# UNDERSTANDING AND CHALLENGING DISCOURSES OF RESILIENCE IN CHILDREN'S NURSING TO INFORM PROFESSIONAL EDUCATION

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# Abstract

Resilience is increasingly being advocated as a potential measure to reduce stress and burnout within the nursing profession. Consequently, nurse educators must integrate evidence-based resilience education into undergraduate nursing curricula. Within the UK, children's nursing constitutes a distinct nursing speciality. Despite this there is a dearth of research into resilience within children's nursing, and little is known about how children's nurses conceptualise, experience, and nurture this attribute. A criticism of resilience research is that it lacks culturally sensitive definitions; and growing concern over the uncritical use of the term raises questions about normative concepts of resilience. This study contributes to a more sophisticated understanding of resilience within children's nursing which has implications for nurse education, the profession, and future research.

An interpretivist approach was adopted which employed certain research methods consistent with Heidegger's principles of interpretative/ hermeneutic phenomenology. Purposive sampling techniques were utilised to identify two target groups of participants – qualified children's nurses (QNs) and student nurses (SNs) studying to become children's nurses. QNs in one healthcare trust, and year two and three undergraduate BSc SNs in one school of nursing were invited to take part in the study, resulting in ten QN and eight SN participants. Semi-structured interviews via Microsoft Teams were conducted and a social constructionist model of resilience was used as a lens to help interpret the findings. *Descriptive coding* was used in the first cycle of data analysis, followed by *pattern coding*. Finally, elements of *theoretical coding* were used to identify 'umbrella' themes central to the development of theory within this thesis.

This study found that QN and SN participants defined resilience in terms of 'coping' and 'carrying on' in the face of chronic, endemic pressures as opposed to dominant definitions which position resilience as an ability to adapt to or bounce back from adverse events. Resilience was identified as a central element in the professional identity of a children's nurse, and a strong desire to develop and demonstrate resilience was evident in both QN and SN participants. A significant pressure to demonstrate resilience was described; alongside a potentially maladaptive resilience discourse which encourages a culture where deficits in resilience are viewed as a personal weakness or failure. Such a discourse of resilience within nurse education and nursing practice, is problematic as it does not adequately account for the wider contextual challenges to resilience and may place unreasonable pressure on individuals to cope and make up for organisational deficits.

There is a need to rethink such views to enable an understanding that everyone has capacity to be resilient but that there are varied ways to display it. This may enable a move away from unhelpful binary conceptualisations of resilience and help to counter the blame culture that is evident when nurses or students struggle to cope with ever increasing demands.

Within this thesis, I propose that the phenomenon of resilience must be viewed within the context and demands of the profession. Furthermore, nurses and student nurses should be educated to understand that failure to cope with constantly increasing workplace demands does not constitute a failure of personal resilience and does not constitute a 'weakness' in themselves or others. Instead, increased focus should be placed on wider contextual stressors and QNs and SNs should be empowered to challenge unreasonable demands and request support to reduce endemic challenges to their resilience.

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# Definitions and abbreviations

### Definitions

| | |
|---|---|
| Clinical area | Clinical area in which student nurses undertake clinical placements as part of their undergraduate training – This includes acute hospital settings but also varied community settings. |
| Fit testing | A method for checking that a specific model and size of tight-fitting facepiece matches the wearer's facial features and seals adequately to the wearer's face. |
| Higher Education Setting | Higher education institution responsible for the local delivery and management of NMC-approved programmes in line with governing body programme standards. |
| Proficiencies | Series of statements which identify the professional standards nurses, midwives, and nursing associates must uphold to be registered to practise in the UK. |
| Resilience | The outcome from negotiations between individuals and their environments for the resources to define themselves as healthy amidst conditions collectively viewed as adverse (Ungar 2004). |

### Abbreviations

| | |
|---|---|
| BO | Burn out |
| CF | Compassion fatigue |
| ITU | Intensive Therapy Unit |
| NMC | Nursing and Midwifery Council |
| PICU | Paediatric Intensive Care Unit |
| QN | Qualified nurse |
| RCN | Royal College of Nursing |
| SN | Student Nurse |
| VT | Vicarious Traumatisation |
| WHO | World Health Organisation |

# 1. Introduction

This chapter will start by depicting the wider context for the study, which includes some personal reflection on my own experience and how this has shaped my research. Next the contemporary landscape of children's nursing will be discussed before the rationale for focussing on resilience within children's nursing, and children's nurse education will be presented. The chapter will conclude by presenting the theoretical framework that has guided development of the study, the aims and objectives of the study, and the forthcoming structure of the thesis.

## 1.1 Wider context for study - researcher positionality

Dodgson (2019) explains that the credibility and rigour of qualitative research is enhanced when researchers explain any contextual intersecting relationships between themselves and the study participants. Researchers should also clearly explicate their positionality and foreknowledge in relation to what is being studied as this aids transparency and helps to determine the relevance of the research, and the credibility of the findings (Berger, 2015). Such transparency and clarity is a minimum requirement for qualitative research and has been established as one way to enhance rigour, quality and trustworthiness (Teh and Lek, 2018). Furthermore, a clear description of any contextual intersecting relationships such as shared experience with study participants is useful as it can deepen the reader's understanding of the research presented (Berger,2015). Consequently, this chapter begins with an autobiographical reflection on my own experience and how this has shaped my research.

As a former children's nurse, I have personal knowledge and experience of working within the UK health care system and the pressure and stress this can entail. I had always considered myself to be a resilient person, yet as my career progressed, I realised that I was finding it increasingly difficult to cope with the pressure and chronic stress of the role. Advances in medical technology meant that the care many children required was becoming more complex in nature. At the same time, the wards on which I worked were chronically understaffed which made it increasingly difficult to provide the quality of care I aspired to. I found this difficult to cope with and constantly worried about the care I was able to provide. Was it good enough? Had I missed anything? Could or should I have done more? This level of stress and anxiety started to seep into all areas of my personal life; I could feel my resilience declining, and I started to dread the thought of going to work. While many colleagues were experiencing similar personal and professional challenges, discussion around this was discouraged. There was a palpable attitude between nurses that colleagues who struggled to cope, lacked resilience, or who went off sick, were in some sense unprofessional or a burden as they added to everyone else's workload; a view I shared at times. Ultimately, I took the difficult decision to leave the frontline career that I was passionate about to move into nurse education; a career that I am equally enthusiastic about. Despite enjoying my career in nurse education, I have often wondered whether I left frontline work because I was not resilient enough, or strong enough to stay. At times this has led to uncomfortable feelings where I have questioned whether I am training students to enter a profession I was unable to remain in myself.

The situation I describe is contextual and represents a personal experience of working in one hospital trust over a particular period. Contemporary research

however, along with unprecedented recent strike action, suggests that the situation within UK health care may not have changed significantly from the personal experience I have described. To contextualise this further, I will begin with a discussion of the contemporary landscape of children's nursing.

## 1.2 Contemporary landscape of children's nursing

Every day nurses are faced with numerous stressors which range from caring for patients and their families during emotionally challenging times, to excessive workload, staff shortages, time pressures, and frequent exposure to human pain and distress (Drury, Craigie, Francis et al, 2014; McCann, Beddoe, McCormick et al, 2013). When considering the role of a children's nurse in contemporary health care, there is a body of literature which purports that nurses who work with children may experience higher levels of stress, compassion fatigue, vicarious traumatisation, and burnout than colleagues in other fields of nursing due to the unique nature of their role (for example, Jacobs, Nawaz, and Hood, 2012; Hecktman, 2012; Pradas-Hernández et al 2018). It should be noted that terms like stress, burnout, compassion fatigue, vicarious traumatisation, and resilience are all separate concepts in their own right; however, they are closely related and often discussed together within the literature. Stress is seen as a risk factor for the development of vicarious traumatisation (VT) and compassion fatigue (CF), which if sustained is thought to increase the risk of burnout (BO); resilience is seen as one possible measure to ameliorate stress, CF, and BO (Hesselgrave, 2014). While it is acknowledged that these concepts are often interlinked, for the purposes of this study, the focus will be upon resilience within children's nursing.

Caring for a child who is sick or dying is particularly stressful, especially when one considers the value society places on protecting and caring for children. Paediatric hospitals are identified as high stress workplace environments and Sekol and Kim (2014) argue that children's nurses may experience "overwhelming emotional stress, helplessness, pain and sadness while working with sick or dying children and their families" (p116). As such, it is argued that children's nurses can experience higher levels of burnout and post-traumatic stress symptoms than workers traditionally thought to be at high risk, for example, trauma workers like paramedics (Robins et al, 2009). Furthermore, it is argued that such stressors challenge the way that children's nurses practice which can test fundamental assumptions of what it is to be a children's nurse resulting in disillusionment, discontent, issues with professional identity, and an increase in staff attrition (Borhani, Abbaszadeh, Nakhaee, et al, 2014; Bong, 2019).

A recent report from the Nursing and Midwifery Council (NMC) (2022) cited that more than 25,219 UK nurses left the register between April 2021 and March 2022. This constitutes a 13% increase compared with figures for the previous year. The third most cited reason for leaving was too much pressure leading to stress and poor mental health (18.3%), the fourth most cited reason was a negative workplace culture (13%). (Please note these statistics are for all fields of nursing including children's nursing as separate figures were not available).

This is relevant to student nurses as they spend 50% of their training within clinical areas alongside qualified nurses, so are exposed to similar stressors. This study aims to explore what these stressors are, how they are described by student nurses, and how they influence their understanding, development, and enactment of resilience. When considering the time students spend alongside

qualified nurses it is perhaps unsurprising that studies have identified high levels of stress within the student nurse population, and high attrition rates (Jack and Donnellan, 2010; Grant and Kinman, 2013; Thomas, Jinks and Jack, 2015).

A recent investigation into undergraduate nursing attrition found that 33% of students who commenced a three-year degree in 2018, did not graduate in 2021 (Stacey, 2022). Furthermore, the latest data from UCAS (Universities and Colleges Admissions Service) suggests that 7% fewer nursing students started courses in September 2022 (Stacey, 2022). This is an alarming situation when considering current nursing vacancy statistics (as of 30th June 2022) that show vacancy rates of 11.8% (46,828 vacancies) across the UK, an increase from 10.3% (38,814 vacancies) the previous year (NHS Digital 2022).

In such a difficult landscape the issue of nurse, and student nurse, attrition has never been more pressing. In recent years discussions focussing on the sustainability of the nursing workforce have placed increased emphasis on improving the resilience of health care professionals (for example, Williamson, Health, and Proctor-Childs, 2013; Lee and Gagne, 2022). In 2018 The NMC launched ambitious new standards that set out the skills and knowledge the next generation of nurses will require to enable them to deliver world class care. Resilience figures as a more central feature in these new standards. This leads into the rationale for the focus on resilience within this study.

## 1.3 Rationale for the focus on resilience

As a former children's nurse and now a nurse educator, I am acutely aware of the increasing number of students who appear to be struggling to cope with the demands of their nurse training. I have a particular interest in student welfare and pastoral support, consequently this is an issue that has concerned me for

some time and was one of the driving forces behind the research I will present in this thesis.

When considering potential strategies that could enhance personal wellbeing, the concept of resilience is gaining in popularity within international nursing literature, (for example McDonald, Jackson, Wilkes et al, 2015; Stephens, 2013; Zander et al, 2013; Berger, et al, 2015; Hesselgrave, 2014; Bong 2019). However, with a widely used everyday word such a resilience, there are many ways in which it can be understood. While definitions of resilience vary within the literature, most identify the ability to "recover from adversity, react appropriately or 'bounce back' when life gets tough" (Grant and Kinman, 2013, p5).

Of particular relevance to nurse educators are definitions that position resilience as a process rather than a fixed attribute (Garmezy, 1985). Seminal theorists such as Michael Rutter (1987) argue that resilience constitutes a fluid quality that acts to modify responses to psychosocial risk, while theorists such as Bonanno (2005) and Luthar (2006) argue that resilience fluctuates over time as new vulnerabilities and strengths emerge from changing life circumstances.

Resilience is increasingly emphasised as an essential aspect of many professional roles such as social work (e.g., Hendry 1975, Grant and Kinman, 2013) and teaching (e.g., Day and Gu, 2010, Day and Chi-Kin Lee, 2011, Price, Mansfield and McConney, 2012). Undergraduate nurse education is also considering how to enable the individual to 'bounce back' despite the 'adversity' they are likely to face in the workplace (Price et al, 2012; Mcdonald, Jackson, Vickers, and Wilkes, 2016).

A stance which conceptualises resilience as a process rather than a trait has been significant as it offers the possibility that resilience can be enhanced. Viewed in this way, resilience may protect against some of the negative consequences of stress in nursing, thus the ability to display resilience is increasingly being seen as a quality that should be encouraged and promoted (Cope, Jones, and Hendricks, 2014; Morse, Kent-Marvick, Barry et al, 2021). Teaching and social work face similar issues to nursing with high levels of stress and burnout caused by long hours, excessive workload, a requirement to manage complex, uncertain situations, a perceived lack of control over workload, problems with professional identity, and high early career attrition (Price et al, 2012; Grant and Kinman, 2013; Bong, 2019). Across all of these settings, it is perhaps not surprising that the notion of enhancing resilience has become so appealing. That said, resilience concepts and discourses vary and, in my view, can have very real effects on the professionals and trainees that use, and are described by them.

Some question dominant normative views of resilience. For example, Price et al (2012) argue that within the neoliberal world of business, such discourses serve to enable or encourage already overworked employees to cope with ever increasing pressures. This discourages any attempt to change or resist the pressures of the workplace as within such discourses individuals simply learn to 'bounce back'. Price et al (2012) point out that perhaps the question we should be asking is why certain professional workplaces are so adverse that staff either leave in large numbers or need to learn resilience to cope. Indeed, there is an active debate on whether resilience is, or should be, a normative concept, that is to say whether resilience should be viewed as "good", "bad" or neither (Olsson, Jerneck, Thoren, et al, 2015).

Existing discourses on resilience are overwhelmingly normative in nature in the sense that resilience literature almost exclusively positions resilience as something that is good or desirable (Olsson, Galaz and Boonstra, 2014; UNDP, 2014). This propensity to see resilience as an overwhelmingly positive or desirable concept is viewed as problematic by some. For example, Chamorro-Premuzic and Lusk, (2017) argue that while resilience is undoubtedly a useful and highly adaptive trait, too much resilience can be maladaptive as it can focus individuals on impossible goals or make them unnecessarily tolerant of unpleasant or counterproductive circumstances.

Within university settings, resilience has been a 'buzz word' for several years, fuelled by a growing conception that young people, as a generation, are less resilient than previous generations (Binnie, 2016). Anecdotally, this is a view I have heard expressed by qualified nurses in relation to the student nurses who have been graduating through the nurse education programme over recent years.

It is argued that young people, as well as the general population, often see the term resilience as a synonym for strength and therefore view a perceived lack of resilience to be a sign of weakness (Binnie, 2016). In a similar vein, Cole-King (2015) refers to an unacceptable attitude in which resilience can be used to name and shame 'weak' doctors for not being tough enough to cope with the pressures placed upon them. This is a view that I alluded to within my earlier personal reflection and constitutes a considerable gap within the body of knowledge which will be discussed further in the proceeding sections.

## 1.4 Theoretical framework

One of the criticisms levelled at resilience research is that is lacks culturally sensitive definitions, in particular definitions that consider what the target group themselves understand as resilience (Mohaupt, 2008). A further criticism is that a lack of focus on the potential role and influence of social networks, organisations, and social capital, result in an 'individual focussed' perspective (Mohaupt, 2008, pg.67) which results in resilience being viewed as a personal trait as opposed to a process which can be viewed at contextual and larger sociocultural levels (Luthar and Zelazo, 2003; Aldwin, 2012). This can contribute to situations where individuals are blamed for a lack of personal resilience and can influence neo-conservative policies which emphasise self-help while offering little guidance on policy implications at an organisational or state level (Boyden and Cooper, 2007).

To address these concerns, a social constructionist model of resilience has been adopted as a preliminary framework to guide the development of this study (see Chapter 2). Secondly, an interpretive methodological framework, which borrows from interpretative phenomenological traditions, has been employed to assist in an exploration of the research aims and objectives (see Chapter 3).

## 1.5 Research purpose and aims

A review of the literature (Chapter 2) revealed that there is a dearth of research, into the role, significance, development, and sustainability of resilience within children's nursing and children's nursing education. While resilience is increasingly being advocated as a potential measure to reduce stress and burnout within the nursing profession, little is known about how children's nurses understand or experience resilience within their daily lives (Daesin) –

(Heidegger 1962). Furthermore, growing concern over the uncritical use of the term 'resilience' leads to several questions:

- What does it mean to be resilient in contemporary health care?
- What does this resilience look like?
- Is there a pressure to be resilient?
- How easy is it to be resilient?
- What are the implications if one deems themselves or others not to be resilient?
- How important is resilience to the professional identity of a children's nurse?
- Can and should resilience be taught?

Liersch-Sumskis (2013) points out that before one can consider any measures that aim to enhance resilience, one must understand what it means and how it is experienced by those who are the focus of any study. This study will therefore focus upon those meanings and contribute to a more sophisticated understanding of resilience which could be used as the foundation for future studies and inform children's nurse education. Consequently, I propose one main research statement which is supported by four research questions.

## 1.6 Research questions

### 1.6.1 Main research aim/ statement

Understanding and challenging discourses of resilience in children's nursing with the aim of informing professional education.

### 1.6.2 Research questions

1. How is resilience understood and conceptualised within children's nursing and why is it conceptualised in this way?

2. How do student nurses learn about resilience during their training programme, and can enhanced resilience be taught?
3. To what extent, and in what ways, are the discourses of resilience within children's nursing helpful or unhelpful?
4. What are the implications for children's nurse education and the wider nursing profession?

Content pertinent to each of the four research questions has been included within the semi-structured interview guide that forms the data collection method for this study. All questions were designed to be answered through responses to the interview questions, they were however, also designed to enable the formulation of recommendations based on the interview responses; this is particularly true of research question 4.

## 1.7 Structure of the thesis

The thesis will follow a traditional structure of abstract, introduction, literature review, methods, findings, discussion, and implications and concluding remarks. Due to the nature of undergraduate nurse education, it has been necessary to consider resilience within the clinical placement setting as well as the educational setting, and to seek data from both qualified nurses and student nurses within the professional arena of child nursing. This was necessary to provide a context for the phenomenon of resilience within nurse education, an exploration of how resilience is conceptualised and incorporated into professional identity, and a deeper understanding of how students learn about resilience within the professional sphere of children's nursing.

Before continuing, there are several relevant factors to note. Firstly, while the focus for this study is on children's nurses and students, many of the findings show distinct similarities to other fields of nursing or nursing more widely. As

such, not all findings are claimed to be specific to children's nursing, and it is possible that the findings could be representative of nursing in more general terms. Where findings are specific to children's nursing this will be identified.

Secondly, this thesis will adopt the funnel technique of writing in which broader ideas will be presented before the focus is narrowed to develop and construct arguments pertaining to contemporary conceptualisations of resilience and their implications for undergraduate nurse education. These arguments will be developed throughout the preceding chapters before being explored in depth and applied specifically to nurse education within the latter half of the discussion chapter and the final concluding chapter.

## 1.8 Chapter summary

This chapter has introduced the wider context of the study and has identified the rationale for a focus on resilience within children's nursing. It has introduced the theoretical framework that has guided development of the study and explicated the main research aims and objectives. The next chapter will synthesise my review of relevant literatures that has informed the development and interpretation of this study.

# 2. Literature review and theoretical framework

This chapter will present a review of the literatures that have informed the development and interpretation of this study. The chapter will start by identifying the relevance of resilience within the nursing profession before identifying why this is important for children's nurses. It will provide a broad overview of literature relating to resilience inclusive of the constructionist model of resilience which has been used as a framework to guide development and subsequent interpretation of this study. It will then briefly explore the significance of resilience to the professional identity of children's nurses before explicating why the phenomenon of resilience is relevant to nurse education, and thus provides an important focus for this EdD study.

## 2.1 Resilience within the nursing profession

As identified within the previous chapter, there is widespread recognition of the emotional challenges inherent within the nursing profession (for example, Jackson, Firtko and Edenborough, 2007; Hart, Brannan, and DeChesnay, 2012, Pradas-Hernández, Ariza, Gómez-Urquiza, 2018; Taylor, 2019). This can lead to high levels of stress within qualified staff and can be attributed to stressors such as the requirement to manage complex, uncertain situations; a perceived lack of control over workload, and interactions with patients and service users that can elicit strong emotional reactions (Coyle, Edwards, Hannigan et al, 2005; Grant and Kinman, 2013).

High levels of stress have also been identified within nursing students (Deary, 2003; Jack and Donnellan, 2010; Grant and Kinman, 2013). Research findings suggest that the nurse training period can be more stressful than qualified

practice and there is evidence that many students do not feel adequately prepared for the realities of practice which can subsequently influence the development of psychological and physical health problems (Hodges, Keeley, and Troya, 2008 in Hart et al, 2012).

Nurse education programmes need to prepare students to manage the realities of professional practice (Scammell, 2016) and there is a growing belief that to achieve this, more attention should be given to emotional resilience (Grant et al, 2013; Thomas and Hunter-Revell, 2016, Jackson, Vandall-Walker, Vanderspank-Wright, et al 2018). Emotional resilience may be of particular importance to health care professionals as it is argued to help them adapt in positive ways to stressful events whilst also helping to foster effective coping strategies, improving wellbeing, and enhancing professional growth (McDonald, Jackson, Wilkes et al, 2012; Stephens, 2013). Within undergraduate nursing courses, efforts to enhance resilience are now commonplace (Aburn, Gott and Hoare, 2016; Brewer, Kessel, Sanderson, et al 2019). It is interesting that such efforts are not solely based on academic success, but also linked to sustainability of the nursing workforce and efforts to prepare students for the challenges they will face in their future careers (Health Education England, 2018).

Despite this, even though resilience is now commonly seen as a vital characteristic of nurses, (World Health Organisation, 2020) and is well-documented within general nursing literature, (for example, McGowan and Murray, 2016; Delgado, Upton, Ranse, et al, 2017; Li and Hasson, 2020) an early scoping review, undertaken at the start of the EdD process, highlighted a lack of research into the phenomenon of resilience within children's nurses. During this initial search of the literature, it was necessary to broaden search terms to include 'burnout,' 'compassion fatigue', and 'vicarious traumatisation',

to find articles which referred specifically to resilience in children's nursing. This literature review was undertaken as part of the taught element of the EdD and aimed to ascertain what was known about resilience within children's nursing. It is notable that while twenty studies were included for consideration, only five referred specifically to resilience in children's nursing. The remaining fifteen mentioned resilience but the focus was on closely related phenomena such as stress, burnout, compassion fatigue, and vicarious traumatisation. No articles were found which referred specifically to resilience within the paediatric student nurse population during this initial review. Hence a gap in the knowledge about resilience within children's nursing, particularly in relation to how children's nurses understand and enact resilience was identified. An extract from the initial literature review performed is included in Appendix 8.9. This includes details of the search strategy employed, the results of the literature search, and a summary of the literature.

Furthermore, it is notable that while resilience is widely written about within nursing, it tends to be broadly defined and generally applied, leading to a variation in terms, definitions, and descriptions of the phenomenon, (Stephens, 2013). While Stephens argues that the concept has significant potential to help nursing students face the challenges inherent in their chosen profession, she identifies that further clarification of the concept is necessary if nurse educators are to plan effective interventions and transform nursing education to better support student needs.

In the context of social work, Grant and Kinman (2013) highlight a similar lack of consensus. They argue that to develop effective, evidence-based interventions it is important to gain a deeper understanding of how professionals such as nurses, social workers, and educators conceptualise resilience by exploring what

they think it is, why they think it is important, and how they think it could be enhanced. This formed one of the drivers for this research study which aimed to explore how resilience is understood and conceptualised within children's nursing and why is it conceptualised in this way? To consider this further it was important to explore the construct of resilience in more depth.

## 2.2 Resilience

Over the past four decades, research into resilience has increased substantially within several academic disciplines such as the behavioural sciences, psychology, psychiatry, social work, nursing, and education. Consequently, this has led to variations in the language used to describe the same phenomenon. For example, invulnerability (Anthony and Cohler, 1987), hardiness (Kobasa, 1979), stress buffering (Haggerty et al, 1994), and stress related growth (Aldwin, 2007) have all been used to refer to resilience. This has contributed to difficulties when attempting to develop an operational definition of resilience as a construct. Fletcher and Sarker (2013) argue that the precise nature of a definition is influenced by the historical and socio-cultural background within which the research was conducted, the researcher's positionality, and the populace sampled. The perspectives that follow do not represent an exhaustive list of conceptualisations of resilience; rather they are presented to illustrate the challenge of defining terms. The following sections will summarise some of the key debates surrounding the conceptualisation of resilience before identifying the model that will be used to frame this research study.

### 2.2.1 Resilience as a personality trait

Proponents of trait theory suggest that resilience represents several relatively stable personal qualities or personality traits that enable an individual to flourish and bounce back in response to adversity (Connor and Davidson, 2003; Kirkwood, Bond, May et al, 2010; Ong, Bergeman, Bisconti et al, 2006). Resilience can also be viewed as a personality factor which affords protection from adverse life events and negative emotions through flexibility, inventiveness, and resourceful adaption (Roth and van Collani, 2007). From this perspective resilience can be viewed as an individual attribute and may consequently be defined as a personal strength or vulnerability (Windle, 2011). The theory of trait resilience was derived from studies which focussed on personality characteristics that were deemed to be typical of resilience (for example, Connor & Davidson, 2003; Ong et al., 2006; Wagnild and Young, 1990). Connor and Davidson based their research on identifying common characteristics that were observable in individuals who were deemed to have successfully adapted following a major life adversity. This ultimately resulted in them developing a 25-item resilience scale, commonly referred to as the CD-RISC, which is a tool that is widely used today to identify and measure resilience.

A second notion of trait resilience was advocated by Block and Block (1980) who used the term ego resilience to depict a constellation of traits such as flexibility and resourcefulness which were argued to play a role in the enactment of resilience. Block and Block purported that individuals who were identified as being high in ego resilience tended to be more curious in nature and have accompanying personality traits which enabled them to conceptualise and solve

problems and maintain a sense of optimism in the face of adversity. They argued that this made such individuals more resourceful and quicker to adapt in new situations. In later research, personal characteristics of a similar nature (such as extraversion, self-esteem, self-efficacy, and flexibility) have been referred to as individual protective factors which allow an individual to change, modify, or mitigate personal responses to various environmental stressors (Rutter, 1985).

For individuals at the lower end of ego resilience however, the outlook was bleaker. Such individuals were described by Block and Block as being 'brittle' and were described as having difficulty in recovering from stress because they "exhibited little adaptive ability when encountering novel or stressful situations" (Oshioa, Taku, Hirano, Saeedd, 2018, pg 55). Adherence to such a conceptualisation raises the important question of whether resilience can be developed or enhanced. The main point of contention here is that a view which depicts resilience as a stable personality trait can imply that an individual who does not possess this attribute is a failure in some way (Windle, 2011), weak, or perhaps a burden as described in my personal example. Such criticisms led to a second wave of resilience research which moved away from the identification of key characteristics associated with resilience to an approach aimed at understanding how personality factors interact with elements such as culture and the wider environment.

Theorists such as Norm Garmezy accepted that personal characteristics should be included within research into resilience but argued that a broader conceptualisation was required which also considered external factors such as family and societal support structures (Garmezy, 1974, Garmezy, 1985). The notion of resilience as a fixed trait has been further challenged by theorists such as Luthar (2000), Masten (2001), and Bonnano (2005) who identify that, rather

than being fixed, resilience is fluid and tends to vary from situation to situation, throughout a situation, and across an individual's lifespan. Consequently, it is argued that just because an individual may react positively to a stressor at one point in their life, this does not indicate that they will act in the same way to such stressors at other times in their life. As Michael Rutter once stated, "if circumstances change, resilience alters" (Rutter, 1981, p.317).

### 2.2.2 Dynamic conceptualisation of resilience

Contemporary resilience literature widely conceptualises resilience as a dynamic process which involves positive adaption to significant stressors or adversity. Researchers who adhere to this model of resilience suggest that a wide number of factors interact to determine whether an individual demonstrates resilience or not (for example, Masten, 2001; Bonanno, 2005; Fletcher and Sarker, 2013). Rutter (2012) argues that resilience cannot be a personality trait as he asserts that individuals can only exhibit resilience in response to the presence of adversity and has consequently developed the idea that resilience operates along a continuum which positions risk and protective factors at one end and vulnerability and resilience at the other. Rutter contends that these factors operate concurrently and are mediated by mental operations and coping style (Atkinson et al, 2009).

Central to the dynamic conceptualisation of resilience is the notion that it is not static and as such can and does change over time. In 1989, Emmy Werner published the results of a thirty-two-year longitudinal study in which she followed a group of 698 children in Hawaii, from birth through to the third decade of their lives. During this time, she monitored these individuals for exposure to stress. Among the many findings from this study, Werner showed

that resilience could change over time. Some individuals who had previously been identified as resilient, appeared to be unlucky and experienced multiple strong stressors during their lives; consequently, their levels of resilience were observed to decline. Conversely, some individuals who had previously been judged as less resilient during their early lives, were able to overcome the adversity they experienced to demonstrate enhanced resilience in their later years. This raises the question of how this resilience may have developed.

In her seminal work entitled 'ordinary magic', Masten (2001) argued that rather than being anything extraordinary, resilience was a phenomenon that was grounded in ordinary things such as close friendships, family, and love. Furthermore, Masten highlighted the importance of positive experiences within both education and workplace settings and argued that personal strength gathered from previous experience; along with support from family and friends during stressful or challenging times were critical to a person's ability to be resilient. Ecological models of resilience take such ideas further.

### 2.2.3 Ecological model of resilience

The Ecological model of resilience resides alongside dynamic conceptualisations of resilience as one of the dominant discourses in contemporary resilience research. Ecological approaches are informed by Systems Theory (von Bertalanffy, 1968) and emphasise predictable relationships between risk and protective factors, circular causality, and transactional processes that foster resilience. Within the ecological paradigm, resilience is defined as health despite adversity (Masten, 2001) and this model advocates that while individuals can demonstrate resilience, so too can groups and cultures (McAllister, 2013). The ecological model of resilience (Masten and Powell, 2003) illustrates the

possibility of there being a web of bi-directional relationships between individuals and groups for example family, peers, school, neighbourhood, and wider society (Figure 1) (Mental Health Foundation of Australia (2009) In McAllister and McKinnon, 2009).

