“Making a Difference”: The Lived Experience of Student Nurses in Training

Thomas O’Toole

A thesis submitted to the University of Huddersfield, under the supervision of Dr. Timothy Gomersall, in partial fulfilment of the requirements for the degree of MSc by Research

"Making a Difference": An IPA Investigation into Compassion Fatigue and Satisfaction in Student Nurses

Table of Contents

Abstract 2
Introduction 2
The Challenges of Nursing Training 3
Models of Stress and Compassion Fatigue 4
Literature review 7
Gaps in the Literature 12
Research aims 12
Method 12
Design 12
Recruitment 13
Inclusion criteria 13
Participants 13
Data collection 14
Data analysis 14
Ethical Considerations 16
Results 18
Descriptive Statistics 18
Interpretative Phenomenological Analysis 18
The importance of empathy 19
"Sinking before you even get the chance to swim" 28
"Them and us" 37
Conclusion 46
Discussion 46
Limitations and reflexive notes 49
Directions for future research 51
Implications for practice 51
Conclusion 52
References 53
Appendix 61

"Making a Difference": An IPA Investigation into Compassion Fatigue and Satisfaction in Student Nurses

Abstract

Aim: The present study examines the experiences and challenges faced by student nurses in training in the contemporary NHS

Method: An initial quantitative survey design was used to ascertain levels of compassion fatigue and satisfaction in the population of student nurses, with the descriptive statistics being used to inform the interview schedule used in the following qualitative interviews. Interviews were analysed using Interpretive Phenomenological Analysis.

Findings: Three experiential pillars were identified; "Sinking before you even get the chance to swim", The importance of empathy and "Them and us" which encompass a range of lived experiences for student nurses.

Conclusions: This study yields an insight into the lifeworld of student nurses not previously attained, with the findings being used to propose changes to the clinical placement system in an effort to remedy increasing attrition rates. Further avenues of investigation are also discussed.

Introduction

Nursing has long been regarded as a highly stressful profession, with research identifying the psychological and physiological toll this profession can have on an individual across their lifetime. These negative consequences in healthcare professionals (primarily physicians) have been found to range from higher levels of depression and suicide attempts, to an increased prevalence of alcohol and substance abuse, in addition to a higher divorce rate in healthcare professionals compared to the general population (Balch, Freischlag & Shanafelt, 2009).

A recent survey conducted by the nursing standard has revealed that 75% of nurses do not have time for a break during their shift, 59% go through entire shifts without the time to drink water and 57% have no access to healthy or nutritious food at their workplace (Jones-Berry, 2018). Consequently, the recent annual NHS staff survey (2018) collated the responses of 497,000 healthcare employees across 230 NHS trusts and found that up to 40% of staff reported feeling unwell as a result of work-related stress in the past 12 months. In addition, 28% of staff have observed something that, if undetected, may have led to patient harm. This report further states that over half of NHS staff are reportedly thinking about leaving their current post, with 21% wanting to quit the NHS altogether. These statistics reveal the most significant staff downturn in the past 5 years, with commentators stating that these pressures are not just a matter for staff themselves but have a knock-on effect on patients too. Satisfaction in the quality of care that staff feel they can provide is continuing to decline (Bodell, 2018). In addition, it has been reported by Hawkins Jeong & Smith (2019) that over half of newly qualified nurses experience workplace bullying and harassment, being subjected to disrespectful, unprofessional and uncivil behaviour. Newly qualified nurses have a heightened susceptibility to this negative workplace behaviour due to their vulnerability in the profession, perceived lack of capability, place in the hierarchy, leadership style and influence of management.

In addition, the emotionally taxing nature of the job role has been seen to have detrimental consequences, with reported levels of depression and anxiety being significantly higher in nurses than in the general population (Tsaras et al., 2018). This, in conjunction with the difficulties discussed above are pervasive throughout the nursing profession, culminating in the apparent haemorrhaging of nursing professionals and students alike, with more nurses leaving than joining the profession; 1 in 10 nurses are leaving their jobs each year, with 33,000 leaving in the last year alone (Snug, 2018).

The challenges of nursing training

In the UK, nurses have to complete an undergraduate degree accredited by the Nursing and Midwifery Council (NMC), split 50/50 between learning and practice. Prospective nurses must then be registered with the NMC and have completed an accepted pre-registration nursing programme. After becoming an accredited nurse, students then have the option to complete more training in a variety of clinical specialisms such as cardiac nursing, infection control and theatre nursing.

Nurses aim to serve the needs of the patient to the highest possible standard. When healthcare practitioners are physically and emotionally well, they can connect in an effective and meaningful way with their patients and provide a high quality of care. However, there are numerous wide-spread challenges to nurse wellbeing (i.e. job satisfaction, compassion fatigue, depression and suicide risk) all of which are entwined and pervasive throughout the undergraduate training and professional careers of nurses. In addition, these issues have been associated with multiple patient outcomes; suboptimal care, lower satisfaction, decreased access and increased health costs (Thomas, Ripp & West, 2018).

Depression and anxiety have been found to be significantly more prevalent in nurses than in the wider population; Tsaras et al. (2018) assessed a sample of 110 nurses in Athens, Greece, finding depression and anxiety in 52.7% and 48.2% of nurses respectively. Lifetime levels of depression among healthcare staff in the US have been found to be around 20%, similar to those of the general population, with further research stating that suicide is a disproportionately high cause of mortality in the healthcare practitioner population (Balch, Frieschlag & Shanafelt, 2009; Frank, Biola & Burnett, 2000). Balch, Frieschlag & Shanafelt (2009) suggest that the culture of medicine accords a low priority to the mental health and wellbeing of practitioners, remaining untreated until the practitioner's capacity to treat is compromised due to an ethos of blame and punitive action. It has further been suggested that the traits that make a good healthcare practitioner may in fact have adverse consequences for the individual, working to compound the effects of stress (Balch, Frieschlag & Shanafelt, 2009). Because of this, it has been stated that an estimated one in ten nurse sick days are down to stress or depression alone (Jones-Berry & Munn, 2017).

In addition to the myriad of personal health consequences for the sufferers of chronic stress, there are also institutional-level ramifications, impacting not only the practitioner, but the patient as well. Hobbs et al (2016) conducted an analysis of 100 million consultations in England and stated that the workload of healthcare practitioners in primary care settings has increased by around 16% from 2007 to 2014, further suggesting that English primary care may be reaching a "saturation point" (Hobbs et al., p. 2324). Hobbs et al. (2016) go on

to state that that this increased workload may lead to a higher patient demand and a lack of support from peers and superiors alike; this increased strain may lead to severe psychological consequences such as poor wellbeing, stress and compassion fatigue. Consequently, it has been suggested in a systematic review of 46 studies by Hall, Johnson, Watt, Tsipa and O'Connor (2016) that poor healthcare practitioner wellbeing and moderate to high levels of compassion fatigue are associated with poor patient outcomes. Chief among these poorer outcomes is an increase in medical error, estimated to cost the NHS around £1.3 billion in litigation costs, and £2 billion in additional bed days per year (Donaldson, 2002). In addition, a dose-response relationship has been established between compassion fatigue measures and suboptimal patient care (Shanafelt and Tait (2002). This may even have contributed to an increase in mortality in the older population, who are the most dependant on social and health care (Hiam, Dorling, Harrison & McKee, 2017).

Models of Stress and Compassion Fatigue

Student nurses may lack the experience to suffer fully from compassion fatigue and burnout, however this population is crucially under researched across the field. Current research posits a handful of applicable models and theories to help elucidate experiences of stress and burnout to qualified nurses, which may partially apply to the experience of being a student nurse.

Stress

Stress is a pervasive phenomenon across cultures, having multiple determinants and consequences throughout an individual's life. In most contemporary literature, stress is defined as a pattern of physiological, behavioural, emotional and cognitive responses to perceived stimuli that are viewed as threatening to well-being (Lazarus and Folkman, 1984). Throughout literature, stress is presented via three models; stress as a stimulus (social), stress as a response (physiological) and stress as appraisal-based process (psychological).

In psychological and sociological literature, one of the most frequently cited models of stress was developed by Lazarus et al. (2001). This transactional model suggests that stress is the direct product of a transaction between an individual and their environment, which may tax their resources and thus impact their wellbeing. Wellbeing is proposed to be mediated by the appraisal of this transaction. In regard to workplace stress, the working environment is perceived to be the stressful by the individual (as environmental demands exceed their personal resources, with the appraisal of this stressor being influenced by a range of personal factors (e.g. personality, coping skills, specific demands etc.). This model further states than an individual's cognitions and perceptions of their lived experience are processed in tandem with their ability to cope.

This framework is useful in understanding how an individual perceives and appraises stressful stimuli. However, since its inception, this model (specifically the role of appraisal) has been criticised for being overly simplistic, foreclosing on an individual's history (socio-cultural context & work trajectory), occupational and personal goals, future and individual identity. (Harris, Daniels & Briner, 2004). Lazarus (2006) further acknowledges the shortcomings of transactional models in understanding coping with stress in specific

workplace contexts, being too broad to account for occupational stresses. This makes the transactional model inappropriate to be applied to nursing students, who occupy a distinctly niche role, suspended between both the stresses faced by students and the challenges faced in the world of professional nursing. As such, models which distinctly incorporate the workplace should be considered.

Compassion Fatigue and Burnout

Maslach (2016) offers a contemporary definition of burnout as "a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job" (Maslach, 2016, p. 103). This phenomenon primarily affects workers whose role consists of constant demands and intense interpersonal interactions with people who have a high level of physical and emotional need (Balch, Freischlag & Shanafelt, 2009). As a clinical syndrome, burnout is most commonly characterised by emotional exhaustion, depersonalisation and a decreased sense of personal accomplishments (Thomas, Ripp & West, 2018).

While similarly characterised to burnout, compassion fatigue (CF) itself centres more around the erosion of the individual's fundamental beliefs about the world. Pearlman & Saakvitne (1995) state that through vicarious trauma (VT) an individual's worldview can shift when working with patients and clients who have experienced trauma. A clear distinction to make; feelings of burnout do not necessarily mean that the individual has an altered perception of the world, or that their capacity for compassion has deteriorated.

A further elaboration on VT, an element of CF proposed by Stamm (2002) is Secondary Traumatic Stress (STS), who defined the phenomenon as work-related, secondary exposure to extremely stressful events (e.g. hearing a colleague tell stories of stressful events they have experienced. Stamm (2002) contends that the symptoms of STS are quickly onset, with a focus on a specifically stressful event and range from fear, to insomnia and avoidance behaviours). It is proposed that 75% of nurses experience at least one STS symptom per week, with factors such as patient death making a major contribution to these experiences (Morrison & Joy, 2016).

In regard to the wider context of compassion fatigue, it has further been suggested by Leiter & Maslach (2003) that in addition to intrapersonal factors, wider social and organisational conditions may play a role in the process of compassion fatigue; six domains of job-person mismatch have been suggested: work overload, lack of control, insufficient reward, breakdown of community, absence of fairness, and value conflict. These areas may be congruent with an individual, facilitating engagement, however they may also be incongruent with the individual, aggravating compassion fatigue.

Compassion Satisfaction

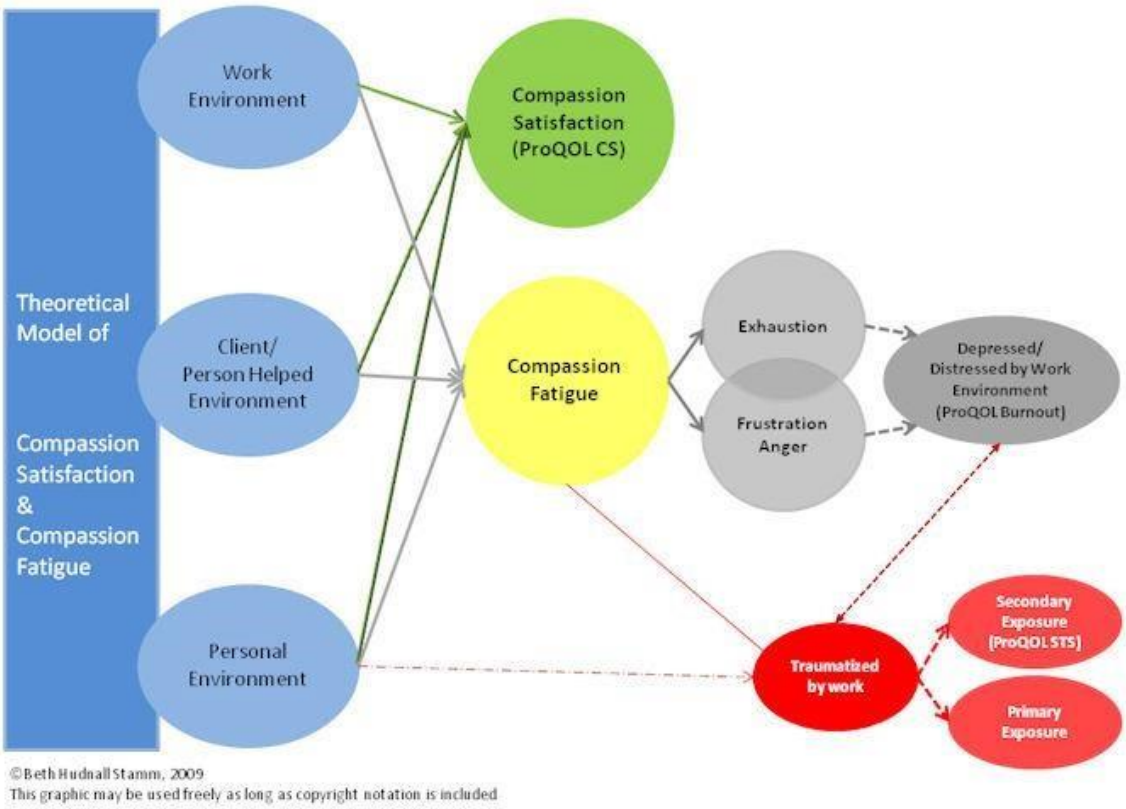
Stamm (2002) contends that it is equally important to investigate the inverse of compassion fatigue; compassion satisfaction (CS) is defined as the positive aspects of helping and is an important aspect of stress and compassion fatigue. Sacco & Copel (2018) conducted a review of the literature surrounding the phenomena of CS, reviewing the articles found via a variety of literature databases. It was found that there are 11 characteristics that are the positive feelings, occurring as a result of working with patients and families. These

characteristics include; well-being, fulfilment, reward, accomplishment, joy, enrichment, invigoration, inspiration, revitalisation, gratitude and hope. In addition, seven antecedents to CS were identified across the literature, including perceiving caregiving as a calling, an empathetic relationship with a family in crisis, a continuous exposure to a stressful environment with collegial support, the development of resilience, the development of coping mechanisms, practicing self-care and achieving a work-life balance.

The Professional Quality of Life Scale

Examining workplace stress and compassion fatigue from a social perspective, the most commonly cited theory of CS and CF is the Professional Quality of Life (ProQOL) model (Stamm, 2010), which describes factors such as work environment, the client helped and personal environment and states that these may contribute towards compassion fatigue and satisfaction. It is further suggested that compassion fatigue is broken down into compassion fatigue and secondary traumatic stress, with compassion fatigue being comprised of feelings of exhaustion and frustration, and secondary traumatic stress being primarily constituted by workplace trauma (see figure 1. for a complete model). The ProQOL model is a significantly more appropriate fit for nursing students than the border models of occupational stress previously seen throughout literature within this remit. Stamm's (2010) model of professional quality of life captures the dyadic relationship between compassion satisfaction and fatigue experienced by healthcare staff, while incorporating aspects of the individual's environment.

Figure 1. A diagram of the CF-CS model



However, a relevant criticism of these taxonomic, abstract models is that they situate compassion fatigue in the job-person fit, however, Bianchi et al. (2014) argue in support of an integrative view of health, suggesting that the work-restricted scope proposed by Maslach (1982) is anachronistic. It is stated that compassion fatigue should not be circumscribed to the sphere of work alone, but instead should incorporate multiple contexts, combining within and between-individual perspectives to shape a lifespan approach to compassion fatigue (Schaufeli, Maassen, Bakker & Sixma, 2011). However, it is arguable that a taxonomic model of workplace stress in student nurses may not be viable, as each individual's perceptions of stress and compassion fatigue are unique, it may, perhaps, be better to move away from generalisable models and examine stress and compassion fatigue as a lived experience in the contemporary workplace. Thus, while these models may have utility in a broader capacity, a move away from generalisable models is needed in this area, to capture (as much as is knowable) the lived experiences of student nurses.

Literature review

In contemporary qualitative literature there exists a variety of research synthesis methods, the most pervasive among current articles are the thematic synthesis, meta-ethnography and meta-synthesis (Thomas & Harden, 2008). When searching for literature in a traditional meta-analysis, it is crucial to locate all relevant studies, however for a qualitative synthesis this may not be required. Doyle (2003) states that a qualitative literature search should be "Purposive rather than exhaustive because the purpose is interpretive explanation and not prediction" (Doyle, 2003, p. 326). This suggests that it may not be entirely necessary to find and include all possible studies in the analysis; the results of a conceptual synthesis will not change if five rather than ten studies contain the same concepts. Instead the cut-off point should depend on the range of concepts identified and their congruence among the literature. Because of this, the concept of conceptual saturation may be more apropos to qualitative research (i.e. searching for literature until no novel concepts are revealed). Further support for this concept comes from Carroll, Booth & Lloyd-Jones (2012), who examined the impact of excluding inadequately reported studies systematic reviews and found a correlation between quality of reporting and value as a source for synthesis. This study lends further credence to the case for the exclusion of inadequately reported studies in systematic evaluations.

A literature search was conducted using databases which index articles related to the phenomena of interest; CINAHL and PsychINFO were searched as both databases contain a wide array of relevant research from the nursing and psychology disciplines alike. These two databases were also chosen because they cover a vast amount of contemporary literature, allowing for an overview of the area, but do not return an unwieldy number of articles to sort through for a project on a limited timescale Variations of the search terms "nursing or nurses or nurse etc…" and "stress, stressed or burnout or burned out etc…" and "compassion fatigue or compassion satisfaction" and "IPA or interpretive phenomenological analysis or phenomenology etc…" were used in an attempt to capture all relevant articles. IPA was specifically searched for as it calls for as tightly defined a phenomena as possible, and so the same principles were applied to the literature search . The initial CINAHL search yielded 128 results, 11 of which were chosen for analysis. Using PsychINFO, 106 search

results were returned, with 10 being chosen for this review. Articles were selected based on relevancy, specifically methodology (Interpretive Phenomenological Analysis), sample (nurses) and topic (stress and compassion fatigue). In total, 21 articles were selected for the purposes of this review, these studies were conducted in a range of countries, with the majority being doctoral theses coming from the US. This is evidence of a distinct gap in the literature in regard to the challenges faced by student nurses.

