will have punitive responses to students speaking up creates barriers to their speaking up behaviours. Students described the unsupportive clinical setting creates further barriers to speaking up (Fisher & Kiernan, 2019). A supportive workplace culture recognises that students are learners in the healthcare setting and should be encouraged to engage in patient safety behaviours, including speaking up. This encourages others to engage in such behaviours, resulting in speaking up being normalised for all health care professionals, including students (Brown et al., 2020; Mansour et al., 2020).

Education focused on speaking up and preparing students for the workplace enables them to know and understand speaking up actions (WHO, 2011). There is no standardised approach to assertive communication education across nursing courses. Some education providers consider it essential to deliver this content to students before attending their clinical placement experience. Assertive communication education before placement enables students to feel empowered and confident to speak up (Hanson et al., 2020). However, assertiveness is also a culture-bound concept. Students who speak up in a fair or just culture will have increased confidence to voice concerns. Conversely, a culture that is not supportive will not accept assertive communication by students (Mansour et al., 2020).

Students speaking up behaviours are influenced by their perceptions of themselves and the environment in which speaking up or remaining silent occurs. There are risks associated with speaking up related to the student's professional relationships with health care staff and their perceptions of the level of support during the clinical placement. Students recognise hierarchical gradience is present and can negatively impact

students' professional relationships. Supportive and encouraging mentors and role models increase the likelihood of students speaking up. However, the workplace culture also needs to support students and not rely on isolated individuals. Students' perception that speaking up is risky remains and relates to the potential responses of others and its impact on the clinical placement experience and results. Students speaking up requires knowledge about safety issues in practice and education about effective assertive communication.

2.6. Nursing students' psychological safety

The real-world healthcare context is laden with potential threats, particularly to students' psychological well-being. Fowler and Rigby (1994) discussed the concept of students' psychological safety in nursing education and argued that students often experienced distrust and anxiety. In their study, students were exposed to incivilities and described experiences of fear and distress in clinical and academic learning. These events were most evident during the clinical placement learning experience, where students felt unsupported by educators who lacked skills in providing a psychologically safe learning experience setting (Courtney-Pratt et al., 2018). Psychological safety is a critical concept associated with helping people overcome defensive behaviours and learn new behaviours. Psychological safety is an atmosphere where one can take chances without fear and manage change with sufficient protection from harm (Schein & Bennie, 1965). When students overcome barriers to learning and change in interpersonally challenging work environments, they will feel psychologically safe in the clinical learning environment (Edmondson et al., 2016).

The theoretical underpinnings that are predominately used to explain how psychological safety develops and is influenced include social learning, social exchange and social identity theories (Newman, Donohue

& Eva, 2017). A psychologically safe work environment is one in which employees feel safe to voice ideas, collaborate, take risks or experiment, willingly seek feedback, and provide honest and truthful feedback. It is an environment where employees can overcome threats to an individual or an organisation's learning (Edmondson, 1999). In a psychologically safe work environment, employees perceive that being themselves or saying what they think will be respected by their colleagues and that individuals will not be rejected because of these actions. Psychologically safe learning environments allow nursing students to make mistakes during their learning without consequences. Behaviourally psychological safety is demonstrated by people undertaking risky behaviours such as open communication, seeking feedback and the ability to voice concerns. A psychologically safe work environment influences positive outcomes, including learning and performance for health care workers and students (Newman et al., 2017).

Edmondson's (1996) study found different beliefs about risks and social consequences in health care teams' responses to reporting errors. Some teams openly acknowledged and discussed errors that occurred to avoid recurrence, while team members did not disclose errors to others in other settings. Psychological safety is a critical characteristic that results in successful, high-performing teams. A psychologically safe environment influences employees' behaviours, leading to open communication and the ability to voice concerns without risk and seek feedback. These behaviours influence workplace outcomes, including performance and learning in the workspace.

While individuals in workplace relationships consider how individuals view and trust each other, the concept of psychological safety differs as it focuses on how the members of a team perceive expectations within the dynamics of trust and respectful communication and the teams' professional relationships (Newman et al., 2017). Creating learning

environments conducive to psychological safety inclusive of nursing students impacts their experience of successfully transitioning to clinical practice. During the clinical placement experience, students are self-conscious about their clinical abilities and are concerned that they may do something wrong and appear incompetent. Self-consciousness is associated with the verbal and non-verbal cues that shape students' expectations and learning experiences. Past experiences, including previous placements and work-related experiences, influence students' clinical placement expectations. However, there are times when students are hesitant about engaging in learning as they are unsure when expectations are not clearly defined. Clear expectations give the students direction and a space where they can engage with confidence (Lyman & Mendon, 2021).

Effective interdisciplinary psychological safety enables collaborative practice and enquiry that demonstrates respect and value of everyone's contributions despite their discipline or hierarchical level (Pfeifer & Vessey, 2019). In this environment, health care team members are welcomed and encouraged to express opinions and recognise that criticism in any form will be supportive and constructive rather than belittling or destructive. Interpreting feedback also impacts students' psychological safety in the learning environment. Verbal and non-verbal ambiguous or negative cues reduce the students' self-consciousness and negatively impact their psychological safety. Clear and direct feedback helps students reflect and self-evaluate their performance during practice and provides reality rather than the anxiety of the learning experience. Students' learning is negatively impacted when they feel psychologically unsafe as they have difficulty concentrating, retaining information, and performing clinical skills, resulting in a feeling of incompetence. A poor approach to giving feedback makes students feel inadequate and fear negative consequences, including retribution and rejection (Lyman & Mendon, 2021).

Students' perception of psychological safety influences their confidence and engagement in the clinical placement setting. They are also affected by how they perceive themselves and how others perceive them as students. Students' professional identity is associated with the meaning of the position, the associated activities of the position, and correlating behaviours. Through professional socialisation and personal identity, students' values, beliefs and ethics are linked to their understanding and attitudes toward themselves and the profession. Actual experiences and interactions with RNs, the context and socialisation in the clinical setting also impact nursing students' professional identity (Fitzgerald, 2020). However, if professional socialisation experience is associated with low psychological safety, students will perceive the profession and themselves negatively. The loss of psychological safety will reduce the students' confidence, alter their perspective, and decrease their learning and productivity.

When students engage in the clinical learning environment, they move forward and adapt and grow, impacting learning in the clinical placement experience. When the placement experience has high levels of psychological safety, this catalyses positive reflective feelings that self-fuels the cycle for a positive learning experience (Edmondson et al., 2016). As students gain experience, they develop coping strategies to protect themselves in an environment with low psychological safety. These strategies include maintaining perspective, self-affirmation and maintaining productivity. Over time, the clinical placement experience can help students develop confidence as individuals and learners. They become less reliant on seeing other perspectives and need positive affirmations or feedback. Students utilise their prior learning and clinical placement experiences to support their self-confidence, enabling them to engage in future learning experiences (Lyman & Mendon, 2021).

A team's shared belief defines the team's psychological safety and that risk taking is not a fundamental factor within the team (O'Donovan et al., 2021). A psychologically safe team presents a consistent approach with common goals across the team, particularly when there is a sense of confidence that the team will not reject, punish, or embarrass someone for speaking up (Lyman & Mendon, 2021). Trust requires the expectation that others' actions or responses to incidents such as errors will be favourable despite others feeling vulnerable. A team's psychological safety extends beyond interpersonal trust and requires individuals to be comfortable with themselves, knowing that all in the team hold the position of mutual respect (Edmondson, 1999). If students during the placement were psychologically safe, they would be included in the shared beliefs and common goals. However, students have reported that they frequently experience negative psychological safety interactions in the clinical setting, including being unsupported and intimidated (Courtney-Pratt et al., 2018). Students describe challenging professional interactions and experiences with other health professionals, giving them a sense that they do not belong in the clinical learning environment.

The safety culture, leadership and interpersonal relationships impact students' psychological safety during the clinical placement experience. Creating a positive, psychologically safe experience for students can be developed by leadership providing clear guidelines and expectations at the commencement and throughout the clinical experience. Leadership and role-modelling best practice put students' emotional stressors at ease, leading them to have positive interactions throughout the placement experience. Positive interactions include embracing students as part of the team and flattening the hierarchical gradient, reducing students' anxiety, decreasing their responses to withdrawing and remaining silent (Lyman & Mendon, 2021; Metzger et al., 2020a).

Students describe challenging professional interactions and experience verbal and non-verbal interactions with other health professionals, also contributing to a sense that they do not belong in the clinical learning environment. Belonging has been described as a central, universal social need, posing a sense of well-being, or understanding, of association with others, being a respected team affiliate and being accepted by the nursing profession (Levett-Jones et al., 2009). However, the reality is that the interactions students experience impacts their professional identity relating to their sense of belonging or fitting in diminishes as they progress through their course, and self-confidence often remains low throughout their study (Courtney-Pratt et al., 2018; Hensel & Laux, 2014). This loss of self-confidence is associated with students' perception that the clinical placement setting is not a safe space to share ideas, discuss errors in practice or speak up. When students believe there is low psychological safety, they perceive risks associated with voicing concerns such as being rejected from the team or failing the clinical placement (Fisher & Kiernan, 2019).

Connecting with other health professionals and communicating and engaging in collaborative practice is essential to students' professional identities. However, it is difficult for students to make professional connections if they perceive the environment as psychologically unsafe. The student's response to psychologically unsafe environments includes withdrawing and not engaging in the learning experience. Effective support strategies build students' psychological safety, positive relationships, and professional identity (Clements et al., 2015). Supportive learning environments that make students feel safe help prepare students to interact and collaborate within practice. Recent literature confirms that a better approach to inclusivity in nursing is needed. Encouraging inclusivity within the healthcare profession will positively influence organisational attitudes, behaviours, and norms that enhance patient care and outcomes (Chicca & Shellenbarger, 2020).

Inclusivity involves intentionally engaging in effort and actions that foster a consciousness of belonging by encouraging meaningful interactions and connections among people and groups representing different perceptions or experiences (Metzger, Taggart & Aviles, 2020b). Respectful and inclusive interactions achieve social justice and eliminate inequalities that improve health care outcomes. Nurse educators, mentors and facilitators who foster a psychologically safe environment for students positively impact student interactions and actions, including students speaking up and patient safety (Chicca & Shellenbarger, 2020).

Nursing students overcoming fear in the clinical learning environment is a courageous undertaking. Students' moral courage relates to individuals' ability to rise above any fears they may have and act upon what they believe to be the right course of action based on their individual ethical beliefs. Nursing students who experience an unsupportive environment feel psychologically unsafe and believe risks are associated with voicing concerns and discussing issues with other health professionals. The concern about taking the right action rises, resulting in the students experiencing moral distress (Gibson, 2019). It is well established that students experience anxiety and fear during the clinical placement experience hence the concept of courage relates to students overcoming fear (Bickhoff et al., 2016; Courteny-Pratt et al., 2018). Students speaking up is an attempt to correct safety concerns during the clinical placement is associated with their psychological safety and courage as they have to validate their fears and determine if they will take action despite the consequences (Gibson, 2019).

In health care teams, psychological safety is a foundational component in supporting patient safety and continuing to learn from previous events. Psychological safety influences health care professionals, including students' interactions, confidence and actions, directly impacting

the quality of care provided to the public and patient safety (Pfeifer & Vessey, 2019). Learners making mistakes should be expected, and psychological safety is maintained as team members acknowledge, speak up, and learn from those mistakes. Learning behaviours intercede between psychological safety and team performance. Psychological safety pleads the effects of support and leadership in the setting and role-modelling learning behaviours such as speaking up about errors in practice (Edmondson, 1999). Nursing students' experiences of psychological safety are associated with the organisation and the health care team's responses to students voicing ideas or being themselves. A team approach that creates a psychologically safe environment requires all of the team to hold a position of mutual respect. A team approach would allow anyone, including students, to speak up without risk and not be associated with an individual's position or stature (Pfeifer & Vessey, 2019). Students feel psychologically safe when educators and mentors support them. A psychologically safe environment that includes students would not require students to overcome fears and be courageous when voicing concerns or giving opinions in the clinical setting.

2.7 Conclusion

This chapter presents the complexities of nursing students speaking up to prevent patient harm in the healthcare setting. The narrative review of the literature provides an overview of the defining elements of speaking up and the circumstances and factors that influence nursing students' speaking up behaviours in clinical practice. Speaking up in practice is influenced by the healthcare setting's individual, organisational, and socio-cultural context. These factors include leadership, interpersonal relations, and safety culture. Further, the clinical settings influencing factors, students learning about speaking up, assertive communication and patient safety risks inform students' speaking up behaviours. Finally, students' perception of themselves, including their sense of belonging to the clinical

team and associated psychological safety within the team, leads students to speak up or remain silent.

Health care professionals and students consider speaking up a professional responsibility and personal obligation as the right thing to do to prevent patients from being harmed. Speaking up is an action with theoretical underpinnings, including advocating for patient safety as a professional and moral responsibility of all health care workers. The obligation to maintain patient safety is directed and regulated by national governing bodies, whereby standards require health care professionals to speak up and prevent patient harm. Governing and regulatory bodies require nursing curricula to develop courses that address the national safety standards and prepare students to maintain patient safety during clinical placement experiences. The specifics of the content, and how students learn about patient safety, speaking up, or assertive communication within curricula are inconsistent and unregulated. Students' learning about speaking up and patient safety and how it translates to clinical practice is unknown. A theory-practice gap is evident when students transition from education to clinical settings however, the aspects or details of the student's knowledge gap vary between students and clinical placement settings. It is evident that curricula need to be scaffolded, and speaking up knowledge, skills, and attitudes should be integrated throughout nursing courses. Students' learning needs to include developing moral courage, psychological safety, and assertive communication competence.