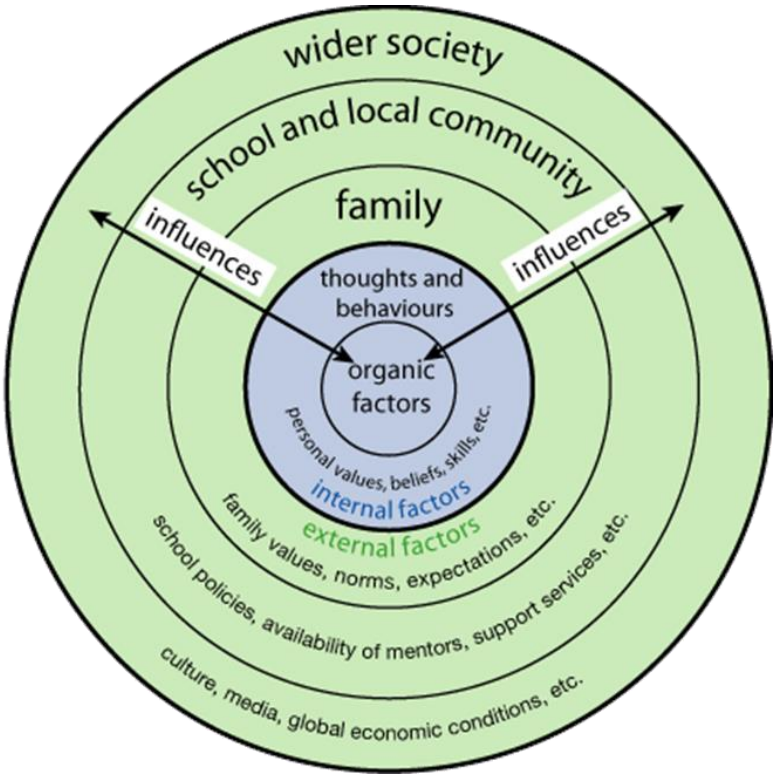



Figure 1: Ecological Model of resilience

As such, resilience may be viewed as a complex cultural construct that includes the concept of groups, for example, families demonstrating resilience, which results in dynamic interactions between individuals and group members that can promote positive adaption to adverse experiences (Luthar, Cicchetti and Becker, 2000). Participation in community activities is identified as important as this encourages the development of social networks which can subsequently provide support for less resilient members of the community (Boykin and Toms, 1985; in McAllister, 2013). This view of resilience also postulates that resilience may be contextual and dynamic as individuals may not display resilience in all aspects of their lives. Similarly, different life transitions, which may require specific coping

mechanisms or social support, may activate different genetically determined biological reactions (Tusaie and Dyer, 2004). Furthermore, some resilience resources may be readily available in some contexts but not in others, therefore resilience is viewed as the outcome of an interaction between stressor, context, and personal characteristics (McAllister, 2013, Smith and Drower, 2008).

Over the past two decades however, criticism of this model of resilience has been growing. Ungar (2004) argues that while ecological approaches to resilience consider relationships between the individual and their environment, they also draw on notions that there are predictable, causal relationships between risk and protective factors. This leads to assumptions that if certain conditions are in place, resilience should emerge. This approach has been criticised for drawing on a scientific approach that makes unsubstantiated causal claims. Furthermore, the assumption that resilience is underpinned by normative development goes undisturbed. Thus, the ecological approach fails to attend to the cultural assumptions implicit in the term 'normative' and can lead to situations where people, not considered to be resilient, are blamed for their "perceived lack of inner strength to overcome their lot in life" (Ungar, 2005, p.91).

### 2.2.4 Constructionist model of resilience

Constructionist models of resilience have developed from criticisms of ecological models which dominate contemporary resilience research. Critical and constructionist theorists argue that ecological approaches which emphasise predictable relationships, causality, and transactional processes, are inadequate to account for the diversity of people's experiences of resilience. Equally they are not able to accommodate the plurality of meanings that individuals negotiate

within their self-constructions of resilience (Ungar, 2004). In contrast, a constructionist approach to resilience reflects a postmodern interpretation of the phenomenon and defines resilience as the "outcome from negotiations between individuals and their environments for the resources to define themselves as healthy amidst conditions collectively viewed as adverse" (Ungar, 2004, p.342).

A constructionist interpretation of resilience encourages receptiveness to the plurality of different contextually relevant definitions of resilience. Resilience is thus understood as "the outcome of negotiations between individuals and their environments to maintain a self-definition as healthy" (Ungar, 2004, p.352). The resultant positive (and negative) outcomes of these negotiations should be interpreted within the pathogenic or salutogenic discourses in which the negotiations take place. Ungar argues that, historically, much research into resilience has been anchored within a pathogenic discourse which perpetuates the false dichotomy of resilient and non-resilient individuals. Within a salutogenic discourse (Antonovsky, 1987), emphasis is placed on how a person may be helped to move toward greater health; this rejects pathogenic discourses which separate health and illness. By adopting a constructionist approach, Ungar argues that pathogenic discourses can be replaced by an understanding of resilience is a phenomenon that resides in all individuals even when significant impairment is present (Ungar, 2004).

Furthermore, the resources available to individuals will influence how and whether they are able to express resilience (Ungar, 2007). As such, resilience is viewed as a social construction that is characterised by a non-systematic, non-hierarchical relationship between risk and protective factors. Therefore, a constructionist view of resilience may allow for alternate accounts of resilience related phenomena that deepen our understanding of how 'at risk' populations

discover and nurture resilience in ways that may be invisible initially (Yellin, Quinn and Hoffman, 1998; Ungar, 2001; Ungar, 2004).

Adopting a constructionist position on resilience provides an opportunity for researchers to produce findings that are meaningful to research participants (Ungar,2004). Such a position aligns well with the aims and objectives of this study and is consistent with an interpretivist approach. Furthermore, as nurses can be described as an at-risk population in terms of resilience; and as little is known about how resilience is understood, nurtured, and experienced within children's nursing, this model of resilience was deemed appropriate as a conceptual framework to guide further development of this project.

In view of the emphasis on resilience in nurse education, this study also included an exploration of the perceived importance of resilience to the participant group and a consideration of whether they considered it to be an important element within the professional identity of a children's nurse.

## 2.3 Resilience and professional identity

A person's professional identity (PI) constitutes a component of their overall identity and is influenced by their position within society, their interactions with others, and their interpretations of experiences (Sutherland, Howard and Markauskaite, 2010). Schubert, Buus, Monrouxe, et al, (2023) state that professional identity is our sense of who we are and our sense of how we should behave in a professional arena. Professional identities of all kinds, including nursing, are acquired through professional socialisation which is a complex interactive process whereby the content of the professional role (skills, knowledge, and behaviour) is learned, while the values, attitudes and goals

integral to the profession and the occupational identity of the profession are internalised (Goldenberg and Iwasiw, 1993).

It is generally accepted that professional socialisation involves both explicit teaching and informal learning in addition to subtle and in some cases explicit coercive practices (Davis, 1975; Apker and Eggly, 2004; Traynor and Buus, 2016). While the formation of professional identity has been found to be an evolving phenomenon that is developed and redeveloped over a nurse's working life; the nurse training period is identified as a crucial period. In part this is due to the vulnerability and disorientation of a neophyte in the workplace which leads to a strong desire to fit in and can act as a catalyst for changes in attitudes and behaviours (Becker, 1961, in Hinkle, 1961; Traynor and Buus, 2016).

As one form of social identity, professional identity concerns group interactions within the workplace and relates to how people compare and differentiate themselves from members of the same and other professional groups (Sun, Gao, Yang et al, 2015). With increasing emphasis on resilience in nursing, complex constructs like 'nurse resilience' need to be carefully considered as they have the potential to shape nurses' identity and the nature of nurses' work, especially if increasingly incorporated into nurse professional standards and undergraduate nurse education.

There is however, as identified in Section 1.3, some concern over the increasing, and at times, uncritical use of the term resilience (Leitch and Bohensky, 2014). Therefore, this study will explore the potential impact the phenomenon of resilience has on the daily lives of children's nurses and will consider how this might inform professional identity.

Consciousness about the way words and texts have and continue to be used to construct identities is important in any consideration of resilience and professional identity. Gee (2010) argues that many words and terms evoke 'first thoughts' or 'taken for granted assumptions about what is typical or normal' (p.1). Gee argues that such first thoughts and assumptions are not neutral; rather they are developed through a complex, socially situated network of experiences and understandings that are often informed by hegemonic discourses that develop through the media, research, and public policy (in Price et al, 2012). Thus, from both an interpretive and phenomenological perspective it is important to consider what the word resilience means to children's nurses and students. This will include an exploration of what the characteristics of a resilient nurse are and how these are constructed.

## 2.4 Relevance to the nurse education setting

As identified in Chapter 1, high rates of attrition in both qualified and student nurses, combined with lower UCAS application rates for undergraduate courses such as nursing pose a significant cause for concern (Traynor and Buus, 2016, NMC 2022, Stacey 2022). The University and College Admissions Service (UCAS) published data in March 2023 that identifies a further 19% decrease in the number of applicants to undergraduate nursing courses across the UK compared to 2022 (UCAS, 2023, Council of Deans of Health, 2023). Unfortunately, the data published does not separate out child nursing from adult or mental health nursing but anecdotally, this drop in applications corresponds with current child admissions figures for this institution. Furthermore, it is notable that many institutions which deliver child nursing courses have gone into early clearing for September 2023 admission due to reduced application rates. This is something

that is uncommon for my institution which is usually significantly oversubscribed for children's nursing. As identified by the RCN (2023a) when viewed alongside a record 47,000 nursing vacancies in England, and continued attrition, such figures are a significant cause for concern.

In early July 2023 the government announced the implementation of the NHS Long Term Workforce Plan which will aim to increase the number of nursing and midwifery training places to around 58,000 by 2031-32 (NHS England 2023; Hallwood, 2023). While specific increases in child nursing places have not been identified yet, a commitment to explore and extend the provision of dual registration courses for child and Learning disability nursing has been articulated (Hallwood, 2023).

While this plan has been widely welcomed by institutions such as the Council of Deans for Health, (2023); the RCN (2023b); NMC (2023); and health think tanks such as the Kings Fund (2023), initial responses identify some cause for caution. For example, there needs to be realism about the investment in the buildings, technology, teaching staff, and equipment that would be required to realise such ambitious plans. More importantly however, to date, the plan does not detail the measures that will be taken to retain current staff and improve the culture and working environment within the NHS (Kings Fund, 2023). This remains an important element and in the absence of detail regarding future plans, nurse educators remain beholden to current measures which emphasise resilience-building as one way to enhance the sustainability of the nursing workforce. In 2018 the Nursing and Midwifery Council (NMC) launched ambitious new standards that set out the skills and knowledge the next generation of nurses will require to enable them to deliver world class care. Resilience figures as a more central feature in the new nursing standards, with the NMC stating that:

> *"In order to respond to the impact and demands of professional nursing practice, they [nurses] must be emotionally intelligent and resilient individuals" (NMC, 2018, p.3).*

It therefore seems clear that nurse educators are tasked with providing initiatives and education aimed at enhancing opportunities to develop resilience within undergraduate nurses and consequently the nursing profession. It must be noted however, that when resilience is discussed in relation to individuals in such a way, the contextual aspects of resilience can be lost. Consequently, this may result in individuals being burdened with the responsibility of increasing their resilience, while detracting away from an examination of the external, and environmental factors that can affect resilience. The Kings Fund (2023) states that recent staff surveys show work culture, bullying, and harassment continue to be an issue within the NHS; hence more needs to be done to not only retain existing staff but encourage new staff into the profession (regardless of the number of training places we may be able to offer).

While resilience is no doubt a useful attribute within the nursing profession, the current pressures placed on nurses and student nurses mean that it is important to view the phenomenon of resilience from a critical stance. This enables an exploration of the dominant discourses and understandings of resilience, alongside, the stressors that may impact on resilience, the resources available to maintain or enhance resilience, the way students and nurses learn about resilience, what they learn, and how this ultimately impacts on their working lives. Within this study it is important to consider how terms like 'nurse resilience' are constructed, by whom, and to what effect. This is especially important as such notions can become enshrined in professional standards and become a powerful mechanism of control over the construction and development of a student nurses' professional identity and the nature of their work.

Nurse educators are responsible for preparing students to become nurses who can meet the demands and professional expectations set out by the Nursing and Midwifery Council. The growing emphasis on resilience within that preparation, alongside social constructionist models of resilience, however, raise some questions. For example: What does it mean to be resilient within children's nursing? How do nursing students learn about the value of resilience? Do nurses/ student nurses already demonstrate high levels of resilience within their professional roles? Is it reasonable to expect nurses/ student nurses to demonstrate higher levels of resilience? Are there consequences of an increased pressure to demonstrate resilience? If so, what are they and do they have implications for professional identity and the future of children's nursing?

One of the charges nurse educators face is to embrace and integrate evidence-based resilience education into contemporary nursing curricula. This should, however, not be based unquestioningly on dominant normative models of resilience, but instead should emanate from a critical stance and be grounded on a sophisticated understanding of resilience as it is conceptualised and described by children's nurses. Thus, I contend that a study which aims to understand how resilience can be both understood and challenged within children's nursing is needed. This can provide a basis for future teaching methods that encourage receptiveness to the plurality of different contextually relevant definitions of resilience and deepen our understanding of how children's nurses discover, learn and nurture resilience. It is hoped that this could result in teaching strategies that are more meaningful, practicable, and helpful.

## 2.5 Chapter summary

This chapter has presented the background and contextual literature pertinent to this study. Models of resilience have been presented and the social constructionist model has been identified as an important model that will be used to interpret the study findings. The importance of resilience to the professional identity of children's nurses has been introduced, and the relevance of a focus on resilience to the child nurse education setting has been explicated. The next chapter will present the chosen methodological framework adopted.

# 3. Methodological approach

The previous chapter presented the background and contextual literature pertinent to this study. This chapter will explicate the chosen methodological framework, including the underpinning ontological and epistemological decisions, before providing a detailed account of the methodology employed.

## 3.1 Ontological and epistemological stance

This research project focuses on how resilience is understood and conceptualised within children's nursing and why it is conceptualised in this way. Consideration is given to how student nurses (SNs) learn about resilience and the role that qualified nurses (QNs) and nurse educators play in promoting current discourses of resilience. The propensity to see resilience as a universally positive or desirable concept will be challenged and an argument will be presented which suggests a potentially maladaptive discourse of resilience within children's nursing. Consequently, this project focusses upon meaning and aims to contribute to a more nuanced understanding of the phenomenon of resilience within children's nursing. Such questions are ontological in nature as they force a movement beyond method and logic to the underlying question of meaning in human affairs (Denzin, 1984). Denzin purports that exploration of meaning requires interpretation rather than logic, however he points out that this can pose a challenge for researchers as interpretations are often pre-reflective and embodied. While this may be overcome in part by observation in practice, the meaning embedded in practices, feelings and thoughts of individuals ultimately needs to be shared and co-constructed through language (Johnson, 1987; van Manen, 2007). This seems to call for a subjective ontological stance, in which reality is constructed through being in the world and in shared practices, and an

interpretive epistemology that can access people's ideas and experiences (Higgs and Trede, 2010)

The ontological and epistemological stance adopted in this study derives from an interpretivist set of principles that adhere to the belief that the social world can only be understood from the standpoint of the individuals being investigated (Cohen et al, 2011). Dudovskiy (2016) argues that researchers adhering to an interpretivist epistemology need to take account of the multiple realities revealed by the varying perspectives of individuals, their contexts, and the phenomenon under investigation.

## 3.2 Methodological framework: interpretive study grounded in interpretative/hermeneutic phenomenology

This study will adopt an interpretivist approach. In doing so it will employ certain research methods which are consistent with Heidegger's principles of interpretative/ hermeneutic phenomenology. Heidegger (1962) suggested that rather than focussing on people or phenomena, the exploration of lived experience or 'dasein' should be the focus (Thompson, 1990). This is important as the aim of this study is not to arrive at a universal definition of resilience but rather to gain a deeper understanding of how this phenomenon is understood by children's nurses and how this subsequently influences everyday experiences, and the development of resilience within student nurses. Within interpretive phenomenology, lived experience must be understood before it can be interpreted and shared. Thus, this study will aim to go beyond a mere description of core concepts and essences, and in line with Heideggerian principles will aim to look for meanings embedded within common practices (Lopez and Willis, 2004).

To explicate my research position clearly, I am not adhering to phenomenological principles in a pure manner and therefore am not professing to be conducting a phenomenological study. Rather I am borrowing from interpretative/hermeneutic phenomenology in order to guide and provide a structure to the methodological design of this study. As a method, phenomenology is grounded in the rich portrayal of experience. It takes account of context and subjective meanings and is therefore considered a suitable approach for recognising and valuing the voices of research participants, and for exploring a multifaceted phenomenon such as resilience which can be interpreted differently by different people.

A feature of interpretative phenomenology that will be adhered to within this study is the belief that it is impossible for a researcher to rid the mind of preconceptions and to approach something in a completely blank or neutral way. Instead, interpretative phenomenologists use their own experiences to interpret those of others and may use these experiences and prior knowledge (fore-structure) to guide their research questions (Balls, 2009) and assist in interpretation (McComiell-Hemy, Chapman, and Francis, 2009). In view of my prior lived experience as a children's nurse, my connection to student nurses in my current role as a nurse educator, and my existing knowledge on resilience, it was considered unrealistic to suspend personal knowledge and experience. This was particularly true as this fore-structure had fuelled my interest and inspired the focus for this research. Such a stance necessitates a need for reflexivity which will be addressed later in this chapter.

The proceeding sections will present the methodological decisions that have been taken and will identify where key principles, grounded within the

interpretative phenomenological tradition, have been used to structure the design of this study.

## 3.3 Considerations regarding access and sampling

When deciding on a sample population researchers must make decisions about the focus of the study in addition to which people it is possible or desirable to select (Cohen et al, 2011). One sampling method commonly used within both interpretive and phenomenological research is purposive or purposeful sampling (Teddlie and Yu, 2007; Palys, 2008). Purposive sampling relies on the judgement of the researcher and requires that the researcher draw upon theory and practice to objectively choose participants who will help to answer the research question and achieve the research objectives (Dudovskiy, 2016). Purposive sampling is the strategy employed within this study. To enhance the credibility of this sampling method four aspects were considered: sample universe, sample strategy, sample size, and access to the sample (Robinson (2014).

### 3.3.1 Sample universe

The 'sample universe' or study population constitutes the 'totality of persons from which cases may legitimately be sampled in an interview study' (Robinson, 2014. Pg.25). To define a sample universe Patton (1990) argues that inclusion and exclusion criteria should be specified to define clear boundaries around the sample universe. Furthermore, Mason (2002) argues that the more explicitly a sample universe is defined the more transparent and valid any potential generalisations can be. Figure 2 depicts the sample universe for this study.

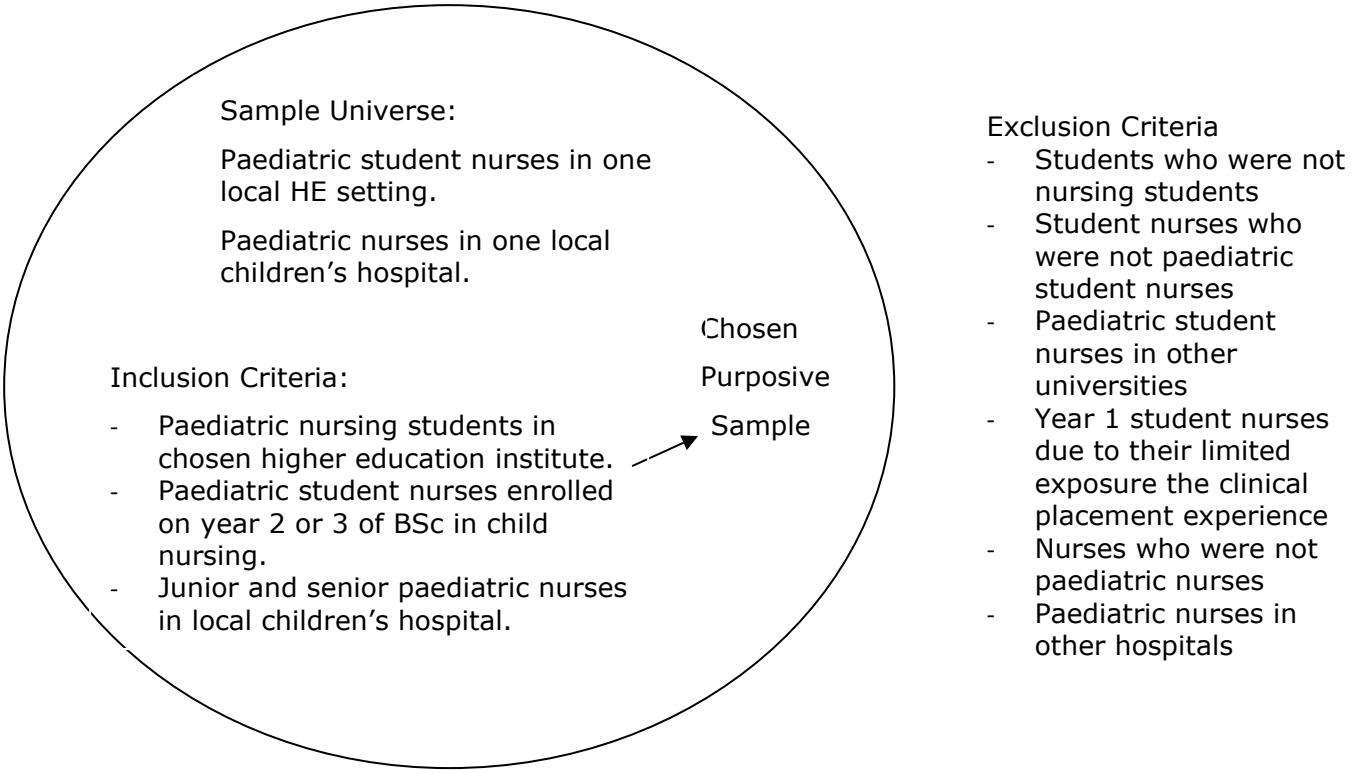



Figure 2: Sample selection adapted from Robinson (2014).

### 3.3.2 Sample strategy

The choice of a particular type of participant who is likely to have experienced the phenomenon under investigation is necessary for both interpretive and phenomenological research (Crotty 1996).

This thesis has been completed as part of an EdD qualification where a salient goal is to understand how contemporary conceptualisations of resilience might impact on a nurse education setting. It is important to acknowledge however, that pre-registration nurse education also takes place within the clinical setting, thus the influence of the qualified nurse mentor must be considered. The role of the QN mentor is seen as pivotal to learning and the socialisation of students into the professional sphere of nursing. Role modelling is viewed as an important element within this socialisation process and the attitudes, beliefs and values held by qualified nurses are an important factor. As resilience has been identified

as an important aspect in the professional identity of a nurse it was necessary to consider the QN as a potential role modeller of resilience, thus, both SN and QN participants were recruited to take part in this study.

The initial study design included an intention to try to recruit participants with varied levels of experience, for example, junior and senior students and qualified nurses. This was grounded in findings that resilience within children's nursing was seen to develop with increased experience (Berger, Polivka, Smoot and Owens, 2015; Hecktman, 2012; Sekol, and Kim, 2014). While the recruitment strategy did purposively target certain pools of participants, it did not target specific individuals as it was deemed this may be unethical and put undue pressure on participants to take part (see Section 3.3.4). Consequently, while a sample of junior and senior SN participants was achieved, the same range of experience was not achieved within the QN sample where all participants were relatively senior. There was, however, variation in levels of seniority and time worked as a nurse within this participant group. This could have impacted on the findings of this study, so it would be interesting to repeat the study to gain the views of less experienced QNs.

### 3.3.3 Sample size

Qualitative interpretive studies typically require a smaller sample size than quantitative studies. There is no clear consensus, however, on what constitutes an appropriate sample size; this is particularly true of phenomenological studies. As interpretive research focusses on the collection of reflective descriptions, interpretation and making meaning, it can be argued that it is not necessary to obtain specific numbers of participants to be able to make generalisable statements (Mason 2010; Pereira 2012; van Manen 1997). However, as this

study aimed to explore the experiences of both students and qualified nurses, more participants were required. For practical reasons Crouch and McKenzie (2006) purport that a sample size of less than 20 participants helps to improve the open and frank exchange of information by enabling the researcher to build and maintain a close relationship with participants. Van Rijnsoever (2017) however, recommends a sample size of 20–30 participants but suggests that data collection should continue until a point of saturation is reached. Based on this information, an initial sample size of 10 QN participants and 10 SN participants (total n=20) was proposed. This was achieved for the QN participant group, but not the SN group where it was only possible to recruit 8 participants. In line with notions of inductive thematic saturation of data however, 8 SN and 10 QN participants was deemed sufficient, so no further participants were recruited.

### 3.3.4 Access to the sample/ further sampling considerations

The final stage in sample selection is to consider access to the sample population. I have frequent professional contact with the paediatric SN population as well as clinical nursing staff. While this can assist with the recruitment of participants it raised some ethical considerations. For example, such familiarity had the potential to influence a participant's ability to provide valid informed consent as they may feel under pressure or obliged to consent. Furthermore, when conducting research of a sensitive nature, which can be defined generically as any research that intrudes into the private sphere (Renzetti and Lee, 1993), familiarity between researcher and participant can be problematic. Oakley (1981) argues that the presence of an established prior

relationship can hinder honesty but can also be exploitative as some participants may be tempted to disclose more to a person with whom they are familiar.

A further issue pertained to my role as a nurse academic and the inclusion of student nurses within the target sample. Clarke and McCann (2005) argue that student participation in research conducted by researchers who are also responsible for teaching them poses specific ethical issues. These centre on the power differential between a student and their lecturer and can lead to issues relating to abuse of power, coercion, lack of meaningful informed consent, and problems with confidentiality (Clarke and McCann, 2005; Brody et al, 1997). Therefore, when recruiting student participants, it was essential to ensure they were clear about their right to refuse to take part or withdraw from the study at any time without penalty (Polit and Hungler, 1999; National Health and Medical Research Council, 2002). This will be discussed further in Section 3.7.1.

### 3.3.5 Recruitment of participants

The strategy to recruit SN and QN participants was similar except that it was necessary to use a gatekeeper for initial communication with QN participants (this is a requirement for research conducted within the NHS). To recruit participants an invitation email (Appendix 8.1) and participant information sheet (Appendix 8.2) were developed. SN versions and QN versions were produced. For SN participants, the invitation email and information sheet were sent by me to all year 2 and 3 nursing students on the BSc Nursing – child course. For QN participants the gatekeeper sent the invitation email and information sheet to all qualified children's nurses working within the identified hospital trust. SNs and QNs were directed to contact me via email or phone if they were interested in taking part. After any affirmative response a consent form was emailed to the

SN or the QN and a date arranged for the interview (Appendix 8.3). One further email reminder was sent to SNs and QNs (via the gatekeeper) three weeks after the initial email (Appendix 8.1). No further interview requests were sent after the reminder email. At all communication opportunities potential participants were reassured that they could withdraw consent or decline to take part at any stage of the process. After the initial and reminder emails 10 QN participants were recruited to the study and 8 SN participants (4 year 2 students, 4 year 3 students).

## 3.4 Methods to generate data

From an interpretative phenomenological perspective, meaning must be the result of co-creation between the researcher and the researched as opposed to merely the interpretation of the researcher who may have different contextual factors or agendas (Flood, 2010). Within interpretive and phenomenological research, interview is the main method of data collection as this allows participants descriptions to be explored, illuminated, and probed (Kvale, 1996) through reflection, clarification, requests for examples and descriptions, and listening techniques (Jasper, 1994). The interview is often used to elicit a life story or narrative from the subject which centres upon the phenomenon of interest. Interpretive or hermeneutic phenomenology is concerned with interpreting concealed meanings within phenomena. Thus, the purpose of the interview is to derive shared meanings by drawing from the subject a vivid picture of the lived experience complete with the richness of detail and context which shape that experience (Clarke and Iphofen, 2006). Such an approach blends listening and narrative and is usually either unstructured or semi-structured to allow participants to tell their own experiences in their own words.

When deciding upon the most appropriate type of interview, decisions should be based upon the fundamental questions that prompted the need for an interview in the first place. While tradition dictates the use of unstructured interviews within phenomenological research, semi-structured interviews are also commonplace and are often used within interpretive studies (Balls, 2009). The purpose of interviewing in this study was to explore how resilience is conceptualised within children's nursing, why it is conceptualised in this way, and the implications this may have for nurse education and the wider profession. Consequently, the method chosen to generate data was semi–structured interview.

To assist in structuring the interview, an interview guide was developed (Appendix 8.4). This identified broad topic areas to be covered and potential probes which may be used to obtain greater detail from participants (King, 2004). In line with phenomenological principles, this guide was based upon my knowledge and prior experience (fore-structure) but also upon relevant literature identified within the previous two chapters. Of particular bearing was literature which identified varied models of resilience, the challenging nature of children's nursing, the perceived importance of and emphasis on resilience within children's nursing, and emergent literature which pointed to a potentially negative side to resilience. Furthermore, the lack of literature exploring what children's nurses understand resilience to be and how this is experienced within their working lives further influenced development of the interview guide.

This resulted in four main areas for exploration, namely general views about resilience and participants understanding of the term, potential challenges to resilience, the perceived importance of resilience inclusive of implications if

participants deemed themselves or others not to be resilient, and finally, potential enablers of resilience.

Clusters of questions were developed around these main themes to assist with the interview. Due to my novice status as a researcher, the interview guide developed was quite detailed. It should be stressed however, that while all interviews covered the main four themes, the interview guide was not adhered to in a strict manner. Turner (2016) writes that interview guides act as an aide-mémoire during semi-structured interviews, while Silverman (2013) argues that departures from a semi structured interview guide are encouraged as they allow the interviewer the flexibility to pursue unexpected or interesting topics that emerge during the interview.

Consequently, not all questions were asked during each interview and all interviews started with open questions such as "What do you understand by the term resilience?" Probing questions tended to focus on prompts to encourage further elaboration, for example, "can you tell me a bit more about that?" or why/ how questions, such as, "Why do you think that might be the case?" or "How did that make you feel?" More specific questions from the interview guide were asked as relevant to each individual interview to ensure that the four main topic areas were covered.

As this interview guide was based partially on my own fore structure, in line with Heideggerian principles, reflexivity was essential throughout the data collection stage. This aimed to ensure that the interview schedule was not applied too strictly which could impact on the balance between direction and flexibility. The interview guide was tested using two pilot interviews with an SN and a QN volunteer. This enabled refinement to ensure questions were appropriate and

facilitated personal reflection on my own influence and potential impact upon the interview process.

All interviews were conducted on a one-to-one basis. The initial design was for interviews to take place 'in person' however, the advent of Covid-19 prevented this. A minor amendment was submitted to the School of Education ethics committee which enabled interviews to take place over Microsoft Teams or telephone. Seventeen of the eighteen interviews were conducted via Microsoft teams with one being conducted over the phone at the participants request. All interviews were audio recorded before being transcribed verbatim. To conform with phenomenological principles, transcription of all interviews was performed by myself to allow familiarisation with, and full immersion within, the data.