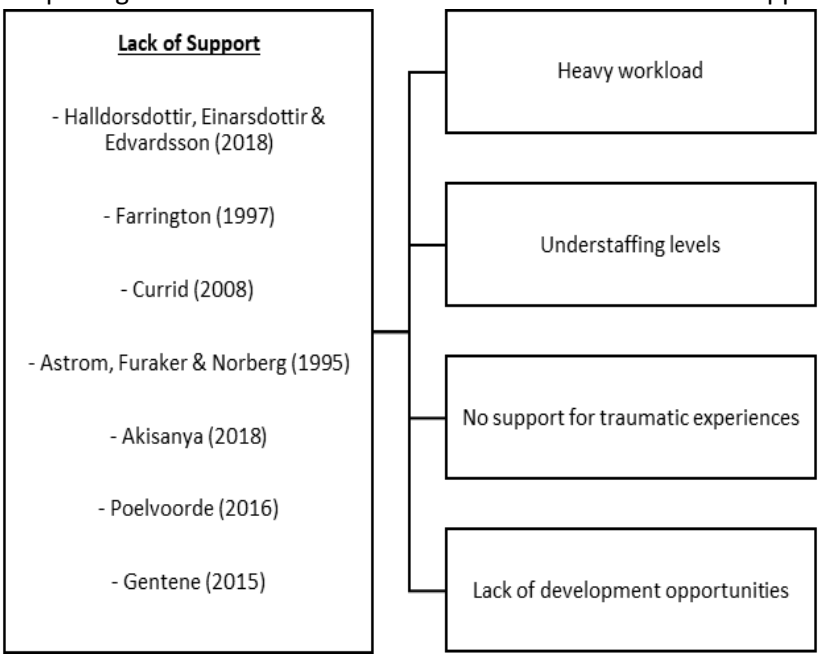
Lack of support

Across the selected literature, a lack of support was consistently identified of one of the most stressful challenges experienced by nurses and student nurses. See figure 2. for a complete overview of the sub-themes established.

In regard to the everyday factors associated with support, a piece of doctoral research conducted by Gentene (2015) identifies the importance of a healthy lifestyle in the prevention of compassion fatigue, in addition to the pivotal role of social support in coping with compassion fatigue. However, as previously discussed, Jones-Berry (2018) stated that 57% of nurses do not have access to healthy food and drink at work, and Hawkins, Jeong & Smith (2019) suggest that over half of newly qualified nurses have experienced workplace bullying from peers and superiors alike. This juxtaposition is key to the proliferation of compassion fatigue throughout the nursing profession, with the recommended, preventative factors not being seen across the contemporary NHS.

From an institutional level, challenges such as understaffing, unmanageable workload and reduced opportunities for professional development have been identified as having a negative impact on an individual's own motivations, contributing significantly to feelings of compassion fatigue among nursing professionals.

Figure 2. A diagram exploring the studies and sub-themes related to the "lack of support" theme



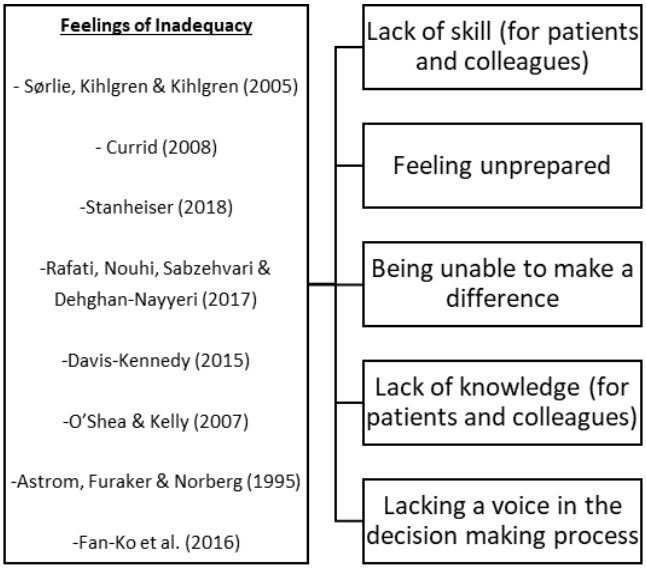
Feelings of inadequacy

Another prominent challenge experienced by nurses was found to centre around individual feelings of inadequacy. See figure 3. for a complete overview of the sub-themes established

Feelings of inadequacy have been identified as the primary source of stress in nursing students, with a perceived lack of knowledge being the driving factor in this process. Rafati, Nouhi, Sabzehvari & Dehghan-Nayyeri (2017) investigated the experiences of Iranian nursing students during their first clinical rotation. It was found that student nurses felt they had an inadequate scientific knowledge base for answering the questions of patients, doctors and nurses alike. These feelings led to the perception that, because of their inadequate knowledge, they would deliver sub-standard care to the patients, potentially harming the patients and themselves due to this perceived negligence.

These findings are congruent with wider research across cultures; Fan-Ko et al. (2016) conducted a study assessing experiences around a first clinical rotation in Taiwan. Self-doubt worry and a difficulty adjusting to the learning process were all found to be impactful for feeling of stress in student nurses. Overall, research in this area suggests that a perceived lack of knowledge and skills are crucial in driving feelings of inadequacy (and consequently stress) in student nurses (Davis-Kennedy, 2015).

Figure 3. A diagram exploring the studies and sub-themes related to the "Feelings of inadequacy" theme

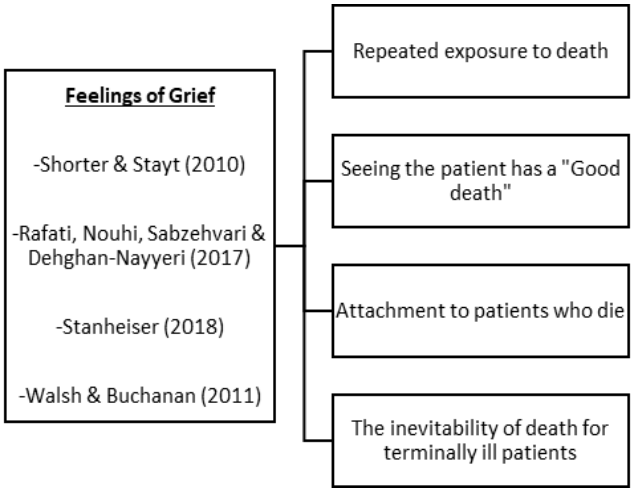


Feelings of grief

Throughout the selected literature, another facet of nursing which was identified as potential cause of compassion fatigue is grief. See figure 4. For an overview of the subthemes established.

Grief is a prevalent cause of stress across all healthcare professions, however, research suggests that student nurses are particularly susceptible to feelings of stress surrounding the death of a patient, perceiving their own inadequacies as the cause of death (Rafati, Nouhi, Sabzehvari & Dehghan-Nayyeri, 2017). Research examining experiences of death and grief in nurses suggests that patient death is less traumatic if the patient died, what was perceived to be a 'good death' (i.e. how the patient wanted). Conversely, a patient's death was found to be more traumatic if the nurse had developed a 'meaningful engagement' with the patient and their relatives (Shorter & Stayt, 2010).Walsh & Buchanan (2011) further suggest that a repeated exposure to death may result in a heightened level of occupational stress and consequently compassion fatigue, with the converse, emotional disengagement, impacting the quality of care provided for both the dying patient and their family (Shorter & Stayt, 2010; Stanheiser, 2018).

Figure 4. A diagram exploring the studies and sub-themes related to the "Feelings of grief" theme



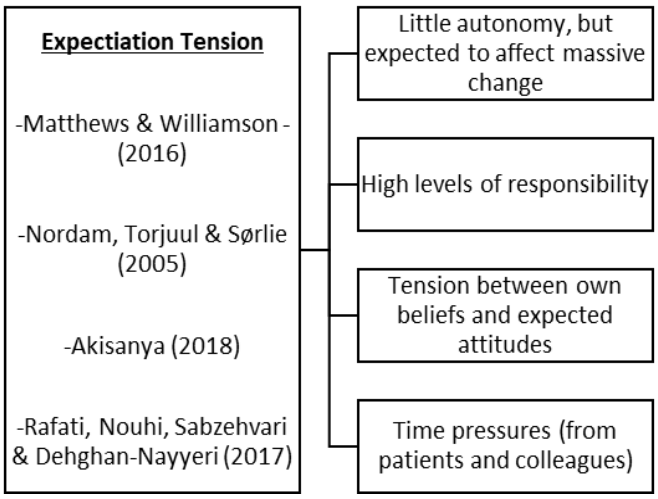
Expectation tension

The studies examined suggest that, across the nursing profession there exists a tension between the expected attitudes of nurses and their own, personal moral code. See figure 5. for a full overview of the subthemes established.

Matthews & Williamson (2016) found that the disturbing behaviours and compassionate disengagement common across nursing are often normalised and detached from the outside world. Matthews & Williamson (2016) further state that healthcare professionals often experienced tension between their personal moral code (prioritising empathy and support) and the emotional detachment and control expected by their host organisation, contributing to moral distress and inevitably, compassion fatigue.

This research is in line with various other studies (Akisanya, 2018; Rafati, Nouhi, Sabzehvari & Dehghan-Nayyeri, 2017) who outline the importance of the difference in expected organisational attitudes and personal beliefs, with a prolonged tension between the two contributing significantly to stress and compassion fatigue in nursing professionals, especially newly qualified nurses and students.

Figure 5. A diagram exploring the studies and sub-themes related to the "Expectation tension" theme



A greater understanding of the perceptions and experiences of stress may work to aid the NHS and higher education establishments in more effectively supporting student nurses, decreasing stress and compassion fatigue levels, with the end goal being to improve wellbeing for student nurses.

Gaps in the Literature

At present, the literature in this area covers and establishes commonalities across the lived experiences of nurses. However, the evidence comes from a diverse array of countries, with each study having a slightly different emphasis and sample. This results in a small yet uneven body of literature, with substantial gaps which the present project aims to address. As such, the present study will add novel and timely knowledge to this research area by focussing explicitly on student nurses in a contemporary UK sample with the aim of "getting under the skin" to understand the lifeworld of student nurses. This research is paramount to understanding the lived experience of student nurses, in an effort to combat the institutional and personal ramifications of stress and burnout discussed above.

Research aims

This project aims to answer the research following questions:

- "What is the lived experience of student nurses in training in the contemporary NHS?"

- "What meanings do stressful and challenging situations hold for student nurses in the contemporary NHS?"

Method

Design

Due to the lack of research in this population, an initial survey design will be used so assess levels of compassion fatigue and burnout in the sample group. Following the broad

methodological approach of Doran et al. (2016), the results of the survey section will be used to assemble an interview schedule which has been tailored for the present, niche sample in an effort to capture the most insightful and rich data possible.

The survey section of the study utilised a cross-sectional design, in effort to build a snapshot of CF and CS levels prior to interview. After completing the questionnaire, participants with high scores in compassion fatigue and compassion satisfaction were asked to progress to the interview stage. During the interview stage, a semi-structured interview schedule was utilised to foster a relaxed and conversational tone, while providing a structure and allowing the researcher to probe unexpected aspects of the participant's account (Howitt, 2010).

Recruitment

The lead for adult nursing was contacted, providing recommendations on the groups to contact and the time of year to distribute the study. Second and third-year nursing students were identified as the most vulnerable to experiences of compassion fatigue and satisfaction alike, while having some clinical experience to draw on. In addition, mid-March was selected to be the most stressful time of year for nursing students, with students being more likely to talk about their experiences.

An email containing a link to the Qualtrics webpage for the PROQOL (Stamm, 2002) & descriptive measures was sent out to all second and third-year adult nursing students, incentivised by a £25 Amazon gift card raffle. For the second stage of the study, respondents who wished to discuss their experiences further included their email address in the Qualtrics questionnaire and were contacted shortly after.

Inclusion criteria

For the interview section of the study, initially, participants were to be sampled from the top and bottom interquartile ranges of their ProQOL scores in a purposive method, however, due to time constraints, any/all participants who replied to the invitation were interviewed. Because the first stage of the study was sent out to only second and third year adult nursing students, this kept the interview sample homogenous, and tightly defined.

The exact inclusion criteria were:

- Full -time student
- Enrolled in adult nursing at the University of Huddersfield
- Currently in their second or third year of study
- Any age
- Any gender

Participants

For the survey section, there were 72 respondents, with 6 incomplete entries being eliminated, leaving 66 complete responses from which to derive descriptive statistics.

For the interview stage, three of the participants were indicated that they wanted to be contacted for a follow-up interview, being contacted via the email address they provided when

consenting to be contacted. The fourth participant contacted the researcher independently after discussions with their tutor, who recommended the study.

Data collection

Participants received an email detailing the present study; all third-year nursing students were contacted. Participants who registered an interest in the research were invited to complete a short questionnaire measure of CF&CS (PROQOL; Stamm, 2002) administered via email to eligible participants. In addition to the PROQOL, data on the student's year of study, age group, gender, religion and socio-economic status was collected. Data on student's contact details (email addresses and phone numbers) was collected for follow up interview purposes. These were stored in a password protected document on the K: Drive and were deleted after the completion of the study.

For the interview section of the study, participants were invited to a quiet room on the university campus to discuss their experiences of stress and compassion fatigue in greater depth. Participants were presented with an information sheet and consent sheet and the interviewer explained the aims of the study and answered any questions the participant had. Once the participant was satisfied and had signed the consent form, the interview was initiated. The interview schedule included questions like "Can you tell me what you think the most challenging parts of nursing are?" and "Can you tell me about any positive experiences you've had in this job?" (see appendix A for full interview schedule). The audio of the interview was recorded for later transcription and the interviewer took notes throughout for probing questions. Participants gave their informed consent and were briefed, debriefed and fully informed as to the aims of the study (see appendix B for consent, brief, debrief and information sheets).

Data analysis

For the ProQOL scale, participant scores were calculated to gain insight into levels of CF and CS in the sample. The subscales for Compassion Satisfaction, Burnout and Secondary Traumatic Stress were calculated for the sample. Basic descriptive statistics or all three independent variables were analysed, with the results being used to inform the interview schedule used in the second stage of the study.

In regard to interview data, the audio was transcribed via orthographic transcription, according to the recommendations of Parcell & Rafferty (2017), capturing the exact words and meaning of the participant (including affect and pauses), however details such as intonation and pause length were omitted (as seen in conversation analysis transcription) due to time constraints and also in an effort to maintain readability .In addition a foot-pedal and voice transcription software was used in order to save time and produce an accurate transcription of the data.

The transcripts were then uploaded to Nvivo for analysis and analysed using the steps suggested by Pietkiewicz & Smith (2014). Interpretive Phenomenological Analysis (IPA) is concerned with providing an in-depth, nuanced analysis of a phenomenon of significant or existential importance to the participant. IPA incorporates the philosophical principles of phenomenology (the study of phenomena and how they are perceived and understood by

the individual), hermeneutics (the subjective interpretation of an account) and ideography (a focus on the uniquely individual aspects of human nature; Smith, 2011).

The proliferation of pure or Transcendental Phenomenology stems from the early 20th Century work of Husserl (1980) who states that we cannot get an objective or "god's eye" view of a phenomena, meaning our interpretation is clouded by our attitudes. It is also suggested that we can step outside of these attitudes by "bracketing" our belief in this assumption. This stance is known as the "Epoché" and allows us to understand that our reality is constructed via consciousness. This process of "eidetic reduction" is useful for researchers, acting as a reminder to cast aside any taken for granted assumptions. However, while "bracketing" has utility in theory, minimising the effects of our pre-conceptions on the research process, it is arguable that this is not practically achievable.

This theory was further developed by Heidegger (1962) who, with a concern for the ontological matter of existence adapted phenomenology to address questions of existential philosophy and hermeneutics. According to the phenomenological principle of hermeneutics, to understand an individual's perspective, you must recognise the language and mindset of the person, as this mediates their view of the world (Given, 2008). For use in this analysis, Heideggerian interpretations of the following concepts will be explored and applied to the data; Dasein (being aware of one's involvement in the lifeworld), temporality (an awareness of the cultural – historical past, speciality (closeness and de-severance) and death (the end to the lived experience of Dasein).

Interpretive Phenomenological Analysis also incorporates the theoretical orientation of Ideography, understanding each participant in their unique context, starkly juxtaposed against the nomothetic principles of quantitative psychology, using representative groups to establish the probability of a phenomena occurring. IPA requires the in-depth examination of a participant's context; only then can researchers understand the world through the eyes of the individual.

With IPA, researchers seek to understand the subjective standpoint of the participant by seeing the world through their eyes, while realising that this is never truly achievable, with the researcher playing an active part in the gathering and interpretation of data. The term "double hermeneutic" is often used throughout IPA research; the process is twofold, with participants making meaning of their world and the researcher seeking to decode this meaning, effectively making sense of the individual's sense making process while understanding their context. Additionally, Pietkiewicz & Smith (2014) further suggest that the researcher moves between emic and etic perspectives (from the perspective of the participant and from the perspective of an observer, respectively), with the emic perspective protecting researcher from issues of reductionism and the etic point of view giving the researcher opportunity to develop higher-level theories.

The IPA method of analysis suggested by Pietkiewicz & Smith (2014) is as follows:

Multiple readings and note making

- My familiarisation with the data started during the transcription process, following this, I re-read the data enough times to obtain an understanding of it, making notes of interesting codes as they appear throughout.

Transforming notes into emergent themes

- Similar codes were collated into themes, which were named and organised by relevancy.

Seeking relationships and clustering themes

- Themes were then reorganised and structured into a hierarchy, with inter-related sub-themes coming under the same cluster.

Writing up the study

- These themes were grouped across participants and the study was written section by section.