The clinical placement environment influences students' speaking up and health care team members' behaviours and attitudes. A clinical placement environment with weak leadership results in a culture that does not promote a psychologically safe space inclusive of students that enables them to speak up about patient safety risks. This psychologically unsafe environment for students primarily derives from the student's perception

that they do not belong in the space or are considered members of the health care team. Students' sense of not belonging directly impacts their speaking up behaviours. When students attend clinical placements, they are transient health care team members influencing their perceptions about what safety and cultural rules apply to them as students. Students describe being yelled at and intimidated in the clinical space. If a just and safety culture applied to nursing students, they would feel they belong and feel psychologically safe to speak up about patient safety risks. This is not the case; students describe a fear of consequences, including reprimand and failing the clinical placement. These feelings result in students remaining silent when observing patient safety risks.

CHAPTER 3: CLARIFYING THE CONCEPT OF NURSING STUDENTS SPEAKING UP

3.1 Introduction

This chapter comprises a published Concept Analysis of nursing students speaking up for patient safety in the clinical environment. The initial literature review to determine previous research and findings that had been undertaken about nursing students speaking up experiences revealed that there was minimal literature relating to student experiences. Much of the previous research focused on Registered Nurses, Medical Officers and other health professionals with minimal focus on nursing students in the clinical placement setting. As a result, the concept analysis refines and clarifies the notions around students speaking up in practice. It provides a detailed theoretical and functional definitions aligning with the focus of the aim for this research.

3.2 Publication background

The concept analysis was conducted to provide a foundation and to clarify of the focus of the study. It is seminal work that focuses on the nature of nursing students speaking up in the clinical environment. It enabled the creation of boundaries around the term of speaking up by defining and differentiating speaking up from other terms such as reporting errors and whistleblowing. Utilising the clinical placement setting and the students experience in the learning environment provided a focus that operationalised the concept of students speaking up to prevent patient harm.

The analysis drew on literature from 1970 – 2015 to include seminal theories that are the foundations of nursing practice that are essential

underlying theories, such as advocacy, on which the action of students speaking up rests. The Walker and Avant (2010) method for analysis informed the approach to the concept analysis. Previous literature focused on students speaking up provided minimal evidence of examples of a model, borderline and contrary case of students speaking up. Therefore, the Walker and Avant method was modified for this concept analysis.

This publication is the first to present the defining attributes and antecedents of nursing students speaking up in health care. The analysis is unique as it applies Morrison's (2011) employee voice behaviour to nursing students in the healthcare setting. An adapted model of Morrison's work focusing on nursing students presenting a structured and detailed model of the antecedents and consequences associated with the individual and contextual influences of students' voice behaviour when speaking up in practice.

To date, this publication has forty-eight citations (Appendix D) where researcher has applied the definition, acknowledging the defining attributes and the social and cultural challenges students experience. The concept analysis informs clinical practice and education providers of essential constructs associated with students' experiences that aim to improve student contribution in maintaining patient safety. In line with the university thesis submission requirements, a complete version of the published paper is included on the following pages.

An abstract was submitted for review to attend the 2018 NETNEP conference in Banff, Canada. Among the 950 other abstracts, it was accepted for oral presentation titled; *Speaking up to maintain patient safety in the clinical setting: Australian pre-registration nursing students' experiences, willingness and capacity.* See Appendix E for the abstract acceptance communication. I attended and presented at the conference among many other delegates which also received UNE media attention

reporting the attendance at the conference, the focus and aim of the presentation to an international audience. See the abstract and the conference presentation acceptance letter and UNE media release are included as Appendix F.

3.2.1 Citation

Fagan, A., Parker, V. & Jackson, D. (2016). A concept analysis of undergraduate nursing students speaking up for patient safety in the patient care environment. *Journal of Advanced Nursing 72*(10), 2346–2357. doi: 10.1111/jan.13028

3.2.2. Journal selection

The Journal of Advanced Nursing (JAN) is recognised as an international journal that targets readers committed to advancing evidence-based practice in health care. The journal readers include practising nurses and midwives, managers, nurse educators and nursing students, and those who inform decision-making in practice. JAN has a Scopus Q1 rating, and in 2021 impact factor of 3.057 and is ranked 21/125 (Nursing and 20/123 (Nursing (Social Science)). Patient safety is a worldwide concern that has been the focus of health care for more than twenty years. This journal aims to reach an international audience and inform about nursing students speaking up experiences globally that inform policymakers in health and education.

3.3 Authorship statement

I undertook the literature review in December and January of 2015-2016 with support and guidance from the university librarian, who assisted with the search's database selection and MeSH terms. I was responsible for developing the manuscript's overall draft and making modifications and adjustments in response to the review by the study supervisors. Throughout the development of this manuscript, I consulted with my study

supervisors, who agreed on the version of this manuscript. I independently developed the adapted model of Morrisons (2011) employee voice behaviour that focuses on nursing students (Figure 1). The supervisors acknowledged the development of this model as an independent original and valuable contribution to the paper.

CHAPTER 4: STUDENTS EXPERIENCES OF SPEAKING UP

4.1 Introduction

Chapter four presents the first of two publications focusing on the findings of this research. This paper addresses the first research question determining the students' perceptions and experiences of speaking up for patient safety. Students' perceptions of the barriers and enables to speaking up are clarified. The findings drawn from both the individual interview questions and the collective perspectives outlined in the focus groups. This paper is unique, presenting the students' expressions of dissonance and confusion when observing safety risks and individuals justifying their breaches from policies that aims to maintain safety practice.

4.2 Publication background

This paper sheds new light on the emotional responses students experience when observing safety risks in practice. The findings enrich and extend what was previously known about student challenges during placement and their speaking up experiences. This paper presents new information about the unpredictable trajectory of students engaging in speaking up to prevent patient harm and reports on some extraordinary perceptions of students' feelings of dissonance and confusion about their responsibility to maintain patient safety and their relationships with RNs. The key finding in this paper is students' dissonance and confusion experiencing conflicts about their responsibility and other health care professionals' responsibilities to maintain patient safety. The results are inimitable as it presents students' thoughts about health care staff justifying their actions when they knowingly breach policies or take shortcuts in practice. The findings in this paper clarify the complexity of the rural healthcare setting and the socio-cultural challenges students experience during placement.

An abstract was submitted for the 2020 NETNEP conference in Barcelona, Spain. Among the many abstracts, it was accepted for a poster presentation titled; "Pre-registration nursing students' perceptions and experiences of speaking up for patient safety in Australia; conflict, confusion and inconsistencies". I was unable to attend and presented at the conference due to COVID-19 impact and cancellation of the conference. The abstract and the conference acceptance letter in are included in Appendix G.

4.2.1 Citation

Fagan, A., Lea, J., & Parker, V. (2020). Conflict, confusion and inconsistencies: Pre-registration nursing students' perceptions and experiences of speaking up for patient safety. *Nursing Inquiry, 28*(1). 00:e12381. https://doi. org/10.1111/nin.12381

4.2.2 Journal selection

The journal Nursing Inquiry was chosen to publish the first findings paper because it is an international peer review nursing journal that focuses its interest on nurses in health care and aims to stimulate and examine current nursing practices, conditions and contexts. Our study is a good fit with this journal's focus as it engages in dialogue that challenges current thought on a wide range of nursing and health phenomena. The journal aims to inform policymakers about the ongoing issues associated with students in the clinical placement setting that impact patient safety. Nursing Inquiry has a Q1 Scopus rating with a 2021 impact factor of 2.65. It is rated 29/125 (Nursing) and 27/123 (Nursing (Social Science)). This publication currently has twelve citations (Appendix D: Citations). The publications citing the findings extend the focus beyond nursing students speaking up by informing research relating to educators, clinicians and new graduates, psychological safety in Australia and internationally.

4.3 Authorship statement

Findings papers one and two were developed to report the study's findings. Two major themes of the findings were identified and the decision was made to divide the findings between two publications. I was responsible for developing the manuscript's overall draft and making modifications and adjustments in response to the review of the study supervisors. The study supervisors and I discussed this manuscript's progress throughout, and we all agreed on the final draft.

CHAPTER 5: STUDENTS' SPEAKING UP STRATEGIES

5.1 Introduction

This paper presents original findings about nursing students' strategies when speaking up for patient safety. This paper builds on the concept analysis that recognised students' sense of agency and their attitudes and confidence that affect their speaking up behaviours. This paper confirms the findings of the concept analysis and those reported in the first paper. The findings give evidence that the attributes and antecedents impact students' speaking up behaviours and students believe speaking up is a professional responsibility. Student experiences of dissonance and confusion leads them to employ speaking up strategies to mitigate personal risk when observing potential patient harm.

5.2 Publication background

Students engaging in strategies also confirms that students believe that speaking up is risky, as presented in findings paper one. The strategies students employ indicate they perceive that there is a need to negotiate the social and cultural complexities of the clinical placement environment. The paper explains students' strategies to mitigate risk when speaking up in a complex clinical environment. The findings in this paper gives strength to the adaptation of Morrison's (2018) employee voice behaviours model that was developed and published in the concept analysis publication. It demonstrates that individual and contextual factors impact students' voice behaviours. The impact of the socio-cultural factors on students speaking up behaviours are primarily influenced by their experiences and the culture of the healthcare environment. This paper is the first to validate how students aim to gain a sense of agency when speaking up.

An abstract was submitted for the 2020 NETNEP conference in Barcelona, Spain. Among the many other abstracts, it was accepted for oral presentation titled "Australian pre-registration nursing student tactics and strategies when speaking up for patient safety; what clinicians and educators need to know". Due to COVID 19 the conference was cancelled, and I was unable to present these findings. The abstract and the conference acceptance letter are included as Appendix G.

5.2.1 Citation

Fagan, A., Lea, J., & Parker, V. (2021). Student nurses' strategies when speaking up for patient safety; A qualitative study. *Journal of Nursing and Health Sciences. 23* (2), 447-455 https://doi.org/10.1111/nhs.12831

5.2.2 Journal selection

The Nursing and Health Sciences was selected for publishing the second findings paper as it is an international journal that looks to share nursing and health science knowledge globally. Findings paper two is unique as it presents strategies students use when speaking up. The publication is a good fit with this journal that focuses on improving health outcomes as it enables the reader to develop an understanding of students' thoughts and behaviours to prevent patient harm. The Nursing and Health Sciences journal has a Scopus Q2 rating and a 2021 impact factor of 2.214. and is ranked 57/125 (Nursing) and 54/123 (Nursing (Social Science)) journals. This publication currently has three citations (Appendix D).

5.3 Authorship statement

I was responsible for creating the overall draught of the second findings manuscript and making changes and improvements in response to

the study supervisors' reviews. My study supervisors and I discussed this manuscript's progress throughout, and we all agreed on the final draught and the journal selected in which we published the manuscript.

CHAPTER 6: DISCUSSION AND CONCLUSION

6.1. Introduction

This study aimed to explore pre-registration nursing students' perceptions and experiences of speaking up for patient safety in rural and regional healthcare settings in NSW, Australia. Specifically, the study aimed to examine nursing students' perceptions and experiences of patient safety breaches and speaking up for patient safety during their clinical placement experience. It also aimed to determine what factors impact nursing students' propensity to speak up when they observe errors in clinical practice, and what specific strategies or common approaches they employ to speak up or not speak up when they witness imminent potential harm. Additionally, we sought to understand if and how students' perceptions and experiences of speaking up change through the course of their studies.

Through an Interpretive Description lens, the study contributes to understanding of the students' subjective and experiential knowledge that gives insight into the realities of students' clinical placement experiences. This study is the first to discern students' perceptions and experiences of speaking up for patient safety in rural and regional clinical placement settings, recognising the reality of the socio-cultural constructs that students encounter across the diverse placement settings that impacts their experiences.

Individual interviews enabled students to reflect on their experiences and express their thoughts about speaking up in practice without external influences on their perceptions. Through focus group discussions the researcher explored the students' common and uncommon experiences and emotions in their conversations and interactions. We recognised commonalities associated with the participants being in a student position

that impacts their professional identity. We build on what is already known about their experiences and challenges in the clinical placement setting by focusing on students' speaking up behaviours during rural clinical placements. Engaging participants across all year levels informed the findings about the time and context of how students' developing professional, clinical and cultural knowledge impacts their speaking up behaviours. There is recognition that students' actions are associated with their development of knowledge and insight into clinical and professional practice that is gained through the reality of the clinical placement experience.

The findings of this study have been reported in three peer-reviewed articles published in international journals. The first paper published in 2016 in the Journal of Advanced Nursing analysed the concept of nursing students speaking up for patient safety. Titled; *A concept analysis of undergraduate nursing students speaking up for patient safety in the patient care environment*, the concept analysis draws on previously published work to explore perspectives relating to nursing students speaking up. The investigation was a critical first step in the study because the majority of published research on speaking up was related to RNs and other health care professionals such as medical officers. This concept analysis is the first that differentiates how nursing students speaking up experiences differ from others because of their particular position and relationships within the health care team. We provide a clear definition of speaking up in relation to nursing students that facilitates an understanding and operationalises the concept that can be applied to students learning, clinical practice and future research. The analysis recognises students' individual position and the defining attributes specifically for students speaking up, including advocacy, agency and the use of voice and being heard. The concept analysis clarifies these differences from an individual and contextual perspective. Individual antecedents defining students speaking up behaviours include their knowledge, attitudes, confidence, and

cultural and generational origins. Contextual antecedents that are directly associated with students' experiences include their attitude and confidence, support and supervision.