Finally, phenomenological principles stipulate that interpretation (data analysis) should occur alongside data collection (Crist and Tanner, 2003). Phenomenological studies tend to be iterative in nature and thus interpretation is essential at all stages in the research project and should guide and direct future interviews. Thus, interviews were transcribed, and first cycle coding was undertaken as soon as possible following completion of each interview. This allowed reflection upon personal interview skills, success of the interviews, potential biases or fore-knowledge that might impact upon interpretations, and a guide for further interviews.

## 3.5 Data analysis

Data analysis within qualitative research often relies on inductive reasoning processes that allow the researcher to derive structure and meanings from the data. Within data analysis it is common for researchers to use some form of coding within their analysis of qualitative data (Braun and Clarke, 2006; Williams

and Moser, 2019; Parameswaran, Ozawa-Kirk; Latendress, 2020; Saldaña, 2021). Coding is a data analysis method that is iterative in process and allows the organisation of similarly coded data into categories that share certain characteristics. It is important to note that coding is not just about labelling data but also about making links that enable the emergence of new ideas and the generation of new theory. Saldaña (2021) separates coding into two stages, first cycle and second cycle coding. First cycle methods are used during the initial stages of data analysis, second cycle coding methods are then used to help further consolidate, filter, and categorise data. Second cycle methods are more sophisticated as they involve additional analytical skills such as synthesis, abstraction, conceptualisation, and theory building (Saldaña 2021).

The first cycle coding method adopted within this study was descriptive coding, as defined by Wolcott (1994). Descriptive coding summarises the basic content or topic of a passage of qualitative data into a word or short phrase. During this stage it is important that these codes represent the identification of a topic rather than merely an abbreviation of the content. Saldaña, (2021) argues that descriptive coding is appropriate for nearly all qualitative research but is particularly useful for novice researchers who are learning how to code, hence this was deemed a suitable approach for the first cycle of coding. All interview transcripts were analysed to generate basic descriptive codes which facilitated an initial organisational understanding of the data. This resulted in a list of codes which summarised the contents of the data and provided a basis for second cycle coding.

The approach adopted for second cycle coding was pattern coding, as described by Miles and Huberman, (1994). Pattern codes are inferential codes that can be used to identify an emergent theme by grouping codes generated during first

cycle coding into smaller themes or constructs (Miles and Huberman, 1994). Pattern coding is identified as being useful in:

- The development of major themes from data.
- The search for causes and explanations within data.
- The examination of social networks and patterns in human relationships.
- The formation of theoretical constructs.

Miles and Huberman (1994)

Consequently, this method of data analysis seemed to fit well with the aims, the ontological and epistemological foundations of the study, and the subsequent methodological design. During this stage similar codes were assembled to analyse their commonality, look for patterns, and ultimately consider how codes might link and interact with one another. Pattern codes were generated (see Figure 3) then a concept map (see Appendix 8.5) was produced using elements of theoretical coding (Glaser and Strauss, 1967) to identify core 'umbrella' themes that were central to the development of theory within this thesis (see Figure 3).

In the below example, codes generated during the first cycle analysis, were re-coded in the second cycle of analysis, then recoded a second time, and finally re-coded into an overarching theoretical code. Saldaña (2021) writes that a theoretical code functions like an umbrella that covers the accounts of all other codes and thus assists with the identification of the primary theme of the thesis; in this case the argument that there is a maladaptive discourse of resilience within nursing (see subsequent chapters). As such, while other codes and categories are present, they are linked to the central core category or code.

Figure 3 shows how the first cycle codes informed and were recoded into the initial second cycle codes. This is quite a complex diagram visually, so to aid in

clarity a separate diagram for each second cycle code (stage 1) is available to view within Appendix 8.10.

Figure 4 shows how the initial second cycle codes were reorganised into the final second cycle codes (stage 2) which will be discussed within the findings section. This figure also shows how these second cycle codes feed into the overarching theoretical code for this thesis and how they relate to the research questions. Once again, visually this is a complex diagram so for ease of viewing, the diagram has been broken down into the two separate stages within Appendix 8.11. The first diagram depicts initial (stage 1) second order codes to final (stage 2) second order codes, the second diagram depicts how the final second order codes relate to the research questions.

The diagrams depicted in figures 3 and 4 highlight the complexity of relationships between the findings within this thesis. It should be noted however, that even these diagrams represent a simplification of complex reality. Nevertheless, they are included to provide both a description of the coding strategy employed, and a diagrammatic representation of the findings which may assist in the subsequent explanation of them.

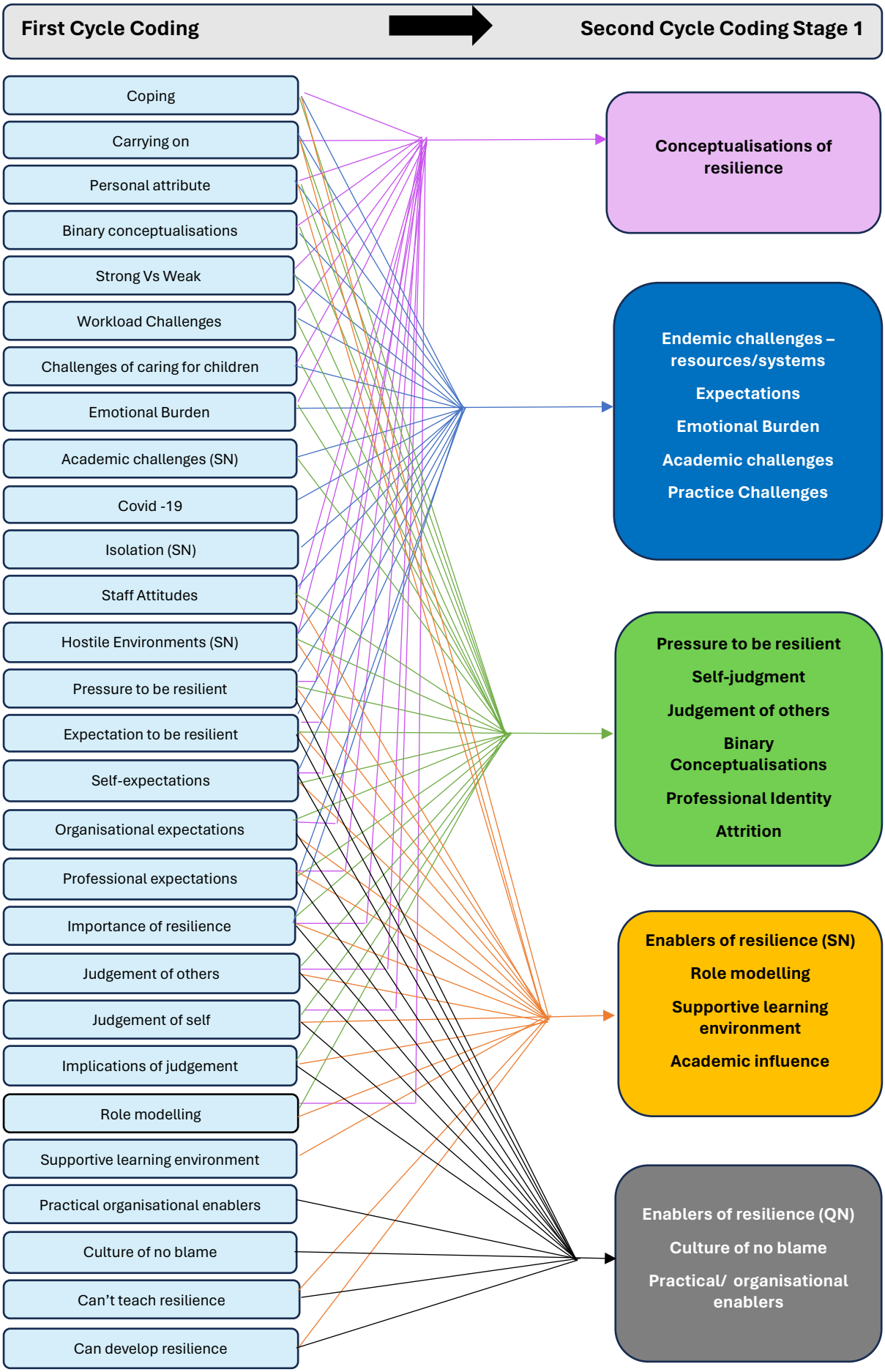



Figure 3 showing first cycle codes to initial second cycle codes.

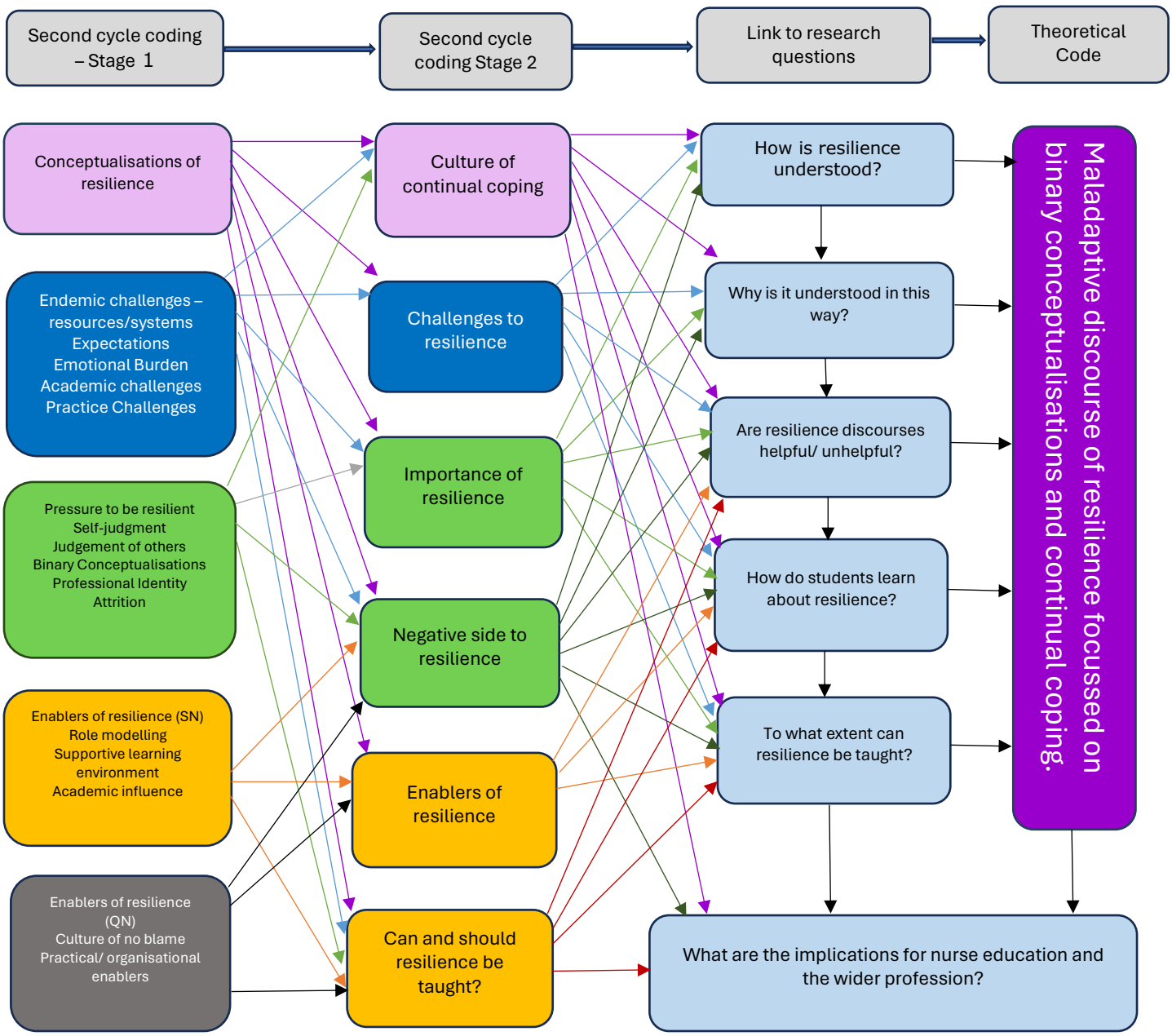



Figure 4 showing second cycle codes stage 2 and how they inform the theoretical code and link to the research questions.

The data analysis strategy depicted above was aimed at enhancing the credibility of the findings. While there is certainly merit in the strategies adopted, it must be acknowledged that the process of coding is subject to the foreknowledge, subjectivities, predispositions, and personality of the researcher. Thus, additional strategies were employed which aimed to further enhance the credibility and trustworthiness of this study.

## 3.6 Efforts to ensure trustworthiness

Common criticisms of qualitative research are that it is subjective, anecdotal, and open to researcher bias (Koch and Harrington, 1998). To protect against such criticisms, it was essential to take measures to maximise the quality of data collected and the subsequent analysis performed. Guba and Lincoln (1994) argue that to develop trustworthiness in qualitative research, attention to five criteria is required: credibility, dependability, confirmability, transferability, and authenticity.

### 3.6.1 Credibility

Credibility refers to the truth of the data, and the subsequent interpretations and representations the research makes (Polit and Beck, 2012). Flood (2010) argues that credibility can be enhanced by the co-creation of meaning which can be achieved by referring data and interpretations back to the sources to verify the research findings with the participants (Guba and Lincoln, 1981; Cope, 2014). A qualitative study can be deemed credible if the descriptions of an individual's experiences can be immediately recognised by that individual as their own (Sandelowski, 1986).

To support the credibility of this project it was important to demonstrate clear engagement with participants. This involved ensuring that initial data collection and subsequent transcription constituted an accurate representation of the interview interaction through participant checking (Cope, 2014). A summary of the themes that emerged and the subsequent interpretations was also produced. Participants were asked if they wished to receive a copy of their interview transcript or a copy of the summary following the interviews. Those who did (n=3 participants) were sent copies and given the opportunity to make corrections, and feedback on whether the findings were representative and credible (Guba and Lincoln, 1981; Cope, 2014). No participants requested any changes to transcripts. While feedback was limited to three participants, this suggested the transcripts reviewed were representative and credible.

### 3.6.2 Dependability

Dependability refers to the consistency of data over situations deemed to be similar (Polit and Hungler, 1991; Polit and Beck, 2012). The emphasis however, within interpretive research on the uniqueness of human situations and experiences means that it is not necessarily open to such measures of validity. Balls (2009) proposes that the concept of auditability should be used as the measure of dependability in interpretive studies. The presentation of a transparent audit trail is a central strategy to enhance the credibility and dependability of qualitative research. To address this issue, it was important to keep all material used within the research process. This included process notes, transcript notes, audio tapes, data analysis, and drafts of the final report. These have been kept in a logical, organised manner, which complies with ethical

guidelines on the storage of data to provide a clear decision trail from conception to completion of the study (Appleton, 1995).

### 3.6.3 Confirmability and authenticity

Confirmability refers to the researcher's ability to show that data is a true representation of the participant's responses rather than the researcher's viewpoints or biases. Authenticity refers to the extent to which the researcher articulates the emotions and feelings of participant's experiences in a faithful manner (Polit and Beck, 2012). Both can be achieved by providing rich participant quotes which clearly depict relevant themes, but also through a process of researcher reflexivity (Cope, 2014). Reflexivity is a core concept within interpretative phenomenological research. Dowling (2006) argues that for researchers to understand the experience of others they must '*challenge, dismantle and move beyond the boundaries of their own horizons*' (Wilson 2014, p.32). This involves thoughtful and reflexive engagement throughout the entire research process. Furthermore, it requires researcher's to clearly explicate any assumptions about the experiences being studied and to consider how these might influence their research (Wilson, 2014).

On a personal level, one action taken to enhance awareness of my foreknowledge of the phenomenon of resilience was the completion of a personal critical reflection. Critical reflection can be defined as a personal activity which allows one to look outwards at the social and cultural elements that influence our practices, and inwards to challenge the processes by which we make sense of the world (White, 2001). I have reflected upon five life events (critical incidents) that have been significant in forming my personal values and beliefs, and subsequent experiences of resilience. In doing so, I have attempted to identify

my own personal narrative in a bid to understand how my values, beliefs and knowledge have been constructed and shaped by my lived experiences. This is an action that has been completed for my own benefit and the narrative produced is not intended to form part of the dataset for this study. In part this is due to a desire to ensure this project does not become self-indulgent. Rather this activity has been undertaken to enhance personal self-awareness and to acknowledge the 'self' as part of the process of knowledge creation (Healey, 2005).

In addition, a further action taken was to maintain a reflexive journal which articulated an open and honest account of my own thoughts, feelings, and behaviour in relation to the research process (Lambert et al, 2010; Cope, 2014). By adhering to this recommendation, I hoped to remain aware of my own contextual standpoints, attitudes, beliefs, and biases.

### 3.6.4 Transferability

Transferability refers to findings that can be applied to other similar groups or settings (Polit and Beck, 2012). The question of transferability is less appropriate in interpretive research because the aim is not to produce a theory of general application. However, if researchers provide sufficient detail about the study setting, the participants, and the research process, not only can the research be audited, but it may also be repeated in other settings (Jasper, 1994). Cope (2014) argues that a qualitative study can be judged as having met this criterion if the results have meaning to similar individuals who were not involved in the study. Hence this study may be deemed to show transferability if other children's nurses or student nurses can relate to the findings in a meaningful way. To achieve this, I have tried to provide sufficient information on the sample

participants and research context as this could allow the reader to assess whether the findings are transferable (Cope, 2014).

## 3.7 Ethical considerations

In 1979 the Belmont Report identified three core principles for the ethical conduct of research (see Figure 4). This list of principles leads to several ethical considerations to ensure this study fits within the code of research conduct and research ethics stipulated by the University of Nottingham.

From the conception of a research project there are ethical issues in relation to beneficence and justice that needed to be considered. One such issue was how to present oneself to participants to ensure they were not exploited (Hennink et al, 2011). This was addressed by careful consideration of the following issues: informed consent, self-determination, minimisation of harm, anonymity, and confidentiality (Hennink et al, 2011; British Educational Research Association - BERA, 2018; University of Nottingham, 2016).

1. Respect for persons: Participants welfare should always take precedence over the interests of science or society. Participants should be treated with courtesy and respect and should enter research voluntarily and with adequate information.
2. Beneficence: Researchers should make efforts to maximise the benefits of the research for wider society and to minimise the risks to research participants.
3. Justice: Researchers should ensure that research procedures are administered in a fair, non-exploitative and well considered manner.

Hennink, Hutter and Bailey (2011)

Figure 5: Core principles for ethical conduct.

### 3.7.1 Informed consent, self-determination, and harm minimisation

The first step in achieving informed consent involves seeking permission not only from the potential participants but also any relevant agencies or stakeholders. This involved providing clear information about the research objectives, how data would be collected, stored, and used, who would have access to the data, how it would be anonymised, and how harm to participants would be minimised (Hennink et al, 2011). For this study to go ahead it was necessary to gain permission from both the School of Education, and the local NHS Trust, before gaining appropriate ethical approval (discussed in 3.7.3).

A second important consideration was to ensure that all potential participants understood the purpose of the research study, the process they would be asked to undertake, why their participation was deemed necessary, how any information would be collected, and ultimately how and to whom it would be reported. They were also informed about retention, sharing, and any possible secondary uses of the research data, along with their right to have access to any personal data that was stored, and related to them (BERA, 2018). The securing of a participants voluntary informed consent prior to engagement in any research process is considered normal practice; thus, it was vital that clear information was provided that avoided any deception or subterfuge to allow participants to make informed decisions (University of Nottingham, 2016; Busher and James, 2015). As recommended, written consent was obtained from each individual participant prior to any research activity taking place (Hennink et al, 2011). Participants were also clearly advised of their right to withdraw from the research project at any time and for any or no reason (BERA, 2018).

To facilitate the above a participant information sheet, which clearly detailed all relevant information, including the participant's right to decline to be involved in the study, was produced. As a researcher it was necessary to accept that participants could withdraw from, and not continue with, an interview at any point if they wished. Had this happened it would have been important to examine my own behaviour to evaluate whether my actions had contributed to a participant's decision to withdraw.

Furthermore, it was important to consider any unexpected detriment that may occur because of taking part in the study (BERA, 2018); this links closely with the requirement to protect participants from any harm. Hennink et al (2011) point out that qualitative research often focuses on the personal experiences and beliefs of study participants, which can lead to participants experiencing strong emotions. This study asked participants to discuss their views on resilience so there was the possibility that this may cause participants to revisit distressing memories or events. It was important to be prepared to respond with empathy and sensitivity had such a situation arisen (Hennink et al, 2011). To enhance this, an additional participant information sheet was produced which detailed the professional support agencies and organisations available to participants should they feel this would be of benefit (Appendix 8.6).

### 3.7.2 Anonymity and confidentiality

A further standard measure to protect participants and minimise harm is to guarantee confidentiality and anonymity (Cohen et al, 2011). Confidentiality refers to not disclosing information that is discussed between researcher and participant, while anonymity refers to the process of removing all identifiable information from data collected and subsequently used including interview

transcripts and audio tapes (BERA, 2018; University of Nottingham, 2016). Hennink et al (2011) point out that confidentiality is harder to achieve in qualitative research as there is often a need for researchers to include quotations from participants within their reports. Hence the careful selection of quotations and strict adherence to principles of anonymity are of increased importance in interpretive research. Within this study, participants were recruited from one children's hospital, or one School of Nursing, which increased the likelihood of participants knowing one another. Consequently, when reporting findings and selecting suitable supporting quotations, careful deliberation was required to ensure that participants remained anonymous. The issue of access and sampling posed some further ethical considerations which have already been discussed in Section 3.3.4.

### 3.7.3 Application for ethical approval process

Applications for ethical approval were required from the School of Education Research Ethics Committee (for application and approval see Appendices 8.7)

As this study included NHS staff as participants the study also required additional approval from The Health Research Authority (HRA). HRA approval applies to all research taking place in the NHS in England and Wales. HRA Approval brings together the assessment of governance and legal compliance. This is undertaken by HRA staff, with the independent ethical opinion undertaken by a Research Ethics Committee (REC) so that only one application needs to be submitted. HRA approval applies where the NHS organisation has a duty of care to participants, either as patients/service users or NHS staff/volunteers (Health Research Authority, 2018). HRA approval was obtained via the Integrated Research Application System by completing an IRAS Application. (This

documentation has not been included in the appendices due to the length and detail of the IRAS application. This is available to examiners however, on request).

Additionally, as a member of staff from the University of Nottingham conducting research that recruited staff through the NHS, I was required to obtain a formal declaration of sponsorship from the University of Nottingham. This was obtained via the Research Governance Co-ordinator based in the department of Research and Innovation (UoN). To secure UoN sponsorship, a sponsor review of all study documents inclusive of the IRAS application (before submission to the HRA/REC/UoN ethics) was required to extract the required information for governance and insurance purposes and to advise of any necessary changes. Where the University of Nottingham acts as sponsor for research that requires HRA approval it was mandatory that UoN templates were used for all study documentation. Furthermore, a Statement of Activities and Schedule of Events was required and completed. (Available to examiners on request).

## 3.8 Chapter summary

This chapter has explicated the chosen methodological framework, the underpinning ontological and epistemological decisions, and a detailed account of the methodology. The next chapter will introduce the findings from interviews conducted with both qualified children's nursing staff (QN) and student nurses (SN) studying to become children's nurses.

# 4. Findings

This chapter will introduce the findings from interviews conducted with both qualified children's nursing staff (QN) and student nurses (SN) studying to become children's nurses. This thesis constitutes the culmination of an EdD study where the ultimate focus will be on student learning and recommendations aimed at nurse educators. However, to get to this position, it is first necessary to consider the phenomenon of nurse resilience within wider organisational and social contexts. The ontological and epistemological stance of this study necessitates such an interpretive approach where 'lived experience' of the participants is explored before being interpreted. Thus, wider contextual factors that influence conceptualisations if resilience, and challenge or enable resilience must be considered before final arguments can be formulated. This also includes an exploration of the influence of resilience as a concept on the lives of children's nurses and student nurses.

As already identified, figures 3 and 4 (pages 57 and 58 respectively) highlight the complexity of relationships between the findings within this thesis. Significant thought was given to the possibility of constructing a simple diagrammatic model that may assist further with an explanation of the findings. The complexity of the relationships identified however, made this difficult as the findings did not fit neatly into a diagrammatic model. Consequently, the findings will be presented in line with the final second order codes (themes) generated and depicted within figure 4.

Five themes will be covered in this chapter, these are, an exploration of how staff and students conceptualise and define the phenomenon of resilience (which relates to the culture of continual coping identified within figure 4), the

importance of resilience to the profession, challenges to resilience, the potentially negative (maladaptive) side to resilience evident within the profession, and finally, possible enablers of resilience. The final theme identified within the secondary coding cycle pertaining to whether resilience can and should be taught will be explored alongside recommendations for future practice within chapter 5 (Discussion).

Before presenting the findings relevant to each of the above themes in detail, it is perhaps useful to foreground this discussion with a summary of the main findings and arguments that will emerge from this chapter, namely that this study provides evidence of a maladaptive discourse of resilience within children's nursing that focusses on individuals and a culture of continual coping'. This argument has been presented within figure 4 (page 58) as the overarching theoretical code that constitutes the central tenet of this thesis. Consequently, the secondary codes discussed within this section are all linked to, and inform, this central theoretical code. The following section will provide a summary of the core theoretical argument, the remainder of the chapter will provide an in-depth account of the findings that have informed this key argument.

## 4.1 Maladaptive discourse of resilience in children's nursing

This study provides evidence that there is a maladaptive discourse of resilience evident within children's nursing. In terms of an understanding of resilience, the dominant discourse described within this study focussed on individuals and a culture of continual coping. This is different to more traditional definitions of resilience that position resilience an adaptive ability or an ability to bounce back from an acute stressor.

The conceptualisation of resilience evident within this study, seemed to be conditioned by the endemic pressures evident within the working environment. This resulted in an expectation that staff and students would not only cope with the pressures already evident in their daily working lives; but continue to cope with ever increasing pressures regardless of how realistic or reasonable these pressures were. Such a discourse of resilience is unhelpful as it does not adequately account for wider contextual challenges to resilience within the workplace. It may also place unreasonable pressure on individuals to cope and make up for organisational deficits, whilst simultaneously relieving wider organisations from their responsibility to mobilise resources and change their systems to better support children's nurses and students.

Findings from this study further suggest that such a discourse of resilience has the potential to perpetuate harmful binary conceptualisations of resilience such as 'strong Vs weak' or 'resilient Vs not resilient'. Such conceptualisations can lead to feelings of inadequacy, distress, anxiety, and stress, and disempower nurses from challenging unreasonable workload demands for fear of being viewed as weak.

Furthermore, findings suggest that this maladaptive discourse of resilience is perpetuated, communicated, and reinforced on multiple levels inclusive of professional regulators such as the NMC (Nursing and Midwifery Council), wider organisations such as hospital trusts, and the higher education environment. In terms of this EdD thesis, this has significant implications and raises important questions about whether the discourse of resilience in children's nursing is helpful or unhelpful and consequently how we should approach the issue of nurse resilience within the higher education setting.

The following sections will present the findings in relation to the final secondary themes (codes) generated during the secondary coding process, namely, culture of continual coping, the importance of resilience, challenges to resilience, the potential negative side to resilience within nursing, and finally potential enablers of resilience. Links to the central theme of a maladaptive discourse of resilience will be explicated throughout.

## 4.2 Conceptualising resilience – culture of continual coping

The first section will report the findings in relation to how staff and students understand the phenomenon of resilience. This will be split into two subsections: a) defining resilience, and b) the perceived importance of resilience within children's nursing. In view of the interpretive nature of this study, and the emphasis on the constructionist model of resilience, it was important to start the interviews by asking staff and students to describe what resilience meant to them and what they understood by the term. While there were differences in the definitions, there were some marked similarities in participants understanding of the phenomenon of resilience, namely the concept of 'coping', 'carrying on', and resilience as a 'personal attribute'.

### 4.2.1 Coping

One consistent finding within QN definitions of resilience was the concept of coping. Six of the ten participants included the term coping within their definitions of resilience and all participants identified coping as being a central theme at some point within their interviews:

> *Um, your ability to cope. Um, your ability to continue. I mean, in a professional sense, your ability to continue to function. Erm…As a full*

> *professional nurse in the face of…. Insurmountable stress and workload (QN1).*
>
> *..its linked with coping mechanisms I think so erm, developing strategies to help you as an individual…… so it's not necessarily about altering the level of stress that happens in a situation, it's about then how you can, manage the situation, not only at the time but afterwards as well and continue to work in, in situations that are ongoingly stressful (QN2).*

One participant struggled to articulate a definition of resilience, eventually deciding upon the concept of coping, and subsequently using this term rather than resilience throughout the interview.

> *I think this is interesting 'cause I'm actually quite struggling to. I'm struggling to articulate what, what it means, so maybe that's important isn't it? So, someone that can cope someone, that doesn't flail from one thing to another (QN3).*

Finally, one participant, even though they cited coping within their definition of resilience, identified some unease with the perceived link between resilience and coping:

> *I think it worries me that it gets mixed up with coping and I sometimes think that coping, and I guess I speak from personal experience. We think we must keep coping and keep putting up with things and coping no matter what (QN4).*

This was an interesting comment that alluded to a potentially negative side to the phenomenon of resilience which will be explored in more depth later in this chapter. Within the (SN) interviews the term coping was also referred to, being mentioned by two of the eight SN participants, for example:

> *Um, to be able to cope with the demands of...What it takes to become a children's nurse. So as a student and then once qualified to be able to cope with all the different types of pressures that you see (SN1).*

While 'coping' was referred to broadly in many student interviews, it did not feature as explicitly within their definitions of resilience. Furthermore, in contrast

to staff interviews, students did not seem to struggle to define the term and seemed to have more familiarity with the concept.

### 4.2.2 Carrying on/keeping going

The second theme that featured in definitions of eight of the ten QN participants was the notion of 'carrying on' or 'keeping going', despite facing stress and adversity within their working lives. This was seen as an essential part of the children's nurse's role and was mentioned by all participants at some point within their interviews.

> *I think resilience is something where you've got that ability to carry on, regardless of what you faced for that day, so you know if you're having a really bad day, it's the, it's the concept of 'it's fine. We can keep going (QN5).*

> *Um, I don't know if this is right. I always think of it as. Your ability to keep going (laughs). Erm. Yeah, I, I guess emotionally and physically to be fair, but mainly emotionally…Like if I'm thinking am I being resilient it's, do I feel like I can keep going? (QN6).*

> *For me resilience is the ability to keep going no matter what life throws at you (QN7).*

Within the SN interviews, the notion of 'carrying on' or 'keeping going' also featured prominently. This concept was seen as an essential part of the children's nurse's role as well as the student nurse's role and was mentioned by all SN participants.