In the case of the 4th and final interview, coding and analysis were carried out with a view to identify negative cases, incongruous with the developing themes to test for conceptual saturation.

This method was adhered to throughout the analytical process, yielding a narrative account of the study comprised of themes, exemplified with extracts from the data. Pietkiewicz & Smith (2014) suggest that these steps are a flexible guideline to be adapted by the researcher in an appropriate and creative way.

Ethical Considerations

Permissions for the study were obtained from the University of Huddersfield. The host organisation provided access to and made recommendations for potential participants; experienced nursing students. All participants were provided with an information / briefing sheet and debrief sheet, supplied by the researcher. Each participant confirmed or declined their involvement in the study directly to the researcher after being fully informed of the aims of the study.

Participant confidentiality was maintained throughout the study and all information and analysis remained anonymous to all except the researcher and supervisors. Responses to the stress measure were stored and analysed to identify relevant participants and were then immediately deleted. Interview recordings were uploaded to a password protected electronic file as soon as possible and the original file was immediately deleted from the MP3 recorder.

Interviews were transcribed by the lead researcher and electronic transcriptions were held in a password protected electronic file, with all electronic files were held on the University of Huddersfield K: drive which is password protected. All participants' names were coded and remained anonymous throughout analysis and reporting of the research findings. Any identifying details of the participant, other people or the location of study that may be mentioned in interview were anonymised in the transcripts and analysis. Participants were

advised that they have the right to decline to answer certain questions, and the right to discontinue their participation in the study at any time and without question. In addition, participants were further advised they have the right to withdraw data within 2 weeks from the date it has been collected. Following their involvement in the research, participants were directed towards helpline contacts for support during and after the data collection period. Available help will be detailed in the debrief sheet, which will include relevant links to counselling services.

The principles of respect, competence, responsibility and integrity included in the British Psychological Society's code of ethics and conduct were adhered to in the fullest degree.

Results

Descriptive Statistics

Descriptive statistics were recorded for all 66 respondents. The statistics recorded are not intended to shed light on the understanding of the experience of being a student nurse, only to give a guide to the CF/CS found in the cohort. A table showing the scores for each subscale in addition to the recommended cut off score for each subscale can be found below (table 1).

Table 1. ProQOL cut off scores and sample frequencies

	Compassion Satisfaction Score	Burnout Score	Secondary Traumatic Stress Score
Low (<22)	0	7	17
Moderate (23-41)	41	57	48
High (>42)	25	2	1

The purposes of collecting these descriptive data was to investigate whether CSS, BS and STSS differed on any of the demographic variables, in addition to assessing prevalence of these variables in the sample. The results highlighted the importance of CS to student nurses, an aspect not previously considered in any depth, however, this may be due to the hesitance of severely burned out nurses to participate in the study, and the tendency for nurses struggling with CF and burnout to drop off the course entirely. Due to the relatively high CS scores and middle - low Burnout scores, the study was amended and adapted in a few ways; the introduction was partly re-written, placing more of an emphasis on CS and the ProQOL model than before and the interview schedule was altered to probe participants about the perceived rewards of nursing in addition to the stresses. These alterations alone highlight the importance of the exploratory statistical data collected; as established, this is a relatively novel research area in the contemporary NHS, with the background literature almost entirely foreclosing on the importance of CS. No inferential tests were conducted, however the descriptive statistics helped influence the second phase of the study and helped to increase the quality of the data collected.

Interpretative Phenomenological Analysis

The present study included the narrative accounts of four student nurses, with in-depth interviews consisting of rich, ideographic accounts of the stresses and rewards experienced by student nurses throughout their placements. Throughout this analysis, the participant's own words will be used to illustrate the established themes. Pietkiewicz & Smith (2012) state that this has two functions: enabling the reader to view the importance placed on the interpretations in addition to retaining the participant's ideographic voice, presenting the emic perspective.

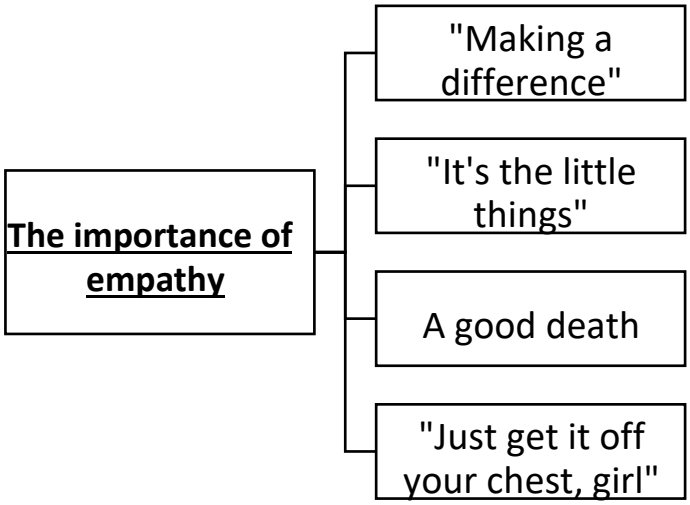
Following the coding of the data as outlined above, three inter-related, clustered themes were developed: The importance of empathy, "Them and us" and "Sinking before you even

get the chance to swim" (for an overview of the sub- themes see figures six, seven and eight respectively).

The importance of empathy

Another of the most pervasive themes across all accounts focusses around the importance of empathy to the patients and staff alike. Through the coding and analytical process, these themes were found to be multifaceted, but consistent across accounts, with each participant adding insight to how intrinsic empathy is to the lived experience of being a nurse (see figure. 7 for an overview of this theme). The American Psychological Association defines empathy as "understanding a person from their frame of reference rather than one's own, or vicariously experiencing that person's feelings, perceptions and thoughts". Clear examples of the multifaceted nature of this lived phenomenon can be found below.

Figure 7. A hierarchical diagram of the themes clustered around the phenomena of empathy.



"Making a difference"

Across all participants, the feeling of making a meaningful impact on the patient's physical and mental wellbeing was evident to be incredibly rewarding for both the student nurses and patients. A clear example of this comes from participant DE:

DE*: "Erm, well in a ward setting it's just nice when your patient can go home, when your patient is getting ready for discharge and you know you've done all you can for the stay because a lot of the patients we look after will be on the ward for a few months they are quite long term… and to see that change around from when they first come in being quite poorly and vulnerable to when they're leaving, going back to their families, thanking you for everything you've done…"*

DE talks about how uplifting witnessing a positive change in a patient can be with patients with a long-term illness who the participant has spent a considerable amount of time with. The participant also mentions how rewarding affecting a change for a vulnerable patient can be, with the participant doing all they can to see the patient transformed, able to leave the ward and return to their loved ones. For DE, understanding the patient in their own context is key

knowing they can return to relative normalcy because of the difference you have made in their lives is an important facet of reward in empathy.

These ideas are furthered when DE talks about the experience of being able to help not only the patient but offer support for the patient's family too. The experience of being a student nurse, knowing you can help patients and family is exemplified in the following abstract:

DE*: "Especially when a patient comes out of hospital and they are dying being able to put things in place for them, sorting their medications and taking the burden off the family, and you can see the weight lifting off the family because they've been given the help they need, erm we had a patient who is palliative in the community and his wife has been looking after him for the past 7 months and she wasn't aware there was support available so for us to go in there and tell her you're entitled to carers and you don't have to worry about money, we can give you equipment and I think that was really rewarding to make that difference even if it is just that one person this week knowing that we can go in and make things easier is really rewarding".*

The theme of making a difference is continued here, with DE discussing the rewards felt by being able to meet the values he holds for nursing, being able to effect change for his patients. Also discussed is the reward of being to provide support that would otherwise be entirely unattainable helping to alleviate the stresses of caring by letting them know they're not alone, that there are multiple avenues of support available from support to equipment. The phrase "weight lifting-off" is of saliency here, bringing forth ideas of spatiality, in particular a sense of freedom from the hefty burden of care. This extract shows how important understanding the situation of that patient is, knowing how much the relevant support can make a difference in that patient's experience, while eliciting feelings of reward for the nurses through providing the standard of care they not only want to, but feel they must.

Participant CD gives a similar account to DE, talking about the power of affecting a transformative change for the patient, while offering further insight into the specific role of being a student nurse:

CD*: "Seeing patients satisfied, honestly when you walk in and they're just like 'thank you so much' and you see them walking out of the hospital a new person, a healthier person and you don't always get that happy ending unfortunately, but I will say it feels like you get appreciated more as a student than a nurse because nurses are just so bogged down by paperwork, this new electronic system all they do is sit behind a computer so were responsible for the "oh do you need a cup of tea, are you comfortable?" and its these little things, They appreciate it, like "oh I was coughing, and she came with some water for me" then the family appreciate that".*

This extract further supports the experiences stated by DE, making a transformative difference in the life of the patient. An addition to this, is the insight that the participant experiences more appreciation because of their status as a student and relative lack of feeling "bogged down" by the mire of administration jobs. This position in the hospital hierarchy has an interesting impact on feelings of temporality; the participant feels that have more time to spend with their patients and are able to understand the needs of the patient more, seeing

them in their context with their family. As a result, student nurses are more able to offer support which nurses with a heavier workload would not be able to. Because of this, the participant feels as though they are able to experience more appreciation from the patients than other nurses would.

Another salient example of "being there" for patients comes from AB in the following excerpt:

AB*: "Erm so I once got a card and it said we may never remember your name but will always remember how you made us feel, and that was just golden, especially with all the shit you see there, I could have gotten a thousand pound bonus on my salary that month because it just makes you feel right, like that's what it's about you know… And she sent me the card because of that, because it meant a lot to her. She come over from Germany, I'm sure it was Germany to sit with her dying sister because she was too poorly to track her home and she was sat there with her all the time with this dried rose and it was all just dead clinical you know and we were stood there like "just let her hold the flower" you know, put the flower in her hand and she was proper clinging to it like And we were just like what's going to comfort this woman more a student saying let her hold the flower or this older nurse shouting at them about infection control. And with that card I said I'll remember her forever and I really do."*

This passage is important in understanding the sense-making that student nurses derive from being able to give a patient a "good death", showing the impact a small act of kindness and empathy can have on the life of not only a dying patient, but their friends and family too. Although technically against hospital policy, the gesture of allowing a family member to give a dying loved one a dried rose made an immeasurable difference for the family, so much so that they sent a thank you card to AB. This card is "worth more than a thousand-pound bonus" to AB, further emphasising the importance of empathy in nursing.

This theme encompasses the essence of making a significant difference in the lives of patients and their family. Another facet of this theme is the perspective of the participant and the importance they place on feelings of significance; feelings that they matter in their work and to their patients, which, in a sense is facilitated by their position in the hierarchy of the hospital, allowing the participants to spend time with their patients in a meaningful way. The theme of making a difference is a significant aspect of the broader theme of empathy, offering a view of the rewards of nursing through the eyes of the participants.

"It's the little things"

A very closely related theme to "Making a difference", the theme of "The little things" centres more closely around the importance of small acts of empathetic kindness throughout nursing, specifically the importance of the more physical acts of patient care. This is exemplified in the words of participant AB, who offers two examples of how important "the little things are":

AB: *"I like passing my day with like talking to people and stuff so when there's kind of a quiet moment I'm going to talk to patients and see if you need anything so like if they've had a strip wash in the morning, seeing if I can help them with a shower you know just like practical things not like sitting down and bitching off about this that and the other because it's a mad culture I in the hospital you know, You know being a tea bitch or something I'd rather go*

around with the patients and get involved with the tittle tattle, and believe me there's a lot of that, there's a lot of that (laughs)"

AB: *"Just daft things like I say just offering people things, because they don't need it, you could just offer somebody like a shower in the morning and they're like so grateful for it, families are always like "thank you so much" and it's like, wow, but also I think that's what makes me sad about seeing the shit side of nursing, because you can see how grateful people are for your service"*

In these quotes, the participant talks about how other nurses spend their quiet moments "bitching off about this, that and the other", something which is apparently abundant in hospital life. Instead of getting involved in the "mad culture" of hospital cliques she finds her time better spent interacting with patients, understanding the small, comforting things that help to give a sense of normality in a novel situation. AB empathically helps with the little, practical things that might otherwise go unnoticed. These sentiments are congruent with the account of BC, who talks about not only the physical aspect of helping, but the psychological facet too:

BC: *"I'd much rather sit and take the time, especially with people with dementia, everyone's rushed off their feet but a couple of minutes, just when you're giving them their meds have a bit of a chat, so you're still doing your job and making sure they take it, chatting with them could be the highlight of their day, anything mental health really, people don't get that if you're sat there alone all day and you already have depression and you'll just go insane I know I do if I'm at home all day, and you do get them nurses that are just like never been to Uni but they have the experience and can pick up on the important little things".*

Here, BC tries to understand the patient's perspective, offering empathetic support through the acts of talk and being physically and mentally present for the patient. BC talks about how she feels being alone all day and tries to show her patients these small acts of kindness because it is how she would want to be treated in their situation. Similarly, to previous extracts, BC draws upon ideas of temporality and spatiality, creating time for the "important little things" in the almost suffocating, hectic schedule of a nurse.

Later in the interview, BC tells an in-depth story about the importance of "the little things" to patients and patient's families in nursing:

BC*: "I think it's the small things that people miss, so yesterday we had a young lad come into resus and he'd had a few days of alcohol abuse and substance abuse and his friends were there and nobody had talked to them and his dad was there and nobody talked to them in the relatives room, nobody offered them a drink and because of the state he was in we had to have all these monitors and tubes and everything and it's not nice to see and I always think family shouldn't see that until we can start taking some of those monitors off because it's quite scary and they were just letting them come in and not thinking about how the relatives are feeling and in that case you just need to think about them it's a traumatic experience I think that's what a good nurse is someone you can trust and build a relationship with… It's not all about*

your verbal communication sometimes you just need to sit there and be there next to them, it's the little things".

In this account, BC again explains just how much of a difference she feels seemingly small acts of removing the tubes and offering a drink can make in making the family of a patient feel less distressed in an extremely upsetting scenario. This story exemplifies how entrenched empathic behaviour is in nursing, understanding how distressing seeing a loved one in an alien setting can be and taking the time to ease the family's upset through a small acts of kindness.

In addition, BC also provides another example of how meaningful a seemingly meaningless act can be to a distressed person in an unfamiliar setting:

BC: *"We erm we had a young girl in and she was y'know, bleeding (.) quite heavily and it hadn't stopped for a few days and she hadn't had a period since April so she thought she was pregnant, but she'd done all the tests and they were all negative. I went and asked her to do a sample, like a urine dip and I did a pregnancy test and it was a really faint positive, so I asked a doctor and he said it was definitely positive, when I went back to tell her she said she'd been to the toilet and there was erm, tissue coming away so I was like "oh, miscarriage, or like, an ectopic pregnancy" so I talked to the doctor and he said we will have to get a room ready for her because we can't let her go on the toilet she has to go on the commode. So I went back and told her and obviously she was really distressed erm, and I explained what we will have to do and I went with her to the room and sat with her while she was on the commode because she was all alone, so I sat with her while she was letting it all come away and that was horrible, that was my first day in A&E and that was just the big thing that happened".*

This story shows how BC believes in the importance of small acts, like of sitting with a patient and physically being present during an incredibly distressing time. BC shows that this intrinsic empathy, knowing that the patient doesn't have anybody else with them and taking the time to simply sit with them through a horrible situation can make all the difference for a patient. This is especially important considering the context of the BC, who, herself is experiencing this horrible, emotionally charged situation alongside the patient, but is helping to remedy the isolation and fear of going through an event like this alone.

These stories and accounts help to shed light on the experiences of student nurses, understanding a patient's context and taking the time to put the patient at ease through small, everyday acts of kindness, helping the patient recover some sense of normality. From making a drink for somebody, to removing the tubes from a patient so their family is less distressed, to staying with a patient who has nobody else to be there with them, this aspect of empathy, doing "the little things" can have a substantial impact on the experiences of the patients and nurses alike.

A good death

A theme found to be pervasive across all responses is the importance of being able to give a terminally ill patient a "good death". The following stories exemplify the links between empathy in nursing and "a good death" for patients. Two particularly meaningful accounts come from participant AB:

AB: *"He'd been married to this woman for 63 years she had advanced lung cancer and she was admitted from hospital and she was on her last legs she's not going to get better from this she wanted to die at home like the things in place and stuff so this poor man picked this like scooped her up and brought home sat up all night with her and he rang up the district nurse crying his eyes out and she was that nasty with him because he didn't follow procedure she had to be there and bring the equipment in so I was like to her do you want to ring up and arrange all of that and we'll just go in here and I really took the emotional lead there with that man and he sent me a card after you know and she just went in there and started shouting at him and I really didn't like that."*

AB: *"The man had this big family and they were all the house in his house and this is why I like district nursing because people have rights in their own homes he was there with his family and they were wanted to say bye to him and then there was this nurse who just went in there told them in a really abrupt way to move out of the way of the bed and I was just like do you not know how to speak to people I wouldn't want to be spoken to like that if I was my dying relative, and people are quick to forget about that I think they wouldn't want it doing to their families so why do they think they can do it to others?"*

In these excerpts, AB talks about the importance of empathy in palliative care, describing how, in her opinion, older, more experienced nurses are more concerned with adhering to procedure, being hard-faced with patients in vulnerable situations. This is starkly juxtaposed against the attitudes of AB who wants to give the same level of empathetic care she would want her family to experience, taking the "emotional lead" in challenging situations to make sure the patient and their family is made to feel comfortable in a distressing situation. These displays of empathy are important as they clash with the dictated procedure adhered to by the more experienced nurses (a theme which is later analysed in the "them and us" cluster), AB does this as she believes it incredibly important to help patients have a good death. In doing this, she in embodying her beliefs as a nurse, helping her make sense of the lived experience of nursing but potentially causing herself issue with staff stemming from empathy for the patient and their family.