Two findings' papers were published in 2020 and 2021, respectively. The first of the findings' papers published in 2020 in the journal Nursing Inquiry was titled; *Conflict, confusion and inconsistencies: Pre-registration nursing students' perceptions and experiences of speaking up for patient safety.* This paper adds to the previous body of knowledge about student experiences by describing students' responses to the inconsistencies they observe in practice compared with what they learn at university. This paper adds to that knowledge by defining how students feel about their knowledge when they know and observe health care staff to take shortcuts that risk patient safety. Students experience dissonance when observing a practice that breaches protocols or does not adhere to best practices. The students are confused when observing poor practices and health care professionals justifying their actions. The findings of this paper promote awareness of the students' reactions to their experiences, providing insight and informing educators and clinicians about the students experiencing dissonance when observing a practice that is conflicting and inconsistent with best practice.

The second findings paper published in 2021 in Nursing and Health Sciences was titled; *Student nurses' strategies when speaking up for patient safety: A qualitative study*. Past research describes students fearing speaking up (Fisher & Kiernan, 2019) or students overcoming fear and speaking up (Jack et al., 2021). This paper reports findings revealing that students undertake deliberate actions to gain a sense of agency and mitigate perceived risks of speaking up during the clinical placement experience. We provide clarity about the students' actions and the strategies they employ when speaking up. This paper gives health care professionals insight and a greater understanding of why students respond the way they do when observing patient safety risks. Creating a safety

culture has been a focus in healthcare that aims to enable health care staff to feel safe and speak up to prevent patient harm. However, our findings inform clinicians and educators that students do not feel the safety culture is inclusive, and that students are not encouraged to voice their patient safety concerns. Issues of concern for students are around speaking up or remaining silent, incivility from other health care professionals, and not feeling psychologically safe or part of the health care team. It addresses a gap in the current body of knowledge of students' experiences, that predominately focuses on metropolitan healthcare settings. Our study acknowledges the essential nature and diversity of the rural healthcare context, and how students respond, and the strategies they use to speak up in rural and regional healthcare settings.

Four premise statements presented here are derived from the findings presented in previous chapters. An initial overarching premise is;

Nursing students speaking up to prevent patient harm in the rural and regional healthcare setting is a complex socio-cultural phenomenon.

Three sub-premise statements highlight the detail of this complexity. Premise One argues that students' speaking up experiences are not uniform but rather a complex interplay of perceptions, knowledge, expectations and the unknown that each different placement presents. This premise correlates with the concept analysis and the interaction between individual characteristics and complex contextual issues in rural healthcare settings. Students' perceptions and experiences of the contextual issues including the lack of structure, support and a health care team that is displaced from the placement site impacts student responses to safety issues. These contextual issues and students' dissociation from the health care team leads them to develop strategies as a response to the lack of inclusions and isolation from the safety culture.

The second premise argues that students' speaking up behaviours change according to their knowledge and experiences of interpersonal interactions with health care staff and how they are supported in the clinical setting. Student experiences in the past and during the placement drive their responses to safety situations. Their interactions and speaking up behaviours are reactions to the people and personalities they encounter as they become aware of the unpredictable nature of the clinical environment and safety culture. Students who become aware of these complex environments and people become astute and develop speaking up strategies to negate negative response when they address safety risks.

Finally, premise three contends that students' experience of speaking up contributes to the development of their professional identity and is associated with their sense of self including courage, confidence and responsibility to maintain patient safety**.** The concept analysis clarified students' individual attributes including students' sense of agency, and responsibility to advocate for safety adds to their speaking up behaviours. However, their perceptions and experiences often result in a sense of a loss of agency damaging their psychological safety when observing safety issues. Some students can evaluate their professional identity and their defining attributes of confidence and knowledge moving forward, strategizing to reduce risks associated with speaking up. The strategic response aims to support their professional identity as a respected member of the health care team who is responsible in preventing patient harm.

Together, these premise statements characterise the significant findings from the study and form a framework for discussion, together with reflection on the relevant literature. Following discussion of these premise and the findings, recommendations for practice, policy, education, and future research are presented, followed by reporting of the study's limitations.

6.2. Overarching Premise: Nursing students speaking up to prevent patient harm in rural and regional healthcare settings is a complex socio-cultural phenomenon.

It's not a perfect world; you have two worlds colliding, you have to implement the policies and procedures of the healthcare system, and then you have the variables of the personalities and people compromising patient safety (Hermione, 3rd Year Focus group).

Students experience challenges associated with the complexity of the social, cultural and contextual factors that impact patient safety-related behaviours in the rural clinical placement setting. The students experience inconsistencies and contradictions while working with individuals with different attitudes and personalities. These relate to the variation in cultural attitudes and perspectives about workplace patient safety, roles and responsibilities across healthcare settings. Students experience varied levels of inclusivity across the different placement experiences. In rural settings, particular contextual factors such as isolation, limited resources, support and supervision, and differing scope of professional practice requirements create additional challenges for students. The above statement by Hermione, a final year student, cited in the findings of paper one, identifies the quintessential complex nature of students speaking up experiences.

Complexity extends beyond the context, people, and individual personalities to include the governance, policies and procedures that impact health care professionals and student behaviours. Organisational governance influences health facilities safety culture and how health care teams embrace safety behaviours. Organisational governance should promote adherence to safety policies such as the eight National Safety and Quality Health Service (NSQHS) standards that aim to protect the public

from harm (ACSQHC, 2019). However, there are times when the desired consistency of safe care sometimes strays from the rules and breaches in safe care occur in practice. Organisational governance of rural health care is often not physically located at the actual rural site risking a lack of regulation, supervision and adherence to safety directives in practice.

Past research has focused on Registered Nurses and other health professionals speaking up experiences with little attention to how student experiences might differ. To clarify the notion of students speaking up, a concept analysis using a modified Walker and Avant model was conducted. The concept analysis findings were used to adapt Morrison's (2011) employee voice behaviour model for undergraduate nursing students, highlighting elements contributing to the complexity of nursing students' speaking up behaviours. These elements include the students' perceptions and behaviours which are influenced by organisational and individual factors, professional interactions, education through clinical placement and education providers.

The contextual factors contributing to the complexity for students include the organisational structure and safety culture coupled with the approach to students' supervision and support during placement. The study's findings add a nuanced understanding of how the students experience these essential contextual factors initially identified in the concept analysis. The concept analysis identified antecedents for speaking up for individual students; level of knowledge, attitudes and confidence, and perspectives of the cultural and generational factors that position them differently from other health care professionals when speaking up for patient safety. The contextual factor antecedents identified by the participants in this study situate students differently from other health care professionals when advocating for patient safety and influence their perceived effectiveness or consequences of speaking up.

Students believe they should speak up and are frequently conflicted from within when aiming to do so. Their perceptions of available support influence them. For example, at times, students are welcomed and encouraged to speak up, while at other times, they feel ostracised and excluded for daring to speak up. The students' experiences relate to their transition from the education providers learning environment to an ever-changing unpredictable clinical environment and health care professionals' actions and responses. The clinical placement enables students to develop knowledge through their experiences, giving them insight into the social constructs of the healthcare environment. When students transition from the education setting to the healthcare setting, they attempt to judge the risk factors and align their speaking up behaviours with the various clinical placement setting safety cultures and health care staffs' behaviours and personalities.

Students are also challenged with the realities that small rural communities present. For example, challenges associated with the health professionals that students work alongside often having close social and personal relationships with rural health care team members, patients, and their families. Students must get used to working staff in a small rural town with individuals they know socially. Due to the low staffing levels in rural agencies, they are also required to collaborate with the same individuals every day and deal with challenges that comes with working in rural communities and the ambiguity of roles (Lea & Cruickshank, 2007). The student's knowledge or lack of knowledge of these relationships in rural healthcare settings influences their speaking up behaviours

The students often feel disempowered, alienated and marginalised by health care staff during their clinical placement experience. These feelings lead students to think carefully about what they have learnt about patient safety and their position in advocating for a patient's safety or for their own safety. As a result of these internal conflicts and their loss of agency, students weigh up any potential risks before acting and speaking up to

prevent patient harm. The students recognise and value the importance of maintaining professional relationships that impact their sense of belonging in the clinical environment. Students were at times unsure if there are generational influences on their professional relationships and speaking up behaviours. The participants identified that these influences are associated with students having greater concerns and challenges when developing and maintaining relations with more experienced nurses. Mature-aged students also perceived that their age should help enable speaking up; however, their position as a student hindered them from voicing concerns. Intergenerational differences have been noted to affect performance and productivity in a workspace, well-being, and patient safety (Stevanin et al., 2018). Students feel isolated, apprehensive and fear that there may be negative impacts on professional relationships and or ramifications associated with their actions to prevent patient harm. This study demonstrates that students continue to experience incidents previously reported such as incivilities, and their sense of not belonging remains an ongoing issue during the clinical placement experience (Bickhoff et al., 2018; Courtney-Pratt et al., 2018; Levett-Jones et al., 2007; 2009).

Beyond the impact of the healthcare context, students' perception of themselves as individuals and members of the health care team impacts their speaking up behaviours. Students feel strongly about their professional responsibility to speak up and the need to advocate for patient safety. Paper two highlights new findings that students are challenged by an internal conflict about whether they should speak up or remain silent. The paper describes how they speak up against challenging personalities and how fear of an unpredictable reaction often prevents them from voicing their concerns. Individual factors that complicate students' speaking up behaviours include their changing and varying levels of confidence, courage, safety knowledge, and moral or ethical position. New to previous studies, we have identified that the students' sense of agency plays a crucial role in students speaking up behaviours. To gain a position with agency, the students determine the possible risks and strategies for their approach

to speaking up. That is, they reflect on their position and evaluate the possible responses they may receive when speaking up about safety concerns. There is an interplay between the placement organisations' safety culture and the students' individual factors that changes students' perceptions about speaking up as they gain insight and knowledge through the clinical placement experiences. The trajectory for a change in speaking up behaviours is unpredictable, and it cannot be assumed that students' confidence and speaking up behaviours has a single trajectory of increasing or declining as they move through their course.

Factors influencing students speaking up behaviours are multifaceted, signifying that a single intervention in either the education or clinical placement setting is unlikely to empower students to speak up easily and confidently. Students in this study experienced varied lengths of clinical placements across many healthcare service locations. Interventions that assist students in speaking up, must be able to be adapted to many clinical placement locations. Nursing students speaking up for patient safety behaviours are influenced by their thoughts, perceptions, and social constructs when interacting with the placement supervisors, the multidisciplinary team, the RNs they work alongside, and the governance and leadership in the clinical placement environment. Students speaking up behaviour also depends on their self-perception in the clinical placement environment. Therefore, interventions that aim to enable students to speak up would need to consider these health care professionals and the socio-cultural influences on students speaking up behaviours.

6.2.1 Sub-premise one

Students' behaviours and motivations to speak up are not uniform but rather a complex interplay of perceptions, knowledge, expectations and the unknown that each different placement presents.

Throughout the nursing course, students undertake clinical placements within various healthcare organisations and clinical contexts. Rotating

through different placement organisations and settings means students are exposed to diverse governance, leadership and management styles and health care disciplines. However, the characteristics and variability within rural clinical placement settings in terms of support create complex and challenging issues for students to embrace and navigate. Inextricably linked are issues associated with significant and longstanding workforce challenges facing rural clinicians and other health service providers beyond the metropolitan areas. Rural and regional healthcare organisations have been and continue to experience a crisis in resourcing associated with a critical staff shortage to support safe health care and meet every day basic requirements (NSW Parliament Legislative Council, 2022). The lack of staffing compromises the healthcare organisation ability to adequately support students during their placement. There are instances when there is no structured orientation, and students must find their way and inform themselves about the organisation, culture, people and expectations. Students' knowledge develops through experiences, the inconsistencies in the placement experiences creates uncertainty. However, they lack confidence and understanding of the expectations and responsibilities regarding speaking up for patient safety.

Students speaking up or remaining silent correlates with their lack of knowledge about the health care team, the leadership and organisational governance in the healthcare setting. Students lack understanding of the complexities of the placement's organisational governance and the leadership influencing the safety culture. Being a transient team member, students struggle to develop camaraderie, familiarity, or confidence in the health care team (van der Riet, Levett-Jones & Courtney-Pratt, 2018). In addition, they lack insight into the beliefs, attitudes, perceptions and values and patterns of behaviours of employees towards patient safety in the clinical setting. This lack of insight results in students' lack of trust in the healthcare setting's professional relationships and safety culture. The lack of a structured learning environment, staffing crises and limited support in terms of designated supervisors such as clinical facilitators or nurse

educators within rural and regional clinical placements, intensify students' lack of trust in the health care professionals and clinical placement setting.

A lack of inclusivity, clear expectations and direction result in students being unsure of how they contribute to the safety culture during the placement experience. Students respond to non-inclusive behaviours by remaining silent. Positive interactions with health care professionals, such as inclusivity, increase students' likelihood of speaking up. They recognise that positive role models exhibit inclusivity, provide clear and encouraging direction, and purposeful and supportive interactions with peers. Inclusivity results in the students feeling they belong as health care team members during their clinical placement experience.

The development and maintenance of a safety culture rely upon all levels of the health care team and effective communication and trust between all levels of the organisation's executives and management (Murray & Sundin, 2017). An influential safety culture that is inclusive of students would enable students to participate in maintaining patient safety and feel safe to speak up. A patient-centred safety culture provides safe patient care that allows all health care professionals, including students, to have shared values and feel empowered to participate in a zero-tolerance approach toward sub-standard or unsafe care without fear or ramifications. However, students know they have a professional responsibility to maintain patient safety but lack of inclusivity hinders their participation in maintaining safety.