> *It's kind like of like you just can do it again and again and again almost. Erm, like. Not letting things constantly get to you, don't give up easily, you know, they keep going? (SN2).*

> *As a nurse or as a student nurse we're dealing with a lot of erm, things on placement. So that could be like, you know, your safeguarding, it could be like, really awful things like, you know, the death of a child. So, it's your ability to take that, process that, and, you know, come out the other side and still be able to carry on with what you're doing almost (SN3).*

A related concept, evident in six of the eight student descriptions, was the need to control emotions to allow individuals to 'carry on'. For example, resilience was described as follows:

> *The ability to not let your emotions get carried away with you (SN4)*
>
> *It's just being able to leave what was troubling you on placement, leave it at placement and, you know… Cos otherwise it starts eating into your personal life as well and I think that can be really destructive sometimes, but yeah if you can leave it, if you can leave it there, then that's the biggest act of resilience there is…(SN3).*

Interestingly, participant SN4 identified that while she felt it was important for nurses and students to be able to control their emotions; this did not mean that they needed to 'close off' their emotions, rather they perhaps needed to be more aware of them and acknowledge them.

> *I think being resilient is actually being really open to all your emotions, not closing them off. Erm, and sort of, not letting them, you know, overthrow you and make you like not be able to function, but…Actually, it's sort of accepting emotions (SN4).*

The focus on controlling emotions in student definitions is perhaps not surprising when one considers the emotive and challenging experiences, they may face within a professional nursing environment. This will be discussed in more depth in Section 4.2.

### 4.2.3 Personal attribute

In line with theories which position resilience as a trait, a factor consistently identified within QN participant definitions was the notion that resilience was a personal attribute, or an individual characteristic that people possessed which enabled them to cope and carry on despite the adversity they may face within the workplace setting.

> *So, resilience to me means that you, it's your ability to cope with situations and particularly stressful situations, and it's what you have in your personal armoury that helps you to cope with that. And I feel that…actually, different personality styles have different levels of resilience (QN8).*
>
> *I would say it's the mental reservoir of strength that people are able to call on. You know, in times of need…and to carry on, on a day-to-day basis without falling apart (QN9).*
>
> *I don't know it's. Having something inside you that will help you to manage. Just busy life really and protecting a little bit against stresses (QN3).*

In terms of personal attributes that were associated with 'resilient' people, it was notable that these were largely positive in nature (QN responses), for example: strong (n=5), leader (n=3), self-aware (n=3), confident, organised, calm, forward thinking. This seems to conform to the normative discourse of resilience identified in Chapter 1. As previously discussed, this notion of resilience has been challenged within contemporary resilience research which varyingly describes the phenomenon as a dynamic process that can fluctuate over time and be influenced by internal and wider external factors. While this more complex understanding of resilience was articulated by some QN participants later in the interviews; the notion of resilience as a personal trait or a personal attribute did pervade within QN definitions. As shown within the next quote, it is possible this concept may be a factor that is becoming increasingly evident within the nursing setting.

> *Like I guess probably 10 years ago I would have described it in a, really like a way we would describe a material like something was resilient. It could cope with things it could put up with things. But I guess more and more we've started to use it haven't we, as an attribute or a, a, a personality trait. So, for me, I suppose, it means having the ability to keep going, despite perhaps difficult things happening around you. And I don't think I mean extraordinarily difficult things. I think I mean the difficult things which are life at the moment (QN4).*

This was an interesting comment that alluded to the fact that resilience was increasingly being seen as a requisite attribute within nursing. It is notable that SNs also attributed similar positive qualities to resilient people, for example, strong (n=8), confident, self-aware, calm, adaptable, practical, hopeful, supportive.

> *I don't know whether it's like stereotyping, in what I'm saying, but, to me, I perceive a nurse to be a very strong character. Someone that should be confident in what they're doing erm, and be adaptable to, to various different situations (SN1).*

While this notion of positive personal attributes was present in SN participant definitions, students were more likely to acknowledge that individual differences in resilience levels were evident. Consequently, there was a stronger emphasis within student responses on resilience as a process that could be affected by social factors like life experiences and developed through exposure to experiences within the practice setting, for example.

> *I think it's something that you grow to be from your experiences, things that have happened. Just learning how to deal with certain things and I think it's something that you build on. You know? Obviously, people have different, go through different things throughout their life. So, somebody can be more resilient a lot earlier than others depending on, on, their life situations (SN5).*

This links to seminal theories in which resilience is seen as a fluid quality that acts to modify responses to psychosocial risk (Rutter 1987), or a quality that may fluctuate over time as new vulnerabilities and strengths emerge from changing life circumstances (Bonanno, 2005; Luthar, 2006). One interesting point to note was that while resilience was predominantly described as a positive attribute, participants also identified some negative aspects. Specifically, both groups identified that ‘hardness’ was a characteristic which seemed to be associated with resilience within the nursing profession. For example, one QN

participant identified that resilient people sometimes had to develop a 'hardness' to allow them to cope with the pressure they were facing:

> *But I do think you do have to have an element of being. You know, quite hard as well in terms of letting things wash off you and so it doesn't stop you from carrying on (QN5).*

This was reiterated several times by this participant as a negative but sometimes necessary aspect of the role of a children's nurse, which the participant disliked.

> *I think when I started nursing, I was quite shocked at how hard some people could be, and how closed off some people could be. And, actually, there is a lack of emotion, and it is just like a crack on kind of situation, but actually that is required sometimes as well (QN5).*

A second, linked negative aspect was the notion that nurses should not 'have' to be 'too' resilient. In other words, to care for their patients and to empathise with them, they did need to feel some of the pain children and their families were going through, but this needed to be balanced with professionalism.

> *One of the things I often talk with students and nurses, and actually everyone, it's about… is, is it OK to, to cry with patients? And I always say if you were crying with every, every family, I'd worry about you, but if you didn't cry with any family, I'd also worry about you. So, I guess, you know, being too resilient may be a concern too, you know, in terms of, that things should affect you, because, you know, otherwise are you a little bit, you know, burnt out or broken? (QN4).*

For SN responses, the concept of 'hardness' in addition to an 'expectation' of resilience were raised by six students. For example,

> *I know we think of nurses now as caring, compassionate, everything like that. But I think there is an underlying expectation that, you know, you don't get upset about things and, you know, something awful could happen and you've got to remain like poker faced (SN3).*

> *I think there's a fine line between. Erm, no emotion and resilience, it's difficult but you can show resilience but still show emotion. Yeah, you know, that you don't have to be soulless to be resilient at all (SN6).*

While it was evident that, for most participants, resilience was conceptualised as a positive quality, the above responses are important. Not only do they hint at a less positive side to resilience, but they contribute to evidence that QNs and SNs in this study conceptualise resilience in terms of 'coping' and 'carrying on' despite the challenges they may face. This finding forms a central theme within this study and has important implications, for the nurse education setting as well as the nursing profession. This will be explored further later in this chapter and then in Chapters 5 and 6.

To build upon and understand conceptualisations further the next question to explore was how important participants perceived resilience to be within children's nursing. Consequently, all participants were asked to describe how important it was to be resilient as a children's nurse or student nurse.

## 4.3 Importance of resilience in children's nursing

All QN participants identified that resilience was extremely important to the role of a children's nurse. QNs felt it was important for them to demonstrate resilience to ensure that the children and families received the care they deserved:

> *I think it's important to have it to be able to get you through those erm, tough days and those very tough scenarios, and to be able to deal with something really, really, difficult, but then not let it be detrimental to the care that you're offering (QN5).*

> *I think you need to be resilient because, when I think of the patients and the children you're looking after, they don't need to see if you're not coping (QN8).*

> *I think it's important to be resilient because the children are, or the families are, going through a really painful time and that is upsetting. If you take a step back and actually think about what they're going through, you could get yourself in a really dark place about it. And then, also, you're going to go home and take it home, erm, and I do think it's got the potential to really impact on who you are (QN2).*

While the third quote identifies the importance of resilience to enable nurses to support families, it also describes the importance of resilience in enabling nurses to protect themselves. This is also echoed in the below quote:

> *It is [resilience] vital actually 'cause I think you, you, otherwise, you sort of. It's almost like you've just not got enough skin, isn't it? You, you are much more vulnerable if you can't, you know, bounce things back. If you can't find a way of coping with stresses (QN1).*

In view of the perceived importance of resilience to the profession, one participant (QN8) identified that she had started to ask potential nursing candidates about resilience within job interviews. This is interesting and reflects a movement within some professional arenas, particularly medicine, where resilience tests have been considered for prospective medical students, to select the 'most' resilient applicants. This is argued to be problematic however, due to potential difficulties in measuring resilience via resilience tests. Furthermore, conceptualisations of resilience which position it as a fluid quality that fluctuates over time, further call into question such an approach. One QN participant reflected some of these concerns by questioning the current emphasis on resilience within children's nursing. Rather than resilience being the issue, she pointed to the excessive challenges of the profession and the external factors that can impact upon resilience:

> *I think the idea that we've all, the whole world, has just got to get more and more resilient. I do think actually there are, there's a lot to be stressed about. And there is something about the institution trying to manage the amount of stress that they are putting on people because I*

> *think. When you see people who you see as resilient start to crack a bit under the pressure, you think hang on, well, how resilient can we be as humans, and how much is it that external stresses need to be reduced? (QN2).*

The issue of external pressures on resilience is important and will be discussed further in Section 4.3. Like the QNs all SN participants identified that it was important to be resilient within children's nursing to ensure that families received appropriate care, for example,

> *Yeah, cos you do deal with a lot of difficult things, you deal with a lot of pressures. You deal with a lot of erm, challenges and so it's important to face those and, you know, show resilience so that you can carry on doing what you need to do to make sure all these children are looked after well, and, you know, to the best of your abilities (SN3).*

One student identified that while resilience was important, it was equally important to be empathetic and that resilience should not take the place of empathy within children's nursing.

> *It's important to have resilience, but don't lose your empathy. Keep your empathy cause, cause, in my opinion, if you've not got any empathy, I don't really know why you're a nurse. It should be a legal requirement, cause there's lots of nurses that don't have empathy, and they're the ones that I question as to why they ever became a nurse (SN6).*

This posed an interesting question regarding whether resilience and empathy might be viewed as binary opposites. The notion of binary conceptualisations of resilience will be built upon within the preceding chapters. Such ideas are important within this study and will provide insight into how resilience might be developed and communicated to student nurses within both the clinical and the nurse education setting.

Finally, seven SN participants pointed to the need to be resilient to cope with the challenges inherent in being a children's nurse, for example:

> *Erm, I think it's important, but I don't…I feel like there's, quite a lot of pressure around being it, and if you're not then, like you're maybe seen as not as strong (SN2).*

The notion of pressure to be resilient and the desire to be seen as strong are also important themes within this thesis that will be developed further throughout this chapter and Chapters 5 and 6. The point to note at this stage, however, is that participant quotes suggest they perceive resilience to be an important attribute within children's nursing. Therefore, it was necessary to explore why it was so important, what aspects of the nursing role required resilience and what aspects, if any, posed challenges to resilience within the field of children's nursing.

## 4.4 Challenges to resilience

As all participants identified resilience to be a central characteristic of a children's nurse, they were asked to describe why they deemed resilience to be so important within their role. To help explicate this, participants were asked to identify any issues which challenged their ability to be resilient. The challenges identified by participants from both groups were numerous in nature. Consequently, they have been grouped into four broad subthemes for the QN participants: 1) resources and systems, 2) expectations, 3) Covid 19, and 4) emotional burden. For the SN participants, it was necessary to consider challenges within both the practice and the academic setting. Four subthemes were also identified here: 1) resources and systems, 2) the academic setting, 3) Covid-19, and 4) emotional burden and staff attitudes.

While there were some similarities between emergent subthemes, there was divergence in the focus dependent on whether participants were qualified nurses or students. For the first subtheme – resources and systems, QN and SN

participant responses will be presented together, after this, to aid clarity and fluid discussion, QN participant results will be presented followed by SN participant findings. It is not possible, within the limitations of this thesis, to do justice to all the challenges identified, therefore, the most cited examples will be presented. This aims to give a flavour of the challenges rather than a detailed account of all challenges evident within contemporary practice.

### 4.4.1 Resources and systems

#### *QN responses – resources and systems*

The first set of challenges has been grouped under the theme of resources and systems and includes accounts of staff shortages, high patient dependency, lack of resources, and high workload. By far the most cited challenge (identified by all QN participants) was a lack of staffing. This was identified as an issue not only because it added to the stress and pressure placed on staff but also because it led to situations where there were not enough staff to provide the standard of care required. For example, "*Staffing every single day, there's never enough staff" (QN6).* One participant referred to the specialist nature of children's nurses and the national shortage of them whilst also acknowledging that it takes time to train a nurse which adds to the shortage of staff.

> *I mean, children's nurses are specialist nurses and children's nursing is a specialty. We can't knit specialist nurses just overnight, can you? (QN3).*

Furthermore, one participant went as far as to say they would take a pay cut if they could have more staff.

> *Staffing. Erm and I'm not even saying bucketloads, I'm just saying like the legal requirements (laughs). And yeah, I don't even care about money. If you gave me another nurse, I'd take a pay cut (QN6).*

The staffing situation is further impacted by the fact that many children cared for within contemporary hospital settings are increasingly complex in terms of the medical care they require. While this is undoubtedly a positive consequence of medical advancements, it means that the dependency of the children is much higher and thus the nursing care required is also higher. Six of the ten QN participants identified dependency as a challenge, especially when staffing was deemed to be insufficient. One participant (QN5) stated that nurses often had to argue and put a case forward for extra help as there was a tendency for clinical areas to be staffed to certain levels regardless of the dependency of the patients. The participant continued that whether you subsequently got any additional help depended on whether the unit manager was sympathetic to the arguments put forward, but also whether there were the resources available or in other words, the staff available. Often this was not the case and while the participant did understand this, she felt that managers did not always appreciate the pressure this placed on staff and the quality of care they were able to provide. This leads into a discussion around appropriate staffing levels and indeed safe staffing levels which were deemed to be problematic by five QN participants. For example, one participant identified that it was a luxury to have a quiet shift on a ward where staff were able to provide a high quality of care. Furthermore, if staff were to find themselves in that "luxurious" position, managers would often deem the ward to be overstaffed and move nurses to cover other areas. Another participant pointed out the potential negative effect that this had on resilience and coping as they identified that one of the ways individuals cope with pressure is by being able to recuperate when the working environment is less busy and chaotic.

> *You know if your ward has a quiet day nowadays you are sent to another ward to help them. And how do we cope with tough times? It's by ebbing and flowing, isn't it? But that doesn't exist now (QN4).*

Thus, staffing was seen as one of the main challenges in terms of resilience however, other challenges in terms of physical resources were also identified.

> *I think we have been under resourced because people don't understand the level of care that children require (QN8).*

Perhaps the most significant example of under-resourcing was provided by a participant who had spent a two years nursing in a "resource poor" country and identified increasing similarities between that environment and the UK setting.

> *More and more I see the skills that I needed to work in a resource poor setting, there, as now being needed, you know, in the NHS (QN4).*

This was a poignant comment which highlighted the challenges children's nurses face when trying to deliver high quality care to their patients; especially when one considers the level of expectation there is in relation to the care the NHS should deliver. This level of expectation was a challenge that was highlighted, to some degree, by all participants interviewed and forms subtheme 4.3.2. This also relates to systems issues such as workload which was identified by all participants to be an issue and was felt by many to be unmanageable at times and compounded by staffing and resource shortages.

> *I think the challenges are probably mostly volume. You know, it's that bombardment constantly and, and that, that feeling of firefighting all the time, which leaves you in a stressful situation (QN10).*

The relentless nature of this was also identified by the below participants.

> *Arghhh, just overwhelming workload! It was just relentless (QN1).*

> *I think at the minute, I think everybody's just exhausted. Yeah, I think genuinely that people are on their knees because it, it's hard work (QN7).*

This placed a huge perceived pressure on nurses to 'carry on' and to continue to cope in the face of ever-increasing pressure and at times was felt to be unacceptable – this will be discussed further in Section 3. While these findings concentrate on QN responses they are important to nurse educators as student nurses spend half of their undergraduate education within clinical settings being taught and mentored by qualified nurses. Therefore, SNs are frequently exposed to the resourcing and system deficiencies evident within contemporary healthcare. Consequently, it is perhaps not surprising that SN responses showed some similarities to QN responses within this subtheme.

### *SN Responses – resources and systems*

Like nursing staff, students also identified general resourcing issues such as staffing, high patient acuity, and high workload as a challenge. In general, however, responses showed that students identified this as being more of a challenge to the resilience of qualified staff, for example,

> *Obviously, the pressures at the minute like staff shortages, staff sickness. Erm, a lot of wards I've worked on there's always being staff shortage, so it just makes it harder. A lot of the staff are more tired because they're either doing overtime or they're doing more than they normally would do. And obviously people can get more emotional when they're tired as well, so it makes everything more stressful and more difficult (SN5).*

While all students referred to resourcing issues at some point, there was less emphasis on them, in comparison to QN interviews. This is perhaps due to the protected supernumerary status of students in addition to the impact of Covid-19 which, at the time of data collection, led to many paediatric wards being quieter than pre-pandemic resulting in less pressure on issues like staffing and workload (see Section 4.3.3).

### 4.4.2 Expectations – QN responses

The next three sections will focus on QN responses. The rationale for this within an EdD study is two-fold. Firstly, as has been alluded to in Chapters 1 and 2 and will be discussed in more depth in Chapters 5 and 6, QNs play an important role in modelling resilience to SNs. Consequently, they play a central role in communicating the norms, values, and expectations in relation to resilience to the SN population. This makes an understanding of the challenges to a QN's resilience relevant. Secondly, the phenomenological principles underpinning this study suggest that an exploration of the lived experience of both QNs and SNs is important to provide context and meaning and enable an interpretation of findings that will be relevant to the participant groups.

The challenges identified by qualified nurses within this subtheme fell into three main categories, parental expectations, expectations of oneself, and media and public expectations.

Five participants identified that parental expectations could be challenging, particularly in view of the difficulties previously identified within the resources section**.** QNs identified that they joined the nursing profession because of a desire to help people; thus, they found it particularly difficult when the quality of care they were able to offer did not match up to parental expectations.

> *Meeting parents' expectations, or not, erm more often. Erm aggression that you get from them and disappointment. Which is really hard because you want to, like you wanna be doing the best job. They just can't see what else you're trying to juggle and manage. It's not 'cause I'm sitting here drinking tea. Um? So that's really difficult (QN6).*

The concept of parental disappointment was described by three participants and appeared to be particularly challenging. This was made more difficult since QN

participants often had high personal expectations of themselves in terms of the care they wanted to provide. Eight participants identified that they found it difficult and distressing when they were not able to provide the care that they aspired to.

> *I think we also have got really high expectations of what we want to be able to deliver and. So often we can't deliver what we want to deliver so you feel that sense of failure with the under resourcing, particularly for the ward staff, you know? Running around trying to do things has been really difficult for them, and if you get to the end of the shift, and you think 'Well, I didn't achieve what I wanted to' then you just feel terrible, don't you? (QN8).*

One participant identified that sometimes this drive to provide high quality care could be viewed as problematic by colleagues.

> *She often says that, like, I will strive for too much. I strive for too good a service and that is what's crumbling me. That's maybe what's making me feel less resilient (QN6).*

When asked how she felt about this the participant replied "sad" because "surely we should all want it" however she acknowledged that more and more she was starting to see that what she wanted to provide was not achievable within the limitations of her job. Despite this, she still found it difficult to accept a lower standard of care.

> *But I just find it really difficult to draw a line. And then I don't. And then I do too much, and then you feel like you're gonna crumble (QN6).*

This is a concept that I can relate to personally as, for me, the inability to provide the standard of care I aspired to was one of the main drivers for leaving clinical practice.

A further challenge identified by QN participants was public and media expectations. It is important to note that this study was conceived well before the emergence of Covid-19 however, while not a central aim of this study, it

would be impossible to complete this work without considering the potential impact of Covid-19 on both the challenges children's nurses face and the impact it may have had on resilience. This is particularly pertinent when one considers that the interviews took place in September 2020, just prior to the start of the second wave of Covid-19. One of the issues, identified by participants in relation to Covid 19, was how they felt this changed the expectations that were placed upon nurses by both the media and the public. In terms of media/ public expectations, two participants made comments. One participant identified the discomfort and embarrassment she felt about the national clap for the NHS. While she recognised that there was something "lovely" about it initially she felt that this became "more shallow" and "meaningless" as it went on and the goodwill that had initially been evident seemed to disappear.

> *And now, now here we are, and that goodwill is completely gone. And you know, I understand that people are constantly writing to the Chief exec to say they've seen two nurses talking less than two meters, you know? And, you know, here we are with people not really abiding lock down laws and, you know? So that makes it seem even more ashen and shallow, doesn't it? (QN4).*

Further to this she identified that at no point did the 'National Clap' make her feel more resilient, rather it made her question what the public thought nurses were doing previously.

> *Do you think we weren't working four weeks ago or four months ago, what did you think we were doing then? (QN4).*

Institutions such as the media can create powerful discourses through the language they employ. One participant had a strong reaction to the language used at the start of the pandemic to describe nurses.

> *Oh God, this year we're bloody soldiers, have you not noticed that? I hate it…I don't use the H word, but I'm really, I'm so angry about that. We are not military personnel. Do you know what I mean? We don't get that level*

> *of danger money for a start, you know? We all knew we were putting our registration on the line with what we did and that if we didn't…fulfil what was expected of us that we could lose our registration, but not at any point in my career, or in my training, was it ever suggested I would be expected to lay my life on the line for this job…And I don't think that was expected actually either, in the end, but the kind of language that was being used in the media. It was, it was almost like people thought that's what we were doing and expected us to do that, and I was really angry about it (QN1).*

For this participant, the language used was inappropriate and made her uncomfortable and indeed angry with the expectations she perceived as being placed upon her. It also added to the environment of fear that was evident at the start of the pandemic.

> *it was really scary at the beginning. None of us really knew what we were doing, and we were seeing nurses die (QN1).*

Again, these are poignant comments that show not only how powerful words can be and how they can shape and influence concepts like resilience or professional identity, but also the unique position nurses faced throughout the pandemic. There were, also, additional issues that came with the emergence of Covid 19.

### 4.4.3 Covid 19 – QN responses

Perhaps a surprisingly positive finding in relation to patient numbers during the pandemic is that, unlike some sectors within adult nursing, children's nursing was largely unaffected by high numbers of Covid positive patients. In addition, there were fewer patients admitted to hospital for three main reasons. Firstly, children tended not to become seriously ill with covid, secondly all elective surgery cases were cancelled, and thirdly there was a reticence to bring children into hospital for fear of contracting Covid 19. Consequently, due to a lack of patients, some wards temporarily closed meaning that staff were moved to join

other wards. Thus, for a time, this relieved staffing pressures as there were fewer patients to look after and more staff within each clinical area.

> *So, they just didn't need, need that ward open so they closed that ward, moved the staff, which then meant you've got loads of extra staff, erm, which was really good for paediatrics (QN5).*

This enhanced resilience to some extent by relieving some of the practical staffing pressures. A negative consequence to Covid 19 however, related to limitations that were placed on visitors. Unfortunately, children still became sick during this time, often with non-covid-related diseases; the advent of Covid meant that extended family members often could not visit to support a sick child and their parents. This placed additional stress on parents who were already under immense pressure and led to feelings of distress and dissatisfaction among QN participants.

> *You know we have children dying on our PICU and we can't let grandparents come in, you know, and that leads…. You feel that you're not doing a very good job. You're certainly not providing the gold standard that we would want to (QN4).*

This participant went on to speak with some eloquence about the impact she felt the pandemic had had on children's services and children's nursing. When asked how she thought Covid had impacted on the role of the children's nurse she stated, "There's no, there's no light to the dark, is there?" She continued that some of the mechanism's nurses use to cope with the "really dark stuff" is to "see friends and family", "do exercise that makes you fit" and that covid had taken a lot of that away. However, perhaps the most revealing quote was as follows:

> *I mean the Children's Hospital has barely been touched by the actual disease, but the ramifications are just huge, you know? Er, seeing the delayed presentation, the increase in safeguarding and just. I mean to tell parents they cannot both sit next their child's bed is, you know? And*

> *that's why I say about Covid. It's such a cruel disease, 'cause it's not just taken lives, but it's taken our ability to comfort, and taken our ability to grieve. Or, you know, or, or, to have joy (QN4).*

This provides a small insight into the emotional burden that staff were facing throughout the pandemic however, it is important to note that even pre-pandemic, the emotional burden of working as a children's nurse was significant and clearly identified by all QN participants.

### 4.4.4 Emotional Burden – QN responses

There is much literature which cites the emotional burden of nursing in general. As identified in the literature review section, there is evidence that nurses who work with children may experience a higher emotional burden due to the unique nature of their role. Within the QN responses, caring for a child who was sick or dying was identified as being particularly stressful. One participant recounted that the hardest challenge she had faced to date was when one of her long-term patients died. She found this extremely difficult and was affected for a significant period.

> *That was really difficult. But yeah, resilience then's out the window! I don't think I coped at all (laughs) (QN6).*

All participants identified the challenge of watching children and families going through difficult times. There were many quotes that could have been used to illuminate this issue, however, the following quote has been chosen as it summarises many of the issues identified.

> *I think, as well, just the daily toll of seeing really sick children and, and, I think more and more, with the mental health difficulties of the kids, and safeguarding, it feels like we have a really warped impression of childhood. Erm, because we only see this extreme. Not always, but often. It feels like that is what Nottingham's childhood experience is, which is really sad often. And so, I guess, dealing with those patients, time after*

> *time, different patient every time, different story, different abuse, different sad situation. And then just sort of trying to, shake that off and carry on (QN6).*

As can be seen the rise in the advent of mental health issue was identified along with safeguarding issues which were discussed by four other participants and identified as being something that posed a particular challenge to resilience.

> *Safeguarding issues. They're something that will really challenge me and will really break my resilience. You know, the thought of children being frightened or alone, I think that's really challenging (QN4).*

A further issue that was identified by three participants was the fear of making a mistake that could harm a child and the worry and stress this could cause.

> *it's that constant fear of the high-level interventions, that actually, if you get it wrong you could really either kill somebody or do them some serious damage (QN2).*

> *The worry. I worry more now than I ever have done about, is somebody gonna come back and say I didn't do that right (QN7).*

This issue was also linked to resourcing and system issues such as high workload as participants identified that when staffing was low, dependency was high and consequently workload was high, there was more potential to make a mistake. All the above issues were reported to impact on resilience, with some QNs reporting feelings of chronic anxiety which seemed almost endemic within the role of a nurse. In view of these challenges, it is perhaps not surprising that resilience is viewed as such an important attribute.

In terms of student nurses, while some protection is afforded by their student status, NMC proficiencies and regulations require students to take a more active role in patient care as they progress through their training. Supervision becomes more distant and to successfully complete the practice element of their course, students are expected to function independently as a newly qualified nurse

during their final placement. In addition to this, SNs have the additional academic demands of a BSc in nursing to successfully navigate. Consequently, acute, and chronic levels of anxiety have also been recognised in the student nurse population, thus it is important to consider challenges to SN resilience in both clinical and academic settings.

### 4.4.5 Challenges within the academic setting – SN responses

Students were firstly asked to identify factors within the academic setting that could pose challenges to their resilience. It is notable that this cohort of students have had a unique university experience and perhaps unsurprisingly the challenges identified were predominantly attributed to Covid 19. Many of these are outside the remit of this study however, a consistent finding within the SN responses related to social isolation and a lessened student experience, both of which were reported to lower levels of resilience.

#### *Student Experience and Isolation*

The social impact of Covid on the student experience was the issue cited most often by students with five students citing this as a challenge to their resilience. In part this pertained to frustrations about not being able to have the 'normal' university experience in terms of socialising; but also, the stress and pressures of being away from home and family, and the inability to socialise with friends which led feelings of frustration and isolation.

> *I'm not having the normal experience that a student nurse has. And theory is supposed to be kind of like a break for me. Like, I see theory as a holiday, so I can go in and see my friends and sit in the lecture theatre together. I'm not getting any of that, so I think it kind of makes my resilience very, a bit negative, and a bit like I've not really got the ability to cope with this theory kind of thing some days (SN7).*

> *Obviously, we weren't able to go back home and, like be with the family. And you aren't allowed to mix with friends. Then you have the pressure of "oh, if I went on a walk with that person and hugged them", breaking the law, and put patients at risk as well, so you have extra (SN4).*

The issue of isolation featured clearly in the student interviews as students identified the lack of access to friends and family who acted as their "main support network" (SN2). This echoes some of the QN comments in which (QN4) identifies the role that friends and family play in enabling resilience. Therefore, the enforced isolation was deemed to be a barrier to the maintenance of resilience. Furthermore, this was deemed to add pressure to a course that already places high demands on students in comparison to some more traditional undergraduate degrees. While these pressures were perhaps not different to students studying for other degrees at the same time, what was different was student nurse exposure to Covid-19 through the clinical element of their course.

### 4.4.6 Covid 19 – SN responses

Students were asked to identify how Covid-19 had impacted on their experiences within the practice setting and their resilience. Responses fell into two subthemes, PPE, and fear and anger.

#### *PPE*

All but one student, whose interview took place just prior to the start of the pandemic, identified PPE as something that made their time in practice more challenging; both on a personal level, but also in relation to the care they were able to provide. Interestingly this did not feature prominently in QN interviews.

> *We had to wear like massive. Those massive like suits with the, like, it was like a Martian suit 'cause I wasn't fit [tested]. Oh, it was horrible! I had to wear it for like 6 hours (SN2).*

> *Wearing masks every day for 12 1/2 hours like. That is so resilient, and there's so many times that I just wanna rip it off and talk. You know, children, especially children, like you are, you know, covering linguistic features up, so to speak. It's so crucial, and when they can't see that facial movement and that expression, I think it really is. It is a bit of a block on your actual level of nursing that you can give (SN4).*

The wearing of masks was seen as a significant barrier to communication with children by most students, particularly when one considers that young children may have limited linguistic skills and understanding. As such, children's nurses have always relied on facial expression, and tone of voice, alongside age-appropriate language when communicating with children. Consequently, it has been necessary for staff and students to try to adapt their communication skills throughout the pandemic. One student identified that she felt the ability to achieve this was an example of how nurses have been able to demonstrate resilience.

> *I think that's, that shows a lot of resilience. Thinking of ways that you can better your care despite having a mask, or PPE, or barriers (SN4).*

This perhaps identifies a slightly different definition of what resilience is and fits into the notion that resilience is about being able to adapt to situations in a positive way. Certainly, during the pandemic, students were required to enter and adapt to a very different nursing environment from the one they had previously experienced. This led to a sense of fear and anger for some students.