Participant DE talks about a patients unexpected passing and the impact this can have not only on the family, but the nurses too:

I: ***"Sure… with the patient who passed away in your first year, what's the story behind that?"***

DE: *"That was a really traumatic case we had this lady who come to us and she died a lot quicker than expected She's only very young and she had two young boys She was given months rather than years and it turned out to be days rather than weeks. So obviously we've arrived at the property to find two young boys who were saying that their mummy is sleeping So we walked in and she's unresponsive and she had passed away but obviously that individual didn't have anything in place at that time because she didn't expect to go as quickly so we had to remain in the property because we had two children, we had to contact next of kin and social services and we were there for a good few hours, and coming out of that because of the young*

children and the situation we walked in on we had quite an in depth debrief It wasn't necessarily traumatic for me because I've been doing that job for a while but for the nurse who I was working with she's never seen that before so they explained where should go for help if she needed it occupational health and counselling so they put things in place which I think is good"

In this passage, DE shares the account of the passing of one of the patients he was attending to. He describes the aftermath of the death and his role in comforting the children present, spending time with them after contacting the relevant services. Of note is the fact that DE states that the death itself wasn't particularly difficult for him, as he had been in similar situations in the past and had built up a certain "resiliency" towards emotionally difficult situations. This phenomena of "building up a tolerance" is congruent with the words of BC, who shared similar sentiments. However, even with this resiliency both BC and DE reiterate the importance of taking a moment to process these situations, either in the staff room or during a debrief. Also, of note is the matter-of-fact way in which DE speaks about death here, he initially describes the scene as "really traumatic"; the sooner than expected death of a mother, an event with wide-reaching emotional consequences. However, due to the emotional distance DE creates as a way of coping with such events, his words do not ring with the same emotional upset as other participants. This is important to understanding the lived experience of a student nurse, highlighting another method through which nurses cope with the severe emotional disruption of the job.

BC also tells a similar story about the importance of having empathy to make a difference not only for the patient, but for the family too:

BC: *"We had the paramedics hand her over the phone and she had a GCS of 3, which is basically dead anyway, she had a DNR so we knew not to, to be fair she held on for a long time, but then we had her daughter, no it was her carer with her and her daughter came later, but erm, her daughter had a stroke which left her quite disabled so it was difficult to see her daughter and her daughter's, and it was really sad, me and this other nurse were sat at the station just crying and it was the daughter more than anything, I heard from behind the curtain "Am I going to be on my own now?" and me and the carer and the other nurse were just absolutely bawling, we didn't want to go back in there, but we pulled ourselves together and brought them all a cup of tea and because of how the daughter was(.) it was hard, we were just explaining that she could still hear her, the way the daughter was it was almost like having a child and having to explain that, it was just really sad, but again we created that space for them, and they came up to us after and said thank you"*

This account explores a facet of empathy in death not previously explored, the emotional toll of working in the healthcare industry. An empathetic understanding of the participant's world has utility to nurses, as it enables them to give a better, more personalised quality of care, yet exposing learning nurses to distressing situations regularly. This forces student nurses to develop a coping mechanism, in this case, BC copes with the emotional strain by taking a moment to understand the viewpoint of the patient and family member, bringing them cups of

tea and explaining what is happening to help ease the family through this emotionally challenging time, giving the family the time and space to be with their loved one

The above extracts show multiple aspects of empathy regarding patient death. One of the most important parts revolves around having empathy for the patient and their family, with the nurse understanding the patient in their own context and doing what they can to make each party comfortable in these distressing situations to give the patient a "good death". Each response to bereavement seen above has a function in coping with the death of a patient, either creating a distance or closeness with the dying patient, ensuring that the nurse experiences a "good death" with the patient. Both approaches protect the nurse from the constant emotional strain of seeing patients come and go by ensuring that every effort has been made to give the patient a good death. Another important side to this lived phenomenon is the idea of nurses having empathy for each other, with the more experienced nurses understanding how challenging it can be seeing a patient pass, especially for the first time, making allowances and directing nurses to the appropriate support where relevant.

"Just get it off your chest, girl"

This cluster is comprised of stories and quotes which centre around the lived experience of dealing with difficult situations and the empathetic support needed by student nurses in order to cope with the stresses of the role. Accounts exemplifying these notions can be found below in the words of AB

BC: *"Just extra support for when you're out on the ward, 'cause you get it in uni, but sometimes a having somebody on the ward is great, like a nurse educator, somebody who isn't necessarily clinical but they're there for support and training and a shoulder to cry on, I think that's a really good idea… I think they should have that for all students, maybe not every ward, like one for 2 wards… create a role to support students because it would be nice to have somebody there, like when there are 4 critical patients you just get brushed to one side, but if you had somebody there for students, and staff, somebody to just look after your wellbeing, it's alright having Uni, but if there's nobody there on site, you need someone who's job is just you, not patients, because staff need looking after, it's difficult what we go through, you know?".*

It is significant that two of four participants directly mention the need for a specific role in nursing, somewhere between a nurse educator and a counsellor. Both participants refer to a lack of "psychosocial" support on the wards for students and staff alike, expressing how difficult the role can be and stating the importance of looking after the staff, not specifically one to one, but knowing there is somebody looking after the needs of staff on the wards; "a shoulder to cry on", further highlighting the importance of empathy in the nursing profession and the instrumentally destructive impact of a lack thereof.

Support from the academic side of the equation is also incredibly important, as the party who oversee the placements that student nurses undertake, the University staff have a vast amount of responsibility and influence in resolving any issues that may occur while a student is on placement. The following extract highlights this:

I: "*Sure, thanks for talking about that, so changing track a bit, if you could change something to reduce stress in nurses what would it be?*"

BC: *"Erm, I'm not sure because this uni are actually really really good with that, supporting students, like, I mean my personal tutor has been really good, I remember second year, they say you get second year blues, I remember just going in to have a chat about it and I just said I was really struggling, and she just stopped and gave me a hug and said I was the 20th person she's had in, its normal, I think it needs strengthening in the placements, some, like the staff need to know what you need a bit more, like the one I'm in now is great, with the support, it's like I work there, they're flexible with hours like if I need to make up some the week after I can do so I can still have a life"*

From this extract it is evident that when BC was struggling in her second year, her tutor was empathetic and understanding of her situation, guiding her through. From the extract, the tutor made BC feel as though her worries and concerns are normal, being the "20th person she's had come in" and offering her physical comfort. This is a small act of empathy on the part of the personal tutor, but it made a considerable impact and difference to BC.

Another compelling account discussing the psycho-social needs of student nurses comes from DE, who offers a perspective on the ways in which support changes throughout years of study.

DE: *"As a staff nurse I think they just expect you to get on with it, it's part of your job and I found as a third year it's what they expect of you If you've had a stressful day you can go into the office and moan about it but they do expect you to get on with it. In my first year we found a patient who had passed away when they got to the property and the support we got for that was great we have the whole team there and a proper debrief. They signposted places you can get help if you need it, whereas in third year, they just expect it to be part of your job. And I don't think you'll get that support from the management or leaders I don't think they're that willing to help you so if you have had a particularly stressful day or the something that's worrying you you can speak to your colleagues about it but then they just kinda expect you to get on with it and deal with it…"*

This passage taps into an experience not much discussed among the participants; BC talks about "second year blues", however DE's account of being expected to "get on with it" in his third year offers depth to this sentiment. As previously discussed, in second year academic pressures line up with placements, causing a stressful time for student nurses, however, they are still seen very much as students, which comes with its own pros and cons (i.e. being "treated like a child" and an increased level of empathy respectively). However, in third year from DE's account, student nurses are seen in a similar light to qualified nurses, being offered slightly more autonomy, but less support. The above excerpts help to shed light on the causes and consequences of phenomenon of empathy among and between nurses, helping to describe another facet of nursing than commonly seen in the literature.

The above extracts illustrate the importance of empathy and social support in nursing, with effective psycho-social support coming mainly from tutors. Participants identify a lack of ward-side support, stating that, while student nurses are told who to speak to in times of distress,

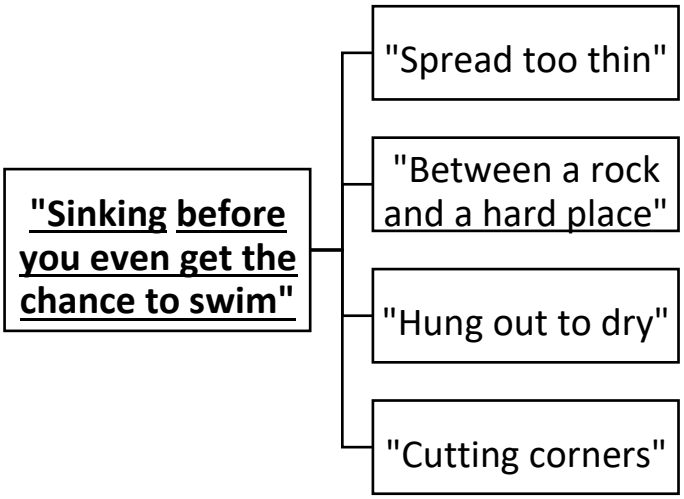
there is still a need for an approachable, centralised figure on the placements to come to with issues. Student nurses have a need to be understood in their own context in an empathetic way, to help cope with the traumatic incidents regularly experienced in the lived experience of a student nurse, with these experiences being summed up in the words of BC; "Because staff need looking after, it's difficult what we go through, you know?".

Overall, the above theme cluster investigates the different facets of empathy as experienced by student nurses. The phenomenon of empathy is shared not only between the nurse and patient, but among nurses, academic staff and healthcare professionals alike. These relationships are influenced by the levels of empathy shared; where there is little empathy the relationships deteriorate, conversely, where each person attempts to understand the position of the other, these relationships thrive, making the life of a student nurse significantly easier. The importance of empathy in nursing is apparent, with the ability to understand an individual in their own frame of reference almost being the most crucial skill in a nurse's repertoire. This ability allows nurses to make a significant difference in the lives of patients and their families.

"Sinking before you even get the chance to swim"

One of the most commonly reported themes across all participants revolves around feelings of sinking and barriers to learning and consequently good care. The participants all give emotive accounts of the lived experience of feeling "out of your depth", encountering barriers to learning and having to deal with their consequences. The multifaceted nature of this phenomenon is explored through the eyes of each participant below (see figure 6 for a pictorial representation of the themes in this cluster).

Figure 7. A hierarchical diagram depicting the themes clustered around the lived phenomena of "sinking".



"Spread too thin"

Most participants spoke about feeling their schedules were too busy, struggling to balance their placements and personal life. In the following excerpt, BC discusses her experiences of having a "million things to do at once" during her rotation in an accident and emergency room:

BC: *Yeah, so A&E is always [stressful] every day, especially when you've got a full resus room with 3 of you in there, like you're always bouncing from one to the other because they all need a set of obvs that they need every 15 minute, in A&E you also have loads of different doctors all demanding different things from you, I made this piece of paper its all boxed off and it's got all the patient numbers in it so when a doctor asks me to do something I write it down then tick it off when I've done it, to keep track, because it can just feel like you've got a million things to do at once".*

This quote illustrates the hectic nature of the BC's lived experience; her account of being a student nurse on a ward, pulled from one task to another, having to prioritise which patient has your attention from one moment to the next. BC's finds that her experiences in A&E are so demanding that she has created a table to track her tasks and better make use of her time. This aspect of temporality is key to the lived experience of student nurses, eliciting feelings of a seemingly juxtaposed structured chaos. Student nurses have a strict timetable to adhere to, (i.e. certain times to make observations etc…), however, coupled with the wider issues of short staffing, creates an uncertain chaos in the day-to-day lives of student nurses. It is seen to be particularly difficult to not only track tasks, but to know how and when to prioritise patients, giving special attention to certain injuries who may need to be monitored more closely. This excerpt paints a picture of the demands of student nurses, and how they are dealt with. CD offers another point about how it feels to be a student nurse, spread thinly between each facet of life in the passage below:

CD: *"Placement is the most challenging part of uni life, like you get into a routine at uni and then you get dragged out of it and thrown in at the deep end all on your own like as a nurse you're part of it, you're part of the team, but as a student you're an outsider looking in, you're not involved and then you're not involved with your friendship groups at uni so you're, (laughs) just swinging in the middle somewhere, you don't know where your feet are."*

This excerpt is important as is sheds light on how CD feels as a student nurse, not really belonging to any group, "swinging in the middle". Regarding spatiality, this phrase creates feelings of distance; being untethered both from the placement system and personal life. This disconnect is an important facet of the lived experience of student nursing, emphasising just how othered student nurses feel. Not being able to full fall into a routine and feeling like an outsider due to the impermanent nature of the placement system.

DE shares the viewpoint of CD, but talks more around what being spread too thin means for him as a nurse, voicing his opinion on the ramifications of this issue in the passage below:

DE: *"It's completely different to how I thought it would be, a LOT different to what I thought, and that mainly comes from the placements, I thought you'd have time for your patients, that you could make a difference, I find community you've got a bit more time for your patients but you're still overworked, still stretched so in a typical day you'd have 17 patients, some of those patients could take more than an hour so that will extend your day, so I do find my perception of nursing is not in reality what it is, it's very different."*

I: "Sure, so how is it different from what you imagined?"

DE: *"Erm, it's got to be the time you don't have the time I thought you would, being able to have that interaction with your patients doing your personal cares that's not something I've come across as a nurse that's more your healthcares and I think the biggest factor is the understaffing they've got and as a student you see which wards are struggling, I've been on wards with two nurses for 40 beds and wards with four nurses for 40 beds and you can tell when you've got the team you need you've got more time for everybody, erm, and the stresses are more prominent when you're running on little staff, and you're having to overcompensate for the people who aren't there."*

In this extract, DE talks about how the reality of nursing has not met his expectations of the role, with the leading cause of dissatisfaction coming from being "stretched", having a high workload means that DE cannot spend the time he wants to with his patients, even during his time on the community placement he still found himself overworked, with each patient extending his day. This quote demonstrates the disillusionment felt by DE. This extract brings forth ideas of temporality, with DE feeling he does not have the time he needs to deliver proper care. In addition, DE talks about the impact of understaffing, having to account and work for the nurses who should be there but aren't, which only compounds the

other stresses discussed, with the "stresses [being] more prominent when you're running on little staff".

Overall, this cluster describes the lived experience of being a student nurse, and feeling "spread too thin", with the stresses faced on in the job role growing due to a diminished workforce who aren't present due to the stresses of the profession. This vicious cycle perpetuates and strengthens the stresses faced by student nurses, with students not being able separate their placements and their personal lives, coupled with the hectic timetable of a student nurse, with the some working full-time in their placements and also maintaining a part-time job. This phenomenon works to deter student nurses from following the profession after graduation, with CD mentioning that she considered dropping out of the course because of the strain that working in her placements has put on multiple facets of her academic and personal life.

"Between a rock and a hard place"

This cluster of experiences focusses around the phenomena of strain, exploring the tension felt by student nurses in difficult situations. In the following texts, AB speaks about the tension she has experienced on the wards:

AB: *"It's hard to want to remain that caring especially when it is the way it is, when you're kind of between a rock and a hard place…"*

AB: *"You bite your tongue so much and I feel like I'm not doing my job properly like as a student or as a nurse I've got a duty of care for patients and I'm not biting my tongue for that because if I do I'm not putting a patient's best interest at heart am I? And people make it to personal. People haven't got the balls to be like that because I don't wanna fall out with this person or not have this person make a brew for them, so you've just got to deal with that"*

In these extracts, AB talks around feelings of conformity, having to go against her own judgements in order to not disrupt the status quo of the hospital hierarchy. AB talks about how these feelings of repression make it difficult to want to continue to work in the nursing profession, especially on the hospital ward. AB talks about the metaphor or "biting [her] tongue", an image which embodies feelings of strain, of wanting to speak out but being unable. Of note is her feelings on the topic of the patient's best interest, believing her duty of care is to put the patient's needs first, even if it causes a friction between herself and the other members of staff.

CD talks about more general tensions and conflicts she has experienced during her placements, focussing more on the clashes that nursing has had with her personal life in the excerpt below:

CD: *"As a student you don't want to bring up these issues because you're scared they're going to fail you so you have to, like on some occasions ive had a doctor's appointment or I've had to pick the kids up or whatever you've had to do and it's like "well you're supposed to work a long day today" and like "well technically I'm not getting paid for these hours and I'll make the hours up to you during the week but today I just really need to get off" you know you could have all sorts going on at home and if it was a member of staff they wouldn't question it and as a student I have to say I have a voice as well, I'm not just an extra piece and more often than not they count you in the numbers so there's six members of staff but they'll count you as seven and especially when you've spent six months away from wards at uni you'll forget some stuff, like how to give a bed bath like obviously you'll remember and you'll be okay doing it by yourself after a while, but in that sense you are running around like a lost puppy and if you speak up too much some people have an issue with it (laughs)."*

In this passage, like AB, the tension is between CD and her superiors, with CD having issue more with the uncaring nature of her management, being afraid to bring up personal life conflicts and issues with her mentors in case she fails the placement. CD draws allusions to running around like a "lost puppy" but being too afraid to speak up in case somebody takes issue with her. This metaphor is interesting in understanding the lifeworld of a student nurse; "lost puppy" relates lacking a master, or in this case a mentor, experiencing life without direction or help. This is an evocative use of metaphor, concretely setting the lived experience of nursing in the frame of ownership and power. CD also speaks about lacking a voice, which further ties into her use of metaphor, being a "lost puppy" but lacking the voice and power to ask for help. These feelings are in line with the experiences of AB. In addition, CD makes a point to emphasise the stresses of balancing her personal life with her placement, saying that if she were a qualified nurse, the other staff members wouldn't have an issue with leaving early to pick up the kids, however, because she is a student, she finds the staff a lot less lenient, feeling she doesn't have a voice while being counted in the numbers and being held responsible for the job of a qualified nurse without the respect.

DE echoes the sentiments of AB and CD on the tensions they have experienced on the wards. DE talks about his own experiences briefly in the section below:

DE: *"I do find community they don't use you [in the numbers]. And I've enjoyed it more because of that on the wards there are days you don't want to go in because you know how short-staffed they are and you know you'll be a healthcare but you can't bring it up because that nurse signs you off so you can kick up a fuss and risk not passing or get your head down and that's a worry everybody has, especially if you have a mentor who might not be supportive, you've always worrying if you're good enough to pass, that's a major stress, then if you've got personal stresses in your home life or you're struggling with uni that leads to a massive drop out."*

A recurring theme throughout every participant's transcript, DE says he prefers community-based nursing to ward-based because he isn't used as a spare pair of hands; included in the

numbers when he shouldn't be. DE talks about how he hasn't wanted to go in on days he's knows the ward will be understaffed and so he will be used as a HA. However, DE feels he has just had to conform and not bring up the topic to his mentors, again out of fear they might fail him. DE suggests that the attrition rate he has noticed on his course may be down to the constant worry about not being good enough, coupled with the tension of being used as a HA and any personal stresses. This quote is congruent with the feelings of AB and CD while expanding on their answers by directly suggesting he feels a tension and conflict about being sued as a HA, but not being able to say anything about it.