The students in this study report that lack of inclusivity continues to be a significant issue, they describe instances of being ignored and not heard when speaking up. Chicca and Shellenbarger (2020) found that their participants perceived that the clinical environment demonstrates inequalities, lack of respect and non-inclusive interactions towards diverse and minority student groups. However, the participants in this study

confirm that issues extend beyond minority and diverse student groups. Indeed, all students expect to be acknowledged, included and treated fairly. Therefore, all students would benefit and appreciate inclusive behaviours during the clinical placement experience. Inclusivity for all students would help them positively mold their attitudes and behaviours about the nursing profession, and clarify speaking up roles and responsibilities, ultimately improving patient outcomes (Metzger et al., 2020b).

Generational variance across the student cohort may change the students' expectations associated with communication, approach to feedback, inclusivity and risk-taking (Seibert, 2021; Shorey et al., 2021). The participants of this study suggested that generational differences may influence their speaking up behaviours Essentially, the generational impact on student perceptions of speaking up is unclear; it is not known how the differences in generations' communication skills, socialisation and adversity levels to risk-taking impact their perceptions of the health care team, inclusivity and desires to speak up. Some students spoke about being fearful of the older RNs and hence were less likely to address safety concerns with them. However, age was not always a determining factor for speaking up, indeed a significant number of students are older than the RNs they encounter in practice.

Students speaking up without fear requires a just culture that includes students. Students develop knowledge through the placement experience and gain insights into the complexities of the socio-culture of the healthcare setting. However, with each new placement, the students lack familiarity with the health care team and the safety culture. The lack of familiarity means they frequently negotiate situations and develop strategies to mitigate perceived risks associated with reporting incidences or speaking up about patient safety issues. These negotiations are complicated by the unknown or the anticipated response the students will receive should they speak up. Students in this study find themselves in

difficult situations, lacking a sense of agency that requires them to weigh up the risks and whether to prioritise, the safety of the patient or themselves. The concept analysis clarified that students need to consider the organisational perspectives of the safety culture, students are influenced by the personalities of others, and their personal attributes, including knowledge and confidence (Fagan et al., 2016).

In a just culture, a student feels psychologically safe and does not have a fear of ramifications when speaking up. An inclusive and just culture would enable students to act on their beliefs and responsibility to speak up for patient safety (Chicca & Shellenbarger, 2020). The students' position in the health care team makes them reluctant to report or speak up. Students continue to describe feeling inferior or in a subservient position. They continue to experience a lack of inclusion as team members creating challenges to their speaking up behaviour. When the students constantly rotate between different healthcare settings across rural and regional health districts, the orientation and knowledge of the safety culture are unpredictable and constantly changing. The students identified their behaviour changed as the placement experience gave them insight into the cultures and risks. The changing circumstances contribute to the students' uncertainty about speaking up as they determine where they fit when they commence a new clinical placement experience.

6.2.2 Sub-premise two

Students' speaking up behaviours change according to their knowledge and experiences of interpersonal interactions with health care staff and how they are supported in the clinical setting.

In this study it was found that student nurses speaking up behaviours change throughout their nursing degree courses and students experience various enablers and barriers to speaking up relating to the support, the people and the culture of the healthcare environments. This finding

supports and builds on those of Levett-Jones et al. (2009) who found that students in some placements are welcomed; in others, they feel excluded and often reprimanded for taking the initiative. Clearly the participants in this study were challenged as to whether they should speak up or withdraw and remain silent due to their lack of sense of agency. They were aware that there are risks associated with not knowing the responses they may receive when speaking up. Hence, they reflect on their internal decisions and motivations rather than the external responses of others. In this study the students' experience of speaking up behaviour changes are associated with their knowledge development and learning through the education provider and the clinical placement setting. Education and clinical placement providers are required to facilitate student learning about patient safety. However, due to the inconsistent approach to safety education and lack of information about a student's ability to transfer the learning to the placement, it is challenging to determine students' knowledge and ability to practice in a way that aims to maintain patient safety.

Despite students learning about safety, there are irregularities across the years regarding when, how and why students speak up or remain silent. The trajectory of students speaking up behaviours is changeable depending on their experiences and cannot be assumed to simply increase (Jack et al., 2021) or decline (Usher et al., 2018) as they progress through their nursing course and clinical placement experiences. Instead, as shown in this study, students speaking up behaviour changes in response to their experiences and interactions with health care professionals and RNs during their current and previous clinical placements alerting them to the challenges, risks, and possible responses. We found that some participants spoke up in their first year of study and remained silent in their final year. In contrast, other students did not speak up initially but were more likely to do so as they progressed through their studies. Students' interactions and experiences with others during the clinical placement setting led them

to become shrewd. They judge the situation and understand and deal with the potential difficult or dangerous consequences of speaking up.

There were instances where students who participated in this study were less likely to speak up to prevent patient harm in response to negative or challenging interactions such as aggression towards a student by health care staff, which is similar to findings in a study by Fisher & Kiernan (2019). We demonstrated that speaking up is influenced by the student's knowledge of what is correct or incorrect in practice. However, it is more than knowing about clinical skills as it includes understanding the healthcare setting's complex multiple realities, such as the culture and people. During first-year placement experiences, students generally did not speak up due to limited experiential learning and knowledge gaps about what was expected or normal in practice. The students' not knowing about practice issues resulted in students being exposed to often tragic and traumatic experiences. One of the focus groups with second year students highlighted that they had developed some knowledge as a group. Collectively they acknowledged that their knowledge had grown so that they could identify when RNs strayed from best practice. Some spoke up, while others remained silent, fearing it would damage professional relationships. Final-year students reported having the knowledge that enabled them to speak up during placement. Still, they are silenced by the potential of a negative response from RNs. They do not want to risk failing a final placement and delaying completing their degree. Unlike the findings from Jack et al. (2021) where students continued to speak up even though they experienced being shut down, dismissed or ignored; our study demonstrates that there are times when students choose to remain silent irrespective of the year level in the course.

Final year students acknowledged that part of their professional responsibility to patient advocacy is learnt and instilled at the beginning of their studies. Similar to other studies, they believe that speaking up is a

professional responsibility (Fagan et al., 2016; Fisher & Kiernan, 2019, Usher et al., 2018). However, negative placement experiences taint their learning and perspectives about the profession. Negative placement experiences also decrease the student's motivation to learn. Our findings concur with prior studies who found that students' negative experiences can lead to a loss of motivation to learn and may result in absolute disdain for the nursing profession that causes them to contemplate leaving the nursing course entirely (Courtney-Pratt et al., 2018; Jack et al., 2021).

This study found that when students transition from the education setting to the clinical placement setting, their perception of their responsibility to prevent patient harm creates dissonance. They were perplexed, expressing discordance when seeing poor role modelling and poor practice. They are even more confounded when health care staff ask them to collude or collaborate in poor practice or work outside their scope of practice and not adhere to the direction of protocols. The students frequently described collusion associated with breaching medication administration protocols and poor patient transfer techniques that risk injury to the patient. In paper one, there were reported instances where RNs knowingly breached protocols or took shortcuts and then advised the student, *'you don't do this, but I'm going to'* which gives the student no recall to advocate for patient safety. Unlike the findings reported by Jack et al. (2021), where students spoke up despite their fears, the students' fear remained, and the acknowledgement of poor practice silenced them. In these instances, students are challenged as they require knowledge to determine the impact of the shortcut or breach, and the potential harm to the patient, or the severity of breaking the rules. The student needs to weigh the level of risk to the patient against regard for the unique pressures and constraints for RNs in the rural healthcare setting. The RNs statements could aim to protect students from learning that the shortcuts or breaches are standard practice and make it clear that students should not practice in such ways in the future. The resulting confusion and dissonance students

experience needs to be countered by to assessment of the risk and recognition that not all breaches are equal. RNs who encourage students to have conversations about their safety concerns will allow students to feel comfortable speaking up. However, conversations need to further clarify workplace pressures and how their decisions and actions are informed.

In light of no consistent approach to learning about patient safety and speaking up to prevent patient harm. In many instances, it is difficult to determine where safety is learnt in the curriculum (Mansour, 2018; Usher et al., 2018). The students described learning about communication in health care from a general perspective and were unaware of any education that specifically focused on speaking up skills and techniques for patient safety. They identified a gap in their ability and strategies for transferring knowledge, skills and attitudes about patient safety and speaking up in the clinical placement setting.

Our participants experience of cognitive dissonance, where the ideal approach to nursing learnt at university clashes with the reality of clinical practice concurs with student experiences reported elsewhere (Magninnis & Croxon, 2010). The importance of authentic learning to inform students about the complexity of the clinical practice setting in terms of its diversity in people and culture is well recognised (Hanson et al., 2020; Tregunno et al., 2014). However, it is challenging to simulate healthcare socio-cultural nuances, including multidisciplinary care, cultural and clinical contexts. Education is often a siloed approach to teaching and learning within the nursing discipline and other health disciplines such as medicine (Mansour, 2018). This is complicated by acknowledging the issues relating to the student's ability to transfer knowledge and information, interpret the appropriateness of the communication strategies and speak up to prevent patient harm across diverse clinical placement settings (Hanson et al., 2020).

Regardless of the length of time in the degree, students across all years in this study experienced patient safety risks and believed there were instances when speaking up was necessary to prevent patient harm. Students across all year levels also think that it is essential to utilise strategies in speaking up to mitigate personal risk. The students develop knowledge about the people and culture; they modify their behaviours and develop various strategies. First-year students described strategies such as choosing the right tone of voice and aiming not to be annoying in the hope that they would not be responded to negatively. With time and experience, third-year students employed a more sophisticated technique of asking nuanced questions, reducing the risk of being perceived as arrogant and increasing the likelihood of a positive outcome. Building on the work of Sevenhyusen et al. (2021) which identified that students strategize when speaking up, our findings demonstrate that students' strategies when speaking up aim to influence the behaviours and decisions of others, reducing the advent of adverse reactions and consequences, and hence reduce their fear of speaking up. Students speaking up behaviours are undermined by the complex nature of the people and culture in the clinical setting. The students reported that remaining silent reduces their risk of being thought of as lacking knowledge, protects their professional relationships and avoids the risk of not being listened to or heard.

Positive clinical placement experiences increase the likelihood for students to speak up. Students in year two of their studies highlight that no two clinical placement experiences are the same, and the experiences differ amongst and between students. One student undertaking the sixth placement experiencing discontinuity and lack of support *hated every placement* and was disheartened and dreaded the experience. Students cope with the constant changing of placement settings by purposely shifting their perspective and looking for positive interactions. Yet, this was not always achievable. Students in this study reflected on how positive role modelling and encouragement at the first placement helped them remain

positive throughout the following placements enabling them to initiate and continue to speak up. However, these positive experiences were reported infrequently. It was also evident that changing locations for each placement experience contributes to the complexity of the students learning experience. Without knowing individuals, the culture and how clinicians will respond to students speaking up and given their previous experiences, students remain wary, approaching each new situation with caution.

The findings reveal complexity within the placement experiences influences professional relationships, impacting students speaking up behaviours. We argue that the trajectory is complex and inconsistent and relates to the underlying complexities of the people and workplace culture attitudes and behaviours across many rural healthcare services. Students' experiences, interactions and comprehension of the issues are crucial factors in their decision to speak up or remain silent. The issues reported in the literature where students feel they are not supported, welcomed, or valued as learners or team members during their clinical placements remain a significant issue impacting students' actions to reduce the risk of patient harm.

6.2.3 Sub-premise three

Students experience of speaking up contributes to the development of their professional identity and is associated with their sense of self including courage, confidence and responsibility to maintain patient safety.

Students' identity and their perceived position of inferiority in the clinical placement environment impact if and how they speak up to prevent patient harm. Students' safety behaviours depend on their sense of self as health care professionals who believe in the legitimacy of their place in the clinical learning environment and their right to speak up. The findings of this study support those of earlier studies that the critical factors of self that influence their behaviours are their sense of agency, confidence and

courage, personality and sense of belonging to the clinical learning environment (Bickhoff et al., 2018; Courtney-Pratt et al., 2018; Levett-Jones et al., 2007; 2009). These senses are complex as they depend on the student reflectively engaging with their inner self, including their intellectual, emotional and spiritual self, as they interact with the social and cultural aspects of the clinical learning environment.

The Concept Analysis (Chapter 3) of students speaking up identified that students' sense of agency is an antecedent to speaking up. At the same time, students believe that speaking up is a professional responsibility and the right thing to do. The student's inability to predict or control how others might respond to them speaking up results in them developing risk-mitigating strategies to speak up or, alternatively, remain silent. This study found that the students' sense of agency differs from that of the registered nurse. While it is difficult to measure an individual's sense of agency, the students' agency correlates with stress associated with their subservient position and not knowing or being included as a health care team member. Students' loss of agency leads them to be vulnerable to the demands of others, to partake in unsafe practices or remain silent when health care professionals make excuses about poor practices and shortcuts.

Feeling inferior is critical in how students experience clinical placements (Bickhoff et al., 2018; Courtney-Pratt, 2018). Students in this study experienced stress and heightened emotions as they perceived themselves as the underdog and the clinical placement experience exposed them to the risk of being attacked by *big dogs*. The students demonstrate a loss of agency, referring to being challenged and confronted by the *big dogs,* which may be difficult to manage if they speak up. These findings extend beyond those reported previously (Bickhoff et al., 2018). We demonstrate how students attempt to gain a sense of agency during clinical placement. Students gain an understanding of their agency as they weigh up the risk and develop strategies in how they speak up, aiming to control

the responses of others. Students delve into their emotional state, seeking a sense of mutual calm and respect as they carefully choose the right voice or phrasing in a manner that placates a response of agitation and conflict from clinicians.

Students' loss of agency leads them to experience fear in the clinical environment inhibiting their speaking up. A strong sense of agency would increase the likelihood of them speaking up with confidence and without fear. However, another challenge that influenced their speaking up behaviours related to the RNs they work beside in the rural setting being responsible for assessing students. While the RNs supervise the students, they also determine and report on the overall placement result, adding to the elements of dependence.