### *Fear and Anger*

Three students identified the fear they experienced in relation to going out into the clinical setting during the pandemic, for example,

> *I'd worked with quite a few Covid patients, and it just wasn't nice cause you just…You don't want, it feels like you don't, you don't want to go near them. Like being honest, you don't want to go near them, even in all the PPE (SN2).*

> *It's just, like every time we go in there, you're just like risking your life. Which seems insane when I'm a student (SN2).*

For the above student, the issues caused by covid led her to feel anger as she stated that the nursing experience, she was receiving was not what "she had signed up for". In part this was due to the fear of having to go into placement and care for Covid patients, in part, it was because she felt students should be paid for attending placement and, finally, in part because she felt that it had impacted upon her learning experiences.

> *Erm. Well, it's definitely not what I signed up for. I think a lot of us feel that way. We really, like, I try not to think about it too much cause, I could just get angry (laughs). Like it's not what I signed up for. I don't wanna do it. I hate wearing the masks. Erm. Some opportunities like aren't the same. Like, when it's really quiet on XXX, it's because of Covid, so it's like I'm not even learning anything. Like I didn't really feel like I learned that much (SN2).*

The implications of Covid-19 were unique to this group of students, and it is feasible that if this study were repeated some of the above challenges may not feature. This does not lessen the impact that Covid-19 had on the participants within this study. However, this study was conceived well before the advent of Covid-19 and it is notable that SNs in this study identified additional challenges to resilience within the clinical setting that were unrelated to Covid-19, most notably emotional burden, and the attitude of QN's towards students.

### 4.4.7 Emotional burden and staff attitudes – SN responses

Like qualified staff, students identified that they found it challenging when they saw upsetting situations.

> *Some of the things that you see, or go through, could be heart-breaking (SN5).*
>
> *You know, we can see some really, really, awful things safeguarding wise. And we can also, erm, you know, see some really unwell children, and I think these are things that no one should see really. Like, I mean obviously, this is our job, this is our role, this is what we are doing, well this is what we want to do, erm, but I think for a lot of people, if they saw that in their everyday life, they would be completely, completely taken aback (SN3).*

This issue was identified by three students as being heightened further by the fact that the patients being cared for were children. Clinical placements exposed students to distressing situations like the death of a child or safeguarding. As these were often first-time experiences, many students did not have existing coping strategies to help them deal with such upsetting situations. This can be made more difficult by the culture in nursing which expects nurses to control their emotions and behave in a professional manner. This links not only to perceptions of resilience but also the developing professional identity of a student nurse. A person's professional identity is influenced by their position within society, their interactions with others, their interpretations, and their experiences. For student nurses, interactions with QNs play a central role in the formation of professional identity and conceptualisations of resilience. While many examples of positive interactions were identified during the interviews, it was notable that the challenge most cited by students related to the attitudes some nursing staff displayed towards them. While students identified that there were many qualified nursing staff, who provided excellent support, they also identified that there were a significant number of staff who were negative towards students. All eight students identified this as a concern, and all felt that this was something that challenged their resilience.

> *You know the hardest thing that I find where I need to be resilient is when there are team members that aren't nice. That is, for me, the only thing that I struggle with as a student (SN6).*

> *I think I find it funny going into nursing. Funny not in a ha-ha way, I don't find it laughable at all, but going into nursing, I thought seeing ill children would be the hardest part, and it's not actually necessarily that. It's just sort of coping with the demands, and the twelve and a half hour shifts while being with people who don't really seem to care that much about you (SN4).*

Further to this, two students identified that sometimes they felt staff made it very clear that they did not want to have a student with them and when this happened it made them feel like a burden. For example,

> *Often student nurses feel like they are a burden upon the nurses that they're working with, and people do make you feel as if you are a burden sometimes. Like, can I do this? Can I do that?? It'll be like, it'll be like, no. Just kind of almost like "know your place, just wait" kind of thing, you know (SN8).*

Another SN agreed that staff make it "quite clear they don't want you there". When asked how staff make this clear both participants identified that it was less through verbal means and more evident by the nurse's nonverbal communication.

> *So, it can be simple things, so nonverbally, or, you just get that eye rolling thing, you know? Can you take this student with you? You can see that they don't want to. Sighing (SN6).*

This poses a challenge to the nurse education setting as in such cases there is the potential that students are not supported effectively and may be exposed to negative role models. The importance of role modelling to the development and enactment of resilience alongside professional identity will be explored in more depth in Chapter 5. In a slightly different but related comment, one student identified that she was very aware of the pressures that qualified staff were

under and thus often felt like she was adding to their workload, so, if this was further emphasised, it made her feel worse.

> *As a student nurse, as I said, everyone always feels that way anyway, as if you are a burden that nurses, especially on the ward, when they're busy and whatever, that you're just taking up time, you're adding more stress and giving them more of a workload…And if someone's like emphasised that, then now you're scared to step out of line, or you're scared to ask for anything, or do anything, or you're scared that anything you do will like impact you negatively (SN8).*

The issue of fear featured significantly in the above students accounts of her time in practice and her relationships with qualified nurses. While other students did express worries that they may be viewed or judged negatively at times, none expressed this specifically as fear. For this one student however, the notion of being "scared" featured heavily in her interview and thus was deemed important to include in this section. Her fear seemed to centre around the qualified nurse's role in assessing a student's competency to practice as a nurse. She expressed that she always felt scared of making a mistake or raising concerns that might lead to her being viewed negatively by her mentors, which may then lead to her failing her placement.

> *I think that whole mentor-student relationship to begin with, where you're being assessed and you feel that you just constantly have to be on edge because one step out of line and it could result in you having an erm, action plan or being thrown off placement or….And you wouldn't even have to be stepping out of line, but you're just scared to speak up for anything (SN8).*

The same student also identified that, on occasion, she had found ward areas presented an actively hostile environment.

> *There's this huge, like bitchy environment on the wards, and everyone knows this, but no one really does anything about it. There's always this thing of "Don't take it personally". Why should that be the case? It should be addressing this hostile environment that they have on the wards, not*

> *being told to deal with the repercussions of that hostile environment, if that makes sense? (SN8).*

As a nurse educator this quote raises several questions. The NMC stipulates that nurse educators have an important role in supporting students within the clinical setting. The participants reference to common knowledge and inaction in relation to hostile environments is important and should encourage QNs and nurse educators to consider our own attitudes to such environments and the support available to students should they challenge them. This will be explored further in Chapter 5. The comments about hostile environments and fear were specific to the above student however, other students did express concerns in relation to negative environments and judgement of nursing staff which will be explored in Section 4.5.

Further to the identification of hostile environments, there was an emergent notion that the concept of resilience was not always used in a positive way within the nursing profession. As previously identified by Binnie (2016) and as evident in most participants definitions, resilience can be viewed as a synonym for strength, thus one must consider the possibility that a perceived lack of resilience could become a synonym for weakness. One student identified that there could be a darker side to resilience in the sense that, while she thought of it as a positive concept, she felt, at times, it could be used in a negative manner to put people down as being "not very resilient".

> *I think it can sometimes be, not wrongly used, but, I've heard a lot of scenarios with students when a student might have got a bit emotional about a certain situation and one of the nurses is like, "Oh, you know, you're going to see much worse than that". You know, "you need to build up resilience" blah blah blah blah. Erm, and I don't think that's the right way to really go about being resilient, that's not going to make anyone think, "OK, right? I'll be resilient. I'll stop crying". You know? I think it's something that. It needs a lot of like support around and it shouldn't ever*

> *be used in, sort of like a negative way, like "you should need to be more resilient" (SN4).*

This was an interesting point that was reflected in some of the comments within QN interviews where the notion of resilience as a universally positive concept was challenged to some extent. For example, one QN participant identified that resilience can be flawed, and on occasion, result in negative consequences for an individual's health.

> *I can see a different level of resilience in some of us that I don't see in my younger colleagues. I'm not sure that we are right, because I do think that if you don't, if you take that level of resilience, you are probably internalising your issues. And therefore, you're probably giving yourself those issues like blood pressure and other problems that you don't necessarily realise are happening to you (QN8).*

The potential negative implications of conceptualisations of resilience within children's nursing, however, are perhaps best articulated in the below quote provided by a senior member of nursing staff.

> *It does really worry me how we use resilience and the lack of it as being a, a negative quality. I guess it worries me, what do we expect resilient people to do? Do we expect them to do four night shifts in a row? Or, you know, do we expect them to always look after the very difficult patient? So, I think we've started to use resilience as something that we want people to have, and I just worry, why do we want people to have that? Is that 'cause we're expecting coping more and more? (QN4).*

These quotes raise issues about professional expectations, professional identity and what this teaches SNs about resilience in the nursing profession. This is particularly relevant when one considers how instrumental clinical practice is in socialising SNs into the profession and facilitating the internalisation of professional values, attitudes, and goals. When considering the evident value placed on resilience within children's nursing, one might also ask whether the concept of resilience could be misused to devalue individuals or encourage them

to accept ever increasing workload pressures. This leads to questions around a potential pressure to be resilient and the professional implications if one judges themselves or others to lack resilience. This has potentially important implications for SNs, nurse education, but also the wider nursing profession. Thus, QN and SN responses are relevant in aiding interpretation of findings and the subsequent development of arguments relevant to the nurse education setting.

## 4.5 Negative side to resilience

In view of both the perceived importance of resilience in children's nursing and the numerous challenges faced, I wanted to explore several issues in relation to judgements that can be made about resilience within the profession. This chapter will explore some of these issues in more depth. Both qualified and student responses will be discussed within the following subthemes: perceived pressure or expectation to be resilient, judgements nurses make about their own levels of resilience (QN only), judgements made about others' levels of resilience, and finally how such judgements might impact upon concepts like professional identity, professional progression, and professional attrition.

### 4.5.1 Pressure to be resilient.

*QN Responses*

In view of the numerous challenges identified alongside the perceived importance of resilience, I was interested to explore whether participants experienced a pressure to be resilient. When asked about this all QN participants answered in the affirmative, for example:

> *So, I definitely feel there is a pressure to be resilient, especially, in the current, climate that we're in at the minute. Especially with Covid taking place, so I think, that everybody's resilience is being tested more so now, erm, you know, than previous times. So, yes (QN3).*
>
> *Yes, the expectation is huge cause…you can't say no can you (laughs) (QN7).*

One participant identified that she had been trying the raise the fact that too much pressure was being placed upon her and her team but that this had not been acted upon until her colleague finally went off sick with stress.

> *We've been flagging for a long time now that they're putting too much on us; and they are asking too much of us without increasing our hour's or our level of staffing. And I think it was just a bit maybe of a reality hit that the camel's back had broken (laughs) (QN6).*

One participant however, felt that nurses did not always help themselves in relation to this issue and could sometimes feed the problem by continuing to try to cope and not raising or escalating workload pressures as they perhaps should. She continued that many nurses tended to try to carry on and continue to cope with ever increasing work pressures, without challenging them, which ultimately could be detrimental to their own health.

> *So yeah, we just crack on with it don't we, and, yeah, and, and that's, that can work against us because we cope and cope, and then we don't (QN3).*

A second participant identified that individuals who go into nursing tend to do so because they want to help others. While this is an important attribute of a nurse, she identified that this could work against nurses when they were asked to take on more workload.

> *We get sent emails almost weekly saying "oh, we know you're really busy, but you know XXX is really busy today and maybe you could just push yourself a little bit harder and go and help them". Because of the nature*

> *of people who go into nursing. We want to help don't we? And we feel that sort of pressure to help (QN4).*

She continued that the potential implications of this are that people are "squeezed that bit more" and pressured to "extend and extend" at a time when they are already busy and under pressure. As a result, the participant felt that there was an "unbelievable pressure to be resilient" and individuals who were deemed to be resilient were often the people most impacted as they were often the people who were asked to do "just that bit more". She also acknowledged however, that she did not have an answer to this because, as a manager, she knew that when times were difficult the people she would rely on and ask to do more were the ones that she deemed to be resilient.

> *when you are trying to run a service as a manager, you need people to, you need them. So, of course, those people are the ones that you rely on, and they're pushed and pushed and pushed more and more. So yeah, erm I do think that there's a pressure (QN4).*

This pressure to be resilient from management was identified as being an issue by three participants, with two participants identifying that the things being asked of them were sometimes felt to be unreasonable or unachievable.

> *I mean pressure from senior management to take more patients when you, when it's clear that you can't take anymore because of the acuity on the ward (QN3).*

One participant, a specialist nurse, identified that she was being asked to conduct Covid tests for all children who came in to see her in clinic. She was the only nurse running this clinic and identified that practically this would take 30 minutes per patient.

> *I probably have 20 kids come a week, and I'm like, I can't, I can't do that on my own. That just physically, it's not doable, but the pressure is to do it, 'cause I'm, I'm the specialist nurse, so, who else is going to do it? (QN6).*

In a similar vein, a third participant identified that the 'circumstances that we put people in' (within the NHS) makes resilience necessary.

> *I don't think in in our heart of hearts we want people to be that resilient, but our, the way we work actually necessitates it (QN8).*

Three participants identified that pressure could be exerted on them from a variety of sources. For example,

> *And then I guess outside of work, like pressure from family to go home and switch off and be normal when you get back, and, forget the day, [pressure] from people within the hospital to keep absorbing. And from home, and to some extent even the hospital, this stiff upper lip mentality (QN6).*

Thus, at times, it was felt that the pressure to be resilient came from a variety of angles which could be difficult to manage and could result in participants judging themselves negatively if they failed to meet these expectations. It was evident from the QN responses, that not only were they facing incredible workload pressures which put them at risk of issues like vicarious traumatisation, compassion fatigue, and burnout, there was also an expectation that they would simply continue to cope. I do question whether this provides evidence of a resilience discourse within nursing that encourages already overworked individuals to cope with ever increasing pressures and discourages any attempt to resist or challenge them. This will be discussed further in Chapters 5 and 6.

When considering students, one of the tasks of pre-registration education is the socialisation of students into the nursing profession. While this occurs throughout an individual's career, the training period is seen as a critical time during which students learn the norms, values, behaviours, and culture of the profession to which they aspire to belong. The fact that all QN participants spoke

so clearly about the pressure to be resilient leads to questions about how this influences the socialisation of students into the culture of nursing.

### *Pressure to be resilient and self-judgement – SN responses*

What was interesting in the SN responses was that while students reported a pressure to be resilient, they did not perceive there to be an overt pressure to be resilient in the same way as the qualified nurses did. Rather they described an 'expectation' that in turn led to a perceived pressure. Students identified several factors that contributed to this, the first being expectations of qualified staff.

QNs, in their interviews, acknowledged their role in promoting and helping students to develop resilience, with three participants identifying that students should not be 'expected' to be resilient. Nevertheless, there was general agreement that it was important for students to demonstrate and develop resilience. Within the student interviews, all eight students identified that they felt there was an expectation of them to demonstrate resilience. Some students identified that this expectation came directly from qualified staff, for example,

> *I think there's a like, expectation, that you just sort of brush things off sometimes (SN3).*
>
> *I think sometimes there's a tendency for, like older, more experienced nurses, you know, they've seen it all before, they, they can sometimes come across as a little bit cold, erm, not always, obviously that's a generalisation, but you know it's happened a couple of times, erm, and I think they kind of expect you just to be resilient, but I guess they've built up that resilience over time (SN3).*

One student identified that while she thought there was a pressure to be resilient, this was not always an explicitly stated pressure.

> *It's not a spoken pressure. And that's probably what pressure is half the time, so an undercurrent. Yeah, I do think there is a sort of an unspoken pressure to be resilient, ultimately (SN4).*

Two other students alluded to the fact that sometimes the expectation or pressure to be resilient originated from a personal place where students feared that if they did not get on with the tasks they had been allocated or demonstrated any perceived weakness they would be viewed negatively.

> *I feel like if I asked to take a break, I'd be seen as, like, weak or something. Or, that I can't handle it, and then I'll get a bad assessment, and I'll fail my placement (laughs). You know and it all like rolls on (SN2).*

The same student continued that certain placement settings can engender negative cultures or environments in which students are frightened to identify if they cannot do a task because it can lead to "really nasty comments" from qualified staff. This student did stress however, that this was only evident in one of her placement areas.

> *It's like you've Is got to say yes to things, even if you don't want to. It's really, its like so toxic, it's horrible in some places. Not horrible all the time, but I think that one was just difficult (SN2).*

It was evident from SN responses that, despite subtle differences in SN definitions of resilience when compared with QN definitions, all students interviewed had, to some extent, started to internalise and hold expectations of themselves to be resilient, for example,

> *I'm a bit harsh on myself, from my student perspective that I should be resilient, like from day dot, when that's just not gonna happen. Erm, especially when I'm working with like sisters that have been there for ten years. I'm obviously not going to be as resilient as that (SN2).*

> *I feel like I should be hard. So, like, I should be more resilient with this type of stuff and, like have thicker skin. Like why am I getting upset? (SN3).*

One student identified that while she felt a personal pressure to be resilient, she had never felt that staff had expected this of her.

> *There's never been anyone giving the impression that there is an expectation, and no one's ever alluded me to think that I'm expected to be able to deal with this, that, and the other. But it's more on your, it's sort of, following the lead I guess, you know? If I've got someone there that's being resilient, I don't want to be the one, sort of bringing it down for the parents in front of them…So, it's not the expectation from anyone else, that's probably just my own perception (SN6).*

For this student the pressure came more from a desire to fit in and not let others down. Overall, it was apparent from SN responses that the concept of 'being resilient' had been incorporated into student views as a fundamental element of the nursing role. Not only was this something that was expected of them, but it was something that students expected of themselves, aspired to, and felt a need to demonstrate as part of their professional identity. Thus, I wanted to explore how resilience was incorporated into the professional identity of both qualified and student nurses. This included a consideration of how both sets of participants viewed themselves and others in relation to resilience. Student views about their own resilience have been alluded to already in the above quotes. The following section identifies how QN's view themselves in relation to resilience.

### 4.5.2 Resilience and self-judgement

#### *QN Responses*

QN participants were asked if they had ever judged themselves in relation to their own levels of resilience. All participants identified that they had done this at some stage within their career. Many participants identified that if they felt they had not coped well with a situation; it could make them doubt themselves and

their own competency. One participant identified that it could even make her judge herself negatively as a person.

> *Oh my God. I'm a horrific person. I'm a really bad nurse! (QN3).*

Interestingly, one participant identified that she sometimes judged herself negatively when she was required to demonstrate resilience. The participant explained that she sometimes viewed resilient people as being quite "hard" and this made her question whether she wanted to be a resilient person.

> *It makes me question, like is this actually…can I do this? And do I, do I need to be a person that I don't want to be? Am I being put under pressure? And it's, it's turning me into someone that I don't, don't like? (QN5).*

This concept of hardness is interesting. It has been mentioned already and was referred to by three QNs and five SNs during their interviews. This does suggest that 'hardness' is a characteristic which has links to resilience within the nursing profession. This will be explored further within Chapter 5. Related to this, six QN participants identified that it could be difficult to admit that you were not coping for fear of being judged negatively by others or being seen as weak. One participant identified her anxiety after sending an email that identified that she was 'struggling with the demands' that were being put on her.

> *I was nervous to come in the next day as to what the, the, response would be like. Would they think less of me? (QN6).*

Interestingly, two participants identified that it can be more difficult to admit that you are struggling when you are perceived to be a resilient person, or work within a team that values resilience highly.

> *I think it's then very difficult to describe when you're not [feeling resilient] because they can't cope with it. So, you're very aware that if you, if you start to crumble, you know, people say, "well, don't you crumble 'cause*

> *we'll all be down". You know that sort of conversation…You think "Well, actually, I don't feel too great today" (QN8).*
>
> *I now work in a team where everyone is incredibly committed and where it's quite difficult to show weakness (QN4).*

This is a concerning situation that lends support to the argument that resilience, as a concept, is not always used in a positive way within the profession. I have already suggested that the discourse of resilience in nursing may serve to encourage individuals to cope with increasing pressure and discourage attempts to challenge them. The above quotes support this; they also suggest that the concept of being resilient and coping with work life challenges is fundamental within the professional identity of a nurse. Not only is this something that is expected by others, but it is also something that qualified, and student nurses expect of themselves. This is significant for both sets of participants and consequently, I wanted to explore whether qualified and student nurses expect to see resilience in their fellow colleagues, prospective colleagues, and mentors, and whether they judge each other based on perceived resilience.

### 4.5.3 Resilience and judgement of others

#### *QN Responses*

QN participants were asked whether they had ever judged anyone else in relation to their levels of resilience. It was interesting that participants found this quite a difficult question to answer, in part, due to a reticence to admit to judging someone else, and in part because it goes against the stereotype of a caring non- judgmental nurse. However, ultimately, all participants, agreed that they had judged other nurses, or student nurses based on their perceived resilience and that often these judgements were negative in nature.

> *Erm, probably (laughs) this is confidential isn't it? Because you do sometimes just think to yourself "come on" especially if you're on a busy ward and somebodies struggling (QN2).*

As alluded to earlier, one participant identified that they had judged "resilient people" as being "hard" and felt that in some cases individuals displayed too much resilience which then impacted on the care they provided.

> *I've been shocked at how hard people can be. Erm, that their resilience is too much. And actually, it's taken away their compassion, and it's taken away their, just general personality, because they do just want to get on and get the job done (QN5).*

This association between resilience and hardness is notable as it is contradictory to traditional views of a caring compassionate nurse. This is something that featured prominently in SN responses and will be discussed shortly. Another participant alluded to judgement of staff who she perceived to be "martyrs".

> *I used to get really crossed with the martyrs…There's nothing worse, when you're in charge, than those nurses that will not go for a bloody break. They don't help anybody. You know, and they won't tell you what needs doing so that they can get a break. That drives me crazy. You're not helping anybody. Or the ones that come to work when they're really ill and just pass it on to everybody else. That's not resilience, that's bloody mindedness. (QN1).*

This was interesting as it contradicted definitions of resilience where nurses identify a need to 'carry on' or 'keep going' and challenged judgements of weakness if an individual took time off sick. This perhaps points to the complexities in definitions of resilience and the variation in understanding evident within the profession. One participant identified that she felt she sometimes judged people incorrectly and that she had realised this after going through a situation where she had struggled with her own resilience levels.

> *After that patient I was like, 'oh, I need to cut people a bit more slack'. Which has been helpful now (QN6).*

She also identified that knowing more details about why a colleague subsequently went off sick with stress helped her to feel more empathy towards that colleague and less judgemental.

> *I was here the day she came in and saw her crumble, and I think if I hadn't have seen it, I would be feeling differently towards it even now. Erm. I yeah, just, there's more compassion, and I would never expect her to come to work having seen how she was, whereas, if you haven't seen it, then it's a bit easier to wonder and fill in the gaps yourself. So, yeah, I'm ashamed to say that, but...(QN6).*

Within the nurse education setting there is a growing emphasis on resilience, fuelled, in part, by a perception that young people are less resilient than previous generations. When asked whether SNs were resilient there were a variety of responses, and no clear consensus was evident. For example, one participant identified that she did not perceive student nurses to be resilient. "*I don't see so much resilience in them" (QN8).* Whereas, two participants felt that, due to the multitude of external factors students are now required to deal with, some were more resilient than they had ever been.

> *they are really, resilient because they're having to juggle massive work life balance issues because of, no income, you know? So, actually, for all the wrong reasons, we might have a bunch of students coming through, right now, that are more resilient than ever really. Because of what they had to deal with while they've been training (QN1).*
>
> *I think they have shown a lot of resilience just to keep coming really (QN7).*

Where there was agreement, however, was that QNs felt students did get judged in relation to their levels of resilience. Two participants felt this was linked to stereotypes associated with the label of being a "millennial" as well as the more negative label of "snowflake", while another participant pointed to a lack of empathy in staff.

> *A lack of empathy from staff nurses that they've forgotten what it's like to be a student. Erm, and to be that first, you know, deer in a headlight when you first walk on to a ward and you're like. "Oh my God". Erm, and I think. Yeah, it's a lack of empathy, and I think it's because students are compared as well (QN5).*

There was a consensus that it was important for students to demonstrate resilience, but also an acknowledgement of the qualified nurses' role in helping students to develop this resilience.

> *So, I think, yeah, I think it's important, but I think it's important to help to build up their resilience where we can in a positive way (QN3).*

Furthermore, three participants identified that they did not feel QNs should expect resilience from their students as this was something that should be developed through experiences and supported appropriately by staff. For example,

> *I mean, we shouldn't be expecting it of them because we should be giving them an experience that they don't need resilience to cope with. However, probably, realistically, if they want to have a long career in nursing, they will have to develop some because of all the things we've said (QN4).*

While this did seem to demonstrate an acknowledgement of the QN's role in enhancing the development of resilience, it must be remembered, that all students perceived a strong expectation on them to demonstrate resilience. As previously alluded to, one possible explanation for this is that while QNs may not be explicitly communicating a requirement for resilience to their students, the value they place on demonstrating resilience themselves and the judgements they make about others who are deemed not to demonstrate resilience are clearly communicated and role modelled to students so influencing their understanding on what is expected. Students work closely with qualified staff when in the clinical area and so are privy to many of the conversations that take

place within teams. Thus, I was interested in exploring how this formed and shaped student views in relation to resilience and the judgement of others.

### *Resilience and judgement of others – SN responses*

SN participants were asked a series of questions which focussed on whether they had experience of nursing staff judging one another or other students, and whether they themselves had ever judged others in relation to their levels of resilience. All SN participants identified that they had seen qualified nurses judge each other, or indeed other students in relation, to resilience, for example:

> *Yeah, yeah, definitely. I have seen, seen, that and, I've seen people, like, making comments as well about other staff. Or, you know, perhaps some staff just don't cope as well. Erm. Some people are just more emotional, and they, you know, can't deal with it, and then you have the other side. Like there's some that are so hard that, you know, it's just like, as if they've seen it all and nothing affects them anymore. And then, those type of people then kinda look down on the ones that are more emotional (SN5).*

> *Oh, probably yeah. Ah, there are those, they can be really catty. Oh, some of them, it's horrible (SN2).*

Two students identified that some wards seemed to be more "cliquey" than others and that on such wards nurses tended to be organised into cliques based on their attitudes.

> *Like, going on to the wards, I feel like it's very cliquey. I did find it was very cliquey and…the cliques were sorted into people's attitudes to nursing. Like the can't be bothered nurses, and the really like, oh my gosh I really can't wait to go and get out there (SN7).*

> *I think some people do judge them. As if to say the ones that are hard "well you should, shouldn't be that hard. You should show some emotion. What's wrong with you?" And then the ones that are rather emotional, then "Well why are you so emotional?" (laughs) (SN5).*

This type of judgement was perceived negatively by students, but they also acknowledged that sometimes, in response to this, they subsequently made their own judgments, for example:

> *I'm not proud of this, but I definitely, probably, have judged other nurses on their resiliency and I'm sure they do it to me as well. Erm…I've thought that's not the kind of nurse I want to be and the kind of nurse I want to be is a resilient nurse. And it's not so much I've thought they're not resilient, they're an awful person, but I've thought "oh they're, you know, the stresses of nursing have really got to them, and they're clearly not performing at the level that they are capable of" (SN4).*

For SN participants, QN judgements were deemed to be particularly challenging when they were made about other students.

> *I think, in some ways, some nurses are like, "oh well you know you're just a student you're just learning" but I think some will think more down the line like "how are you going to cope when you're a nurse". I think that's something I've heard said a lot of times, not necessarily about myself, but about others. It's like "well how are you going to cope when, you know, you finish", you can't just be like taking all this time off because you can't process something, or you can't deal with something (SN3).*

When this participant was asked how this made her feel she identified that it made her question whether she was "tough" enough to be a nurse.

> *Am I strong enough to be here (laughs)…Yeah, it makes you think then is there something wrong with me? (SN3).*

This served to reinforce a desire to develop and demonstrate resilience in students while also introducing self-doubt. As a professional group, nurses and nurse educators may wish to consider what this teaches students about resilience and workload expectations, and consequently, whether this is a message that should be relayed to the future workforce. Furthermore, it is important to consider whether such messages work to sustain a negative discourse of resilience perpetuated by a culture of judgment.

While students were critical of nurses who judged each other, it was notable that all students also identified that they had judged other people, inclusive of qualified staff and fellow students, based on perceived levels of resilience. This perhaps suggests an internalisation and subsequent repetition of such norms. Within the SN responses, there was less reticence to admit to this, and one student identified that to some extent it was normal to make judgements, however, she pointed out that the important factor was what you did once you made that judgment.

> *I think everyone judges. And I think anyone would be lying if they said they didn't judge. And it's normal as humans to judge. To look at something and form a perception. Like form an idea?... but, I think it's the judgement that you have, what do you do with that judgement…Do you make them feel, erm. Like, do you demean them for the fact that they have now shown that they're vulnerable and emotional, or do you make, like, do you try and pick them up? (SN8).*

This was an interesting point that links to the next subtheme where implications for professional identity and status are considered.

### 4.5.4 Professional identity and status

As part of the set of questions on 'judgment' all participants were asked to describe how colleagues, who were perceived to lack resilience, were viewed by their fellow colleagues. One QN participant identified that to some extent this depended on the culture of the workplace setting. They identified that if you have the "right kind of culture" you would hope that such colleagues were offered support however, they also acknowledged that this may not be what is happening everywhere.

> *You know, sort of, given the support and the time that's needed to, to give them that resilience. Erm, you hope that's what happens. And I think I see more of that in children's than I did in adults. But I can imagine*

> *there's still places where that doesn't happen…especially people who take a lot of time off sick (QN1).*

While one further QN participant recounted a supportive, non-judgemental, culture within the team she worked, the other eight QN participants identified that colleagues who were deemed to lack resilience tended to be viewed negatively by their peers. The most commonly cited negative label attributed to such individuals was 'weakness'. Five participants identified that such colleagues could be viewed as weak, for example,

> *I think it's almost seen as a weakness isn't it, you know, if you're not, you're not kind of like stoical and you can cope with anything, it's seen as a bit of a weakness…Yeah like there's something a bit wrong with you. (QN2).*

> *I do see in the nursing culture, that people often see people as, like weak, if their resilience isn't up to standard. Erm, and potentially not competent, you know? (QN9).*

This seemed to be particularly evident if it was linked to time off sick.

> *It's never been said, but it's almost as though you're weaker if you have time off, erm. That's certainly the impression I've got with my colleague being off at the minute, … so almost as if she's fallen at the hurdle and she'll never be the same again (QN6).*

Two participants identified that while such colleagues may be viewed negatively, attempts could also sometimes be made to protect them from some of the pressures of the job. Ultimately however, if this perceived protection continued, this could start to annoy fellow colleagues who deemed this protection to be unfair.