The above quotes exemplify some of the conflicts and tensions faced on the ward by student nurses. This theme forms an intrinsic facet of "sinking before even get the chance to swim" with the tension felt acting as a barrier to learning and, as DE suggests, possibly being a largely contributing factor to the drop-out rate seen in nursing courses. Student nurses face tension from almost every aspect of hospital life, being forced to do the job of a HA but not feeling able to tell anybody out of fear of being failed, not having their needs respected as much as a qualified member of staff and not always being able to put the patient's needs first are some of the biggest strains faced on the wards by student nurses, all of which make up an important part of prohibiting some nurses from finishing their training.

"Hung out to dry"

This theme places an emphasis on feelings of being out of your depth; not being given the proper support and then being reprimanded for making a mistake. AB shares her accounts of this in the excerpt below:

AB: *"So as a student nurse you supposed to be like you are super-numeracy so you're supposed to be guided, so this was another student on the walk with me she was told to go and take some clippings and some sutures out of a patient and she never done it before at least not properly and she was just kind of told to go and do it and I mean I cause a rod for my own back because I'm really open so I'll put up a fuss, but if somebody is not sure of themselves they'll just toddle on and do that not really know what they're doing, and it was really badly infected but she just a student I mean she was just a young girl and she didn't really know what she was doing. She wasn't really experienced with wounds but then the error was on her head then. But she hadn't been supervised she hadn't been taught through that or taught how to do it or anything, she's been top referring everything but that's not what it's like in real life it's a bit like the blind leading the blind but you really quick to get hung out to dry."*

In this story, AB shares the experiences of another student on her ward who was thrown into a situation in which she did not have any experience and who, without supervision made a mistake dressing a patient's wound and was blamed for it. The last phrase in this passage is key in understanding AB's experiences, seeing the management as ineffectual leaders, not offering support for young nurses, instead, reprimanding them when they make

a mistake. Additionally, the metaphor of "hung out to dry" is used, eliciting feelings of isolation and powerlessness, with your fate being in the control of somebody else, somebody who, as AB states earlier is an ineffective leader, further highlighting the tensions felt by student nurses.

AB shares another story, furthering her thoughts on feeling "hung out to dry" in the text below:

AB: *"So there was this really Gritty one on A&E not so long back, she had to take saturations on this chap and they were at 84% and this young girl was like "I told somebody about this it could be really bad" but everyone was just stood around and this guy had a heart attack. You know, and she wasn't even in our year, she was a second year and she was absolutely traumatised by this man passing away, and she's raised that how she thinks you should raise it. She might not being as assertive as she needs to be but that's really not her fault, she shouldn't have been blamed, so it's like you do find yourself sinking before you even get the chance to swim because you do find yourself put on the line all the time."*

Here, AB talks about another nurse, who noticed an issue with a patient's oxygen levels and tried to raise it but was ignored. Even though she raised this as an issue through the proper channels, she wasn't listened to and was apparently blamed for the situation. The metaphors of "sinking" and being "on the line" are also revisited here. "Sinking before you even get the chance to swim" again draws on ideas of isolation, but also hopelessness, with nurses wanting to thrive, but being weighted down, and disillusioned by the blame culture experienced in hospitals. Additionally, being put "on the line" is also used here, continuing the metaphor of being "hung out to dry". This again draws attention to feelings of blowing in the wind, listing powerlessly with a lack of control and choice. AB states that, as a nurse you always put yourself out there for your patients, but it is difficult to remain that caring when your superiors are quick to blame you for even a small mistake.

In the following extracts, DE shares his experiences of feeling blamed on placement and the consequences that follow:

DE: *"In the hospital you do have that back up to check things, but in community of you make a mistake you're hung drawn and quartered essentially and I am aware of a few patients who have gone on the sue the NHS because their report says they've been neglected but you can only give the advice, you can't make the patients take it*

DE: *"The trust I've been at I've been at for 3 years and I've had a job offer there and a job offer at another trust and I think that's a big part of why I didn't take the job there because I've seen how little support is given to the staff You're often made to feel like you're just a number rather than a person And they're very very quick to collar you if you've done something wrong, but they're not very quick to give feedback if you done something right, so*

you could have feedback for a particular patient whose said that you've made their life hospital easier and even enjoyable to some extent but that praise is never given."

Here, DE talks about how quick his current trust is to reprimand him if he makes a mistake, with some patients suing the NHS over decisions made. DE agrees with the sentiments of AB, stating that management are very quick to reprimand you over a small mistake, however DE also speaks about the importance of positive feedback, of which he has found his current trust slow to relay back, if it is recorded at all. These issues have led to DE taking a job offer at a different trust, showing the real-world consequences of poor management creating a feedback loop of understaffing and dissatisfaction, as no newly qualified nurses want to join wards where they do not feel supported.

Overall, this theme elucidates a smaller aspect of the larger theme "Sinking before you even get the chance to swim" with the blameful culture of nursing being incredibly detrimental to the learning of student nurses. Not only does this blame culture punish nurses for their mistakes, but also when they raise issues the way they should, with this kind of environment deterring student nurses from joining certain trusts, perpetuating the issues present in the specific trust, but also the NHS as a whole.

"Cutting corners"

This cluster of themes centres around experiences of the other staff members not caring about patients, skipping or rushing through procedure to better suit them against the best interest of the patient.

AB: *"I've kind of followed this patient through surgical and then up to the general ward and the surgeon was telling me about how he's wrote his own in-depth 15 minute kind of follow-up ritual, kind of post-operative assessment for the patient because it is like mega surgery and about all these symptoms to look out for about how like inter-cranial pressure could build up because you're like severing a pretty major blood supply to the head. So I'm thinking wow right yeah I'll really watch this guy and then he comes back up to the ward and he was only 55 and he was like sat up in his bed like gasping and he said been on a boat and that he'd been drinking and all the nurses who just kind of laughing at him, and I can remember being stood there and thinking "No, when he's come in he's been talking right as rain, he were anxious about having an operation but he knew he needed it and that's not normal that kind of change". And I remember feeling horrible about it and I talked to other nurses and she just like "oh yeah you'll get used to seeing that on here coming round from when they're being under anaesthetic". She just completely dismissed me and I remember looking at the doctor's 15-minute follow-ups, and it wasn't happening and because it was coming to the end of the shift they just wanted to get his stats up getting stable so they could pass him off to the night team and they were all like stood there drinking a cup of tea… Anyway, so I went home feeling off about it and they came back in the next day at 7 and there was a crash Team he'd arrested on the table and bled out and died."*

In this account, AB describes a situation in which her concerns were dismissed with a devastating outcome for the patient. The nurses on this ward disregarded AB's perspective and the surgeon's post-operative suggestions, in addition to a disoriented and scared patient. AB went home "feeling off" about the situation, seeing the more experienced members of staff being so careless with a patient. Experiencing events such as these may act as a barrier to good nursing, through both the passing on of bad habits and acting as a deterrent for nurses who object.

AB shares another account of seeing healthcare professionals cut corners in the passage below:

AB: *"Another one they do is with observations like if you're a student nurse and you're doing observations you're trained to count them properly and other nurses will be like oh no no, don't bother with that count to 15 and then just times it by 4. But I want to be fair, I want to count how many breaths for real the patient is actually taking not just guess. In here we get told that breathing and respiration rate is the single first thing that tells you that something is going to go wrong, you'll need your eyes and there's watches and clocks on the wall and you got watches and you just need to count for 60 seconds, it's really simple.*

In this account, AB talks about watching a HA cut corners and alter a patient's observations, AB is distressed by this, stating that checking breathing is the one of the first, most simple things they are taught in nursing school, but the HAs have fallen into bad habits which could have detrimental effects for the patients. Like AB's other story, this acts as evidence for a laxed healthcare staff, who student nurses are spending more and more time with due to understaffing and the devaluation of being a student nurse (i.e. being treated like a HA). This passage highlights the tension felt by student nurses, experiencing a strain between what is expected of them, what they expect of themselves and the reality of care on the wards in practice.

Overall, staff cutting corners is another huge barrier to good nursing, with prospective nurses being either off put by the bad practices, or possibly falling into the habits themselves. This deterioration in the quality of hospital care in conjunction with the added time pressures and relaxed management is creating a tension between the care that student nurses want to provide and the practicalities of care on the ward. Consequently, many student nurses are turning away from the career path, searching for an alternative occupation.

Overall

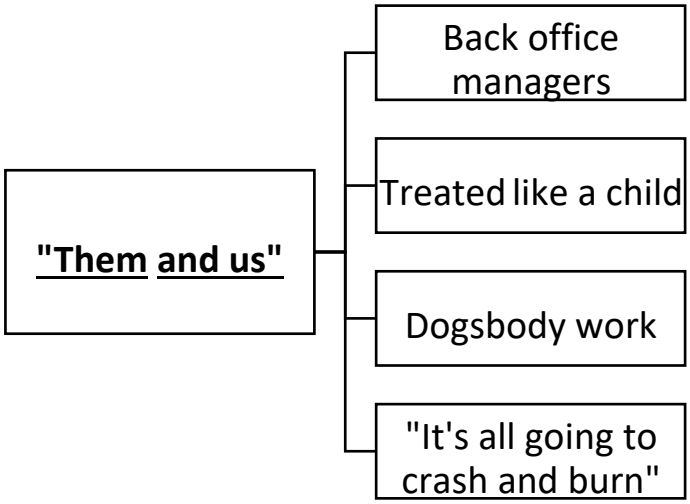
In conclusion, there are myriad barriers to nursing, from understaffing, to the emotional toll of such a stressful role, to moral dilemmas, seeing staff cut corners and feeling blamed by management. All of these works together to create an uncertainty not only about the individual's role as a nurse, but the direction of nursing and the longevity of such a role in the

NHS more broadly. The above phenomena focus around feelings of "being out of your depth", examining the some of the challenges faced by nurses on from the personal to the more organisational with these issues needing addressing to remedy the attrition rates seen in nursing courses across the country.

"Them and us"

This cluster of themes focusses around experiences of tension, specifically with and between fellow s staff members. These themes were found to be present in the accounts of all participants, with each nurse interviewed adding further understanding and insight to the phenomena. This theme is inter-related with "sinking before you even get the chance to swim", but places more of an emphasis on the interpersonal conflicts faced by the nurses and perhaps most prominently feelings and issues around power, a theme which was found to be prevalent throughout the lived experiences of the nurses interviewed. A full breakdown of the sub-themes can be found in figure. 8 below

Figure. 8 A hierarchical diagram of the themes clustered around the phenomena of conflict.



Back office managers

This theme centres around experiences of conflict with superiors, more specifically experiences of the consequences of ineffective leadership and teamwork, setting an inappropriate example for nurses in training. A key example of this comes from BC's transcript.

I: Sure, so you've mentioned your, er, your supervisor who you had an issue with, could you talk to me a little more about that?

CD: *"So erm, it was erm, after my intermediate interview there was a student off sick and a few sicknesses on the ward and obviously we know about staffing shortages and the ward next door got closed down so it was really hectic, and I was in my intermediate interview and I mainly worked with this nurse, well I mainly worked weekends because they had to manage other students but I was more than happy working weekends because my personal life kind of happens during the week day. So my mentor only ever worked*

weekdays, like 7 till 2 or something and I barely ever worked with her, when I did she was always in her back office and I was on wards with a healthcare (laughs) I'm not even joking it was the odd occasion she did med rounds, she did one or two med rounds and I don't think I'd ever seen her give a bed bath".

CD talks about her experiences with her mentor during one of her placements. During this time, CD barely ever saw her mentor, and when she did, the mentor kept her distance, staying in the back office while CD was partnered with a HA, not her mentor. CD remarks that she doesn't ever think she's seen her mentor give a bed bath, this seemingly throw away comment is important as it illustrates the experience of having a mentor who is not present, or willing to get involved with the day to day tasks expected of a nurse.

DE also offers a congruent account with CD, while elucidating further the lived experience being a student nurse, about to graduate and become a qualified nurse in the contemporary NHS.

DE: *"It can be quite a daunting experience, being a student nurse on hospital ward if you've never done that before It can be quite daunting going on to the ward for first time but I have that point of contact it can alleviate some of your fears. But as a newly qualified you don't have anyone to go to, you've got your band 6's and your band 7's but if they're not approachable you don't have anyone really. And I have found the hospitals if your band sixes are not approachable that's where things go wrong because people are scared of going up to them asking them for help, or if you're newly qualified you can have looked at like well you should know that you're a nurse now. So I think it's totally down to other individuals alike there is some very very good ward managers I have come across, who are there for their staff night and day but then there are others who you won't see the full 12 week placement you're there, and they're hidden behind the door doing paperwork with no contact with the staff and it's those wards where the staff retention is very poor, there's very high sickness and the stresses are a lot higher. And I think it shows from your ward manager if you've got a ward manager that works well with your team, everything else just goes smoothly*

Here, DE offers an in-depth account of his thoughts and feelings around the tensions and conflicts experienced during his time on placement. DE talks about the challenges of being a student nurse but emphasises the importance of having a good mentor and a reliable point of contact. DE further shares his perspective on the shift that happens upon qualification, relying on the higher band nurses in place of a mentor. DE talks about how perceptions change in regard to responsibilities, with newly qualified nurses being expected to cope and know what to do in challenging situations. In a similar nature to BC and CD, DE recalls his negative experiences with ward managers "hidden behind the door", commenting that it is the wards on which this happens that he has seen a higher rate of sickness and turnover

Overall, power issues and conflicts with superiors are a commonplace experience in the lives of student nurses, with managers who stay hidden behind their office door having a

detrimental effect on morale, which coupled with the previously discussed issues in "sinking before you even get the chance to swim", may significantly encourage staff turnover. However, the converse is also discussed, with the more supportive and approachable higher bands "mucking in" when they need to, creating a sense of cohesion and parity between the lower and higher band nurses. These thoughts and feelings around issues of power are an important facet of the larger theme "them and us" shedding light on the lived experience of being a student nurse.

Treated like a child

This cluster of quotes places an emphasis on experiences of feeling undermined and demeaned while on placement. This is one of the most wide-spread and impactful phenomena experienced across participants, with each interviewee having multiple of their own examples of experiencing this. A particularly salient excerpt on this topic come from BC.

BC: *"Especially as a student what I find stressful is when you ask another member of staff to do something for you and they don't even listen because your just "STUDENT, DO THIS" if I was stood in blues not in whites you listen… But yeah, I'm just a student, if I don't know something don't talk down to me, that's why I'm here, I'm here to learn y'know? So why be judgemental? I know some of my friends have had that issue on the wards too having people not listen to you or take you seriously because you're a student. I know at other units they have like different coloured lapels and stuff to show what year you're in but we don't have that so they don't know what year you're in, that could have been my final placement for all they knew, in a few weeks when I'm qualified they'll have to listen to me because I'll be in my blues. So that's a challenge, it really annoys me really, just for the patients sake, like if I think there's an issue come and see them for their own sake to make sure there okay, it's annoying because that 10 minutes of them not believing me could make a difference for the patient, in the settings I'm in it could be life and death you know? And I know all my friends could tell you this exact story 10 times over, the not believing you*".

In these passages, BC talks more broadly about her experiences of feeling dismissed by superiors. BC mentions experiences of feeling discriminated against, based on the uniform she wears, by doctors, even though her mentor has seen it fit for her to raise the issue. BC also talks about the phenomena of being called "STUDENT", not being referred to by her name but by a placeholder moniker designed to derogate and make prospective nurses feel inferior. BC also strikes upon a paradox, crucial in understanding the liver experience of student nurses on the wards; BC says "I'm here to learn y'know? So why be so judgemental?" highlighting the strain between being taught and being scolded, with some mentors and staff members not understanding this distinction. Student nurses are in an indeterminate state, between university student and qualified nurse, being treated more like the former, yet striving for the independence of the latter. Here, also, BC talks about the consequences of not being taken seriously, suggesting that both not being believed may cause an issue for the patient, but also the time taken convincing the other staff takes time away from, as previously discussed, an already hectic schedule. The above acts as evidence

for student nurses experiencing a lack of trust and belief, minimising their training and role, in effect making them feel "like a child".

In the following account, BC tells the story of a time when a doctor didn't listen to her concerns about a patient:

BC: *"I had this doctor not believing me one time with you rounds in the morning and this patient had melena, which is this bowel condition, and you can smell it, once you smell it you know what is it as soon as you smell it. So I told the consultant because obviously she needs treating and he was known for being a bit of an idiot (laughs) and I said that he needed to see the patient first, I'd cleaned her up and taken a sample and told him what I was concerned about and everything, done the obs and told him the results and he just looked away, and I was like "excuse me?" and he just said "yes, I heard you, I'll just wait to speak to the real nurse" and I'm like "well she's just going to tell you the exact same thing I've told you so whatever" so I went and told her and she spoke to him and said "why are you not listening to my student?" and he said "well she's a student, she doesn't know what she's talking about" and I was stood right there… but yeah, absolute idiot, he used to do my head in, he used to call me "STUDENT" not my name and click his fingers at me and if he wanted something had click his fingers at me and be like "STUDENT, STUDENT!" and one time I turned around and was like "that's not my name, you know my name, it says it here on my card and ive introduced myself to you like a hundred times, and he was like "okay student", yeah, like don't click your fingers at me I'm not a dog, I won't come running, he was an arsehole.*

Here, BC discusses a specific incident in which she believed a patient had Melina, however, when she brought this issue up through the proper channels, she was dismissed, with the doctor saying he would rather speak to the "real nurse". This is a small, everyday example of the dismissals and put-downs that student nurses experience. In the same response, BC talks further about other run-ins she has experienced with this doctor, again, referring to her only by "STUDENT" and viewing her as so subservient to him, that clicking his fingers was a suitable way to get her attention. BC alludes to being spoken to like a dog, interestingly, this imagery is used in a different way than CD's earlier "lost puppy" metaphor, highlighting issues of power and control, drawing attention to the dehumanising manner in which BC has been spoken to. In this key excerpt, BC also speaks about the consequences of being treated not only like a child, but like a second class citizen, seeing these experiences hugely detrimental to her in her confidence building, but finding solace in the fact that the issues are at least being attended to by somebody. Again, this is an everyday example of the issues faced by student nurses, with superiors constantly offering small yet significant knocks to their confidence.