The students report that they need to find inner confidence, courage, and persistence to speak up. Numminen, Repo and Leino-Kilpi's (2018) concept analysis of nurses' moral courage identified perseverance as an attribute of moral courage. Similarly, students in this study described how they needed to be persistent in their efforts to be listened to, heard and to get an adequate response to their concerns. However, students have to overcome the risks and have the courage of their convictions by developing emotional intelligence and engaging in the best speaking up strategy that mitigates risk to the student.

Students are often confused about their position in relation to people and their place in the culture, within and across the various placement settings. An ongoing issue is the students' perception of themselves as an outsider who is ostracised and excluded. There are complications and inconsistencies associated with students' perception of their identity in diverse clinical environments. Rural and regional settings present many varied and often contradictory social and cultural environments, including inconsistent support and students experience of exclusion occurring in one

instance, and inclusion, embraced and supported in the following placement or vice versa. When students experience acceptance as a member of the team, their confidence and likelihood of speaking up is increased.

The students value of social interactions and positive professional relationships with the health care profession is a recurrent finding in this study. Being accepted, respected, and valued as a health care team member is important to students and gives them a sense of psychological safety in the clinical environment. However, the students often report feeling unsupported generally, and even more so when speaking up. Clinical placements are generally of two or four-weeks duration and are often not at the same healthcare site twice which means that the students are always transient team members. This transient position is problematic for developing strong professional relationships as students struggle to work with synergy, forming working relations and have mutual respect between the staff and students. The findings that students feel it is difficult to speak up to health care professionals with whom they are unfamiliar as they remain outsiders to the team (Ion, et al., 2016; Omura et al., 2018a). Students believe they are not valued or respected, and as a result, when speaking up, they need to back themselves with knowledge or provide the evidence that supports their knowledge about the issues, so their voice is heard. Students continue to feel there is no point in speaking up as their opinions are not valued or heard.

In conclusion, students' exposure to challenging socio-cultural aspects of the clinical environment hinders the advancement of their professional identity and ability to speak up to prevent patient harm. Students observing patient safety risks and the responses they receive when speaking up have long-term impacts that leave students with negative perceptions of the nursing profession and the clinical environment. Students' sense of identity is impacted by their clinical placement experiences, which influences their confidence and psychological safety.

This study demonstrates that students' identity and confidence in themselves, their sense of belonging and agency, being included as a team member and speaking up behaviours worryingly depend on the interactions and behaviours of those they work beside and how other health care professionals treat them. While the clinical placement experience gives students the opportunity to develop their professional identity, constantly having to find the courage and confidence to speak up to prevent patient harm results in negative perceptions about the nursing profession.

6.3 Implications for the Future

Students' clinical placement experience presents challenges associated with complex social, cultural and contextual factors that impact the students speaking behaviours. This section addresses the implications for the future with four major categories. The implication for practice focuses on strategies for developing a culture of inclusivity and a structured orientation to clinical placement learning experiences, enabling students to feel embraced and supported and increasing students' psychological safety. Implication for education requires examination of strategies that overcome fragmentation and increase transferability of patient safety knowledge and speaking up skills from the education to the clinical placement setting. It is necessary to investigate the effectiveness of student support that enables them to feel safe in the clinical placement environment. Finally, the implication for reviewing policy includes developing and evaluating policies relating to students' roles and responsibilities associated with maintaining patient safety and speaking up to prevent patient harm.

6.3.1 Implications for Practice

Student clinical placement experiences can be improved by developing strategies that provide a supportive and informative approach to clarifying the students' roles and responsibilities in maintaining patient safety. This clarity is necessary to create a positive learning environment

and a psychologically safe student learning space. Students experience inconsistencies in the clinical placement, including the lack of structure at the commencement of the placement that resulted in students reporting they did not know who the health care team members were and to whom or where safety issues were appropriately escalated. The knowledge gap about the clinical placement team and the environment leads to the students feeling uncertain about the team member's culture and dynamics. The lack of clarity in the placement about safety responsibilities results in students not feeling psychologically safe and unsupported in the clinical environment. Strategies that provide a supportive environment will reduce students experiencing distrust and anxiety.

There is a need to inform students and placement settings about what is expected of students and how they respond to difficult and complex situations in an environment. The students identified that an organised and predictable environment builds a learner/ facilitator relationship that fosters confidence and trust in professional relationships. Clear expectations will increase students' psychological safety. The attributes of a psychologically safe learning environment enable students in the learning setting to make mistakes without fear of consequences within that space (Lyman & Mendon, 2021). However, not all clinical learning environments are psychologically safe for students. A structured approach that includes information and direction for students outlining objectives clarifies expectations about student responses to safety risks or errors in practice and associated consequences.

Utilising a collaborative approach to developing the structured approach is necessary to ensure the education and clinical placement providers have a clear and transparent understanding of the placement experience expectations. Such collaboration aims to ensure relevant issues are addressed and the programme meets the needs of all the health care team, including a student attending a clinical placement. These are

complicated by the organisational structure, such as geographically distributed teams, which can increase the risk of communication breakdown and patient harm. Developing collaborative teams with a shared approach in developing models or programs establishes mutual respect, trust and closed-loop communication that underpins the conditions required to have effective teams (Weller et al., 2014). Maintaining patient safety and clarifying roles and responsibilities across the health care team, including students, results in an effective team and an inclusive safety culture.

Collaboration that is inclusive of students will balance the understanding of their perspective on the issues and gaps they experience addressing the real problems the students experience and aid their transition to the placement setting. A strategy could include the development of a consistent and structured orientation that includes expectations and directions that will assist students in maintaining patient safety. However, for this to be effective, key stakeholders and leaders need to show their support and commitment to the intervention. Leadership in the healthcare organisation needs to ensure the program is consistently implemented and evaluated to maintain currency and relevance to the needs of the health care team and the students.

The outcome of a collaborative approach to developing interventions will provide transparency and clarify health care team members' and students' expectations of their roles and responsibilities to maintain patient safety. This strategy increases students' perception of a psychologically safe environment that could lead students to engage in the team, share ideas and speak up to prevent patient harm. Psychological safety as a group construct that focuses on patient safety increases the teams' goal, rather than focusing on the individuals' accountability (Edmondson, 1999), which will increase the likelihood of students speaking up and maintaining patient safety. This group construct will engage the quiet or silent members, such

as students contributing to the interventions aiding patient safety and encourage a student to contribute to patient safety discussions.

Our findings indicate that currently health care teams do not always welcome or include students. The health care team needs to promote students being part of the team and develop strategies that support and embrace students during the clinical placement experience. However, the primary goal of the RNs is to care for their patients and to get through the day in the current environment of staffing shortages, severe workloads, and low resourcing in publicly funded healthcare (NSW Parliament Legislative Council, 2022). Given the pressures they face in their job, supporting and educating students may not even be on their sensor because it is not their primary focus or area of expertise. Students describe being excluded and ostracised during the clinical placement experience. Inclusivity involves strategies and practices that intentionally foster a sense of belonging by promoting meaningful interactions among individuals and groups that derive from different positions, traits, perspectives and experiences (Metzger et al., 2020a).

Inclusive learning environments for nursing students that considers the defining attributes of the clinical learning environment, including the physical space, organisational culture, psychosocial and interaction elements support students learning associated with the learning outcomes specified by the university (Flott & Linden, 2016). Inclusivity is valuable to students as it results in positive effects such as a sense of belonging in the clinical learning environment resulting in increased confidence, satisfaction and self-efficacy that promotes learning in the clinical setting (Metzger et al., 2020b). The outcome is that students feel part of the health care team promotes a psychologically safe space to speak up.

Our participants described experiencing challenging professional relationships, stressors, and fears during their clinical placement. Given

that this is a consistent finding over time (Courtney-Pratt et al., 2018) there is a critical need for intentional actions by health care staff that promote inclusivity and a requirement that the organisation's culture needs to embrace students in the clinical setting. Setting them up to have a successful learning experience through various preparatory activities adds value to a student's ability to contribute to overall healthcare (Chicca & Shellenbarger, 2020). Students perceive themselves and are often treated as inferior within the health care team. Embracing positive interactions that negate students' perception of inferiority and demonstrate acknowledgement and appreciation of their value to the team will enable them to contribute to preventing patient harm. Furthermore, there are challenges determining the balance between giving students varied learning experiences across many healthcare services, verses maintaining a consistent experience in a single setting that gives the students the opportunity to belong and included as a valued team member.

Health care professionals who demonstrate inclusive behaviours are approachable and relatable showing behaviours that reflect strong team values to the students, and investment in their learning experiences. Simple, inclusive measures include learning students' names and connecting with them, such as gaining knowledge about their background and interests in nursing. Other inclusive behaviours include health care professionals engaging in storytelling about nursing practice and extending student learning by organising and promoting student and health care professionals' all-inclusive group activities (Metzger & Taggard, 2020).

Students are fearful of, and disconnected from the leadership during the placement. Leadership that ensures inclusivity requires a team approach. Thus, skilled facilitators who identify and promptly address discrimination foster inclusive clinical learning environments. Inclusivity requires a top-down approach and a flattening of the hierarchy through inclusive statements such as 'we are a team, and we are learning together

with a goal that promotes patient and personal safety and positive outcomes' (Chicca & Shellenbarger, 2020, p.229). These strong statements will reflect inclusivity towards students in the clinical learning environment, demonstrating care and respect for the student and promoting that sense of belonging and psychological safety during the placement experience.

A safety culture allows the student to perceive that mistakes in practice can occur without the fear of retribution. Early and open communication from people in leadership positions, such as an educator, helps ease students' fear of the unknown by establishing a trusting environment and professional relationship before the commencement of the placement (Chicca & Shellenbarger, 2020). A practical approach to cultivating a safety culture requires a change-orientated approach to leadership that should promote innovation and change amongst the health care team. The leaders need to monitor the environment for opportunities or threats, foster a climate that envisions change, and encourage people in inferior positions, such as students, to challenge and take risks. Change-orientated leadership increases team members' psychological safety (Remtella et al., 2021).

Effective communication that promotes students' psychological safety and sense of inclusion can be as simple as using the student's name rather than 'the student', demonstrating the notion of respect toward the student. Inclusivity through respect can be shown further through even and positive tones in voice and honest and supportive responses through a personal connection such as eye contact, smiling and acknowledgement through nodding (Chicca & Shellenbarger, 2020). Health care professionals who concentrate on what is being said by the student and not focusing on what will be said next practice active listening. To address students concerns about not being heard, closed-loop communication and direct responses to the student, evidence of reflection on what the student says will acknowledge the student.

Health care professionals embracing and supporting the student through purposeful, inclusive behaviours demonstrates a position of acknowledgement and respect for the student as part of the health care team. Increasing students' sense of belonging and clarifying the safety culture of the clinical learning environment enables them to predict the possible responses to students speaking up, giving them a sense of agency and psychological safety. Inclusive behaviours and learning experiences impact beyond the placement influencing students' aspirations for future career paths. Students with positive, inclusive learning experiences during their clinical placement may be more willing to return to the healthcare setting for future placements and potentially post-graduation employment and impact long-term workforce retention.

6.3.2 Implications for Education

This study highlights the need for multi-dimensional approaches to education that considers the students challenges and experiences associated with the socio-cultural complexities in the healthcare system that enables students to speak up and prevent patient harm. Patient safety and assertive communication education are essential to supporting students to enable nursing students to speak up and prevent patient harm. Currently, there is no evidence of a standardised approach to patient safety, speaking up, or assertive communication teaching and learning throughout nursing programs nationally and internationally (Lee et al., 2016; Mansour et al., 2020; Steven et al., 2014; Tregunno et al., 2014; Usher et al., 2018). Standardisation of patient safety curricula in pre- registration nursing courses nationally will result in an agreed and expected understanding of nursing students' knowledge, skills and attitudes about patient safety and speaking up in the clinical setting. This will generate an agreed expectation relating to nursing students' roles and responsibilities in maintaining patient safety and speaking up to prevent patient harm.

Students transitioning to the clinical placement setting expressed confusion and difficulty assimilating the knowledge learned in the tertiary education setting with practice in the clinical learning environment. The development of a nationally standardised approach to pre-registration nursing curricula on patient safety education and students' strategies in speaking up will assist students in preventing patient harm. Learning in the clinical setting aims to enable students to develop and consolidate knowledge skills and attitudes to care for people and prevent harm. The students experienced increased concerns about their health and well-being and the safety of patients. While the WHO Patient Safety Curricula Guideline gives direction, there is little evidence that the guide is utilised in curricula (Kirwan et al., 2019). Clear direction, content and implementation of patient safety teaching and learning should aim to enable students to transfer patient safety and speaking up competence in the clinical learning environment to maintain patient safety.

In Australia, the curriculum accrediting body stipulates that pre-registration nursing courses are required to provide evidence that the students learning includes the National Quality and Safety Health Service Standards, Aged Care Quality Standards, and the Nursing and Midwifery Board of Australia Registered Nursing Standards (ANMAC, 2019). However, nursing education providers do not have a standardised approach to safety learning outcomes and delivering a patient safety content within the curriculum (Usher et al., 2018). Therefore, students and health care staff do not have agreed safety expectations associated with the students' responsibilities and actions to maintain patient safety. There are calls for more significant distinction and increasing the recognition and importance of safety content and learning (Jones et al., 2021; Mansour, et al., 2018; Usher et al., 2018). Reviewing national guidelines for nursing education and how students learn about patient safety will clarify the current position of students learning and safety curricula across Australia. Therefore, giving direction and scope for improving safety curricula and standardising the

safety knowledge. Undertaking national benchmarking of accredited Australian pre-registration nursing programs patient safety curriculum should focus on strategies and interventions in patient safety content. This includes benchmarking assertive communication education and students learning about speaking up within curricula will provide information and direction where there are strengths, gaps and issues in current safety teaching and learning.