> *Probably not the person you ask to go to the other ward. You know, probably the person that gets a little bit more protected…And, and, that somehow starts to annoy people, doesn't it? If they see that someone's being advantaged in that way, or are not quite, so much a reliable member of the team? You know, you can't keep throwing things at them and they, they keep going (QN4).*

Comments from SN participants showed similar results, for example,

> *I think they're viewed quite poorly by a lot of people, erm, within my experience. I can think of a few nurses who've maybe had a lot, a lot of sickness because of, you know, the stress, and I think they've just been deemed as not emotionally strong enough or resilient enough to be a nurse, and maybe this is not what they should have been doing in the first place. This is not my words this is other peoples (SN3).*

It was notable that seven students identified that in terms of professional status or standing they believed nurses were viewed negatively if they were deemed to lack resilience, for example,

> *I think it's just drilled into you "Oh, if. You can't move past it, is this the right profession for you?" (SN8).*

> *I'd say yes. Because, at the end of the day, they put. By not being resilient they put more pressure on. On their peers, don't they? (SN1).*

Again, this serves to reinforce the value and importance of resilience to SNs in terms of professional identity. Further to these negative views, QN participants identified that a perceived lack of resilience could have an impact on a nurse's ability to progress within the profession. For example, two participants identified that such individuals may be less "trusted" and as such may not be afforded certain opportunities such as the chance to attend national or international conferences.

> *Less likely to progress and develop…but our team are all really big about, like nationally taking the service to networks and things. It's almost as though they wouldn't be trusted to do that (QN6).*

Furthermore, four participants identified that such individuals may find it harder to gain promotion, for example,

> *It could be "well we won't promote so and so because they, they don't cope with stress" or whatever else…But yeah, I think, I think we can be judged on your resilience and thrown into the…be thrown into the lion's den (QN3).*

Such comments add credence to a darker side to resilience within the nursing profession, particularly if resilience or a lack of it is used to prevent nurses from progressing. Such a discourse was also evident in SN responses where SN's worried about being signed off or passing placements if they did not demonstrate resilience or showed any signs of weakness or vulnerability. This shows evidence of internalisation of this negative discourse.

As identified previously, due to concerns over the sustainability of the paediatric and wider nursing workforce, a greater emphasis is being placed on resilience. For example, the nursing regulatory body the NMC (Nursing and Midwifery Council) stipulate in the new Future Nurse Standards that resilience is important to enable nurses to respond to the impact and demands of professional nursing practice (NMC, 2018). In view of the findings presented so far one might question whether this is appropriate not only because of concerns over a potentially negative discourse of resilience but also because it may discourage an examination of the external and environmental factors that affect resilience. It also raises questions around whether the enhancement of resilience might contribute to reduced attrition of nurses and students from the profession as discussed in Chapters 1 and 2. Interestingly when asked whether resilience or a lack of resilience may contribute to nurses leaving the profession, four students identified that they thought this could be the case, but three students disagreed pointing to the fact that decisions to leave the profession were perhaps more likely to be due to external pressures and that there was only a certain amount or resilience a nurse should be expected to have.

> *the workload, the pressures the, the NHS is massively understaffed, isn't it? So, they're expecting more from people nowadays and. People are having to push boundaries and do things that they shouldn't do…So yeah, I think people think that. It's not worth it. It's not worth the stress (SN1).*

> *I think it's almost cruel to say it's a lack of resilience. Because there's only a certain amount of resilience that one should be expected to have. You know, it's like fuel. It's going to wear out and I think that is sort of what's happened. There's a lot of nurses were they're. They can't be pushed anymore…It's yeah, it's not that they're not resilient, it's just. Maybe to protect. To Protect themselves a bit (SN4).*

As a nurse educator it was fascinating, but equally concerning that students who had not even started their professional careers could hold such views. One must wonder how this might impact on such students or the attrition of students from nursing programmes. While beyond the specific remit of this study it is perhaps an area for future research.

Interestingly, when QN participants were asked the same question, all ten participants stated that resilience played a role in decisions to leave the profession however, there was acknowledgement that this may be part of a much more complex picture. All participants identified that while resilience might play a role in nurse attrition, the larger contributing factors related to external pressures inherent within the professional role.

> *I think because. The pressures are too much, which means they feel they're not resilient enough (QN6).*

> *I think people get sick of it. They get sick of the stress and the lack of support. And in our lifetime the staffing situations only got worse. You know, and that sort of, it's a horrible catch 22 situation isn't it? (QN1).*

> *if you don't feel valued… If you don't feel that your contribution is worthy. If it's always too hard. Erm, I think those are the things that make people leave. Them not feeling valued, not being managed properly, not being respected…I've seen some pretty horrific behaviour. Of course, people leave (QN8).*

As can be seen within the above quotes for some QN participants (n=4) there almost seemed to be an inevitability that nurses would leave the profession due to the pressures they were constantly being asked to deal with. One participant

further identified her distress at this and questioned how much it costs the NHS to continue to lose experienced members of staff.

> *I've seen some really good nurses leave and…, that, that's really upset me, when I've seen it happen. We shouldn't be doing that to ourselves, you know, we lose a huge amount of talent from that…And it costs… What we never do, what we never do is the health economics of, of actually losing that person and what it costs to get somebody else back in post (QN8).*

When considering the role of resilience in attrition from the profession, two QN participants identified that nurses already display significant levels of resilience and like SNs questioned why nurses should have to continue to do this just to continue to come to work each day.

> *Why should people have to have this unlimited supply of resilience just to keep being a nurse? (QN4).*
>
> *I think a lot of people are very resilient actually (laughs)… It's always going to be the challenges of what's being asked of them that then ramps it up each time (QN10).*

One QN participant (QN4) identified that she thought people mistakenly believe that it is 'an easy route to leave nursing' but she continued that if "that's what you've trained for" that could be "really scary" and thus sometimes it could be easier "to just keep going" even if that meant you had to accept that you felt a "little bit stressed all the time". Interestingly one QN participant stated that she felt that it was the resilient people who left the profession.

> *No. I think sometimes they're the most resilient people aren't they because they've realised that it's having this impact on them. A lot of people who've stayed in the profession for years and years have just become really hard, don't treat other people nicely, actually are treating some of the students badly, and that passes on to the patients, and... but that's not resilience. That's not acknowledging the emotional impact that this, this career has had on you…Sometimes the most resilient people look after their own mental health don't they and clear off (QN2).*

This is a revealing comment which perhaps points to a situation where individuals are enacting their resilience by leaving the profession. Furthermore, this challenges traditional binary conceptualisations of resilience for example, strong Vs weak and calls into question the notion that simply encouraging individuals to be more resilient will result in less attrition. Indeed, when asked if participants thought nurses needed to be more resilient as a professional group there was a consensus that this was not the case. This was an interesting contradiction when considering the importance and value QNs seemed to place upon resilience and negative attitudes towards any perceived lack of resilience. This will be discussed further in Chapter 5 but can perhaps be explained, in part, by consideration of the following quote:

> *My concern is if we keep using this …if we keep using it as this positive, positive, quality, it gives us an excuse not to change other things, like the things we talked about. Because if we just keep saying, well, you need to be a bit more resilient, you know. When actually perhaps we should be saying what can we change so that you don't have to constantly be scraping at the bottom of the resilience barrel to keep coming to work (QN4).*

These findings potentially add to an argument that the discourse of resilience within nursing could be described as maladaptive as it may focus individuals on impossible goals or make them unnecessarily tolerant of unpleasant or counterproductive circumstances. These are important findings which will be explored further in Chapter 5. Before moving onto this discussion however, it is necessary to consider what this might mean to nurse educators. Despite the concerns raised about a potentially darker side to resilience; contemporary undergraduate nursing curricula requires nurse educators to embrace and integrate evidence-based resilience education into their teaching. While the aim of this study is to contribute to a more sophisticated understanding of resilience

rather than to build it, this must include some consideration of what resilience is, whether it could or should be taught, if so how, and finally, whether enabling resilience will result in improved working conditions for nurses and student nurses.

## 4.6 Enablers of resilience

The final set of questions aimed to elicit participants views on whether resilience could be enabled and if so, how this could be achieved. As such participants were asked two main questions, firstly whether they thought resilience could be learnt or taught.

### 4.6.1 Can resilience be learnt or taught?

As a nurse educator an important theme within this thesis is whether we can or should teach resilience to student nurses. It was therefore important to elicit student views about whether resilience could be learnt of taught.

All SN participants agreed that resilience was something that could be developed over time, but there was no consensus over whether it could be 'learnt' or more specifically 'taught'. Four students identified that while they thought resilience could be learnt and developed, they did not think it could be formally taught, for example in a classroom setting.

> *Yeah, I think it can be learned…Erm, but to have something like a lesson. A class on it, I don't, I don't think. I think maybe something like a motivational speaker coming in. That would. That is as much as someone could be taught resilience, maybe both seeing and hearing other stories of resilience, but having sort like a textbook class, no, I don't think it can be taught or learnt (SN4).*
>
> *Erm, I, I have self-learned I think… not a teacher saying this is how you be resilient (SN5).*

> *I guess you can build it up, but it's not really something you can like, teach, I don't think because it's like really, individual, like to each person (SN2).*

There was a consensus however, that resilience could be developed over time. There were various ways that students felt resilience could be developed, one consistent theme was that resilience could be learnt through observing others and role modelling their behaviour. Students identified that these role models could be personal role models such as parents, identified by two participants, for example.

> *I think people follow the path of what they've seen. So, my parents, have always had resilience, or come across as having resilience, and being very emotional, and supportive. But still very, "well this, this is how it is. This is, it is what it is". That is one of my sayings, "It is what it is". So, I do think a lot of it is learnt behaviour, your role models, I guess (SN6).*

Five students identified qualified nursing mentors as individuals that enabled them to develop and role model resilience, for example,

> *I don't think you could go into your first day of practice being completely resilient and being completely 100% confident in what you're doing. I definitely think that I, especially in my second placement, I kind of learned resilience from my mentors and, like, how they handle situations (SN7).*

Interestingly one student identified that the nurses she found most effective in terms of modelling resilience were the newly qualified nurses, as she felt she was closer to them in terms of experience and so when they demonstrated resilience this seemed more achievable.

> *So, I think there's people that I've looked at and thought "oh my gosh, wow I want to be like you" …It's often newly qualified nurses, because they seem like almost a medium between being a student and being, obviously they are a nurse, but they you know, it's more like within reach…that's almost like a role modelling to students (SN3)*

It was evident within SN responses that qualified nurses had an important role in enabling and role modelling resilience to students; and that students identified nurses as a valuable resource from whom they could learn. This raises questions about the type of role modelling students are witnessing in terms of resilience and how these values are internalised into the student's developing professional identity. As identified in previous quotes QNs were aware of the role they played in providing experiences to enable students to develop resilience. While all QN participants agreed that resilience was something that could be developed over time there was less consensus over whether it could be 'learnt' or more specifically taught'.

No students identified nurse educators as role models for resilience however, the focus in this study was more on qualified nurses. In view of subsequent discussion that will develop in Chapter 5, an interesting area for future research would be to explore nurse educator's attitudes to resilience and to explore student views on the role nurse educators may play in enabling resilience. There are hints to SN and QN attitudes in relation to this however, within some of the responses from both sets of participants which cast doubt on whether resilience can be taught in a traditional classroom setting. Whether this is because current educational teaching methods are ineffective, or nurse educator attitudes simply act to reinforce discourses already evident within practice are something to consider further in the following chapters.

In view of the dismissiveness towards formal educational approaches, the final set of questions aimed to explore practical or experiential factors that could enable resilience. QN and SN participants were asked slightly different questions due to the nature of their roles. To aid in clarity QN responses will be reported first. QNs were asked whether any changes could be made to their working lives,

that might make it easier to maintain their resilience. Responses fell into three main subthemes, resources, culture, and environment.

### 4.6.2 Enablers of resilience – QN responses

Perhaps unsurprisingly, staffing was identified by all participants as the factor that could help the most with improving the daily working lives of a children's nurse. This was identified as a central element that could enhance many areas of a nurse's life for example it would enable staff to take their breaks but also allow them to provide a better standard of care as discussed in section 4.2.

> *Well, I think, just better staffing, erm, making sure people get their breaks, making sure they've got somewhere nice to go and sit, making sure they can get away from the area (QN2).*

Linked to this was the issue of safe staffing; three participants identified that they felt concepts of safe, or indeed minimum staffing levels should be challenged as they were "wrong" and did not allow staff to provide quality patient care.

> *having that appreciation that, actually, if people are having a lovely day, it's because you are safe and actually you've got a safe level of staffing, erm, which means people can have the time to spend with their patients…it shouldn't be you're on the minimum (QN8).*

While staffing was the most identified measure that could enhance the working lives of children's nurses, the highest volume of comments centred around a required change to the culture within children's nursing. There were so many comments made in relation to this subtheme that it is not possible to present them all, thus, a selection of the most cited 'enablers' are presented within this section.

Kindness was identified by four participants as being very important.

> *I think, kindness, you know, what a difference it makes to us all when somebody is kind…but with resilience, I think there are opportunities aren't there, to fill up that that jar and I think kindness is one (QN4).*

Sadly, four participants identified that kindness was "not a given" within the profession with one participant identifying that she did not "expect to be treated kindly" and that sometimes as a nurse it was almost a "surprise to be treated kindly" (QN6).

> *People being kind (laughs). That sounds really stupid, but…but it isn't a taken yeah, so I don't think it's a given sadly (QN6).*

This participant went further to say that at times she felt that the violence and aggression policy could be applied to some staff.

> *What would I ask for? National kindness (laughs) I'm joking (laughs). Erm. As in yeah, I did, I say I am joking, but like we throw around the aggression and violence policy with parents all the time. And I raised it with my boss the other day, I was like, when does it come to the stage where we raise that with staff? Because I wouldn't talk to somebody how we as nurses get treated because we're nurses (QN6).*

This links into issues with nursing culture that were identified by five participants, in particular the notion of developing a culture of 'no blame'.

> *Culture of 'no blame' is really important…You know when there's an incident and you breakdown what happened. But you're not, finger pointing. Erm, that's important…If you want people to accept responsibility for something that's happened, and actually look at how they're going to change it, you've got to create a culture where they feel safe to do it, you know? (QN1).*

Similarly, one participant identified the desire to cultivate a culture where people did not gossip about each other and were therefore less judgemental about one another.

> *I do think as well, resilience is massively impacted in nursing by everybody talking about each other…If, actually, anything that happened*

> *was just judged on that merit, on the merit of what happened, and not on everyone else's two penneth worth that would help (QN2).*

The participant gave an example of when someone makes an error. Often, they will already feel upset about this, but can be made to feel worse depending on how colleagues view their mistake and subsequently whether colleagues talk between one another about it. Thus, the participant agreed that having a culture where nurses do not blame one another for mistakes would be beneficial.

> *if you could try and do something to alter, to make more of a supportive environment rather than, almost like a, you've made a mistake like blame culture, then I think that would help as well (QN2).*

Continuing with the theme of culture, four participants identified the beneficial implications of feeling valued. One participant gave the example of someone thanking you at the end of a difficult shift, whether that be a parent, a patient, or a colleague.

> *And you are lighter as you go home, aren't you? You're just, that's, that helps you with, with your, with your resilience. So, I think feeling valued by your team and by the bigger organization is really important as well (QN3).*

Three participants identified additional support as being a potential factor that could enhance resilience with one identifying that in the current climate there is a lot of emphasis on competency. While this is obviously very important, she felt there should be a shift towards emphasising how to support individuals with resilience more.

> *But I think the emphasis has to change a little bit, more about how we support nurses in our teams and, and, how we think about our own resilience as, as, you know, depending on where we are at in our career pathway (QN10).*

Another participant agreed and identified that there was a need for the nursing profession to pay more attention to supporting its staff to prevent people from feeling that they needed to leave.

> *I would really love to see there being a bit more, you know, helping people with resilience. Because it. I think it's an absolute tragedy when we lose nurses 'cause they can't, can't do their jobs…especially when you watch people that have really crumbled at the end of their careers because it's all got too much…It's, it's just scandalous that that happens (QN8).*

The final element to discuss within this section was that four participants identified practical issues within the working environment where changes could be made to improve their working lives. A finding of note within this subtheme was that participants frequently dismissed their suggestions as either silly or lacking in importance.

> *Like on a really silly level (laughs). Like, this is really pathetic (laughs) and you don't need to put this in, 'cause I wouldn't put this in if I was doing your study (laughs). But, like our chairs don't fit our desks, and they don't, erm. You can't adjust them, and one of our desks is a kitchen table so it's really high. So one of my colleagues has always got shoulder pain and just… like we sit here with, like, wheaty bags on, and stuff like this, and I'm like, it's almost as though we're a patient whilst we're doing our work…In terms of like daily niggles, as in, yeah, if we were comfortable then it would be a lot nicer to do the job (QN6).*

These comments demonstrated some basic issues that should be challenged at a rudimentary ergonomic level. What I found particularly interesting was the notion that these issues were 'silly' or 'pathetic'. Further basic issues were identified such as being able to park so that you could drive to work rather than having to rely on public transport (QN6). Having IT that worked or "always having access to a laptop or a computer" (QN8). Having a space to go to have a break (QN3) and finally having facilities and systems that were fit for purpose.

> *And it's, it's the infrastructure. It's the facilities. It's the IT, it's, you know, a lot of the stuff around what we do probably just in our job. It's not necessarily about delivering the nursing. It's the fact we haven't got rooms, appropriate rooms to deliver our clinics. We, you know, the IT is constantly horrendous, that the systems we use aren't fit for purpose for what we do (QN10).*

As stated, participants often attached less importance to these issues, perhaps because they were issues that directly affected them as opposed to patients or families. One participant, who had identified several significant issues such as the lack of ability to take any of her annual leave due to poor staffing and workload pressures, even expressed disappointment with the improvement measures, she had suggested as she felt like none of them were 'wand worthy'.

> *I feel like that's probably a disappointment and I'll go home and think I feel like none of these things are like magic wand worthy, but they are on a day-to-day basis. They are things that would just make such a difference (QN6).*

A further interesting finding which related to all the improvement measures suggested, including staffing, was that participants often started their discussion from a position of defeat; expressing an attitude that clearly showed they did not expect any of their suggestions to come to fruition. For example, "*It's completely impractical, so this is my, this is my wish list" (QN3).*

What is evident here is that the potential enablers fell very clearly into spheres that were institutional and beyond the control of the individual. Some of these issues seemed to represent basic universal needs that should be addressed at a local trust level. Other issues, such as staffing, are clearly more complex, but it is possible to suggest that if action were taken to enhance the working environments and conditions for staff, this may have a positive impact on staff retention.

While the working conditions of QNs are important for SNs as they share the clinical environment, my focus as a nurse educator needs to be on SNs. Therefore, it was important for me to elicit the views of students about measures that could enhance their experience of studying to become a nurse, and perhaps enable them to develop resilience, or reduce issues that might challenge their resilience. It was interesting that while students were able to identify the challenges they experienced, they seemed to struggle to identify measures that might help to enhance the student experience. Consequently, this section is quite short however, several factors were identified, which focussed on the practice environment, and the university setting.

### 4.6.3 SN responses – Enablers of resilience

#### *Practice Environment*

In terms of the practice environment, the main theme that emerged was the provision of a supportive learning environment. This element was commented on by all students and focussed mainly on supportive staff, being included as part of a team, and positive praise. Five of the eight students identified that it was important to have positive, supportive staff and that this could significantly enhance how resilient they felt, for example,

> *The whole attitude of the ward, and the atmosphere. Like, if you're surrounded by people who are so negative, then you're probably just going to be like, "I've got 11 hours of this, like, and I can't be bothered". Rather than if you are with people who are uplifting and enthusiastic, you're like "yeah let's go I'm gonna do something today and I'm gonna do my best and I'm going to do something really well" (SN7).*

One student identified the responsibility that both staff and students had in contributing to this positive learning environment.

> *…they [nurses]are part and parcel of making a nurse so, give the student every opportunity that is physically possible and challenge yourself to give them more (SN6).*

She continued by saying that it was important for students to contribute, for example, by starting a new placement with their own action plan clearly identifying what they wanted to achieve.

> *So, I guess if you put in the effort, they [QN's] are much, much, more receptive, so that's my other thing for students. Don't be slack (laughs)… So, for staff, challenge them more. And for students, challenge yourself (SN6).*

Four students identified that being included as part of the team could make a significant difference to their resilience and their performance, for example,

> *I think having a good team around you. Feeling part of the team is really important. I mean, I've had a mixture of placements. So, some I felt as if I had worked there forever, sort of thing, I felt that included in the team. Erm, and some you're just not included at all, you don't even have a name. You're just the student. (laughs). Erm. So, situations like that where you feel more part of it. It's certainly a lot easier to be more resilient (SN5).*

Finally, two students identified the importance of giving and receiving praise with one student identifying how important it was that qualified staff also receive that positive praise, especially from their ward managers.

> *the ward managers as well. They should be the ones that are trying to encourage people, and boost people's confidence, and show appreciation to the workforce, but I think they're under that much pressure aren't they? To meet these targets and all the audits and stuff…But you know, they're not gonna get that if their workforce is just drained and feels worthless. I think just a few nice kind words and a bit of positivity go a long way, for me anyway. Makes me feel appreciated (SN1).*

This was an insightful point, as the student was able to identify that, for qualified staff to be able to support students positively, they had to start from a position where they also felt valued and supported. This also reflects the rationale for

considering how the working lives of QNs could be improved as this can impact on the ward culture and potentially enhance the learning environment for SNs. It was interesting that very few students identified resource issues like staffing as being factors that might make the working lives of nurses better, particularly since there is a national shortage of nurses which is potentially being compounded by lower student application rates and high attrition rates amongst nursing staff and students. It was also interesting that the responses given were quite generic and no student made suggestions of measures that might enable resilience that were specific to children's nursing. This was also evident when they were asked about possible factors that might enable resilience and enhance their experiences within the university setting.

### *University Setting*

Once again, SN participants struggled to articulate many ideas and similarly to QNs, students often started from a position of defeat where they almost dismissed their ideas at the same time as expressing them.

> *It's difficult, 'cause obviously what would make it easier is just to like lessen workload, lessen placement. But that's just not gonna happen. It's just not. It's not, like, that's not possible. That's not the reality (SN2).*

One potential enabler however, that was identified by three participants was the provision of opportunities to reflect, talk, and share experiences, for example.

> *I think talking is what makes you more resilient. Being able to discuss things and, you know, get things off your chest. If you keep it and don't talk about it, that's when it can just, affect you more, and I think you are able to move on from things more if you talk about it. Let it out and then, you know, then you have more chance to start afresh, and…not let it bother you later on (SN5).*

This was an interesting point as opportunities to talk and discuss issues as identified in the above quote are offered to SNs within the nursing curriculum in the form of clinical supervision. These sessions are not mandated and historically they have been poorly attended. This may indicate a future area for further development and evaluation. Two students identified that support from university staff like tutors or the wellbeing team was important in this process, for example,

> *having the support of the lecturers or tutors, knowing that the support is there and that you can go and ask if you're struggling in any way. Like, also having the welfare and team that we've got. Knowing that all that's in place is really helpful (SN5).*

Finally, one student identified that taking part in the study interview had been a positive experience and had helped her to reflect on her own resilience and how far she had come throughout her training. This was something that she felt could perhaps be of benefit to other students.

> *I think we should definitely talk about this more. And, I think. So, this study you're doing is something really positive, and it should be, we all should do it, I think. The whole, cohort should do this study. I think it would be really beneficial not just for the results, but for them individually…I think when you talk, when you're asked questions, sort of that interview process, it can almost feel like self-therapy. Yeah, erm, this sort of feels like a self-therapy session (laughs) (SN4).*

For me, this was a significant comment which supports that there is a place for education on resilience within undergraduate nursing, but it should emanate from a critical stance and be grounded in, and encourage, a more sophisticated understanding of resilience. It is therefore possible that the findings from this study provide a basis for future teaching methods that encourage honest discussion about what resilience is, whether it could or should be taught, and how it manifests within the nursing profession. As nurse educators it is

important consider how our students learn about resilience and whether the contemporary discourse, they are exposed to is one that we wish to perpetuate or one we wish to challenge. This will be explored further in Chapters 5 and 6.

## 4.7 Chapter summary

This Chapter has presented the findings from both QN and SN participants and has identified five key themes, namely, a culture of continual coping, the importance of resilience to the profession, challenges to resilience, a negative side to resilience, and finally, potential enablers of resilience. Consequently, arguments have emerged pertaining to a maladaptive discourse of resilience within children's nursing which will be further developed in the following chapters. This will include a consideration of how the findings might contribute to knowledge and theory on resilience within children's nursing and how this theory may be applied to student nurse training.

# 5. Discussion

The previous chapter introduced the findings from interviews conducted with both QN and SN participants. Several questions have been posed throughout the results section and this chapter will attempt to discuss and answer these in relation to the wider literature base and existing policy. Emergent arguments will be formed and developed which will focus on how resilience is conceptualised and incorporated into the professional identity of children's nurses and student nurses. Consideration will be given to whether resilience can be learnt and if so how. The propensity to see resilience as a universally positive or desirable concept will be challenged and an argument will be presented which advocates the need for a more nuanced understanding of the concept within both the nursing profession and the nurse education setting.

## 5.1 How is resilience understood - What do children's nurses and student nurses think resilience is?

The first question to consider is what children's nurses and student nurses think resilience is and how it is conceptualised. Resilience is increasingly being advocated as a potential measure to reduce stress and burnout within the nursing profession (Berger et al, 2015; Hesselgrave 2014; Guo, Luo, Lam et al, 2018). As identified within the introduction and literature review chapters however, little is known about how children's nurses understand or experience resilience within their daily lives - Daesin (Heidegger 1962). Furthermore, one of the criticisms levelled at resilience research is that is lacks culturally sensitive definitions, in particular definitions that consider what the target group themselves understand as resilience (Mohaupt, 2008). In view of this and the

interpretive nature of this study, it is important to start the discussion by exploring how both QN and SN participants define resilience. While there were differences in the definitions, there were some marked similarities in participants understanding of the phenomenon of resilience, namely the concepts of "coping", resilience as a "personal attribute", and "carrying on".

### 5.1.1 Culture of continual coping

When asked to define resilience, the notion of coping was a concept that featured in both participant groups but was more prominent within the QN responses being cited as a central theme of resilience by six of the ten QN participants. It was interesting that three of the QN participants struggled to define resilience and felt much more affinity with the concept of coping and so tended to use this term throughout the interviews as opposed to resilience. This raises a question regarding whether coping and resilience are one and the same thing, at least in the minds of some.

Coping and resilience are often referred to interchangeably within both resilience and nursing literature. There are similarities between the two concepts for example, like resilience, coping has been conceptualised as both a trait and a dynamic process, and many definitions include the notion of trying to restore some form of equilibrium in response to stress (Weisman and Worden, 1976; Pearlin and Schooler, 1978; Monat and Lazarus, 1985). Authors such as Leipold and Greve (2009) argue that the phenomenon of resilience needs to be explained in the context of coping processes that allow growth trajectories to develop and as such resilience and coping can be argued to belong to the same conceptual hierarchy.

Some definitions, however, point to subtle differences between the two concepts. For example, Folkman and Moskowitz (2004) define coping as the cognitive and behavioural strategies required to manage stressful events, while Steinhardt and Dolbier (2008) define resilience as the adaptive capacity to recover from stressful situations in the face of adversity. Similarly, Rice and Boaxia (2016) argue that while resilience and coping may be related, they constitute distinct concepts. They state that coping refers to a broad set of skills and deliberate responses to stressful events, while resilience refers to positive adaption to adversity. The main distinction made is that coping skills can be positive, negative, or dysfunctional, while resilience is described as a concept that denotes positive adaption only.

This distinction will be relevant when we come to consider participants' conceptualisations of resilience. I will go on to argue that definitions of resilience in nursing conform to normative discourses and oversimplify the concept into potentially harmful binary categories. It is notable that the potential relationship between resilience and coping, complicates definitions and understanding of the concept of resilience within nursing. It is also possible that the interchangeability of both terms adds to a perceived pressure to demonstrate 'resilience'. One study participant voiced such concern, stating that the perceived link between resilience and coping could result in situations where nurses felt they must "keep coping and putting up with things no matter what". This perhaps links not only to concepts of coping but also to the emphasis on "carrying on" that was prominent in participant definitions (to be identified shortly).

### 5.1.2 Resilience as a personal attribute

The second element that was evident in participant definitions of resilience was that it was viewed as a personal attribute. In line with person-centred theories which position resilience as a personal quality, both participant groups spoke about resilience in terms of it being a positive personal attribute, or an individual characteristic which enabled them to cope and carry on despite the adversity they may face within the workplace.

Both sets of participants tended to attribute positive qualities to resilient individuals, the most cited of these was that resilient people were perceived to be "strong" (identified by five QN participants and all eight SN participants). Other positive qualities identified by the QN participants were, leadership, self-awareness, confidence, organisation, calmness. SN participants also identified confidence, self-awareness and calmness but added adaptability, practicality, and supportiveness to the list of attributes they associated with resilient people. This seems to conform to the existing normative discourse of resilience which overwhelmingly positions resilience as something that is good or desirable (see for example: Cusack, Smith, Hegney et al, 2016; Olsson, Galaz and Boonstra, 2014; UNDP, 2014; Rice and Boaxia, 2016).

While resilience was predominantly described as a positive attribute, five participants (1QN, 4 SNs) identified 'hardness' as a negative but sometimes necessary attribute of resilient people. Along with strength, resilience literature often cites 'toughness' or 'hardiness' as a feature of resilience (see for example, Duckworth, 2016; Stoffel and Cain, 2018; Roslan, Yusoff, Morgan et al, 2022). This is an interesting description when applied to nursing as it does not conform to the traditional view of a caring compassionate nurse. While participants

largely identified 'hardness' as a negative factor, it was evident that they also deemed it to be necessary at times to cope with the inherent challenges. Students also recounted fears that they were not 'tough' enough, further suggesting that they felt this was an attribute of resilience that they needed to develop. This will be discussed further in Section 5.3.

While there was acknowledgement from all participants that resilience was not fixed in nature and there was capacity for individuals to enhance or develop their resilience, significant emphasis, particularly in QN definitions, was placed on resilience as a personal attribute. This conforms to descriptions of resilience within the wider nursing literature which tend to focus on an individual's motivation to cope, their self-efficacy, and their ability to respond to difficult situations. It is evident that within such definitions the responsibility for the development of resilience remains with the individual so potentially neglecting the role of the organisation or wider community (Stacey and Cook, 2019).