CD shares a similar account of feeling demeaned and spoken to with little respect in the passages below:

CD: *"And my mentor I had an issue with my first placement she erm, put me with healthcares and it's important to learn about the caring side of things but I also need to learn about like the reason why we do certain things why we put this IV up, I can't just know how to care for the patient I need to know why, and I brought that up with her and it was taken the wrong way in my intermediate interview, after that it was like she says do this and you do it…"*

Here, CD talks about how she broached an issue she had with the way her placement was being conducted, being grouped with and doing to work of a HA, instead of nursing (an extremely pervasive issue throughout all accounts). CD brought this issue up in a routine interview and comments how her mentor's attitudes towards her changed. CD further discusses this below:

CD: *"Then one morning she walked in and this is kind of where it all started off and she walked in and one patient had passed away over the night and we were responsible for the final rights and it was my first placement, I didn't know what I was doing, you know, you feel like a fish out of water basically, you don't know the rules, protocols or anything and she walked out to do the handover and it was this tiny little with about six or seven people in it and she didn't even know my name so she referred to me as "Student", she didn't ask me how to pronounce it or give me a nickname or anything and said "you, student are going to do final rights on that patient" and I was like "do I not have a choice in this?" it was 7am and I wasn't physically and mentally ready to do something like that, because you need to be prepared to do something like that she was like "if I gave you a choice you wouldn't do it"… I don't appreciate being talked down to like a child, treated like I'm not good for anything and she didn't understand the line between teaching me and putting me down and I did put a complaint in, don't know how far that went but every other mentor I've had has been great, just that one issue, I haven't had that issue again".*

In this account, CD goes through the details of her biggest struggle with management, being called "student" in a dehumanising manner and being asked to conduct a final rights she did not feel comfortable conducting, especially after not being given a choice in the matter. This strain caused CD to speak out, telling her mentor that she did not appreciate the way she was being spoken to, which fortunately changed her mentor's behaviour. This illustrates the cold way some nursing mentors operate, dehumanising student nurse.

The above accounts tell the story of student nurses feeling dehumanised and derogated, treated like un-trustworthy children while on their placements. The issues here seem to focus around superiors, creating a divide between the higher bands (i.e. doctors and senior nurses) and the lower bands (i.e. student nurses etc…). A pervasive issue across all accounts is the phenomena of being referred to as "STUDENT" an act which has a smaller, yet significantly damaging impact on the fragile confidence of a prospective nurse. All the above works together to create a tension and strain between "us and them", with the stories of

the student nurses depicting clear lines in the sand between the "proper" staff members and the infantilised student nurses.

Dogsbody work

This theme is similar in meaning to the above "treated like a child" but focusses more around the physical experiences of doing the work of a healthcare assistant as opposed to a student nurse. Again, however, this theme is incredibly widespread with, (while some quotes are used elsewhere) all participants discussing this phenomena in some depth. AB offers examples of this experience in the passages below:

AB*: "Well it all depends on what are you working in and what the working conditions are like where you get posted that kind of determines how you get treated sometimes on medical elderly wards I've been like a pharmacy runner, like a dinner lady and have argued to not get shipped out to other wards be an extra pair of hands because we're supposed to be super numeracy It depends on the work environment in general if they're overworked you're overworked."*

AB: *"So staffing is the biggest [issue] you don't have enough healthcare assistants on so students, like I kind of feel that students will just be like doing the HA's jobs, doing their jobs and like cleaning rooms which I don't mind it needs to be done but I can get a bit like hang on a minute I've done 3 years' worth of a degree here I was cleaning bathrooms at 17 and if want to do that I just go and do that and get paid by the hour".*

In these excerpts, AB offers great insight into the super-numeracy issue; student nurses are not supposed to be counted in the numbers on a ward, being super-numeracy. However, due to chronic understaffing, all participants report being used in the numbers. Primarily to do the job of a healthcare practitioner, not a nurse, the vocational role for which they are training. AB remarks that if she wanted to clean rooms, she need not have spent the time and money she has become a nurse. AB also says that, while this issue is pervasive across wards, the extent to which the ward is understaffed has an impact on the amount of actual training the student nurses get. This theme again depicts a divide between the student nurses and other staff, with mentors and superiors making student nurses essentially work the job of a HA, unpaid, thus having a detrimental impact both on training and confidence levels in student nurses.

BC has also experienced this phenomena, further elucidating the subject in the quote below:

BC: *"Yeah, like I was saying it's mainly when they use you as a healthcare, this one time they were really short-staffed, they were short couple of nurses so one of the senior nurses come round and asked my mentor how we are for staff, and my mentor was just like "oh yeah we're fine I've got a Healthcare, got my student here" I was a bit upset by that, especially when you're doing 13 hour shifts yeah like that's a lot I've been doing your health care job and then when your mentor realises they're not actually teaching you anything they'll try and grab you the teach you stuff, but when they've got all the staff they'll ask me to do stuff because you've been signed as a healthcare for the day, and I know from all my friends who are nurses that this is kind of a bugbear across everything really and uni say it shouldn't happen but it's just a constant battle".*

In this section, BC talks about being used as a HA due to understaffing issues, doing 13-hour shifts. BC goes on to say that when her mentor had realised, they had not taught their student anything, they will quickly try to compensate. BC says this is an issue all her course-friends have faced, being signed off in the numbers as a HA for the day, diminishing their learning and demeaning their role as a student nurse.

DE has also experienced this issue, giving an in-depth account of the lived experience of being used for healthcare assistant work in the following interview section:

DE: "*So the last placement I was on the first placement of year 3, for the first week they used me as a healthcare, which, it's okay to work with a healthcare for the first few hours to get an understanding of how the ward works, but if the ward is short they will use us and they forget we're not there for that, a lot of the healthcares will sit back and let the student do it… first year I was used as a healthcare for the entire year they didn't allow me to do much nursing it was all personal cares, second year I had intensive care where the nurses did the healthcare jobs as well as their own which I was happy to do because the nurses were doing it then in third year they do forget you're there as a student and they will use you because its free labour for them at the end of the day so they can save money by taking a healthcare off and putting a student on, which that's not what were there for, uni know it happens but not the extent of it, the learning facilitators do say what you should and shouldn't be doing but it's not followed, if they're short-staffed you've got no chance learning and there have been times where I've thought that was pointless, like you've done the job of a healthcare assistant for free and I've felt like turning round and asking for a pay packet at the end of the week (laughs)*"

In the above passage, DE talks through his experiences across the years, being used exclusively as a HA in his first year, not being able to practice nursing in any meaningful way, simply doing smaller personal care routines, followed by doing the job of both a HA and a nurse in the intensive care ward he was on, taking after the understaffed nurses on that ward who did the same and finally being used as "free labour" in his final year. DE say that his institution is aware this happens, but not the extent of it, being primarily down to the short-staffed nature of the NHS. DE sees his time on understaffed wards as "pointless" as he doesn't learn the job of a nurse, instead being used as a spare pair of hands to do the job of a HA, joking that he should ask for a HA's pay packet for all the work he does. An additional note is that DA says that the HA's will "sit back and let the student do it", using the student nurse to get out of doing the basic personal cares that comprise their job.

The above examples depict the lived experience of student nurses being used as free labour; doing the jobs of healthcare assistants for the duration of their time on the wards. This is due to the understaffing crisis the NHS faces, with each ward missing key members, super-numeracy are having to be used in the numbers to cope with the pressures of the ward, and in some extreme cases having to do the job of a nurse and HA. This issue is incredibly widespread, having a devastating impact on the education of student nurses and creating a distance between the students and the qualified staff, who see them as a free, disposable workforce.

"It's all going to crash and burn"

This theme examines the wider-spread, organisational tensions faces by student nurses, with a focus on the uncertainty felt

I: ***"So, where do you see nursing going in the future? As a profession?"***

BC: *"Well if you compare it to 30, 40 years ago, there's been a shift in the roles I know someone whose been a nurse since she was 18 and has seen it you know, and she said that healthcares do what nurses used to do, then nurses do what junior doctors used to do so it's all shifted and your housekeepers do what your healthcares would have done and now there's the nursing associate role, I've got friends who have been recruited but then they said they'll have to send them elsewhere because they've given the roles to nursing associates now band 4 so now they don't need band 5s and there's not enough room for a band 5 so where does that leave us? Do we do more training to be band 6 or what? So that will be interesting, it might change higher up too you never know, I think it will just keep shifting with every band getting more responsibility, it could either go really well or everyone could be really stressed. Nursing will never change, but the politics will always get in the way, the pay scales and all that, short staffing will be an issue, nursing hasn't changed but it's all the other horrible little bits"*

In this passage, BC talks about a phenomena linked to understaffing, she mentions friends of hers who, after accepting a job at a hospital are having to be sent elsewhere because there isn't enough space for a qualified nurse in the trust's budget, choosing to hire the cheaper, less trained nursing associate role. BC sees the future of nursing as constantly in flux, with each band incrementally getting more responsibilities and the constant addition of lower banded jobs (i.e. nursing associates). The final line of this quote is indicative of the lived experience of being a student nurse, BC says "nursing hasn't changed, but it's all the other horrible little bits". This quote is key, emphasising that the compassionate side of nursing; "the importance of empathy" has and will never change in her opinion, BC further says that the politics, pay scales and staffing will continue to obstruct nursing into the future. These top-down barriers, in particular the ever-changing job responsibilities further emphasise the widening gap between qualified nurses (band 5) and those above.

On the topic on uncertainty, tension, and the future of the NHS, CD also shares views in line with that of AB and BC.

CD: *It's not knowing where you stand in the NHS, we're nurses but we do the job of a healthcare, a doctor, we're running around like headless chickens half the time trying to tie loose ends together and I just think we're underappreciated and overworked and every ward will say the same thing, there are a lot of us but clearly not enough, even as a qualified nurse there will always be short staffing, you'll always be underpaid, but you've got to, like I love the job, doing what you love for a living, like I want to do my masters which is more debt, but if it's what you want to do there just are sacrifices you need to make".*

In her quote, CD, despite "all the other horrible little bits", sees nursing as a calling, something to make sacrifices for and pursue. Like BC, CD mentions the uncertainty of not knowing your place in the NHS as one of the biggest challenges for the future of nursing, offering a more optimistic point of view. Like BC, CD also brings up the issue of pay, acknowledging that nurses will always be underpaid and undervalued, underappreciated and overworked, seeing these as systemic issues not likely to change. CD sees these issues as less of a barrier that AB and BC, viewing nursing as a vocation.

DE also shares the views of the rest of the cohort, shedding further lights on his experiences with the chronic understaffing issues seen throughout the NHS.

DE: *"Obviously with people leaving there's less staff and nobody to replace them so your workload increases, you don't get a family, work life balance and the patients are getting more complicated because were living longer and it all just adds up with social care not being available and people staying in hospital longer with district nursing teams needing proper accommodation and I think that's what's going wrong really".*

In this quote, DE broadens the scope of the uncertainty experienced by student nurses, discussing briefly the strain the crumbling NHS puts on the social care system; "it all just adds up". DE speaks more about the community nursing placements, noting the stresses he's experienced there tend to focus more on resources and facilities with a lack of proper accommodation for those who need it. Perhaps DE's biggest point again centres primarily around a lack of staff, reiterating that lower levels of staff, no matter how well the ward can cope, will always amplify the stresses experienced by student nurses, eating into the work-life balance and multiplying the organisational pressures felt by student nurses.

This theme revolves mainly around the strains and conflicts experienced by the lower grade staff members, feeling othered by the strained NHS. These organisational shifts and changes create a staggering level of uncertainty in the field of nursing, with nurses unsure as to which role and even which hospital they will end up working in, despite accepting jobs at specific locations. This coupled with the day to day diminution in the confidence of student nurses by superiors who view them as "free labour" and mentors unwilling to teach creates a challenging environment to want to enter after qualifying for student nurses.

Overall

The theme of "Them and us" offers key insight into the lived experiences of student nurses on their clinical placements, drawing attention to the strains and conflicts experienced not only institutionally (top-down) but every day (bottom-up). Peers and superiors use student nurses like "free labour", while treating them like children, there is a stark juxtaposition between being expected to be competent and being condescended, with student nurses being stuck in the middle of this paradox.

Conclusion

In conclusion, the lived experience of nursing is an incredibly complex phenomenon, not fully accessible by any party other than those experiencing it. Based on the above, co-constructed data, there are three key pillars to understanding nursing through the eyes of a student nurse;

"Sinking before you even get the chance to swim", which suggests that it is not so much compassion fatigue acting as a barrier to nursing, but “all the other horrible little bits” such as the emotional toll of a stressful role, the moral dilemmas, seeing staff cut corners and the fear of feeling blamed by management for every mistake. These issues act as personal barriers to nursing, managing to deter even the most convicted student nurse from staying on the wards for the rest of their career, and even making some student nurses question their future in the NHS as a whole.

“The importance of empathy” encompasses the skills which are key in thriving in a nursing setting. Interpersonal relationships can make or break the student nurse experience, with the phenomena of empathy being shared across the entire department, from patient to practitioner and vice versa, but also within and between staff members. When this empathy breaks down, departments seem to stop functioning, however conversely, if this empathy remains high, wards seem to cope better with the instrumental top-down stresses of the NHS.

“Them and Us”, like "Sinking before you even get the chance to swim" centres around barriers to nursing, but specifically the conflicts faced by student nurses at both the personal and organisational level. The ever present, distended infantalisation of student nurses by superiors, coupled with the top-down strains placed on individual wards work to create a zeitgeist of uncertainty, not only for the individual, but for the NHS more broadly.

All of this makes for a difficult working environment for prospective nurses, many of whom are considering alternate career paths the escape the uncertainty of the ever-shifting NHS.

Overall, the three experiential pillars described above work to create experiences of a job role marred by both day-to-day and overarching pressures, however, student nurses value empathy and resiliency above all else, with an understanding of the self, and others (both patients and staff) being crucial in the lived experience of student nurses. This coupled with the sense of pride and reward felt by student nurses for being able to make a difference, however small, to a patient’s life makes nursing an increasingly challenging, if fundamentally rewarding profession. The findings of this analysis will be further discussed regarding wider research in the following section.

Discussion

The findings of this study present in broadly similar ways to previous literature around this topic, however with several distinct and impactful differences. In addition to the similarities, these incongruities will be examined below while looking with a wider scope at the socio-political climate in which this study is situated. In general, the clusters of themes found in

the data of the present study fall in line with the themes identified during the earlier literature search conducted, however have been grouped in different ways both more relevant to the present study and the method of IPA, being more centred around the lived experiences of the participants.

Here, the most salient and impactful of the issues and topics discussed during the interviews will be discussed with reference to existing literature on each topic. From the face-to-face interviews and transcripts and spanning across different theme clusters, the most important, over-arching threads of the lived experience of student nurses appeared to be tied to feelings of impermanence, temporality and incompleteness with the time of a student nurse being pulled in numerous different directions. This in turn can be seen to be the root of the challenges and difficulties faced in the everyday life of a student nurse.

Ideas of impermanence can be seen in the experience of being treated in a derogatory manner on the wards can be seen in "treated like a child", "dogsbody work" and "between a rock and a hard place". Feelings of derogation and minimisation are abundant in student nursing. In the literature, Nordam, Torjuul & Sørlie (2005) present professional disagreement as a significant barrier to caring for nurses. The resulting lack of decision making is due to time consuming, circuitous conversations which take time away from patient care leading to the identification of [conflict with] doctors as a significant barrier to good nursing practice. This can be seen in the present study in the words of BC and CD who relay similar stories of not being taken seriously because of their position, even with the support of qualified nurses. Poelvoorde (2016) also identifies a double standard and a perception of a "doctor knows more than the nurse" attitude within nursing. The lived experience of nurses being ignored by doctors has been further documented in literature, primarily through quantitative means, showing that nurses showed a more positive attitude towards collaboration than doctors did, adding suggesting that doctors viewed nurses in a negative light and that they are less amenable to cooperation than nurses (Elsous et al., 2017). Taken in conjunction with evidence suggesting that nurses feel disrespected when ignored by doctors, viewing a perceived lack of education as a cause of this snubbing (Mboineki, Chen, Gerald, Boateng, 2019), a picture is formed of the tense relationship between healthcare staff, with student nurses being the bottom of the hierarchy. The participants further talk about the phenomenon of being referred to as "STUDENT", which has not previously been discussed in literature. Another key aspect of the nursing present in this study is the consequences of this derogation; being used as a HA. Every participant cited this as an extremely prevalent issue to them, however, there have been no further studies found discussing this phenomena, with student nurses talking about it as something everybody knows happens but is rarely spoken about. As such, the present study adds a great deal of depth to the existing literature, in particular research in the modern-day NHS, adding a phenomenological texture to a body of literature mainly concerned with establishing universal, nomothetic principles.

While a smaller theme in the whole, experiences of impermanence can be seen in the death and coping mentioned by participants as their reason for getting into nursing to begin with. There is a wealth of literature around coping with death in nursing, with the present study

finding the importance of a "good death" not only for the patient and their loved ones, but for the nurse too. Research has shown found that nurses showed signs of "normalising death" and describing their emotional disassociation from the dying patient (Shorter & Stayt, 2010; Walsh & Buchanan, 2011). Another finding in Shorter & Stayt (2010)'s study focussed on the importance of peer support (informal conversations as a method of coping). Both of these coping strategies are functional in the nurses lived experiences of coping, and both show similarities with the previously established literature. Folkman & Lazarus (1988) propose two methods of coping; (problem and emotion focussed), with participants in the present study exhibiting both responses when presented with the death of a patient. Participants such as BC, after relying on peer support, then endeavoured to tackle the problem by being empathetic and caring with the family members, trying to offer functional support for the loved ones of the bereaved (problem-focussed). However, participants such as DE fall more in line with the emotion-focussed avenue of coping, but not in a typical presentation. By treating and speaking about death in a matter of fact manner and not giving ideas of death the ability to ruminate by distancing himself from the issue and "normalising death", DE tackles the emotional fallout of viewing such devastating events on a daily basis. As is evident, the present findings fall in line with the surrounding literature and theories, while offering insight into how prospective nurses cope with death, a topic with a scarcity of literature in the UK.