Nursing educators lack knowledge and experience in safety curricula (Jones et al., 2021) and so to effectively benchmark, experts in patient safety knowledge need to drive the project that reviews the evidence of safety learning in curricula. The review needs to include information relating to the qualifications and experiences of the educators demonstrating a level of expertise in safety knowledge and experience. Building faculty capacity who are experts in experiences and expertise in patient safety education is incremental to developing and integrating patient safety learning in curricula (Mansour et al., 2018). Specialised patient safety educators will strengthen curricula development scaffolding integrated patient safety learning. Furthermore, the regulatory, organisational and professional bodies need to consider how patient safety knowledge is translated and enacted in the clinical setting. A review of what changes are required from currently approved curricula needs to enable students to speak up to prevent patient harm during the clinical placement experience.

It is necessary to determine what patient safety learning and knowledge is essential prior to students first clinical placement to support their ability to maintain patient safety. This study's findings agree with Mansour et al. (2018), that students require knowledge associated with the complexities of the socio-cultural dynamics in the clinical placement setting. Patient safety education needs to consider the potential dynamics and interaction between the wider-socio-economic-political system and the transition from education to the clinical setting (Jones et al., 2021).

Learning about clinical placement nuances such as hierarchical tendencies and interprofessional communication should aim to reduce the disparities in the clinical placement experience and reduce students' feelings of inferiority and isolation (Hanson et al., 2020).

Nursing curricula development has been consistently recognised as challenging for academics due to the constant issues associated with prioritising content in an over-packed curriculum (Mansour et al., 2018). There is a shift in the thinking and prioritising of patient safety in curricula for the future nursing workforce. Hence, prioritising patient safety curricula as a stand-alone unit of study would be impractical and against the directive of the WHO Safety curricula guidance and direction (WHO & WHO Patient Safety, 2011). The accrediting body of Australian nursing curricula require clear evidence safety is a priority that is scaffolded throughout the students learning (ANMAC, 2019). Therefore, curricula development requires a clear framework for understanding the components of patient safety knowledge and skills for students to speak up to prevent patient harm. Curricula should focus on enabling and empowering the student to have confidence to prevent patient harm successfully.

Learning experiences that positively engage students in critical conversations about patient safety allows them to explore and practise speaking up in various scenarios (Hémon et al., 2020). Practising these conversations will help students resolve issues relating to confidence to advocate for patient safety. Learning about safety that focuses on socio-cultural issues needs to be an immersive and authentic experience that can translate to clinical placement. Simulation has already proven to be an effecting immersive learning experience across health disciplines (Peadon et al., 2020). Further development in learning that focuses on common and real problems that situate the student in the setting will increase the authenticity of the learning experiences.

Engaging situation-based learning through a problem-based approach to learning is considered an established and effective approach to learning. While curricula need to adhere to many learning styles, problem-based learning has been identified as an approach that fosters the development of critical thinking and perseverance (Seibert, 2021). Furthermore, educators must consider that different generations have different needs in learning associated with unique circumstances they grew up with including economic, social and cultural conditions effecting their perception of formal learning. For example, generational differences in learning as some generations are known to be inexperienced with higher-order critical thinking and tend to step aside from challenges while other generations are known to be independent, self-directed, open-minded and comfortable with authority (Seibert, 2021).

The supposition for educations providers and clinical educators determined that skill acquisition alone is not enough to enable students to speak up safely. Students learning needs to extend beyond developing assertive communication and speaking up skills that consider the clinical learning environment and the socio-cultural nuances of the healthcare organisation. There is a need to create authentic learning experiences that correlate with the socio-cultural elements of the healthcare organisation is challenging (House et al., 2016). The World Health Organisation Patient Safety Curriculum Guide: Multi-Profession Edition (2011) provides clear direction for students learning about patient safety, human factors, understanding, managing and learning from clinical risks and errors, collaboratively managing risk as part of the health care team and including patients and carers when mitigating risk. While students learn about infection control, medication management and invasive procedures, curricula need to build learning about safety aspects and risks need to be obvious and exploited as learning opportunities (WHO, 2011). Students in this study would benefit from that information extending and focusing on

the diversity of rural and regional healthcare settings and the associated issues students may experience during these clinical placements.

6.3.3 Implications for Research

The study findings highlight the critical need for research that looks for ways to reduce students' distress and dissonance during the clinical placement learning experience. Currently, there is no consistent approach to supporting students with patient safety during their clinical placement. Research to determine the most effective support strategies and consistency in support and supervision could result in the healthcare setting having an approach that assists in workforce planning and staffing in the rural health setting. An adaptable approach will help the education providers and rural clinicians to prepare and thus enable students to have psychological safety and the confidence to speak up during the clinical placement experience.

Research needs to examine current Australian pre-registration nursing programs strategies to supervise and support students speaking up during clinical placement in rural and regional healthcare settings. Supervision and support during the placement varied according to the healthcare organisations' placement agreement with the respective university. Students feeling unsupported and vulnerable in the healthcare setting has been a constant issue that has been reported for more than a decade (Courtney-Pratt, 2018; Jack et al., 2021; Levett-Jones et al., 2008). This study did not aim to review the impact of support or supervision on student confidence or speaking up behaviours. However, there is evidence that the lack of support continues to impact students speaking up behaviours negatively. Investigation relating to the impact of the various modes of student support provided during rural clinical placement experiences will inform clinical placement organisations and education providers about aspects that require review and improvement in supporting students during clinical placements.

Further research is required to explore the most effective approach to students' supervision during the placement and the impact on their psychological safety and confidence in speaking up. Due to the variance in the approaches to supervision and support across the placement settings, there is a gap in understanding which supervision approach is most beneficial to students' psychological safety and confidence in speaking up. The approach to clinical supervision impacts students' professional relationships. Limited supervision creates uncertainty and a lack of direction for students resulting in the students being confused and unsure of the expectations and requirements for students to speak up and prevent patient harm.

Placement supervisors providing support to students have been acknowledged as buffers reducing the impact of negative behaviours towards students in unsupportive negative cultures (O'Mara et al., 2014). A conceptual model developed by Cant et al. (2021), of clinical placement supervision, identifies elements conducive to nursing students' learning and clarifies understanding of the complexities associated with student placement supervision. The model acknowledges the responsibility of the health service to support health facility staff working with students and effectively evaluate and report on the student placement learning experience. Application of the model and research that focuses on the rural healthcare sector approach to clinical supervision and support would inform rural clinical placement settings of the best strategies to support and enable students undertaking rural clinical placements. This would give attention to determine the best student support model for rural healthcare settings that acknowledges the realities of rural workforce challenges and socio-cultural dynamics.

The rural healthcare facility management overseeing student placements need to provide supervision that gives the students clarity and

direction about safety and their responsibilities during the placement. The facility's supervisor should offer peer learning opportunities that ensure a safe learning environment and provides mechanisms that enable reporting and role models best practice for nursing (Cant et al., 2021). Issues associated with students' confidence and sense of belonging continue, coupled with the continued staffing and resourcing concerns in rural health organisations. The rural placement RNs should be provided with education and training on how to effectively support students during. Education and training need to consider the associated challenges of the time constraints, distance and travel to attend education (Bowen, Kable & Keatinge, 2019).

In rural healthcare, clinician staffing resources are limited, and clinicians undertaking the role of preceptors for students create further resource constraints and challenges. These are associated with supervisors who are not trained or specialised in supporting students during placements in these rural learning environments (NSW Parliament Legislative Council, 2022; Salifu et al., 2018). What is not evident and what future research could determine is how the limited supervision, support and resources present in the rural setting impacts students' ability to transfer knowledge and speaking up behaviours in the Australian rural healthcare setting. An assessment that provides better understanding of the resources and expectations in each setting will inform what extra support specific to rural placements providers may be necessary to enable students. The outcome may inform funding bodies what additional resources are necessary to effectively support students. Students' positive placement experiences could also assist in retaining a rural workforce.

The current fragmentation of knowledge development and the transfer of knowledge skills and attitudes to the clinical placement setting leaves the students bewildered and dissonant. Investigation into the transfer of knowledge skills and attitudes that focus on patient safety and speaking up from the education provider context to the clinical placement

setting requires assessment and evaluation. Investigating students' preparedness to progress to clinical placement, their foundational knowledge and understanding of associated risks to patient safety, and their professional responsibilities to prevent patient harm will inform future curriculum development. Developing an understanding of the processes and abilities of students to transfer knowledge and demonstrate patient safety competence requires focused investigation. The review of patient safety education research revealed inconsistencies in the effectiveness of educational interventions. There is evidence that education providers are challenged by delivering an authentic learning experience that reflects the nuances of the people and culture of the clinical placement environment. While some research identified that student confidence increases as they progress through their studies, there remain gaps in evaluating a student's ability to transfer knowledge and skills, such as speaking up in the clinical placement setting (Guinea et al., 2019; Hanson et al., 2020).

Previous research suggests the theory-practice gap and practice that potentially obstructs nursing practice and patient safety is a resonating theme in nursing education (Lee, 1996; Salifu et al., 2018). While the current study did not aim to assess or clarify students' ability to transfer knowledge to the rural clinical placement setting, the students experienced rural and regional placements with similar conditions described in Salifu et al.'s (2018) study. Evaluating patient safety risks could be informed by investigating students' capacity to transfer their learning from the education setting to the rural clinical setting and their ability to assess, determine and detect patient safety risks and execute safety acts across year levels of nursing programs.

It is essential to give students a positive learning experience in rural clinical settings to enhance recruitment and retention in the health sector and potentially assist the continued staff resourcing crisis. Students in the rural setting have the potential for increased patient safety risks related to

staffing shortages and increased expectations of students by expecting students' workload to be similar to full-time staff workload (Dahlke & Hannesson, 2016; Killam & Heerschap, 2013). The pressures with limited support for students decrease students learning and increases the risk of patient harm. Additionally, the rural clinical learning environment will have a better understanding and expectations of the student's patient safety knowledge, gaps in knowledge and patient safety capabilities. Developing a better understanding of the best support and supervision approaches for students will assist to provide students with positive placement experiences, increasing the likelihood of prospective employment interest once students graduate.

6.3.4 Implications for Policy

Healthcare policy needs to support strategies that address and improve students' sense of belonging, being part of and contributing to the health care team, being listened to and responded to, and valued. The policies need to define and delineate the students' responsibility concerning patient safety and speaking up to prevent patient harm needs to be clarified. Healthcare policy that promotes inclusivity involves the planned and purposeful incorporation of methods and efforts that foster an awareness of students' fitting in and requires encouraging meaningful collaborations and relations among students and health care staff. These interactions need to respect the different perceptions and experiences of the students and the staff who work alongside the students (Metzger et al., 2020). Implementing a policy that promotes purposeful inclusion will make students and health care workers feel like they belong. Inclusivity leads to students being valued and respected health care team members, having a sense of agency, and being psychologically safe to speak up and prevent patient harm. A review of the current Australian patient safety policies and standards needs to identify nursing students' roles and responsibilities in maintaining patient safety and speaking up to prevent patient harm.

Health care professionals must adhere to Standards of Practice and healthcare policies to prevent patient harm (NMBA, 2016). The policies associated with students' position and responsibility to maintain patient safety and actions to prevent patient harm require reviewing and modification. Tackling underlying issues and errors in health care requires robust reviewing and revising how the systems that impact the quality of care, how policies are designed and how individuals interact and collaborate within the healthcare system. Resolutions may vary significantly depending on the issue, the severity, and the resources available such as finances, time and personnel accessible to address the problems. Health service organisations use risk management processes that develop, review and maintain current and effective policies, procedures and protocols. They monitor and take action to improve adherence to these safety directives and ensure they comply with legislation, regulation and jurisdiction requirements. Reviews of the effectiveness and currency of the policies are undertaken through organisational audits and performance reviews and adapting and responding to regulatory changes, compliance issues and case law (ACSQHC, 2022). However, the nursing students' position concerning their roles and responsibility to maintain patient safety is not evident in these policies.

Socio-cultural safety is prominent in healthcare policies and protocols that focus on respect in the workspace, and collaborative multidisciplinary care in the workplace. Currently, there are gaps in the policies that embrace students as part of the health care team and actions that promote students' psychological safety. An appropriate systems approach to maintaining and improving safety requires focusing on the inclusion of students and their challenges associated with the socio-cultural aspects of health care. Generally, these focus on protocols for routine high-risk issues in health care, such as medication administration and communication errors (ACSQHC, 2022).

Leadership and organisational governance that formally recognises students as part of the health care team and their responsibilities in maintaining patient safety will aid transparency when students consider speaking up to prevent harm. Health care employees work under policies that promote a culture of safety in the everyday work environment. They provide guidelines that direct and encourage health care workers to report, address and analyse errors to identify underlying issues without psychological safety risks. Reports and protocols direct health care employees to engage in a culture of safety that results in all team members feeling psychologically safe in the workspace. However, to maintain a culture of safety, there needs to be organisational governance and strong leadership that promotes the culture of safety and fosters an intolerance for behaviours that discourage students who have concerns about the risk of speaking up and preventing patient harm.