For SN participants there was a clearer emphasis on resilience as a process that could be learnt or developed. It was also evident within the SN responses that SNs viewed resilience as an important element of the nursing role, which they aspired to develop. This provided some evidence that the concept of 'being resilient' had been incorporated into student views as a fundamental element of the nursing role. In part, this originated from a desire to conform to the norms and values they were exposed to and resulted in a desire to demonstrate resilience as part of their professional identity. This issue, along with issues pertaining to normative discourses of resilience, and the responsibility to develop resilience, will be explored later in this chapter.

### 5.1.3 Carrying on/keeping going

Finally, seven QN participants and all eight SN participants definitions of resilience included the notion of "carrying on" or "keeping going" in the face of adversity. This was seen as an essential element of being resilient and was deemed to be necessary due to the number of external challenges the participants faced within their daily working lives.

When referring to nursing and the resilience literature, while there are variations in definitions dependent on the model of resilience one subscribes to, most identify "the ability of an individual to bounce back or to cope successfully despite adverse circumstances" (Rutter, 2008 in Hart, Brannan and DeChesnay, 2014 p.720), similarly to, "recover from adversity, react appropriately or 'bounce back' when life gets tough" (Grant and Kinman, 2013, p.5), or the ability to "adapt and return to the state one was in prior to a particular stressor" (Lang, 2001, in McGowan and Murray, 2016, p.2274). It was notable that this concept of bouncing back, or returning to a prior state, was not evident in any of the participants definitions and was instead replaced by the concept of needing to "carry on". This is perhaps because the notion of bouncing back after an adverse event suggests that such an event is acute in nature. The challenges and difficulties identified by participants in this study however, tended to be chronic and frequent so necessitating a more constant need to "carry on" and to try to cope in the face of ever-increasing pressures.

This suggests that QNs and subsequently SNs conceptualise resilience in terms of coping and needing to carry on despite the challenges they may face. This has potential implications for student nurses, but also the profession as it may contribute to a resilience discourse that encourages individuals to put up with

unacceptable or unachievable demands. To explore this further, it is important to try to understand why QNs and SNs conceptualise resilience in this way.

## 5.2 Why do QNs and SNs understand and define resilience in this way?

Participant definitions indicate that QNs and SNs understanding of resilience is conditioned by their working environment. Responses showed that all QN and SN participants identified resilience as fundamental to the role of the children's nurse due to the numerous challenges faced. Seminal theorists such as Michael Rutter (2012) argue that individuals can only exhibit resilience in response to the presence of adversity. While social constructionists such as Ungar define resilience as the "outcome of negotiations between individuals and their environment for the resources to define themselves as healthy in conditions collectively viewed as adverse" (Ungar, 2004, p.352). Consequently, it is necessary to consider the working environment, the challenges it presents, and how this influences QN and SN definitions of resilience.

Findings that fall under this category will be summarised as they have already been identified in some detail within the findings chapter. It should be noted that this study was conceived well before the advent of Covid 19 as significant workplace stressors have been evident within the NHS for many years. Consequently, the focus of this study is not intended to be upon Covid-19. However, due to the timing of data collection it is necessary to consider the implications Covid 19 has had on resilience within the paediatric nursing profession.

### 5.2.1 Covid-19

There are several contextual factors to consider in relation to Covid-19 and children. Thankfully children as a population group have demonstrated a much lower disease burden from Covid-19 and it has rarely been fatal in children. Recent figures show that up to mid-January 2022 there had been 15,939 cases of hospitalisations in children aged 0-17 due to Covid-19. While this is by no means insignificant, the hospitalisation rate for adults aged 18+ was nearly ten times higher (Morris and Fisher, 2022). Responses from both QN and SN nurses reflect these lower patient numbers in addition to a trend, at the start of the pandemic, towards cancellation of elective admissions, lower cases of viral illness, and a reticence from parents to bring their children to hospital. This resulted in lower patient numbers within the paediatric setting at the time of data collection which had the unexpected consequence of relieving staffing pressures for a period. Despite this, changes to parental visiting regimes, and other potential issues in relation to safeguarding concerns and the mental health of children and young people were cited as challenges to the resilience of participants in this study.

While this study did not focus on Covid-19 it was interesting that QNs did not speak about Covid-19 as much I had anticipated. To clarify, all QN participants acknowledged that Covid had significant negative effects on children's services but there was also clear acknowledgement that Covid-19 had essentially highlighted and worsened pressures that had always been present and would continue to be present.

The final contextual factor of note in terms of QN responses was that none of the QNs interviewed were working in clinical areas designated for the care of Covid-

19 patients and their specialist roles prevented them from volunteering to be redeployed to assist in such areas. The locality of the hospital trust may also be a factor. It is notable that seven Paediatric Intensive Care Units (PICUs) within the UK repurposed their space, staff, and equipment to admit critically ill adults during the pandemic (Sinha, Aramburo, Deep et al, 2021). While the PICU setting within this study were on alert to take adult ITU patients this was ultimately not necessary. Thus, data on Covid 19 within this study must be viewed as context specific in terms of the locality of the trust and the clinical area the participants worked in throughout the pandemic. For the SN responses however, it is plausible that the findings are perhaps more representative of a wider experience for SNs nationally.

For students across the country the pandemic caused significant disruption to the university experience with students being sent home to learn online. This resulted in social isolation from friends and family, and reported feelings of anger, fear, and lack of motivation within the SN participants. It is notable that this cohort of students have had a unique university experience because of Covid-19, so it is unsurprising that many of the challenges identified were attributed to Covid-19. Consequently, the SN responses in this study represent a student experience that is time and context specific. To gain a broader view of the challenges faced by student nurses, particularly within the academic setting, it may be beneficial to repeat the interviews with students commencing the course post pandemic. This does not however lessen the experiences of SNs interviewed in this study, and important issues were identified that clearly impacted on the resilience of this student group.

While the experiences student nurses faced within the academic setting can be likened to those of many students nationwide, the requirement to attend clinical

placements and potentially care for patients suffering from Covid-19 was unique. This engendered both fear and anxiety with five of the eight students identifying fear at entering the clinical areas. Feelings of anger were also expressed by two students with one stating that this was "not what she had signed up for". Feelings of fear were also expressed by the QN participants with them identifying that no-one really knew what was going on at the start of the pandemic. Further to this the language used by the media caused anger at times as well as fear, particularly with reports of nurses dying which understandably heightened fear and anxiety for both groups of participants.

There is much more that could be said about Covid-19 and the impact it has had on children's nurses, however, this is beyond the remit of this study. I am concerned not to devote too much attention to this issue for fear that it does not adequately explain why QNs and SNs define resilience in terms of coping, and more importantly could divert attention from the significant endemic challenges evident prior to the emergence of Covid-19.

### 5.2.2 Endemic challenges to resilience

Challenges which may better help explicate why resilience was defined in terms of coping within this study tended to be inherently endemic. It is notable that some of the endemic challenges described by both participant groups were general in nature while some were more specific to the paediatric nursing role. Discipline specific challenges included dealing with the expectations of parents, particularly if they were disappointed in the care they received, and the emotional burden of caring for children. Caring for sick or dying children was identified as being particularly challenging by both participant groups. This was further compounded by having to witness the child, and their families, go

through difficult times. This was summarised well by (QN6) who identified the "daily toll" of seeing really sick children, "time after time, different patient every time, different story, different abuse, different sad situation". This is a stressor that was also reflected within the earlier literature review chapter for example, (Berger, 2015; Pardo, 2011; Mcloskey and Taggart, 2010).

A further issue that was identified by QN and SN participants as being challenging to resilience was the increase in both safeguarding and mental health issues within the paediatric patient population. There is no doubt that such experiences can be extremely distressing, particularly when considering the societal value that is placed on protecting and caring for children. This is argued by some to put children's nurses at greater risk of experiencing burnout, low resilience, and stress (Robins et al, 2009; Sekol and Kim, 2014).

While these experiences are clearly challenging, they are perhaps not unexpected challenges within a profession that focuses on caring for people during times of pain and distress. Furthermore, such stresses may be viewed as more acute and temporary in nature as opposed to endemic organisational stressors which are chronic, accumulative, and if persistent, may have a greater impact upon mental and physical wellbeing (Card, 2018; Taylor, 2019).

There is evidence from both participant groups, as well as the nursing literature (e.g. Turner, 2014; Taylor, 2019) that organisational challenges, such as staff shortages (Berger, Polivka, Smoot and Owens, 2015; Davis Lind and Sorensen, 2013; Zander, Hutton and King, 2013), excessive workloads (Berger er al. 2015; Czaja, Moss and Mealer, 2012; Zander et al, 2013), lack of resources and organisational support, (Czaja et al, 2012; Sekol and Kim, 2014) and negative

ward cultures, (Aytekin, Yilma and Kuguoglu, 2013; Sekol and Kim, 2014) are more likely to be the primary sources of workplace stress.

By far the most cited stressor was a lack of staffing. While there was less emphasis on this within the SN interviews, lack of staff was referred to by all participants at some point in their interviews. For QN staff this issue featured prominently with one participant even stating she would take a pay cut if she could have more staff. The lack of staffing further compounded stressors such as high patient acuity, contributed to increased workload pressures, and impacted negatively on patient care. This had the potential to challenge the professional identity of both nurses and students by testing the professional standards and expectations they held themselves accountable to. It also had the potential to impact negatively on their resilience, and their risk of developing issues such as moral distress, compassion fatigue, and burnout (Stamm, 2010; Zander, Hutton and King, 2010; Guo et al, 2018). This is a vicious cycle which was linked by participants to low job satisfaction, and attrition of both qualified and student nurses.

Issues pertaining to low morale, job dissatisfaction, and attrition are clear within wider literature. An employment survey conducted by the Royal College of Nursing (RCN) in 2019 suggested that nearly one quarter of nurses and midwives were considering leaving the organisation within which they worked, while 37% were considering looking for a new job. Furthermore, the NHS National staff survey (2019) found that 44% of staff had been unwell because of work-related stress within the last year; while the Health and Safety Executive (2019) citing data from the annual Labour Force Survey, identified that health care staff consistently report higher levels of depression, anxiety, and work-related stress compared to workers in other sectors (Kings Fund 2023b). NHS

Digital (2020) reports that there has been a 35% reduction in health visitors within the NHS from October 2015 – April 2020 resulting in impossible situations where a single practitioner could be accountable for the assessment and care of 750 children and their families (Institute of Health Visiting 2020).

These statistics are just a snapshot but highlight the extent of the challenges evident prior to the emergence of the pandemic with a study by Maybin et al (2016) citing accounts of nursing staff being "broken" and "on their knees". Such issues have been reflected within this study with accounts of staff being "broken" or "crumbling" under "relentless" or "overwhelming" workload.

For SNs the most cited challenge to their reported resilience pertained to negative staff attitudes. All SN participants identified this as a concern and while they were all able to identify that many staff provided excellent support, they also identified a significant number of negative experiences. Examples included accounts where staff made it clear that they did not want to work with a student or showed disapproval of some perceived vulnerability or weakness. Consequently, students reported feeling like they were a burden in addition to feelings of self-doubt relating to whether they were 'tough' enough to be a nurse.

Students also reported fear and anxiety about being judged negatively if they did not perform sufficiently. One must ask how this might influence student nurses' development and understanding of resilience as well as their motivation to continue with their training. Analysis by the Health Foundation and Nursing Standard in 2019 revealed that 24% of Nursing students in England are leaving courses early or suspending their studies. Notably one of the SN participants who took part in this study subsequently chose to leave her course stating that

she did not want to enter a profession where she was "overworked, underpaid, and spoken to like rubbish".

Returning to the question of why QNs and SNs might conceptualise resilience in terms of 'coping' or 'carrying on' QN responses indicated that the workload expectations placed upon them were often deemed to be unreasonable and unachievable, yet there was little acknowledgement of this from management or the organisation. Instead, there was an expectation that staff would 'extend and extend' or 'just do that bit more' resulting in an 'unbelievable pressure to be resilient'. All QNs reported a pressure to be resilient and it was evident from their responses that even though they were already facing incredible workload pressures, there was an expectation for them to 'carry on' and 'cope' with more.

The pressure to be resilient was perceived to come from multiple angles, inclusive of the organisation, colleagues and the QNs themselves. This could result in participants judging themselves and indeed others negatively, particularly if they failed to cope (to be discussed further shortly). This provides evidence of a discourse of resilience in nursing that focuses on continual coping. This could consequently encourage already overworked individuals to cope with ever increasing pressure and discourage any attempt to challenge or resist the pressure.

Like QNs, students also perceived a pressure or 'expectation' to be resilient. While some participants identified that this expectation came directly from QNs, a common theme was that the pressure to be resilient originated within the SN themselves. In part this was due to a desire to conform to the perceived norms of the profession. This links to theories of how students learn about the values that are important to a profession and are socialised into the culture of it (this

will be discussed later in this chapter). In part however, this was also due to a fear of being judged negatively if any weakness was shown.

Hence, we can see how the demands of the working environment feed into and condition an understanding of resilience that is focussed on 'coping' and 'carrying on'. This leads to an important question however, about what happens when an individual is not able to cope or starts to "crumble". Does this mean that they are not resilient, or even that they are weak? If resilience is viewed through the social constructionist lens, one might ask what happens if individuals do not have enough access to the required resources to maintain their own health? Does this make them a 'bad nurse' or a 'less valuable team player'?

Consideration of such questions could further our understanding of why the QN and SN participants in this study define resilience in terms of coping. The next section will explore this along with the nursing culture described by both QN and SN participants. This discussion relates to research question 3 which considers to what extent and in what ways the discourses of resilience within children's nursing are helpful or unhelpful. It will focus specifically on how a lack of resilience is described by both participant groups and explore whether the contemporary discourse of resilience within nursing can be described as a maladaptive discourse.

## 5.3 Is there a maladaptive discourse of resilience in children's nursing?

As has already been discussed being resilient was a fundamental feature of the professional identity of QN and SN participants. Both groups expected resilience of themselves and described feeling afraid, concerned, or worried about admitting to anything that may be construed as a lack of resilience for fear of

being perceived as “weak”. This suggests a less positive side to the discourse of resilience within nursing. However, this became even more apparent when participants were asked to describe how colleagues may be viewed if they were deemed to lack resilience.

To explore this further both sets of participants were asked if they had ever judged anyone else in relation to their levels of resilience. It was interesting that participants found this a difficult question to answer, in part, due to a reticence to admit to judging someone else, in part due to guilt about judging someone else, and in part because it goes against the stereotype of a caring non-judgmental nurse. However, ultimately, all participants had the courage and candour to admit that they had judged other nurses, or student nurses, based on their perceived resilience and that often these judgements were negative in nature.

As has been discussed earlier, the most common positive descriptor associated with resilience in initial definitions was strength. This is something that is also evident within wider literature and when looking in a thesaurus for synonyms for resilience, strength is one of the adjectives listed. Interestingly it seems that, a lack of resilience was viewed as a synonym for weakness within participant responses as this was the most cited adjective used to describe people who lacked resilience.

This was a finding of note and was something that both participant groups were somewhat uncomfortable about. There was acknowledgement from both groups that resilience was a process that could change over time. Equally there had been clear acknowledgement of the challenges to resilience faced by nurses, alongside acknowledgement of the unacceptable pressure sometimes placed

upon nurses to demonstrate resilience. Despite this, when it came to describing a lack of resilience in others, it was evident that nurses often viewed this as a personal weakness or a personal failure. At times such individuals were even described as having "something wrong with them". SN participant responses supported that it was commonplace for QNs to judge each other negatively when there was a perceived lack of resilience or ability to cope, and a tendency to talk about one another in negative terms.

SN participants identified that this reinforced a desire in them to develop resilience and, while they viewed such judgements as a negative element of the nursing culture, they also admitted to participating in such judgements of others. Sometimes this took the form of a direct disapproving response to the judgements they witnessed QN staff make, sometimes it took the form of negative judgements directed towards staff who were deemed to be too "hard", and at other times it involved personal negative judgements that were directed towards fellow students. Furthermore, it led to concerns within the SN participant group about being judged negatively themselves if they were not deemed to be resilient or 'tough' enough.

A notable finding with SN responses was that when they made negative judgements about QN staff, they did not tend to be based around concepts of weakness, rather staff were viewed as being too hard or too tough. When such judgements were made about fellow students however, the concept of weakness was evident. This is an interesting contradiction. What this shows is difficult to say for certain due to the small sample size, but it is perhaps suggestive of an internalisation and repetition of the values and attitudes students are witnessing. Furthermore, such findings may provide evidence of a discourse in nursing which individualises and decontextualises resilience. In doing so this potentially creates

harmful binary categories, for example, ‘resilient’ vs ‘not resilient’ or ‘strong’ vs ‘weak’. One must ask what this means for individuals who might be categorised as not resilient or indeed weak.

Before considering this, it may be helpful to return briefly to descriptions of resilient people as ‘hard’. Along with strength, the resilience literature promotes toughness and hardiness as features of resilience. These are perhaps strange descriptors for a nurse but from both QN and SN responses, as well as contemporary nursing literature, e.g., Chinn (2018) they appear to be attributes that are celebrated within the nursing profession.

One might ask why individuals working in a profession characterised by care and compassion might commend such attributes and use them to make negative judgements about one another. The clue is perhaps within participant responses which identify the chronic nature of the challenges faced and lend support, not only, to a resilience discourse defined by coping, but also to a potential ‘crack in the foundation of the care environment’ (Virkstis, Herleth and Langr, 2018, p.597).

Virkstis et al (2018), have identified several perceived foundational cracks within the health care system, the third of these being that staff are required to bounce from traumatic experience to traumatic experience, to other care activities with no time to recover in between. Chandler and Reid (2016) are particularly critical of neoliberal definitions of resilience that encourage individuals to bounce back towards their initial state prior to exposure to a stressor. This is because there can be situations where the initial state is so flawed to begin with that bouncing back to this state is not only destructive but also a potential catalyst for further injustice.

Similarly, Taylor (2019) suggests that nurses are no longer being asked to simply move past or bounce back from traumatic events, rather they are being asked to endure working conditions where demands routinely exceed resources. As already identified high workload, high patient acuity, and poor staffing is endemic in many environments but appears to be normalised and minimised by a discourse of resilience that focusses upon the individual and relies upon staff to simply try harder and endeavour to make up for organisational inefficiencies and failures. In such conditions it is perhaps not surprising that nurses may struggle to maintain their resilience.

Amsrud, Lyberg and Severinsson (2019) argue that throughout their training nurses are encouraged to make patient care the main priority thus in difficult, hostile situations nurses may prioritise patient care over their own or their colleague's emotional wellbeing. This can be exacerbated if colleagues are not deemed to be performing optimally as this adds to the pressure already being experienced. Within this study, while participants were able to reflect on this and comment that they were uncomfortable about making such negative judgements, in challenging situations, during a busy shift when stress levels were high, there seemed to be less ability to do so. This appears to be when negative judgements about other individuals were formed.

Returning to what this might mean for individuals viewed as weak or lacking in resilience, responses from both QN and SN participants suggested that there was potential for this to negatively influence professional standing, status, and work-related opportunities. This was suggested to be particularly relevant to potential promotion for QNs or successful assessment for SNs.

I suggest that this is an example of how resilience is being used in a maladaptive manner which has the potential to perpetuate injustice. Furthermore, if it is accepted that nurses and students are being placed under chronic, cumulative, organisational stress, one must ask if it is reasonable to ask them to not only cope with the challenges evident, but then work harder to cope with even more. Adhering to such a discourse seems unacceptable and should perhaps lead to questions about whether concepts of resilience may cease to be positive. Furthermore, nurse educators and qualified nurses should consider what this teaches student nurses about resilience, how they learn about resilience (research question 2), and how this might influence the development of their professional identity.

## 5.4 What does this teach students about resilience?

First it is useful to consider the process of inducting student nurses into the profession of children's nursing. This should include a consideration of how professional identity is developed and fostered in student nurses.

### 5.4.1 How is resilience incorporated into a student's professional identity?

A person's professional identity (PI) constitutes a component of their overall identity and is influenced by their position within society, their interactions with others and their interpretations of experiences (Sutherland, Howard and Markauskaite, 2010). Cabellero (2009) defines PI as an identity that is constructed with regard to a reference group of professionals and a specific workplace. Professional identities of all kinds, including nursing, are acquired through professional socialisation which is a complex interactive process whereby the content of the professional role (skills, knowledge, and behaviour)

is learned, and the values, attitudes, and goals integral to the profession are internalised (Goldenberg and Iwasiw, 1993).

While the formation of professional identity may be an evolving phenomenon that develops over a nurse's working life; the nurse training period has been identified as central to the process (Johnson, Cowin, Wilson et al, 2012). In part this is due to the vulnerability and disorientation of a neophyte in the workplace which leads to a strong desire to fit in and can act as a catalyst for changes in attitudes and behaviours (Becker, 1961 in Hinkle, 1961; Traynor and Buus, 2016). The formation of professional identity concerns group interactions within the workplace and relates to how people compare and differentiate themselves from members of the same and other professional groups (Sun, Gao, Yang et al, 2015).

In terms of how students develop or learn about the professional identify of their chosen profession, it is generally accepted that professional socialisation involves both explicit teaching and informal learning, in addition to subtle, and in some cases, explicit coercive practices (Davis, 1975; Apker and Eggly, 2004; Traynor and Buus, 2016). Both nurse educators and qualified staff have a role to play in this socialisation. Traynor and Buus (2016) argue that the overt transmission of professional nursing values occurs within the university classroom setting whereas the practice area provides the informal learning environment. It was evident from the QN and SN responses that all participants believed that it was very important to be resilient as a children's nurse. Furthermore, SN responses revealed that they perceived QNs to play a central role in modelling resilience to them.

Role modelling is widely accepted as one way to impart knowledge, skills, and attitudes and Perry (2009) describes a role model as a positive example, or a "person worthy of emulation" (in Jack et al 2017, p.4708). Jack, Hamshire, and Chambers (2017) note the importance of the concept of the role model within the socialisation process. They point out however, that the process of constructing a professional identity through comparing oneself to role models creates a situation in which both positive and negative role models are possible.

Findings from a descriptive narrative study by Jack, et al, (2017) involving current and discontinued nursing students at nine institutions across the UK found many examples of positive role modelling but also many occasions where students were exposed to negative behaviours. While Jack et al identified that negative exposures could still lead to valuable learning experiences, they also identified that this introduced the possibility that students might emulate the negative practice witnessed. Therefore, we can see the importance of the QN mentor to a student's learning since the values and attitudes they espouse can influence and shape the future PI of student nurses. Consequently, it is important to consider the QN nurse as a potential role model for resilience.

### 5.4.2 QN as a role modeller of resilience

As previously stated, it was evident from the QN responses that resilience was a central element within the role of a children's nurse, and definitions tended to focus on concepts such as 'coping' and 'carrying on'. While this was apparent in response to direct questions about the importance of resilience to the profession, it became even more apparent when QNs discussed the pressure they felt to be resilient. They identified that there was significant pressure from multiple sources for them to demonstrate resilience regardless of the situations they

found themselves in and that when challenges increased further, there was an organisational pressure to "push yourself a little bit harder" (QN4).

QN responses included accounts of participants finding it difficult to admit when they were not feeling resilient or were struggling to cope with the demands of the role. For many this difficulty originated from a fear that they may be viewed as vulnerable, a less valuable team player, or weak. This reflects wider literature which identifies a "harsh climate" in the health care profession which results in the prevalence of a "stoic culture" in many workplaces (Brint, 2017; Gustaffson and Hember, 2022).

While there was no clear consensus over whether QNs expected SNs to be resilient there was a consensus that students and other members of staff could be judged in relation to their resilience. SN responses revealed that students were aware of this culture and worried about being insufficiently resilient, sometimes referring to this as not being "tough enough". Despite these personal anxieties, it was evident that students sometimes disapproved of the expectation that nurses needed to be strong and carry on regardless of the pressure they were facing. This was evident in responses where SNs identified how shocked they had been to witness how 'hard' some nurses could be. Central to the values of nursing is the notion of care and compassion but it is identified within the nursing literature that despite this, nurses sometimes struggle with these central values and fail to care effectively.

It should be noted that students in this study cited many examples of good practice, good care, and positive role models. I must stress that I am not questioning the care or the practice they witnessed, rather this discussion is focussed on findings pertaining to the understanding and conceptualisation of

resilience and the potential implications this has for both nurse education and the wider nursing profession.

In terms of role modelling, there were many accounts of QNs who provided positive role models for resilience. Furthermore, there was evidence within QN responses of a desire to provide opportunities to promote resilience within student nurses and a commitment to support students to develop resilience. The negative experiences reported by SNs tended to centre on the wider culture and association between weakness and a lack of resilience within the nursing profession. As identified previously, while staff and students were uncomfortable, when questioned, about the presence of such a culture, all participants acknowledged that it was present, and all admitted to engaging to some extent in it.

The study by Jack et al (2017), identified incidences where staff modelled negative behaviours unconsciously, and I propose that we may be seeing this replicated within this study. Nevertheless, whether unconscious on not, this suggests that staff may be acting as anti-role models in this aspect by communicating that a lack of resilience, or perhaps more accurately an inability to 'cope' and 'carry on', is a personal weakness to be avoided.

While I do not question that there is a need to be able to cope with the demands of being a children's nurse and that a certain amount of resilience is necessary, I propose that it is unacceptable to expect nurses to continually be more resilient in the face of ever mounting or unreasonable workload pressures. The presence of such a culture within the profession suggests evidence of a maladaptive discourse of resilience that is damaging to both QNs and SNs health and emotional wellbeing.

Kyrkjebo and Hage (2005) argue that consistent exposure to poor practice makes it more likely that students will adopt the same behaviour as they try to fit in with the prevailing nursing culture. Thus, a possible unintended consequence is that students will learn to view resilience in this maladaptive way, internalise this discourse into their professional identity, and go on the repeat the cycle. While this study may not provide definitive evidence of such a view due to its small scale, it does provide evidence that students value resilience as a central element of the nursing role, associate it with descriptors such as strength, feel an expectation to develop it, and worry about being viewed as weak if they do not demonstrate enough.

When considering this, along with the emphasis placed on resilience within nurse education, this raises questions about the value or perhaps the efficacy of resilience as a concept within nurse education and indeed the profession. While experiences in clinical practice undoubtedly provide opportunities to both enhance and challenge SN resilience; education of student nurses within the UK is divided equally between the clinical and the university environment. Thus, it is important to consider how nurse educators may be contributing to the development of, and conceptualisation of resilience in the SN population. The next section will consider these questions and will focus on the current educational approaches used to 'teach' resilience to SN's, whether nurse educators can role model resilience to SN's, and finally whether we should 'teach' resilience to student nurses.

## 5.5 To what extent can resilience be taught and what is the role of nurse educators in 'teaching' resilience?

A logical starting point for this discussion is to consider what approaches are currently used to 'teach' resilience within the educational setting.

### 5.5.1 Current educational approaches to 'teach' or enhance resilience.

In 2018, resilience was incorporated into the Future Nurse: Standards of Proficiency for registered nurses set out by the Nursing and Midwifery Council (NMC, 2018a). These standards aim to provide undergraduate student nurses with a framework of proficiencies to engender the requisite knowledge and skills necessary at the point of registration. The standards state that at the point of qualification, students must be emotionally intelligent and resilient individuals so that they can respond to the impact and demands of professional nursing practice. Specifically, they must be able to:

- '1.5 understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health' (NMC 2018, p.8).
- '1.10 demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences their judgments and decisions in routine, complex and challenging situations' (NMC 2018, p.9).

While these standards are specifically identified, no further guidance is provided regarding how to achieve or assess these outcomes. Instead, Academic Educational Institutions (AEIs) and their practice learning partners are given ownership and accountability for the development, delivery, and management of pre-registration nursing programme curricula which must cover the outcomes set out within the Standards of proficiency for registered nurses (NMC, 2018b).

Consequently, AEIs are responsible for developing initiatives that aim to develop requisite skills within the multitude of proficiencies set out by the NMC inclusive of 1.5 and 1.10. How this is achieved will vary from AEI to AEI and may or may not be based upon resilience research depending on the institution. The dominant discourse within nursing literature tends to emphasise individualised definitions of resilience. Within such definitions the focus remains firmly on the individual to further develop their resilience often in isolation from the organisation or the community they work within.

A recent review of literature by Stacey and Cook (2019) explored the nature and effectiveness of resilience based educational initiatives and identified a range of interventions aimed at improving resilience in both qualified and student nurses. These included the consistent advocation of mindfulness-informed interventions which focussed on the development of self–regulation skills and cognitive reframing strategies. Commonly identified features of such resilience enhancing strategies were the use of workshops where information was shared in a didactic manner, group sessions, and clinical supervision-based sessions, which encouraged the sharing of stories followed by reflective discussion.

The AEI relevant to this study has taken an approach to enhancing resilience that follows the principles of Resilience Based Clinical Supervision (RBCS) (Stacey, Aubeeluck, Cook, Dutta; 2017). For the past twenty years, the Department of Health has advocated clinical supervision be included in pre-registration nurse education to provide opportunities to reflect and review practice.

RBCS is grounded in principles of compassion focussed therapy that emphasise three emotional regulatory systems that aim to 'protect the self from threat,

compete with the self and others for external validation, and soothe the self to enable contentment' (Stacey et al, 2017, p.2). These principles are complemented by the integration of mindfulness, positive reframing, and role play, with supervision being delivered in small groups. Stacey and Cook (2019) point out that while some authors reported positive results following the implementation of their initiatives, all initiatives used a group format and thus it was difficult to ascertain whether the positive impact reported was due to the initiative or the group effect which was not considered within any of the studies reviewed.

Group supervision is reported to have certain benefits such as enhanced personal and professional development and a normalisation of experiences, (Lysaker, Butt and Lintner, 2009; Berglund, Sjögren, and Margaretha, 2012; Carver, Clibbens, Ashmore, et al, 2014). It has also been argued however, that such a group approach can increase anxieties and vulnerabilities due to a tendency to compare oneself to other group members and a perceived pressure to appear confident (McGrath and Higgins, 2006).

A finding of note within Stacey and Cook's literature review was that most interventions utilised a didactic approach where the skills and attributes associated with resilience were 'taught'. This is interesting as within this EdD study, two QN and four SN participants stated that they did not think resilience could be 'taught' or 'learnt' within a classroom setting. RBCS relies less on didactic forms of teaching but does employ mindfulness, positive reframing, and role play to enhance resilience. Interestingly, despite the preponderance of initiatives within the literature that cite mindfulness as a useful intervention, none of the participants within this study identified mindfulness or RBCS as an initiative that might enable their resilience.

Mindfulness is a popular concept within many disciplines inclusive of the wider education setting, largely because such training operates from a more instrumental perspective. It comes with a range of self-soothing and concentration techniques which makes it an attractive intervention that aims to help people to cope with the stressors of daily life while also offering objectifiable and desirable attitudes and skills (Sellman and Buttarazzi, 2020; Brito, Joseph, and Sellman, 2022). Sellman (2020) however, argues that mindfulness, when used in this way, can be problematic as individuals tend to be taught to cope with systems and issues that may be "at least partially, responsible for their suffering" (Sellman, 2020 p.92).