A key thread tied to feelings of impermanence focusses around the impending chaos of a student nurse's timetable and workload. Feelings of being "spread too thin" with a heavy workload having a detrimental impact of the wellbeing of nurses have been seen across literature, with past studies highlighting the difficulties of such a high-pressure role, coupled with chronic levels of understaffing leads to participants experiencing trouble switching off from work and struggling to maintain a healthy social life around the job role (Currid, 2008; Akisanya, 2018; O'Shea & Kelly, 2007). Further literature suggests that nursing workload falls into five main categories; the amount of nursing time; the level of nursing competency; the weight of direct patient care; the amount of physical exertion; and complexity of care. These issues can be seen in the present study, with the most important facets being complexity of care and (perceived) competency, with the aforementioned issues of derogation having significantly detrimental impacts on these. Amount of nursing time is also a key issue; participants such as BC talking about how she has a "million things to do at once", with the juxtaposition of the chaotic rigidity of nursing being a source of huge tension of student nurses. Strains such as these have been found to be contributing factors not only for burnout and moral distress, but patient safety, with associations being established between high workloads and adverse patient outcomes (Matthews & Williamson, 2016; Fagerström, Kinnunen and Saarela, 2018; Johnson, Watt, Tsipa and O'Connor, 2016) This too is congruent with previous studies, with the findings seen in the literature being echoed in the present project, while adding an in-depth qualitative perspective to a growingly quantitative field.

Empathy was seen to another of these key factors driving the lived experienced of student nurses, with empathy (or sometimes the lack thereof) being omnipresent in the profession. However, due to the "middle ground" in which student nurses find themselves, the empathy

they give and receive is also tied to feelings of temporality, with many student nurses moving on to their next placement before being able to fully appreciate the fruit of their labour. In the literature the positive, more rewarding side of nursing is not often investigated, with only a few of the studies found in the literature search covering this aspect of nursing. O'Shea & Kelly (2007) contend that feeling valued and making a difference are cited as the most important positives of clinical placements in addition to financial reward (Halldorsdottir, Einarsdottir & Edvardsson, 2018). Furthermore, Stanheiser (2018) suggests that the failure to meet these standards may trigger the onset of CF symptoms. In the present study, many of the nurses regard themselves as being particularly resilient to the CF and burnout, mostly down to prior life experience. Perry (2008) conducted a descriptive phenomenological analysis into why oncology nurses seem to avoid compassion fatigue, finding that exemplary nurses think of the opportunity to engage in meaningful human-to human encounters with patients a gift. This literature is in line with the present study, suggesting that making a meaningful connection through "the little things" is the hallmark of excellent nursing care. Empathy between nurses was also seen to be important by participants DE and AB, when nurses understand each other in their own context (with managers understanding the stresses of the job and helping where possible) wards were seen to cope better with the tremendous strains placed upon them. There is a scarcity of research into this facet of empathy, especially in regard to nursing, however Levett-Jones, Cant and Lapkin conducted a systematic review of the effectiveness of empathy education in student nurses, finding that nine of 23 studies demonstrated practical improvements in empathy. This, coupled with the lack of research in the area shows that the impact of empathy in nursing is a fledgling research area, with the present study giving examples of the practicalities of empathy between patients and practitioners, but also within the practitioner group itself, introducing a textural, phenomenological approach and showing the impact that the establishment and breakdown of empathy can have on a ward.

The themes discussed above do not fit neatly into the aforementioned taxonomic models of stress. The ProQOL model (Stamm, 2010) is perhaps the most applicable, however fails to account for the wider systematic tensions and pressures explored above in addition to the individual perceptions of student nurses. Any cognitions outside of "Exhaustion" and "anger/frustration" do not into the proposed model. The "student" side of the student-nurse dyad is also unable to be meaningfully captured in models of occupational stress; with models like the ProQOL not accounting for the shift in the work hierarchy conferred by the status of being a student. Following this, the models of occupational stress outlined above (while useful in specific scenarios) cannot be applied to student nurses without distorting the lived experience of the participants to fit with the model.

Limitations and reflexive notes

There are a number of reflexive points which have been noted throughout the process of this study, certain constraints, limitations and contextual factors which have influenced the production of this work. Firstly, there lie limitations around my own abilities as a researcher. This project is my first opportunity to conduct not only an in-depth IPA study, but research of this magnitude in general; there are a number of issues which stem from this; it was my first time conducting interviews in any depth (aside from short assignments in my

undergraduate degree), as such I may have missed certain ques, prompts and avenues for further investigation due to a lack of experience constructing interview schedules and conducting interviews. As such, I have certainly noticed missed opportunities in the transcripts during analysis which may have yielded more (and consequently more in-depth) data from each participant. It was also my first time using the software "NVivo", with my lack of experience with the program limiting the speed and efficiency of my analysis (in particular, I did not start using the "note" function until later into the analysis, a tool which may have helped ease the process if I had adopted it sooner). However, I have had in-depth discussions with my supervisor in the making of the interview schedule, adjusting and tweaking where necessary. I also carried out a pilot interview with one of the lecturers in the nursing department not only to practice my interviewing skills and schedule, but to gain a greater understanding of the course (and consequently the lived experience of being a student nurse) from a different viewpoint. I also attended training workshops in conducting research interviews and how to use NVivo efficiently, which helped to remedy my relative lack of experience. In addition, there were constraints surrounding the masters course more broadly which have impacted this work; the time constraints of the course meant that I could not investigate every avenue of interest in the duration of this course, having to adapt methods and ideas which were initially over-complex and optimistic, particularly in terms of the scope of research which can be completed over the course of a MSc by Research project. However, with the aid of my supervisor, these constraints had the consequence of refining my research ideas, helping me to understand the research process more thoroughly. Another factor of note closely tied to the time constraints issue, is the format of this project; upon initial analysis the quotes selected from the data alone totalled near 25,000 words (the limit for this project). As mentioned above, this made me as a researcher learn to be selective in the quotes included in the project, but also led to the foreclosure of certain avenues of inquiry and the truncation of some areas of each theme. In regard to IPA, it is posited that an objective insight into the lifeworld of the participant is never truly attainable, this was evident in the research process in a few ways; It was difficult separating my own biases and opinions from both the interview and analysis stages, as I have close family members working as nurses and have seen first-hand the difficulties they face, this coupled with my own socio-political views on the position of the NHS made objectivity unattainable. This is perhaps why I initially foreclosed on the avenue of compassion satisfaction, focusing entirely on fatigue and burnout, however, the exercise of collecting descriptive data showed that, in student nurses, while levels of CF are moderate, CS was found to be high in the sample. This coupled with talks with my supervisor about the process of eidetic reduction helped me co-construct the data with the participants, instead of letting my preconceptions and biases lead the analysis. Another reflexive point of note centres around the sample used; student nurses showed minimal signs of actual burnout and compassion fatigue, as such a sample of nurses who have dropped out of study or practice might have been more appropriate to access. However, due to the limited nature of a MSc project to utilise an easily accessible group (i.e. student nurses present on campus and in the system) a decision which did in fact help to identify the potential stresses and strains of student nursing in current students. Additionally, the use of participant validation may have proved useful to elucidate some of the more obscure statements made during the

interviews, however the participants were often on a strict schedule, meeting before or after a shift or on a day off from their placements in which they had to catch up with university work. As such, care was taken for the interviews themselves to be as unobtrusive as possible, with the (often lengthy) process of participant validation being omitted to improve quality of life for participants.

Directions for future research

This piece of research unveils avenues of further investigation for future study. Throughout the piece, the participants talk about how their own experiences and differences make them uniquely suited to becoming a nurse, with each of them talking about how they possess certain levels of resiliency. As such, future research may be concerned with investigating how prevalent and important these perceived individual differences are in the lifeworld of a student nurse, possibly via a cross-sectional survey design. Building on the work of authors such as Foster et al. (2019), this work would study the prevalence of resiliency in nursing students, while placing an emphasis on the place of nurses in the contemporary NHS. Another advancement in the literature around this topic would focus on tracking the perspectives and opinions of nursing students over time, checking in for example once a term for an interview to see how the lived experience of student nurses' changes throughout the duration of their degree. The combination of the two previously outlined studies may in fact be the most beneficial of all; essentially amounting to a cohort study, following a group of student nurses from first-year induction to graduation and qualification, collecting data via interview and questionnaire once a term to fully understand the life course of the student nurse.

Implications for practice

The present study also illuminates a number of practical implications for student nursing. Emerging from the theme of "The importance of empathy" among others, ideas of group cohesion come to light, with multiple participants talking about how important they found it to feel as though they were working in a team, with approachable superiors and effective leadership. Another area worth noting stems from "Them and us", focussing around feelings of powerlessness, lacking a voice, and isolation. A remedy to these issues may be the introduction of "placement groups", with each student nurse staying with the same small group of other student nurses across rotations for the duration of their degree. Each student nurse interviewed has talked about how they have met other student nurses from different years on their placement, which while valuable, the introduction of a "placement group" gives the student nurses a sense of "strength in numbers", which, when coupled with an effective mentor to the small group may help to limit feelings of isolation and "sinking". Further to this, each participant mentions the impact of "being treated like a healthcare" a practice which has become commonplace due to the chronic understaffing prevalent throughout the NHS. To remedy this, the idea "placement groups" may need strengthening from the placement side, with a practicing nurse in the role of a mentor taking responsibility for the actions of the group currently on their ward, ensuring they are not used in the ward numbers at all while acting as an approachable figure for the group if any issues arise. This draws on the strengths of CS and may help to mitigate feelings of being overwhelmed and consequently the large attrition rate seen across nursing courses in the

UK (The Health Foundation, 2019). Of course, the practicalities of suggestions like these are unclear without further communication with the nursing department, a matter which will be followed-up after the completion of this study. Another issue for nurses prevalent throughout this study was the chronic understaffing faced by the NHS, this being the root of many barriers not only to good nursing but to continuing to remain in the profession post qualification. The proposed £5,000 bursary may help mitigate these issues, possibly decreasing the attrition rate and making nursing a more viable career path for many college leavers ("Nursing students to receive £5,000 payment a year", 2020).

Conclusion

In conclusion, the three pillars of lived experience above help to illuminate more clearly the lived experiences of student nurses, highlighting both the institutional and more everyday pressures which act as barriers not only to good nursing, but to making prospective nurses want to remain in the profession. However, the deeply empathetic nature of the role and individual thoughts of resiliency enable nurses to cope with the day to day stress and deliver the standard of care to which they hold themselves. To remedy these systemic pressures, more needs to be done to increase recruitment not only in nursing, but across all health professions, as the participants have identified, the more available staff there are, the less strain is placed on the individual with top-down changes being the only way to break the vicious cycle of understaffing.

References

Akisanya, O. J. (2019). *A qualitative examination of college health nurses' perception of their role in nursing practice* (Ph.D.). Available from PsycINFO. (2135209616; 2018-52508-187). Retrieved from https://search-proquest-com.libaccess.hud.ac.uk/docview/2135209616?accountid=11526

Astrom, G., Furaker, C., & Norberg, A. (1995). Nurses' skills in managing ethically difficult care situations: Interpretation of nurses' narratives. *Journal of Advanced Nursing, 21*(6), 1073-1080. doi:10.1046/j.1365-2648.1995.21061073.x

Balch, C. M., Freischlag, J. A., & Shanafelt, T. D. (2009). Stress and burnout among surgeons: Understanding and managing the syndrome and avoiding the adverse consequences. *Archives of Surgery, 144*(4), 371-376. doi:10.1001/archsurg.2008.575

Bianchi, R., Truchot, D., Laurent, E., Brisson, R., & Schonfeld, I. S. (2014). Is burnout solely job-related? A critical comment. *Scandinavian Journal of Psychology, 55*(4), 357-361. doi:10.1111/sjop.12119

Bodell, M. (2018). Half of NHS staff are working unpaid overtime and the majority want to leave their role. Retrieved from https://nursingnotes.co.uk/half-of-nhs-staff-are-working-extra-unpaid-hours-and-the-majority-want-to-leave-their-role/?fbclid=IwAR2FDUHnAiU1oZPtj8qy4ShgEaqhkHHN4_JJ6N1TU4uzy2nY37RbEcUyhT8

British Medical Association. (2017). The ethical implications of the use of market-type mechanisms in the delivery of NHS care. Retrieved from https://www.bma.org.uk/collective-voice/policy-and-research/ethics/marketization-of-the-nhs

Buchan, J., Charlesworth, A., Gershlick, B., & Seccombe, I. (2019). *A critical moment: NHS staffing trends, retention and attrition* . (). London: Health Foundation. Retrieved from https://www.health.org.uk/sites/default/files/upload/publications/2019/A%20Critical%20Moment_1.pdf

Busby, M. (2018). Nurses pass vote of no confidence in union over pay deal handling. Retrieved from https://www.theguardian.com/society/2018/sep/30/nurses-pass-vote-of-no-confidence-in-union-over-pay-dealhandling

Carroll, C., Booth, A., & Lloyd-Jones, M. (2012). Should we exclude inadequately reported studies from qualitative systematic reviews? an evaluation of sensitivity analyses in two case study reviews. *Qualitative Health Research, 22*(10), 1425-1434. doi:10.1177/1049732312452937

Currid, T. J. (2008). The lived experience and meaning of stress in acute mental health nurses. *British Journal of Nursing, 17*(14), 880-884. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=105802960&site=ehost-live

Davis-Kennedy, K. (2015). *The lived experience: Transitioning from a nurse practitioner student to an employed nurse practitioner* Available from PsycINFO. (1689322077; 2015-99120-270). Retrieved from https://search-proquest-com.libaccess.hud.ac.uk/docview/1689322077?accountid=11526

Donaldson, L. (2002). An organisation with a memory. *Clinical Medicine, Journal of the Royal College of Physicians, 2*(5), 452-457. doi:10.7861/clinmedicine.2-5-452

Doran, N., Fox, F., Rodham, K., Taylor, G., & Harris, M. (2016). Lost to the NHS: a mixed methods study of why GPs leave practice early in England. The British journal of general practice : the journal of the Royal College of General Practitioners, 66(643), e128–e135. https://doi.org/10.3399/bjgp16X683425

Doyle, L. H. (2003). Synthesis through meta-ethnography: Paradoxes, enhancements, and possibilities. *Qualitative Research, 3*(3), 321-344. doi:10.1177/1468794103033003

Farrington, A. (1997). Clinical management. strategies for reducing stress and burnout in nursing. *British Journal of Nursing, 6*(1), 44-50. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=107338453&site=ehost-live

Folkman, S., & Lazarus, R. S. (1988). Coping as a mediator of emotion. *Journal of Personality and Social Psychology, 54*(3), 466-475. doi:10.1037/0022-3514.54.3.466

Frank, E., Biola, H., & Burnett, C. A. (2000). Mortality rates and causes among U.S. physicians. *American Journal of Preventive Medicine, 19*(3), 155-159. doi:10.1016/S0749-3797(00)00201-4

Gentene, L. (2015). *A phenomenological study of nurse strategies to address nursing burnout* Available from PsycINFO. (1676371214; 2015-99080-237). Retrieved from https://search-proquest-com.libaccess.hud.ac.uk/docview/1676371214?accountid=11526

Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods*. US: Sage Publications Inc. Retrieved from https://ebookcentral.proquest.com/lib/[SITE_ID]/detail.action?docID=1995285

Hall, L., Johnson, J., Watts, I., Tsipa, A., & O'connor, D. (2016). Healthcare staff wellbeing, burnout, and patient safety: A systematic review. Retrieved from http://eprints.whiterose.ac.uk/102282/

Halldorsdottir, S., Einarsdottir, E. J., & Edvardsson, I. R. (2018). Effects of cutbacks on motivating factors among nurses in primary health care. *Scandinavian Journal of Caring Sciences, 32*(1), 397-406. doi:10.1111/scs.12474

Hawkins, N., Jeong, S., & Smith, T. (2019). New graduate registered nurses' exposure to negative workplace behaviour in the acute care setting: An integrative review. *International Journal of Nursing Studies,* doi:10.1016/j.ijnurstu.2018.09.020

Heidegger, M. (1962). *Being and time*. San Francisco: Harper.

Hiam, L., Dorling, D., Harrison, D., & McKee, M. (2017). Why has mortality in england and wales been increasing? an iterative demographic analysis. *Journal of the Royal Society of Medicine, 110*(4), 153-162. doi:10.1177/0141076817693599

Hobbs, F D Richard, Dr Prof|Bankhead, Clare, DPhil|Mukhtar, Toqir, MSc|Stevens, Sarah, MSc|Perera-Salazar, Rafael, Prof|Holt, Tim, PhD|Salisbury, Chris, Prof. (2016). Clinical workload in UK primary care: A retrospective analysis of 100 million consultations in england, 2007–14. *Lancet, The, 387*(10035), 2323-2330. doi:10.1016/S0140-6736(16)00620-6

Howitt, D. (2013). *Introduction to qualitative methods in psychology* (2. ed. ed.). Harlow, England [u.a.]: Pearson.

Husserl, E., 1859-1938. (1980). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy*. Netherlands: Retrieved from http://catalog.hathitrust.org/Record/002058047

Jones-Berry, S. (2018,). Revealed – the appalling pressures that threaten nurses' health every day. Retrieved from https://rcni.com/nursing-standard/newsroom/news/revealed-%E2%80%93-appalling-pressures-threaten-nurses-health-every-day-133106

Jones-Berry, S., & Munn, F. (2017). One in ten nurse sick days down to stress or depression. *Nursing Standard, 32*(5), 12-15. doi:10.7748/ns.32.5.12.s13

Lazarus, R. S. (1993). From psychological stress to the emotions: A history of changing outlooks. *Annual Review of Psychology, 44*(1), 1-22. doi:10.1146/annurev.ps.44.020193.000245

Lazarus, R. S., Cohen-Charash, Y., Payne, R., & Cooper, C. (2001). Discrete emotions in organizational life. *Emotions at Work: Theory, Research and Applications for Management,* , 4584.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping* Springer publishing company.