The safety culture in which most of students in this study undertake clinical placement adheres to recommendations by the Clinical Excellence Commission, which guides to assist teams and organisations in undertaking valid and reliable safety culture measurement and reporting. The Commission offers a questionnaire for staff to complete about safety attitudes relating to frontline perspectives of the safety culture of the area. It lists many health disciplines and administrative and organisational support for employees (NSW Government, 2022). Currently, there is no reference to nursing students, and should a nursing student complete the form, they would be at the bottom of the list and defined as 'other'. Healthcare services are constantly saturated with students undertaking a placement in the workspace and students are considered a significant part of the workforce. However, this lack of acknowledgement in policies and guidelines demonstrates that nursing students are not infinitely represented, valued, or deemed relevant to evaluations of healthcare organisational safety cultures.

Healthcare organisations' education and training relating to safety policies and protocols and safety culture need to take an inclusive approach to ensure the students and the health care workers have clarity and understanding of the students' safety responsibilities. Periodical reviews of the policies ensure they align with state and territory safety requirements and reflect current evidence and best practice. Furthermore, it is essential that alignment is maintained with the safety education and training clarifying students' obligations about their responsibilities to maintain safety and speak up as they progress through their nursing studies. However, in Australia education and training of health care staff and nursing students are funded under different financial bodies. Health service provision and staff education and training are under State funded while nursing education and student are the responsibility of, and funded by the Commonwealth government (Australian Government Department of Health, 2022). The dissociation between what level of government support for student education and health care delivery funding potentially contributes how students are supported and the lack of support and acknowledgement of student roles in state funded health services.

Psychological safety is an essential and conceptually sound construct often cited in healthcare policies that focus on developing and maintaining a safety culture (ACSQHC, 2019). Incident reporting systems keep records on organisations' non-compliance with policies, procedures and protocols, which inform quality improvement and organisational planning. A focus on organisational standards and the development of specific criteria relating to students' clinical placement experiences across the healthcare settings will inform the gaps and issues students experience. Documentation through incident reporting will advise on the effectiveness of current processes relating to students' experiences leading to the development of organisational strategies and policies that promote inclusivity and clarify students' responsibilities in speaking up to prevent patient harm.

Policies that aim for an inclusive approach and clearly define students' expectations and responsibilities in a supporting safety culture when transitioning will inform health care workers of their duties to support students when they take action to prevent patient harm. Transparency associated with the desire for a safety culture within policy development review will improve the inclusivity of students and, in turn, improve students' sense of agency and psychological safety. The policy review and development changes will alter the students' position and perspectives and will increase students' likelihood of speaking up to prevent patient harm.

In summary, this chapter has presented four premise statements that explain the complexity of students speaking up in the healthcare setting. Students' experiences are influenced by socio-cultural constructs impacting their safety behaviours. Their perceptions and speaking up behaviours change as they progress and interact in the clinical environment. The rural clinical setting offers students different challenges associated with their interactions and the support they receive during the placement. However, it is not possible to predict what those changes look like and if students speaking up will increase or decrease as they progress through their course. The students' identity is molded through their placement experience and interactions with health care staff and placement supervisors. Students' identity and confidence in health care influence their speaking up behaviours.

6.4 Limitations of the study

This study focused on nursing students speaking up in the rural and regional healthcare setting. The focus of the discussion relating to students observing patient safety risks and experiences is a confronting topic for them to discuss. There is a possibility that students' fear carried through to the interviews leading to students restricting what they share or choosing not to participate in the study.

The study recruited participants from two NSW universities. The student conversations about patient safety learning experiences reflect the curricula from just those universities. Therefore, other universities may teach students patient safety which may differently impact students' behaviours. This limitation is confirmed by Mansour (2018) and Usher et al. (2018) that there is no standardised approach to safety curricula. The finding references a gap in students' knowledge when transitioning from education to clinical settings. We did not aim to measure students' knowledge transfer to practice; evaluation of the gap in knowledge may inform if this influenced their speaking up behaviours. Furthermore, there needs to be a focus gaining a greater understanding of the perceived theory-practice gap students experience focusing on the transfer of safety knowledge to the clinical setting.

While not a focus of this study, it is possible that international nursing students may also bring different individual factors to the health care team impacting speaking up behaviours. Further research exploring international students' experiences in rural healthcare services and their transfer of knowledge to the clinical setting will inform education and health care providers valuable information that will enable better support of international students in these settings. Gaining an understanding of the diversity in international students learning and placement experiences will inform education and clinical placement providers information that will enable better support for students to engage in patient safety behaviours.

6.5 Conclusion

In conclusion, this study has explored the phenomenon of nursing students' perceptions and experiences of speaking up to maintain patient safety in clinical placement settings. The study findings make a valuable contribution to understanding how to improve student speaking up behaviours during their clinical placement experiences that decreases the

risk of patient harm in rural healthcare settings. The findings challenge the preconceptions that students speaking up behaviour relates largely to learning about assertive communication, and their speaking up behaviours increase as they progress through their course. The findings illuminate the unpredictable trajectory of students' speaking up behaviours. Students' speaking up behaviours and responses to safety risks are socially constructed and are influenced by their experiences in practice and the safety culture in the healthcare setting. Students' rural placement experiences lack of support and resources negatively impacts students speaking up behaviours increasing the risk of patient harm. The lack of inclusivity in the safety culture and students' psychological safety concerns results in students developing strategies to mitigate risk and gain a sense of agency when speaking up. Nursing students should be valued as change agents that will help improve inclusivity in the safety culture in the clinical environment, reducing the risk of harm in future healthcare environments. Without urgent attention from education and clinical placement providers, the situation will not improve for students who will remain fearful, conflicted and without agency to prevent patient harm.

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APPENDIX

APPENDIX A: Participant information sheet

School of Health
University of New England
Armidale NSW 2351
Australia
Phone 02 6773 3644
Fax 02 6773 3666

INFORMATION SHEET
for
Participants

I wish to invite you to participate in the research project described below.

My name is Anthea Fagan and I am conducting this research as part of my PhD in the School of Health at the University of New England. My supervisors are Professor Vicki Parker and Dr Jackie Lea

Research Project	**Pre-registration nursing students speaking up for patient safety; a qualitative study.**
Aim of the research	The research aims to explore pre-registration nursing students' perceptions and experiences of speaking up for patient safety.
What will you be asked to do?	You are invited to participate, in this study because you are enrolled in a pre-registration Nursing program at the University of New England or the University of Newcastle. You may participate in the study by agreeing to participate in 1. An individual interview of 40- 60 minutes, or 2. A focus group with peers (approx. 60 minutes), or Both 1 and 2 above. Should you choose to participate the interviews and focus groups will take place at your university or clinical placement setting in a private space. With your permission, the discussion will be audio recorded.
Interviews and Focus Groups	The interviews will explore your individual perceptions and feelings relating to experiences of speaking up to prevent errors in the clinical setting. The focus group discussions will explore perspectives from different year groups of students (1st, 2nd and 3rd year) at the various stages of your study.
Confidentiality	Any personal details gathered in the course of the study will remain confidential. No individual will be identified by name in any publication of the results. If you agree, I would like to quote some of your responses from this discussion in my findings. Pseudonyms will be assigned to replace student names, so you will not be identified.
Participation is Voluntary	Please understand that your involvement in this study is voluntary and you may withdraw from the study at any time without having to provide an explanation. If you withdraw from the study having participated in the focus group, you will not be able to withdraw your conversation that has formed part of the larger group conversation.
Potential distress	Some questions posed during the interviews or focus groups discussion may result in participants having a feeling of discomfort or unease due to the nature of the discussion focusing on challenging situations or experiences. Participants will be reminded before the commencement of the conversation that should they disclose illegal behaviour then I as the researcher have an

	obligation to report such information as per the university's student misconduct reporting processes. Should participation in the conversation cause you any distress, and you feel you require further support you will be provided with the contacts for the University counselling service. The contact names and telephone numbers for the local services should they be needed; UNE **Medical** Centre (6773 2916) and UoN Community Health Centres including; Central Coast Youth Health Services, Wyong (4356 9333). Port Macquarie Community Health Centre (6588 2731), or the Universities counselling services for each University (UNE - 6773 2897 and UoN - 4921 6622), and Lifeline Australia on 13 11 14.
Use of information	Information drawn from the interviews and focus groups will be reported as part of my doctoral thesis, which I expect to complete in January 2021. The study findings will also be published in journal articles and conference presentations. At all times, I will safeguard your identity by presenting the information in a way that will not allow you to be identified.
Storage of information	I will keep hardcopy notes and recordings of the interview in a locked cabinet in my office at the University of New England's School of Health. Any electronic data will be kept on a password-protected computer in the same School. Only the research team will have access to the data.
Disposal of information	All the data collected in this research will be kept for a minimum of five years after successful submission of my thesis, after which it will be disposed of by deleting relevant computer files, and destroying or shredding hardcopy materials.
Approval	This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No HE16-293 Valid to 01/02/2018).
Contact details	Feel free to contact me with any questions about this research by email at afagan2@une.edu.au or by phone on 02 6773 3657. Alternative for de-identified enquiries, please email cchant@une.edu.au, who will forward your enquiry. You may also contact my supervisors'. My Principal supervisor's name is Professor Vicki Parker she can be contacted at vparker3@une.edu.au and my Co-supervisors name is Dr Jackie Lea, and she can be at jlea2@une.edu.au.
Complaints	Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at: Mrs Jo-Ann Sozou Research Services University of New England Armidale, NSW 2351 Tel: (02) 6773 3449 Email: ethics@une.edu.au Thank you for considering this request. Regards, Anthea Fagan

APPENDIX B: Ethics Approval

University of New England, Armidale

Ethics Office
Research Development & Integrity
Research Division
Armidale NSW 2351
Australia
Phone 02 6773 3449
Fax 02 6773 3543
jo-ann.sozou@une.edu.au
www.une.edu.au/research-services

HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM TO: Prof Vicki Parker, Dr Jacqueline Lea & Ms Anthea Fagan

School of Health

This is to advise you that the Human Research Ethics Committee has approved the following:

PROJECT TITLE:	Pre-registration nursing students speaking up for patient safety; a qualitative study
APPROVAL No.:	HE16-293
COMMENCEMENT DATE:	01 February, 2017
APPROVAL VALID TO:	01 February, 2018
COMMENTS:	Nil. Conditions met in full

The Human Research Ethics Committee may grant approval for up to a maximum of three years. For approval periods greater than 12 months, researchers are required to submit an application for renewal at each twelve-month period. All researchers are required to submit a Final Report at the completion of their project. The Progress/Final Report Form is available at the following web address:
http://www.une.edu.au/research/research-services/rdi/ethics/hre/hrec-forms

The NHMRC National Statement on Ethical Conduct in Research Involving Humans requires that researchers must report immediately to the Human Research Ethics Committee anything that might affect ethical acceptance of the protocol. This includes adverse reactions of participants, proposed changes in the protocol, and any other unforeseen events that might affect the continued ethical acceptability of the project.

In issuing this approval number, it is required that all data and consent forms are stored in a secure location for a minimum period of five years. These documents may be required for compliance audit processes during that time. If the location at which data and documentation are retained is changed within that five year period, the Research Ethics Officer should be advised of the new location.

Jo-Ann Sozou
Secretary/Research Ethics Officer

University of Newcastle

HUMAN RESEARCH ETHICS COMMITTEE

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	**Dr Vicki Parker**
Cc Co-investigators / Research Students:	**Ms Anthea Fagan**
Re Protocol:	**Pre-registration nursing students speaking up for patient safety: a qualitative study**
Date:	**04-Sep-2017**
Reference No:	**H-2017-0105**
Date of Initial Approval:	**04-Sep-2017**

Thank you for your **Response to Conditional Approval (minor amendments)** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under **Expedited** review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is **Approved** effective **04-Sep-2017**.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. *If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.*

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request. Your approval number is **H-2017-0105**.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for *Monitoring of Progress*, *Reporting of Adverse Events*, and *Variations to the Approved Protocol* as detailed below.

PLEASE NOTE:
In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- ***Monitoring of Progress***

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment,

of annual progress reports. You will be advised when a report is due.

- ***Reporting of Adverse Events***

1. It is the responsibility of the person **first named on this Approval Advice** to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form (via RIMS at https://rims.newcastle.edu.au/login.asp) within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
    - Causing death, life threatening or serious disability.
    - Causing or prolonging hospitalisation.
    - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
    - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
    - Any other event which might affect the continued ethical acceptability of the project.

5. Reports of adverse events must include:
    - Participant's study identification number;
    - date of birth;
    - date of entry into the study;
    - treatment arm (if applicable);
    - date of event;
    - details of event;
    - the investigator's opinion as to whether the event is related to the research procedures; and
    - action taken in response to the event.

6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

- ***Variations to approved protocol***

If you wish to change, or deviate from, the approved protocol, you will need to submit an *Application for Variation to Approved Human Research* (via RIMS at https://rims.newcastle.edu.au/login.asp). Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. **Variations must be approved by the (HREC) before they are implemented** except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

Linkage of ethics approval to a new Grant

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Associate Professor Helen Warren-Forward
Chair, Human Research Ethics Committee

For communications and enquiries:
Human Research Ethics Administration

Research & Innovation Services
Research Integrity Unit
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 17894
Human-Ethics@newcastle.edu.au

RIMS website - https://RIMS.newcastle.edu.au/login.asp

Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Grant Ref

APPENDIX C: Consent form

Interviews

School of Health
Armidale NSW 2351
Phone 61 2 6773 3340
Fax 61 2 6773 3666
Email: afagan2@une.edu.au

Consent Form for Focus Groups Participants

Research Project: Pre-registration nursing students speaking up for patient safety; a qualitative study. Ethics Approval Number (HE16-293)

I, ..., have read the information contained in the Information Sheet for Participants and any questions I have asked have been answered to my satisfaction.	Yes/No
I agree to participate in this activity, realising that I may withdraw at any time.	Yes/No
I agree that research data gathered for the study may be quoted and published with my identity de-identified.	Yes/No
I agree to the focus group conversation being audio recorded and transcribed.	Yes/No
I understand some of the conversations may be challenging or upsetting.	Yes/No
I understand that any information disclosed during the conversation that is possible misconduct or is unlawful; it is the researcher's duty to report this information according to university policy.	Yes/No
I am 18 years of age or older	Yes/No

....
Participant Date

....
Research assistant Date

Focus Groups

School of Health
Armidale NSW 2351
[redacted]

Consent Form for Interview Participants

Research Project: Pre-registration nursing students speaking up for patient safety; a qualitative study. Ethics Approval Number (HE16-293)

I, ..., have read the information contained in the Information Sheet for Participants and any questions I have asked have been answered to my satisfaction.	Yes/No
I agree to participate in this activity, realising that I may withdraw at any time.	Yes/No
I agree that research data gathered for the study may be quoted and published with my identity de-identified.	Yes/No
I agree to the interview conversation being audio recorded and transcribed.	Yes/No
I understand some of the conversations may be challenging or upsetting.	Yes/No
I understand that any information disclosed during the conversation that is possible misconduct or is unlawful; it is the researcher's duty to report this information according to university policy.	Yes/No
I am 18 years of age or older	Yes/No

....
Participant Date

....
Research assistant Date

APPENDIX D: Citations

Concept Analysis Publication Citations

Aynaci, G., & Guscu, Z. (2018). Evaluation of the perception of patient safety competencies: A cross-sectional study in undergraduate nursing students in Turkey. *Science Conference*, p.414.

Brown, P. (2022). *Nursing students' raising concerns in clinical practice: A grounded theory study of the mentor-student dynamic* (Doctoral dissertation), Cardiff University, UK.

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Yuliana, Y., Hariyati, R. T. S., Suryani, C. T., & Azis, H. (2021). Metode Speak Up untuk Meningkatkan Interprofesional Collaboration Practice. *Jurnal Keperawatan Silampari*, *5*(1), 309-323.

<u>Findings paper 2: Students Stratergies in Speaking up citations</u>

Bagnasco, A., Zanini, M., Catania, G., Aleo, G., Turunen, H., Tella, S., ... & Steven, A. (2022). Learning From Student Experience: Development of an International Multimodal Patient Safety Education Package. *Nurse Educator*, *47*(4), E75-E79.

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APPENDIX E: NETNEP 2018

7th International Nurse Education Conference: Banff, Canada.

Friday, April 17, 2020 at 2:40:48 PM Australian Eastern Standard Time

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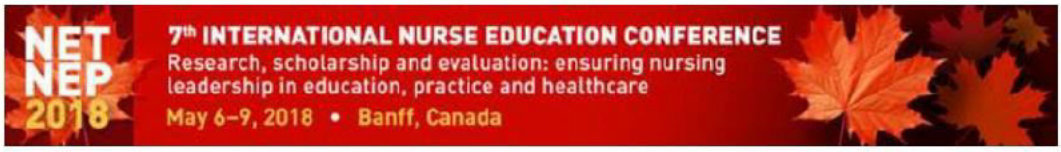
Subject: 7th International Nurse Education Conference
Date: Wednesday, 15 November 2017 at 5:03:48 pm Australian Eastern Daylight Time
From: Content-NETNEP2018
To: Anthea Fagan
Attachments: image001.jpg



Oral Acceptance Letter

ABSTRACT REFERENCE NUMBER: **NETNEP2018_0759**(Please quote in all correspondence)

15 November 2017

Dear A. Fagan,

Thank you for submitting a paper to present at the "**7th International Nurse Education Conference**". On behalf of the Organising Committee, I am delighted to inform you that your abstract entitled **Speaking up to maintain patient safety in the clinical setting: Australian pre-registration nursing students' experiences, willingness and capacity**, has been accepted for an **Oral presentation** at the conference. Abstracts of a very high standard were submitted for the conference and we believe we have selected an excellent mix of abstracts to address the conference themes. We very much look forward to your presentation.

Details of your Abstract are as follows:

Title:	Speaking up to maintain patient safety in the clinical setting: Australian pre-registration nursing students' experiences, willingness and capacity
Authors:	A. Fagan, V. Parker, J. Lea
Presenting Author:	A. Fagan*

Please check the above details of your presentation carefully as all conference material will be printed with this information, the name with the * indicates the presenting author. If there are any corrections, please inform me as soon as possible by email to Content-NETNEP2018@elsevier.com. Should the addressee above not be the nominated presenter, please inform me of the name and email address of the presenter immediately at Content-NETNEP2018@elsevier.com.

You will be informed in a separate email about the scheduling of your presentation, and you will be given a final program at the conference. However please bookmark the conference web-site at https://www.elsevier.com/events/conferences/international-nurse-education-conference to keep up-to-date with changes as they occur.

It is a condition of abstract acceptance that you or a nominated presenting co-author registers for the conference by the author registration deadline of **Monday January 29, 2018**. The abstracts of all unregistered presenters will be removed from the programme after this date.

Register as a 'New Customer' in the registration system if you haven't attended an Elsevier conference before.

Please register online using the following URL: http://conferences.elsevier.com/NETNEP2018?[redacted]&abstracts=0759

Please note that you will need to set up a different password for this system, as it is different from the abstract submission system.

Registration is available online using a credit card. Registration rates are as follows:

APPENDIX F: UNE Media Release

When lives depend on speaking up

Published 10 May 2018

Speaking up for patient safety can be difficult for nursing students on clinical placement, however lives may depend on it, as University of New England (UNE) lecturer Anthea Fagan outlined at the ...

Speaking up for patient safety can be difficult for nursing students on clinical placement, however lives may depend on it, as University of New England (UNE) lecturer Anthea Fagan outlined at the 7th International Nurse Education Conference in Canada this week.

Anthea, who lectures Bachelor of Nursing and Master of Nursing Practice students within the UNE School of Health, is undertaking a PhD on nursing students' perceptions and experiences of advocating for patients in the workplace. She was chosen from 950 applicants to present at the prestigious conference.

"Students asking questions, making statements of opinion or calling for a response is critical to patient safety," Anthea said from Banff. "They are challenged on a number of levels and may fear the consequences, which include negative impacts on their learning, failing their placement or being ostracised."

While on clinical placement student nurses are trying to fit into a new and unpredictable environment. Anthea is finding that their preparedness to advocate on behalf of patients and voice their concerns depends on their moral and ethical beliefs, willingness and level of confidence.

"Students' perceptions of themselves are key: some say 'I'm just a student', while others believe it's part of their job to speak up for patient safety," Anthea said. "The inferior position student nurses hold in the healthcare hierarchy creates tensions and challenges that impact their decisions and actions.

"I hope my research findings will ultimately be applied to learning and teaching, and workplace practice. Speaking up is the responsibility of all health professionals, students and registered practitioners alike. Students are our future healthcare workers and should feel safe to speak up. Ultimately, patient safety is the priority."

Anthea supports students on placement in her role as Clinical Coordinator Academic, and was inspired to conduct the research after hearing of their challenges. While previous studies have explored whistle-blowing or medical interns speaking up, this is the first research of its kind to focus on the experiences of nursing students.

"My aim is to improve the overall student learning experience, prevent errors in practice and keep patients safe," Anthea said. "I hope the research will also assist nursing education providers in their curriculum development and ensure that managers and student supervisors are better equipped to provide appropriate support for student nurses. We need to create a culture of safety that enables them to speak up."

The conference attracts over 500 nursing, midwifery and healthcare delegates from tertiary institutions and industry bodies. "I feel very privileged to be attending and meeting people with such a wealth of knowledge and experience from around the globe," Anthea said.

Contact: **UNE Media Team** | **+61 2 6773 2551** | **media@une.edu.au**

https://www.une.edu.au/connect/news/2018/05/speaking-up-is-the-best-treatment

APPENDIX G: NETNEP 2020

7th International Nurse Education Conference: Barcelona, Spain.

Friday, April 17, 2020 at 2:39:20 PM Australian Eastern Standard Time

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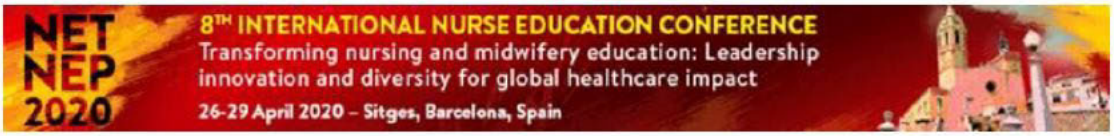
Subject: Oral Acceptance Letter - 8th International Nurse Education Conference
Date: Monday, 25 November 2019 at 8:35:21 pm Australian Eastern Daylight Time
From: Content-NURS2020 (ELS)
To: Anthea Fagan
Attachments: image001.jpg



Oral Acceptance Letter

ABSTRACT REFERENCE NUMBER: **NURS2020_0348**(Please quote in all correspondence)

25 November 2019

Dear A.K. Fagan,

Thank you for submitting a paper to present at the "**8th International Nurse Education Conference**". On behalf of the Organising Committee, I am delighted to inform you that your abstract entitled **Australian pre-registration student nurse tactics and strategies when speaking up for patient safety; what clinicians and educators need to know**, has been accepted for an **Oral presentation** at the conference. Abstracts of a very high standard were submitted for the conference and we believe we have selected an excellent mix of abstracts to address the conference themes. We very much look forward to your presentation.

If you are no longer able to attend and present at the conference in April, or do not wish to accept the presentation type that is being offered to you, please notify us as soon as possible in order to enable us to offer your slot to fellow presenters who may have been placed on a waiting list

Details of your Abstract are as follows:

Title:	Australian pre-registration student nurse tactics and strategies when speaking up for patient safety; what clinicians and educators need to know
Authors:	A.K. Fagan, J. Lea, V. Parker
Presenting Author:	A.K. Fagan*

Please check the above details of your presentation carefully as all conference material will be printed with this information, the name with the * indicates the presenting author. If there are any corrections, please inform me as soon as possible by email to Content-NURS2020@elsevier.com. Should the addressee above not be the nominated presenter, please inform me of the name and email address of the presenter immediately at Content-NURS2020@elsevier.com.

You will be informed in a separate email about the scheduling of your presentation, and you will be given a final programme at the conference. However please bookmark the conference web-site at https://www.elsevier.com/events/conferences/international-nurse-education-conference to keep up-to-date with changes as they occur.

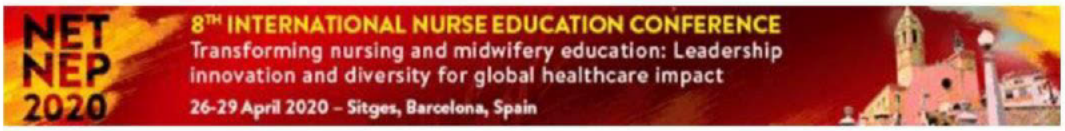
It is a condition of abstract acceptance that you or a nominated presenting co-author registers for the conference by the author registration deadline of **24 January 2020**. The abstracts of all unregistered presenters will be removed from the programme after this date.

Register as a 'New Customer' in the registration system if you haven't attended an Elsevier conference before.
Please register online using the following URL: http://conferences.elsevier.com/NURS2020?
[redacted]&abstracts=0315,0348
Please note that you will need to set up a different password for this system, as it is different from the abstract submission system.

Content-NURS2020 (ELS) 25 November 2019 at 8:59 pm

Poster Acceptance Letter - 8th International Nurse Education Conference

To: afagan2@une.edu.au



Poster Acceptance Letter

ABSTRACT REFERENCE NUMBER: **NURS2020_0315** (Please quote in all correspondence)

Dear A.K. Fagan,

Thank you for submitting a paper to present at the "**8th International Nurse Education Conference**". On behalf of the Organising Committee, I am delighted to inform you that your abstract entitled **Pre-registration nursing students' perceptions and experiences of speaking up for patient safety in Australia; conflict, confusion and inconsistencies,** has been accepted for a **poster presentation** at the conference.

We are aware that this may not be the presentation type that you had originally requested and apologise for the inconvenience, but due to the overwhelming response to the call for abstracts it has not been possible to accommodate all abstracts as requested.
However, please note that should any spaces become available in your desired presentation type, every effort will be made to accommodate your abstract in the relevant section of the programme.

If you are no longer able to attend and present at the conference in April, or do not wish to accept the presentation type that is being offered to you, please notify us as soon as possible in order to enable us to offer your slot to fellow presenters who may have been placed on a waiting list

Details of your Abstract are as follows:

Title:	Pre-registration nursing students' perceptions and experiences of speaking up for patient safety in Australia; conflict, confusion and inconsistencies
Authors:	A.K. Fagan, J. Lea, V. Parker
Presenting Author:	A.K. Fagan*

Please check the above details of your presentation carefully as all conference material will be printed with this information, the name with the * indicates the presenting author. If there are any corrections, please inform me as soon as possible by email to Content-NURS2020@elsevier.com. Should the addressee above not be the nominated presenter, please inform me of the name and email address of the presenter immediately at Content-NURS2020@elsevier.com.

You will be informed in a separate email about the scheduling of your poster, and you will be given a final programme at the conference. However please bookmark the conference web-site at https://www.elsevier.com/events/conferences/international-nurse-education-conference to keep up-to-date with changes as they occur.

It is a condition of abstract acceptance that you or a nominated presenting co-author registers for the conference by the author registration deadline of **24 January 2020.** The abstracts of all unregistered presenters will be removed from the programme after this date.

Register as a 'New Customer' in the registration system if you haven't attended an Elsevier conference before.
Please register online using the following URL: http://conferences.elsevier.com/NURS2020?[redacted]&abstracts=0315,0348
Please note that you will need to set up a different password for this system, as it is different from the abstract submission system.