Maslach, C., & Jackson, S. E. (1982). A social psychological analysis. *Social Psychology of Health and Illness,* , 227.

Maslach, C. (1982). *Burnout, the cost of caring*. United States: Retrieved from http://catalog.hathitrust.org/Record/000189712

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry, 15*(2), 103-111. doi:10.1002/wps.20311

Maslach, C., & Leiter, M. P. (2003). Areas of worklife: A structured approach to organizational predictors of job burnout . *Emotional and physiological processes and positive intervention strategies* (pp. 91-134)

Emerald Group Publishing Limited. doi:10.1016/S1479-3555(03)03003-8 Retrieved from https://doi.org/10.1016/S1479-3555(03)03003-8

Matthews, H., & Williamson, I. (2016). Caught between compassion and control: Exploring the challenges associated with inpatient adolescent mental healthcare in an independent hospital. *Journal of Advanced Nursing, 72*(5), 1042-1053. doi://dx.doi.org.libaccess.hud.ac.uk/10.1111/jan.12889

Meehl, P. E. (1962). Schizotaxia, schizotypy, schizophrenia. *American Psychologist, 17*(12), 827-838. doi:10.1037/h0041029

Morrison, L. E., & Joy, J. P. (2016). Secondary traumatic stress in the emergency department. *Journal of Advanced Nursing, 72*(11), 2894-2906. doi:10.1111/jan.13030

NHS pay deal: The facts. (2018). *Nursing Standard (2014+), 33*(6), 8-10. doi:10.7748/ns.33.6.8.s6

NHS staff survey. (2018). Retrieved from http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

Nordam, A., Torjuul, K., & Sørlie, V. (2005). Ethical challenges in the care of older people and risk of being burned out among male nurses. *Journal of Clinical Nursing, 14*(10), 1248-1256. doi:10.1111/j.1365-2702.2005.01230.x

Nursing students to receive £5,000 payment a year. (2019). Retrieved from https://www.gov.uk/government/news/nursing-students-to-receive-5-000-payment-a-year

O'Shea, M., & Kelly, B. (2007). The lived experiences of newly qualified nurses on clinical placement during the first six months following registration in the republic of ireland. *Journal of Clinical Nursing, 16*(8), 1534-1542. doi://dx.doi.org.libaccess.hud.ac.uk/10.1111/j.1365-2702.2006.01794.x

Parcell, E., & Rafferty, K. (2017). *Interviews, recording and transcribing*

Perry, B. (2008). Why exemplary oncology nurses seem to avoid compassion fatigue. *Canadian Oncology Nursing Journal = Revue Canadienne De Nursing Oncologique, 18*(2), 87-92. doi:10.5737/1181912x1828792

Pietkiewicz, & Smith. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne Psychological Journal, 20*(1) doi:10.14691/CPPJ.20.1.7

Poelvoorde, T. L. (2017). *Being in transition: Accessing the transition experience of bachelor of science in nursing graduates using a heideggerian hermeneutic approach* (Ph.D.). Available from PsycINFO. (1940535331; 2017-16345-043). Retrieved from https://search-proquest-com.libaccess.hud.ac.uk/docview/1940535331?accountid=11526

Rafati, F., Nouhi, E., Sabzehvari, S., & Dehghan-Nayyeri, N. (2017). Iranian nursing students' experience of stressors in their first clinical experience. *Journal of Professional Nursing, 33*(3), 250-257. doi://dx.doi.org.libaccess.hud.ac.uk/10.1016/j.profnurs.2016.09.003

Rosenthal, D. (1963). *The genain quadruplets: A case study and theoretical analysis of heredity and environment in schizophrenia*. New York: Basic Books. doi:10.1037/11420-000 Retrieved from https://search.proquest.com/docview/614225662

Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York, NY, US: W W Norton & Co.

Sacco, T. L., & Copel, L. C. (2018). Compassion satisfaction: A concept analysis in nursing. *Nursing Forum, 53*(1), 76-83. doi:10.1111/nuf.12213

Schaufeli, W. B., Maassen, G. H., Bakker, A. B., & Sixma, H. J. (2011). Stability and change in burnout: A 10-year follow-up study among primary care physicians. *Journal of Occupational and Organizational Psychology, 84*(2), 248. Retrieved from https://search.proquest.com/docview/871412108

Shanafelt, T. D. (2002). Burnout and self-reported patient care in an internal medicine residency program. *JAMA, the Journal of the American Medical Association, 287*(18), 2340.

Shorter, M., & Stayt, L. C. (2010). Critical care nurses' experiences of grief in an adult intensive care unit. *Journal of Advanced Nursing, 66*(1), 159-167. doi:10.1111/j.1365-2648.2009.05191.x

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27. doi:10.1080/17437199.2010.510659

Snug, I. (2018). NHS 'haemorrhaging' nurses as more leaving than joining. Retrieved from https://nursingnotes.co.uk/nhs-haemorrhaging-nurses-as-more-leaving-than-joining/

Sørlie, V., Kihlgren, A., & Kihlgren, M. (2005). Meeting ethical challenges in acute nursing care as narrated by registered nurses. *Nursing Ethics, 12*(2), 133-142. doi:10.1191/0969733005ne770oa

Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. (pp. 107-119). New York, NY, US: Brunner-Routledge.

Stamm, B. H. (2010). The concise ProQOL manual. Retrieved from www.proqol.org.

Steinheiser, M. (2018). *The shared meaning of compassion fatigue among registered nurses working in skilled nursing facilities* (Ph.D.). Available from PsycINFO. (2099979011; 2018-34222-006). Retrieved from https://search-proquest-com.libaccess.hud.ac.uk/docview/2099979011?accountid=11526

Sun, F., Long, A., Tseng, Y. S., Huang, H., You, J., & Chiang, C. (2016). Undergraduate student nurses' lived experiences of anxiety during their first clinical practicum: A phenomenological study. *Nurse Education Today, 37*, 21-26. doi:10.1016/j.nedt.2015.11.001

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8*(1), 45. doi:10.1186/1471-2288-8-45

Thomas, L. R., Ripp, J. A., & West, C. P. (2018). Charter on physician well-being. *Jama, 319*(15), 1541-1542. doi:10.1001/jama.2018.1331

Tsaras, K., Daglas, A., Mitsi, D., Papathanasiou, I. V., Tzavella, F., Zyga, S., & Fradelos, E. C. (2018). A cross-sectional study for the impact of coping strategies on mental health disorders among psychiatric nurses. *Health Psychology Research, 6*(1), 7466. doi:10.4081/hpr.2018.7466

Walsh, M., & Buchanan, M. J. (2011). The experience of witnessing patients' trauma and suffering acute care nurses. *Canadian Journal of Counselling and Psychotherapy, 45*(4), 349-364. Retrieved from https://search-proquest-com.libaccess.hud.ac.uk/docview/1023198882?accountid=11526

Appendix

Appendix A: Interview Schedule

Interview topic guide

1 Intro

- Explain the study ○ Consent form

2 Participant's perspective as a nursing student

• Can you tell me a bit about your role in practice?
- Typical working week, typical cases they deal with + examples

• What different placements have you done?
- How has your role changed between departments?

• Can you tell me about when you decided you wanted to work in nursing?
- What happened then?

• What sort of person do you think thrives in a nursing setting?
- Can you tell me why you said that? Can you give me examples of this?

3 Stresses of nursing students' lives

• Can you tell me what you think the most challenging parts of nursing are?
- Specific examples/ narratives.

• Can you tell me about any stressful experiences you've had in this job?
- What happened then? Did the issue get resolved? How?

• What do you usually do to deal with the stresses of the job?
- Can you tell me how that works?

• What about your colleagues? Can you tell me about any important stressful experiences they had?
- What happened at that time?

4 Rewards of nursing students' lives

• Can you tell me what you think the most rewarding parts of nursing are?
- Specific examples/ narratives.

• Can you tell me about any positive experiences you've had in this job?
- What happened then? Did the issue get resolved? How?

• What do you usually do to deal with the more positive side of the job?
- Can you tell me how that works?

• What about your colleagues? Can you tell me about any important rewarding experiences they had?
- What happened at that time?

5 Contextual processes related to stress / ways of resolving stress

- If you could change one thing to reduce staff stress in a nursing setting, what would it be?
- Why have you chosen that thing? Can you give me examples of when this might have worked?

- Have you noticed any changes recently that might have made the job more or less stressful?
- Please can you explain why?

- Where do you see things going with the nursing profession in future?

- Anything else you'd like to tell me about?

Thank you!

6 Debrief

- Talk through debrief form
- Explain what I'm hoping to achieve with the study

Appendix B1: Information sheet

Study information

Title of the project An IPA investigation into stress and burnout in nursing students

Aims of the project

This study aims to investigate how nursing students cope with the potential stressors associated with university and placement work.

- To examine how experiences of stress unfold throughout different clinical rotations.
- To understand how student nurses make sense of these stressors in a contemporary NHS setting.

Background context of the research topic

Nursing has been at the forefront of public consciousness recently due to ongoing pay disputes, which have led to a vote of no confidence in the Royal College of Nursing (Busby, 2018). In June 2018, the nursing pay deal was accepted, after a long campaign by the Royal College of Nursing (RCN) with all members of nursing staff getting a pay raise of at least 6.6% over three years, with a 3% increase in the first year, however this will vary slightly from role to role ("NHS pay deal”", 2018). However, it appears that this deal was misrepresented; in September 2018 many nurses did not receive the expected pay raise, forcing general secretary Janet Davies to step down and resulting in a 78% majority vote of no confidence in RCN leadership (Busby, 2018). While student nurses are not part of the workforce yet, these pay deals form a part of the wider cultural context for nursing students, with issues of pay and support keeping nursing firmly in the public zeitgeist.

Burnout is a state of psychosocial and physical exhaustion that results from chronic exposure to high levels of stress with little personal control (Maslach & Jackson, 1982). Hobbs et al (2016) conducted an analysis of 100 million consultations in England and stated that the workload of healthcare practitioners in primary care settings has increased by around 16% from 2007 to 2014, further suggesting that English primary care may be reaching a “saturation point”. Hobbs et al. (2016) go on to state that that this increased workload may lead to a higher patient demand and a lack of

support from peers and superiors alike; this increased strain may lead to severe psychological consequences such as poor wellbeing, stress and burnout. Consequently, it has been suggested in a systematic review of 46 studies by Hall, Johnson, Watt, Tsipa and O’Connor (2016) that poor healthcare practitioner wellbeing and moderate to high levels of burnout are associated with poor patient outcomes. Chief among these poorer outcomes is an increase in medical error, estimated to cost the NHS around £1.3 billion in litigation costs, and £2 billion in additional bed days per year (Donaldson, 2002). This may even have contributed to an increase in mortality in the older population, who are the most dependant on social and health care (Hiam, Dorling, Harrison & McKee, 2017).

The vast majority of research in this area has centred around large-scale quantitative questionnaires with an emphasis on stress, recovery and changing consultation rates. However, gaps in the current literature suggest that very few studies have undertaken a qualitative, phenomenological approach towards the causes and consequences of stress and burnout in student nurses, especially in a contemporary academic and healthcare setting in the UK. A greater understanding of the perceptions and experiences of stress may work to aid the NHS in more effectively supporting student nurses, decreasing stress and burnout levels, with the end goal being to increase patient experience and wellbeing.

Research questions

This project aims to answer the research following questions: "What perceptions and experiences do student nurses have surrounding stress and burnout in the contemporary NHS?" and "How do student nurses cope with these stressors?"

Methodology and project design

Participants will receive an email detailing the present study; all third-year nursing students will be contacted. Participants who register an interest in the research will be invited to complete a short questionnaire measure of stress which will be administered via email to eligible participants. Data on student's contact details (email addresses and phone numbers) will be collected for follow up interview purposes. These will be stored in a password protected document on the K: Drive and will be deleted after the completion of the study.

Participant scores will be calculated and those who fall within the upper interquartile range and lower interquartile range will be invited to take part in an interview.

A 1:1 semi-structured interview will be used to interview participants, followed by an interpretive phenomenological analysis (IPA) of the data. The interview will centre around experiences of getting on to the nursing degree; stories about favourite/ least favourite placements and why; most common experiences of stress among nursing students etc…

The audio of the interview will be recorded for later transcription and the interviewer will take notes throughout. Participants will be briefed, debriefed and fully informed as to the aims of the study.

The transcripts will be uploaded to Nvivo for analysis and analysed using the steps suggested by Smith, Flowers & Larkin (2013).

Ethics

This study has been examined and approved by the University ethics board and complies with the ethical guidelines of the University and British Psychological Society.

Appendix B2: Briefing sheet

University of HUDDERSFIELD

Interview Briefing Sheet

Research study to investigate the processes that drive stress and burnout in nursing students

Hello, my name is Tom O'Toole and I am a Postgraduate Researcher at the University of Huddersfield. You are being invited to take part in a study that aims to understand the experiences of student nurses in primary care settings, in particular, experiences of stress and burnout.

This information sheet provides you with further details about your participation in the research and the procedure involved. Please take time to read the following information carefully and please do not hesitate to contact me with any questions, or to request further information.

- The study will investigate experiences of stress and burnout in student nurses
- You have been asked to participate because you are a student nurse who has completed a clinical rotation.
- Participation in this study is voluntary. You may choose not to take part.
- Participation in the study requires your written consent.
- You may at any point choose not to answer the questions without further explanation
- You may at any point discontinue the interview without further explanation
- The research will consist of an interview lasting approximately 1 hour.
- The interview will be audio-recorded, notes will be taken, and your audio responses will be later transcribed.
- Your name will be removed from the written notes and the identity of all names and places will remain anonymous.
- Information obtained during the research will be treated as confidential and securely stored at University of Huddersfield.

If you have any questions about this study, please contact:

Tom O'Toole (Email: thomas.o'toole@hud.ac.uk)

or

Dr Timothy Gomersall (Email: t.gomersall@hud.ac.uk)

Appendix B3: Debriefing sheet

University of HUDDERSFIELD

Debrief Sheet

Thank you for your participation in this research project. I'm hoping to understand why some student nurses have trouble adapting to high stress environments and others do not, and, as a consequence, what can be done to improve provisions for nursing students.

If you have any further questions or would like to be informed of the results of this project please contact the researcher at thomas.o'toole@hud.ac.uk.

If you have experienced psychological distress as a result of the topics discussed, the following services are available for help and guidance:

- Samaritans

  Phone: 01484 533388

  Email: jo@samaritans.org

- Huddersfield Student's Union Advice Centre

  Phone: 01484 473446

Email: advice-centre@hud.ac.uk

Appendix B4: Consent form

University of HUDDERSFIELD

CONSENT FORM

Project title: An IPA investigation into stress and burnout in nursing students.

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate. If you require any further details, please contact your researcher Tom O'Toole (thomas.o'toole@hud.ac.uk).

Please answer and sign each statement concerning the collection and use of the research data.

NAME:	YES	NO	SIGN
I have been fully informed of the nature and aims of this research as outlined in the information sheet.	☐	☐	
I have been given the opportunity to ask questions about the study.	☐	☐	
I have had my questions answered satisfactorily.	☐	☐	

I understand that I can withdraw from the study at any time without having to give an explanation.	☐	☐	
I agree to interviews being audiotaped and give permission for my words to be quoted by use of pseudonym.	☐	☐	
I agree to field notes being recorded and the contents used for research purposes.	☐	☐	
I understand that my identity will be protected, and that all data will be anonymous.	☐	☐	
I understand that no person other than the researcher and supervisors will have access to the information provided.	☐	☐	
I agree to my audiotapes (in line with conditions outlined above) being archived in secure conditions for a period of 10 years at the University of Huddersfield.	☐	☐	
I consent to taking part in the research.	☐	☐	

Signature of Researcher:	
Print:	
Date:	

Appendix C: Descriptive Statistics

ProQOL cut off scores

	CSS	BS	STSS
Low	0	7	17
Moderate	41	57	48
High	25	2	1

Descriptive Statistics for ProQOL Scale and Year Group

	CSS		BS		STSS	
	Second Year	**Third Year**	**Second Year**	**Third Year**	**Second Year**	**Third Year**
Valid	34	32	34	32	33	32
Missing	0	0	0	0	1	0
Mean	39.09	37.53	28.91	30.56	25.3	28.19
Median	40	38	29	31	25	26.5
Mode [a]	39	38	34	31	20	23
Std. Deviation	5.76	5.66	5.73	6.56	6.48	6.07
Range	21	23	24	32	25	25
Minimum	27	25	18	15	15	18
Maximum	48	48	42	47	40	43

[a] More than one mode exists, only the first is reported

Descriptive Statistics for ProQol and Age Group

	CSS				BS				STSS			
	<21	**22-34**	**35-44**	**45-54**	**<21**	**22-34**	**35-44**	**45-54**	**<21**	**22-34**	**35-44**	**45-54**
Valid	15	37	11	3	15	37	11	3	15	37	10	3
Missing	0	0	0	0	0	0	0	0	0	0	1	0
Mean	39.67	37.84	38.09	38.67	29.67	30.46	27.82	27.67	27.47	27.16	26.4	18.67
Median	40	39	37	39	30	31	28	27	29	25	25	15
Mode [a]	40	38	29	34	30	34	24	22	27	24	18	15
Std. Deviation	5.58	5.71	6.64	4.51	6.03	6.13	6.75	6.03	7.04	5.88	6.59	6.35
Range	19	23	19	9	22	29	24	12	24	26	21	11

Minimum	29	25	29	34	17	18	15	22	16	17	18	15
Maximum	48	48	48	43	39	47	39	34	40	43	39	26

[a] More than one mode exists, only the first is reported

Descriptive Statistics for ProQOL and Gender

	CSS		BS		STSS	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**
Valid	62	4	62	4	61	4
Missing	0	0	0	0	1	0
Mean	38.65	33.5	29.52	32.75	26.56	29.25

Descriptive Statistics for ProQOL and Gender

	CSS		BS		STSS	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**
Median	39	35	30	33	26	30
Mode [a]	39	26	30	26	24	30
Std. Deviation	5.64	5.45	6.19	5.38	6.49	4.57
Range	23	12	32	13	28	11
Minimum	25	26	15	26	15	23
Maximum	48	38	47	39	43	34

[a] More than one mode exists, only the first is reported