Similarly, Brito et al (2022) postulate that while mindfulness interventions purport to focus on individual well-being there is a tendency to present an inability to cope with systemic pressure as a lack of individual resilience as opposed to a marker of systemic failure. This is illuminating and seems to reflect the potentially problematic conceptualisations of resilience already discussed. Furthermore, this provides evidence of a discourse of resilience within the nurse education setting that also focuses on the individual and neglects the role of the wider institution.

Stacey and Cook (2019) argue that many resilience enhancing initiatives are based upon an accepted notion that a standardised method of teaching will be effective. They continue however, that this does not consider the diversity of experiences and strategies employed by individuals to maintain a sense of wellbeing. Consequently, they argue that initiatives that are informed by such discourses of resilience are unlikely to provide a solution for complex health care systems. This perhaps provides some explanation for SN participants dismissive attitude towards current resilience teaching methods.

Similarly, Taylor (2019) states that the effectiveness of resiliency training in reducing issues such as burnout has not been demonstrated. Taylor, however, takes this further by arguing that offering resilience training without addressing the workplace conditions that contribute to stress and burnout, undermines resilience and is tantamount to moral cowardice. This is a strong statement but, if true, nurse educators must ask whether they are also unwittingly contributing to a discourse of resilience where individuals are charged with enhancing their own resilience. Equally, as nurse educators, we should consider the acceptability of this, particularly if this charge takes place within the context of ever mounting work pressures, a lack of resources, and initiatives that encourage acceptance of potentially toxic situations.

This raises questions around the role that the nurse educator may play in modelling resilience to SNs. For example,

- Should nurse educators consider themselves to be positive or negative role models?
- Do nurse educators contribute to a wider problem by promoting a discourse of resilience that is focussed on individual attributes and coping?

This study did not seek to elicit the views of nurse educators in relation to resilience, so this constitutes a potential area for future research. Responses within this study do, however, provide hints that nurse educators may contribute to a discourse of resilience similar to that seen in practice. For example, (participant SN8) referred to a general acceptance that some ward environments were hostile, "everyone knows this, but no-one actually does anything about it". She continued that nurse educators should address this situation, but instead there was a tendency for them to expect students to simply "deal with the repercussions of that hostile environment". Such an attitude puts the ownness

firmly on the student to "cope" and does nothing to acknowledge or explore whether the reported situation is unacceptable.

As stated, further research to elicit the views of nurse educators on the role of resilience within nurse education would be useful, nevertheless, the findings from this study raise questions around whether nurse educators should aim to teach resilience and if so, what they should teach?

### 5.5.2 What are the implications for nurse education - Should nurse educators teach resilience to student nurses?

If it is accepted that nurses are being placed under chronic, cumulative stress, one must ask if it is reasonable to ask them to not only cope with the challenges evident, but then be more resilient to cope with even more. I contend that nurse educators need to move away from resilience theories that emphasise individual positive adaption. Instead, as identified by Ungar (2019) we should move towards a consideration of how changes to the environment surrounding an individual might contribute to resilience. To achieve this, nurse educators should start by questioning their own understanding of the concept of resilience. Consequently, we should ask ourselves whether the current discourse of resilience within nursing is maladaptive and therefore a concept that we wish to perpetuate or challenge. To assist with this, it is possible to look to wider theories and theorists such as Ungar and the social constructionist view of resilience.

Mahdiani and Ungar (2021) have questioned the term resilience and pose three important questions. Firstly, 'Is there a wrong degree of resilience?' Essentially here Mahdiani and Ungar consider whether there can be situations where people

have too much resilience. They argue that the correlation between higher levels of resilience and lower vulnerability, which persists in contemporary resilience research, is overly simplistic. Instead, many factors such as the frequency of exposure and timing of stressful events, as well as issues such as fatigue, an individual's social circumstances, and their individual health status will impact upon vulnerability. Furthermore, Polivy and Herman (2000) have argued that having too much resilience can lead to a concept termed 'false hope syndrome' where individuals hold unrealistic expectations of what is achievable. If they are unable to achieve these expectations, this can lead to feelings of disappointment, discouragement, and notions of oneself as a failure. These were feelings identified by participants within this study. Whether they were due to a personal 'false hope syndrome', or unrealistic expectations from the wider organisation, the results were similar in that participants reported feeling disappointed, upset, discouraged, and "broken" when they were unable to provide the care they aspired to. These are all feelings that can impact negatively on resilience, stress, burnout, and job satisfaction.

The second question posed is whether there is 'a wrong context for resilience'. The focus here is on whether every adverse situation calls for a resilience response and whether there are situations where the presence of resilience enhancing qualities can be harmful in the long term for an individual. While many of the examples given by Mahdiani and Ungar relate to disaster risk protection or social factors such as poverty, the essence of the discussion is that constantly striving for resilience, within contexts that are deprived of resources, can be harmful. In such contexts organisations who hold power can use resilience to not only encourage people to tolerate disparity, but also assign the

responsibility for improving their lives to them even though they may lack the agency to do so.

Issue relating to insufficient resources and an organisational pressure to make up for insufficiencies were clear in participant responses. This was evident in accounts of endemic staff shortages, overwhelming workload, and a lack of basic resources such as suitable spaces, ergonomically inappropriate furniture, and IT that worked. Participant accounts supported a discourse of resilience that is focussed on the individual and emphasises a need to cope and carry on despite significant, chronic organisational pressures and inadequacies. This is different to dominant definitions within the resilience literature which advocate an ability to bounce back from acute adverse events. This is a criticism that I have already levelled at the discourse of resilience evident within nursing and will be discussed further in Chapter 6.

The final question posed is 'whether there is a wrong usage for resilience?' Here Mahdiani and Ungar focus on narratives and perceptions of what resilience is. They argue that historically resilience has been applied to exceptional human endeavours and that when this happens it may make resilience appear unobtainable or misconstrue the benefits of more measured action. In this way some acts that have been deemed as resilient can be viewed through different lenses to challenge the binary conceptions of 'resilient vs Not resilient' meaning that a range of actions could be viewed as acts of resilience.

One such example, evident within wider resilience literature, are the studies on 'grit' conducted by Duckworth (2016). Duckworth studied whether 'grit' (like hardiness in relation to resilience) predicted whether US military soldiers finished their training. While measures of grit did indeed appear to predict which soldiers

completed their training, Duckworth also found that 'self-selecting' out of training for individuals who realised that the profession would not be a good fit for them, mentally or physically, could be described as a 'wise' and indeed resilient choice. As such, Duckworth argued that while stories of grit are always constructed in positive ways, failure can also be constructed as a signifier of resilience if the measure of success is changed to include the exercise of individual preferences and, I would add, the maintenance of personal wellbeing.

While these studies were not conducted on nurses, they do perhaps raise questions about resilience and the impact it may have on attrition within nursing. The assumption that nurse and student nurse attrition can be reduced through enhancing resilience has been referred to in earlier chapters. Adoption of a constructionist view of resilience, however, allows for alternate accounts of resilience related phenomena that can deepen our understanding of how 'at risk' populations discover and nurture resilience in ways that may be invisible initially (Ungar, 2001; Ungar, 2004; Yellin, Quinn and Hoffman, 1998).

If we consider individual preference and personal wellbeing to be a measure of resilience this potentially challenges assumptions around enhanced resilience and lower attrition. One might even ask if the current discourse of resilience within nursing is unwittingly engendering a culture were nurses, and indeed student nurses, are enacting their resilience by leaving the profession. This is an interesting paradox as depending on how we conceptualise resilience, a decision to leave the nursing profession, could be viewed as an act of resilience. Consequently, we may need to reconsider how resilience is constructed and used within both the nursing profession and nurse education.

It seems clear that education initiatives that focus upon individuals are inappropriate. Worse than this they potentially do students and the profession a disservice by feeding into the myth that nurses need to be more resilient. While this does not mean that individuals have no responsibility for developing and maintaining their resilience – nurse educators and the profession, should rethink what this might look like and what resources should be available to support this. Therefore, a more nuanced understanding of the concept is required. The final question to consider is how such an understanding can be developed and incorporated into undergraduate nurse teaching and curriculum.

### 5.5.3 How should the concept of resilience be addressed within undergraduate nurse education.

While participant responses indicated that resilience cannot be 'taught' in the classroom setting, there is evidence to suggest that the classroom can provide powerful opportunities to impact on professional attitudes and behaviours (Jack et al, 2017). Furthermore, the classroom setting may provide a safe environment to start discussions around contemporary discourses of resilience.

It is important to note that I do not dismiss the value of resilience within the role of the nurse. Clearly it is important for children's nurses and student nurses to have a level of resilience to perform in a job that is emotionally and physically demanding. Evidence of personal resilience was present in all participants responses and most QN participants felt that they already demonstrated significant amounts of resilience. I propose however, that the phenomenon of resilience must be viewed within the context of the demands of the profession. I suggest that children's nurses and student nurses must be educated to understand that failure to cope with constantly increasing workplace demands

does not constitute a failure of personal resilience and does not constitute a 'weakness' in themselves or others.

The current discourse of resilience within children's nursing, potentially discourages individuals from challenging adverse working conditions for fear of being viewed as weak (Cuthill, 2016), and therefore, may encourage an acceptance of the status quo (Taylor 2019). As identified by Taylor, nurses can face working conditions so hostile that even the most resilient individual may struggle; and as identified by participant (SN4) 'there's only a certain amount of resilience that one should be expected to have'. Therefore, I advocate that students and nurses should be educated and subsequently empowered to question and challenge the current discourse of resilience within children's nursing and perhaps nursing more widely.

As a nurse educator the logical place to start is with education of student nurses. To achieve this however, several factors need to be addressed. The first pertains to nurse educators themselves; this study provides hints that nurse educators also adhere to an individualised discourse of resilience that is focussed on coping. The first step in addressing this is to encourage them to reflect upon, and question, their own views of resilience. Recommendations of how to achieve this will be presented within the final concluding chapter.

The second step is to utilise the classroom setting to develop teaching content that aims to encourage reflection, collaboration, communication, and critical thinking. This should not be delivered in a solely didactic manner but should include strategies that encourage active participation, active listening, and enhanced critical thinking. One such strategy may be the use of debate which is an active teaching strategy that can be used to promote student-centred

learning (Cariñanos-Ayala, Arrue, Zarandona et al, 2021). Debate can also motivate learners to work together or individually to study selected issues, actively listen to different viewpoints, and express their own ideas based on experience and evidence (Xu, 2016). Al-Jubouri (2021) argues that the use of debate like questions in classroom settings can encourage students to move beyond traditional theories to enable a new application of knowledge to ideas, values, and attitudes.

Additionally, debate can be combined with other teaching strategies to enhance and scaffold the learning experience. Within participant responses, one SN participant (SN4) commented upon the experience of taking part in this study and how it had helped her to reflect upon her own resilience. She felt this had been beneficial and stated that she felt the whole cohort could benefit from engaging in such thought processes. This suggested that a session, or suite of sessions, aimed at encouraging students to reflect upon resilience in terms of, what it is, what it might not be, and how it manifests within children's nursing, could be a useful starting point. Consequently, findings from this study have been used as the basis for an initial teaching session. This session aims to use a mixture of personal reflection, debate, group work, theory, and finally group debrief to encourage students to question and challenge contemporary views about resilience within children's nursing. A copy of the plans for this session can be viewed in Appendices 8.8.

As nurse educators there is a balance to find between presenting the norms and values children's nurses are encouraged to aspire to as a professional group, whilst also enabling acknowledgement of the realities, tensions, and challenges evident within the profession. The classroom setting provides us with an opportunity to explore such tensions in a relatively protected space and

therefore provides us with an opportunity to challenge contemporary views of resilience that may be damaging to the individual and the profession.

I contend that a discourse of resilience which has the potential to generate binary categories such as 'resilient vs not resilient' or 'strong vs weak' is problematic. Furthermore, I propose that Ungar's constructionist model of resilience (2004) could be used to encourage an understanding of resilience that moves away from the individual and towards a culturally and socially embedded understanding of the concept. When resilience is viewed in this way it allows us to understand that resilience is more likely to occur when people have access to appropriate resources, support, and services. Admittedly, this is a complex issue that will not be easily addressed. Therefore, the suggested teaching session is only a small step towards achieving a more sophisticated understanding. Many other steps will be required that would involve the wider nursing profession and regulatory bodies such as the NMC these will be considered further in the final concluding chapter.

## 5.6 Chapter summary

This chapter has explored the findings in relation to the wider literature base and existing policy. Emergent arguments have been presented which focus on how resilience is conceptualised within children's nursing and why it is conceptualised in this way. Consideration has been given to how SNs learn about resilience and the role that both QNs and nurse educators have in promoting current discourses of resilience. The propensity to see resilience as a universally positive or desirable concept has been challenged and an argument has been presented which suggests a potentially maladaptive discourse of resilience within children's nursing. Consequently, a more nuanced understanding of the concept is

advocated. The final chapter will discuss this in more depth and will consider how the findings from this study may influence practice within both nurse education and the wider nursing profession. It will also consider how these findings contribute to knowledge in relation to resilience and nursing.

# 6. Conclusions

Chapter 5 explored the findings in relation to the wider literature base and existing policy. Emergent arguments were presented and the propensity to see resilience as a universally positive or desirable concept within the nursing profession was challenged.

This concluding chapter will consider how the findings from this study can contribute to knowledge about resilience in children's nursing, and influence practice within both nurse education and the wider nursing profession. The chapter will start with a personal reflection which will identify how this study has transformed my own knowledge and understanding of resilience. The research questions will be revisited and the findings pertaining to each will be summarised. This will include a consideration of relevant implications for future practice for students, nurse educators, and the wider profession. Strategies for dissemination of knowledge and study limitations will be briefly considered before final concluding arguments are reiterated.

## 6.1 Personal reflection

Prior to commencing the EdD I had a personal interest in the concept of resilience, but I had not undertaken any substantive reading or research into the phenomenon. As such, my views on resilience were not evidence based, and on reflection, largely aligned to normative views of resilience, for example, 'resilience is good', 'resilience is a desirable personal attribute', 'resilience equals strength', 'a lack of resilience equals weakness', and 'resilience is a way to address challenges within children's nursing'. These views of resilience were no

doubt formed from a combination of personal experience, critical incidents throughout my life, and my own socialisation into the nursing profession.

As a nurse educator I have seen a sustained increase in the mental health issues within the student nurse population and these are often exacerbated by the challenging nature of children's nursing. Increasing the emphasis on resilience to try and better deal with the challenges inherent in a career in children's nursing has been referred to in previous chapters, and further influenced my initial views. With that previous naïve understanding I had uncritically assumed that one could simply develop a teaching resource or initiative, and this would enhance resilience in the student nurse population. While such goals are laudable, I now understand much more clearly that addressing the challenge of improving nurse resilience is far more complex than it may seem, and well-intentioned actions might actually prove to be unhelpful.

One factor that I had not appreciated at the start of this process was how extensive the body of literature on resilience is. This was daunting at first and it took time to navigate the body of work. As I began to familiarise myself with seminal writers and theories, I developed a clearer, deeper, and more nuanced understanding of resilience. Initially this remained aligned to dominant and normative theories, but as I read further, I saw glimpses of research that pointed to a less positive side to resilience. This resonated with me and captured my interest as it reflected some of my experiences from clinical practice. This doctoral research journey, from that early reading and through the empirical work, has been transformative for me and changed my view of resilience substantially.

Within Chapter 1, I presented a personal reflection relating to my decision to leave my clinical role and the questions this raised for me about my own personal resilience. In particular, this related to fears that I had not been strong enough, or resilient enough, to remain within a career in children's nursing. I now realise that this is not the case and have been able to 'make peace' with my decision to leave. I now appreciate that my decision did not constitute a personal weakness, rather it was a reasonable, and perhaps even resilient, response to the demands I was experiencing at the time.

My concern, however, is that discourses and anxieties about not being strong or tough enough were clearly evident within both the SN and QN population within this study. Consequently, I wonder how many of my colleagues or students have found themselves in similar positions and blamed themselves if they struggle to cope or contemplate leaving/ decide to leave the profession.

Such a narrative should be challenged as it has the potential to be disempowering. If an individual believes they are, at least partially, to blame for a failure to cope with workload pressures, it is not unreasonable to suggest that this may discourage them from challenging those same workload pressures. It may also discourage them from asking for the help or support that might relieve the pressures for fear of being judged as weak. Such a concern was clear in QN6's responses where she discussed her anxiety about coming into work the day after identifying unreasonable workload pressures.

The findings from this study have engendered a new personal understanding of resilience, particularly within the context of children's nursing that will transform my approach to supporting resilience in student nurses going forwards. To explicate this, and how the findings from this study can further contribute to

knowledge about resilience in children's nursing, I will first return to the initial research questions to consider what the findings show and the subsequent professional implications.

## 6.2 Discussion of the research questions and professional implications

For each of the research questions I briefly summarise the main findings below. While this will involve some repetition from Chapter 5, the aim is to strongly connect the findings to the research questions before then applying these findings to the child nurse education setting in the following section.

It should be noted at this point that while the focus within this study has been on resilience in children's nursing many of the findings appear to have generalisability to the wider profession. While this is a small-scale study the findings, along with emergent literature, are suggestive of a potentially maladaptive discourse of resilience within nursing. I argue, albeit cautiously, that it is not unreasonable to suggest similar findings could be evident were this study to be repeated in other health care settings within this institution and across the UK.

### 6.2.1 Q1: How is resilience understood and conceptualised within children's nursing and why is it conceptualised in this way?

While there are different models of resilience (see Chapter 2), a common theme is the ability to bounce back or recover from an adverse situation. The dominant discourse of resilience described within this study, however, did not focus on bouncing back but instead focussed on individuals and coping. This included an expectation that individual nurses and students would cope with ever increasing

challenges, regardless of how realistic they were. For me, a discourse of resilience that focusses on continual coping is a very different concept to traditional definitions of resilience and one might question whether it conforms to the phenomenon of resilience as defined within seminal literature.

Such descriptions of resilience were evident in both the clinical and educational arena and are problematic as they may be disempowering and contribute to a resilience discourse where individuals are encouraged to endure working conditions where demands routinely exceed resources. As identified in Chapter 5, high workload, high patient acuity, and poor staffing is endemic in many environments but appears to be normalised and minimised by a discourse of resilience that relies upon nurses to simply try harder to make up for organisational inefficiencies and failures.

While student nurses may not be expected to make up for organisational inefficiencies in the same way as QNs, it was evident that the demands of the working environment also fed into and conditioned their understanding of resilience. Like QNs, students perceived a significant pressure or expectation to cope, carry on, and be resilient. In part this was due to a desire to conform to the perceived norms of the profession. It was also, however, partly due to a fear of being judged negatively if any weakness was shown.

As identified in the previous chapter, resilience and coping are related but distinct concepts. I propose that resilience should not be about asking individuals to cope, no matter what. While I acknowledge that some level of resilience is important and indeed useful within a profession such as nursing, there is a need to balance this with mental and physical health. Whilst I agree that resilience may include some ability to bounce back from acute stressors, it should also

include an ability to realise when such stressors are unreasonable and an ability to subsequently take action to preserve mental and physical health without fear of being viewed as weak.

What this action may look like will be different for each individual but, as suggested in the previous chapter, this could include a decision to remove oneself from the source of overwhelming stress by leaving the profession or, in the case of students, leaving their training course before completion. Clearly this is an undesirable situation and leads to the next two research questions which focus on how helpful the discourse of resilience within children's nursing is and what this teaches student nurses about resilience.

### 6.2.2 Q2: To what extent, and in what ways, are the discourses of resilience within children's nursing helpful or unhelpful?

The previous chapter discussed how the demands of the working environment feed into, and condition, an understanding of resilience that is focussed on "coping" and "carrying on". This led to an important question, about what happens when an individual is not able to cope or is perceived to lack resilience. Exploration of this question led to further evidence of a negative element to the discourse of resilience within children's nursing. This was further emphasised when participants were asked to describe colleagues who were deemed to lack resilience. Despite acknowledgement that resilience was not fixed and that nurses often faced "unreasonable" workload demands, findings showed that a lack of resilience was often judged to be a personal weakness or failure. SN participant responses supported that it was commonplace for QNs to judge each other negatively in this regard, alongside a tendency to talk about one another

in negative terms. This served to reinforce in SNs a desire to develop resilience and a fear of being viewed negatively if they did not demonstrate enough.

Clearly this may be described as an unhelpful interpretation or understanding of resilience, especially if this leads to binary conceptualisations of resilience such as 'strong' vs 'weak' or feelings of inadequacy, anxiety, stress, and distress in both the QN and SN population (Chapter 5). Furthermore, findings suggested that nurses who were deemed to lack resilience may be less likely to be promoted while students worried that such a judgment may impact on successful progression and assessment within the practical element of their course.

It is, however, possible to extend this analysis by arguing that such a discourse may serve to prop up organisations that are failing to provide appropriate resources, or reasonable environments to enable or maintain resilience. It may also perpetuate a negative culture which relieves wider organisations from their responsibility to mobilise resources and change their systems to better support nurses. Such a discourse of resilience is problematic and unhelpful as it does not adequately account for wider contextual challenges to resilience and may place unreasonable pressure on individuals to cope and make up for organisational deficits.

An important task of higher education is the development of critical thinking skills as these can empower individuals to act autonomously within the world rather than remain passive within it. Therefore, it is important that student nurses are encouraged to think critically about the phenomenon of resilience and challenge dominant discourses. They should be educated to understand that failure to cope with constantly increasing workplace demands does not constitute

a failure of personal resilience or a 'weakness' in themselves or others. How to approach this, however, is an important question for nurse educators. It is not a simple question and involves consideration of research question 3 which focussed on how students learn about resilience and whether enhanced resilience can, or indeed should, be taught.

### 6.2.3 Q3: How do student nurses learn about resilience during their training programme, and can enhanced resilience be taught?

Both elements of this question have been discussed at length in Chapter 5 so will only be summarised very briefly here. The importance of role modelling in relation to the formation of professional identity and the development of an understanding of resilience has been clearly explicated. Findings supported that the process of constructing a professional identity through comparing oneself to role models creates a situation in which both positive and negative role models are possible.

The research also identifies how students are exposed to an individualised discourse of resilience that encourages them to continually cope regardless of the pressures being faced. QNs and nurse educators are significant to the development and understanding of resilience in the student nurse population and findings suggested that both QNs and nurse educators may be acting as anti-role models at times by communicating that a lack of resilience, or perhaps more accurately an inability to cope and carry on, is a personal weakness to be avoided.

When considering current educational approaches to developing resilience in student nurses it was evident that many teaching methods also adhere to an

individual focussed discourse of resilience which places the responsibility to develop and enhance resilience firmly on students themselves.

This reflects the potentially problematic conceptualisations of resilience identified within the clinical environment and provides evidence that the nurse education setting also focuses on a discourse of resilience that emphasises the individual and neglects the role of the wider institution. Thus, nurse educators must ask whether they are also contributing to a discourse of resilience where individuals are charged with enhancing their own resilience without the necessary resources or agency to do so. This leads to the final research question which focusses on implications for the nurse education setting. This links to the recommendations emanating from this study which will be explicated in Sections 6.3-6.5.

### 6.2.4 Q4: What are the implications for children's nurse education and the wider nursing profession?

This thesis argues that nurse educators should consider whether current educational initiatives encourage acceptance of potentially unacceptable situations. They should also consider the role they may play in modelling resilience to SNs and whether they currently contribute to the promotion of an unhelpful discourse of resilience that is focussed on individual attributes and coping? I propose that educational initiatives which focus upon individuals are inappropriate and have the potential to do students and the profession a disservice by feeding into the myth that nurses need to be more resilient. While this does not mean that individuals have no responsibility for developing and maintaining their resilience, there is a need to rethink what this might look like and what resources should be available to support this.

I argue herein that the phenomenon of resilience must be viewed within the context of the demands of the profession. Furthermore, the notion that failure to cope with ever increasing workplace demands, constitutes a failure of personal resilience should be challenged. To achieve this, there are several factors to consider. Most notably for this study, the education of students, nurse educators, and qualified nurses in relation to an alternate view of resilience.

## 6.3 Implications and recommendations for student children's nurses

This study argues that students are learning and internalising individualised views of resilience throughout their training. Therefore, it makes sense to try to address this as early as possible within the training period when a SNs professional values and expectations are being formed. How to approach this, however, is an interesting question, particularly in view of participant responses which identified that resilience could not be taught in a classroom setting.

An important factor to stress is that the findings from this study do not direct nurse educators to 'teach' resilience. On the contrary, one of the recommendations arising from this study is that education initiatives should encourage students to reflect upon, and challenge contemporary discourses of resilience to encourage a new understanding. The hope is that this could subsequently empower them to more effectively challenge working conditions that are deemed to be unreasonable. Consequently, students should be encouraged to debate and consider what resilience is, what it might not be, how it manifests within children's nursing, and whether this is helpful, unhelpful, or problematic.

As discussed in Chapter 5, there is evidence to suggest that the classroom can provide powerful opportunities to impact on professional attitudes and behaviours. Furthermore, the classroom setting may provide a safe environment to start discussions around contemporary discourses of resilience. Consequently, findings from this study have been used as the basis for an evidence-based teaching session, which will be piloted and evaluated with year 1 students undertaking an undergraduate degree in children's nursing within the SoHS (Appendix 8.8). The plan is to introduce this session to year 1 students following their first placement. The rationale being that this enables reflection, debate, and critical thinking from an early stage in the training process, perhaps before values, behaviours, and beliefs have become internalised and ingrained.

The initial session aims to use a mixture of personal reflection, debate, group work, theory, and finally group debrief to encourage students to question and challenge contemporary views about resilience within children's nursing. Furthermore, the session will aim to encourage open, honest, discussions about resilience, inclusive of theories which challenge binary discourses such as 'resilient vs not resilient' or 'strong vs weak'. This may allow for a reinterpretation of acts that have traditionally been viewed as 'not resilient'. It is also hoped that this may lead to a more sophisticated understanding of the phenomenon and empower students by enabling an understanding that everyone has capacity to be resilient but that there are varied ways to display it. This may start to enable a move away from unhelpful binary conceptualisations of resilience and help to counter the blame culture that is evident when nurses or students struggle to cope with ever increasing demands.

In line with the iterative nature of this study, student evaluation and feedback will be sought to gauge the usefulness of the session but also to gain opinion on

development of a further session to be delivered in year 2 of the programme, and then again in year 3. Thus, the aim is to develop a suite of sessions that can thread through the undergraduate children's nursing curriculum. It is important to note that while the goal is for this initial session to be delivered in year 1, current student nurses in years 2 and 3 should not be forgotten, so the session will also be delivered to them towards the start if the academic year. Evaluation and feedback will be sought from these students, and in particular opinion will be sought regarding what might be useful and helpful in future sessions. By gaining the opinion of students at varying levels of experience it is hoped that subsequent sessions can not only draw from the findings of this study but also student opinion to devise sessions that will support the development of knowledge but also the empowerment of students to view resilience in a more critical manner.

Given the student numbers within the child field of nursing it is possible for me to deliver these sessions initially but as identified earlier, study findings are arguably more widely applicable to students and nurses in fields of nursing other than just child. Student nurses from both the adult and mental health field of nursing would also benefit from such a session. To achieve this the involvement of the wider nurse education community within my own institution would be required.

## 6.4 Implications and recommendations for nurse educators

To contextualise this discussion, I refer to my personal reflection at the start of this chapter, relating to my uncritical knowledge and understanding of resilience before starting the EdD. Study findings and wider literature show that resilience-based education within nurse education largely conforms to normative

discourses of resilience. This study provides evidence that such discourses may be maladaptive, uncritical, and potentially unhelpful.

This thesis suggests that nurse educators should have the opportunity to be educated on contemporary conceptualisations of resilience, inclusive of a potentially maladaptive discourse of resilience within children's nursing. They should be encouraged to reflect upon their own conceptualisations of resilience, why they hold these views, and where these views emanate from. They should be presented with the findings from this study and encouraged to question whether resilience always constitutes a positive or desirable quality. Discussions should be open and supportive to enable criticality and the formation of new knowledge.

The first step in this is to start with nurse educators within my institution. I plan to present this research at relevant SoHS committees, for example, Undergraduate Course committee which is responsible for providing strategic leadership to ensure excellence in Undergraduate Education within the School, and the Education and Student Experience (ESE) committee which aims to push the boundaries of excellence in teaching and learning through the development and delivery of new models of academic and practice learning.

While it is reasonable to apply this research initially to my own practice and that of my colleagues, it seems highly likely that my findings, analysis and recommendations (while small scale) have wider applicability, both to other fields of nursing and for other institutions. Therefore, a longer-term goal will be to share the contribution to knowledge evident within this thesis with the wider nurse educator community. A plan to disseminate this knowledge more widely will be summarised in Section 6.3.

The importance of QNs to the education, training, and socialisation of SNs has been explicated throughout this thesis. It is important to consider the findings of this study and the potential implications for QNs for two reasons. Firstly, because of their role in modelling and 'teaching' resilience to SNs, and secondly, because of the potential importance of the findings to QNs as a profession.

## 6.5 Implications and recommendations for qualified children's nurses and the wider profession

Like students and nurse educators, it is important that QNs can learn about contemporary conceptualisations of resilience, including the findings of this study. Doing so within the qualified children's nursing population is potentially more difficult as practices can be ingrained, endemic and therefore difficult to change. Furthermore, there is the potential that nurses who took part in this study, along with nurses working within the relevant trust, may perceive some findings as being overly critical of them. This relates particularly to findings that nurses often viewed colleagues negatively if they were deemed to lack resilience. It is important to stress that this is not the intention of this study and I attach no blame or judgement to the nurses who took part in this study, the nurses working in the trust, or the wider profession. As previously identified, I have made similar critical observations about colleagues and understand the context they originate from and why.

These findings are not intended to form another proverbial stick for nurses to be beaten with. They are, however, important findings as they highlight a problematic aspect of nursing culture. They highlight the possibility that nurses may be unintentionally contributing to a negative culture that places more pressure on them to cope and discourages them from challenging unreasonable,

unsafe, or unacceptable work demands. Unfortunately, adhering to such a discourse may exacerbate negative working cultures so making conditions even more difficult for QNs both individually and collectively, but also for the future workforce (namely SNs) who may internalise and repeat the cycle.

It is important to inform nurses of the findings of this study so they can reflect upon their own conceptualisations of resilience and coping, and potentially be empowered to challenge unacceptable situations. It may also help the profession to resist the blame culture that is so often in evidence when a nurse feels unable to cope with the demands placed upon them.

A first step could be to present the findings from this study to senior nurses within the relevant children's hospital. An invitation to present to senior nurses within the children's hospital has already been secured and will be acted upon. Within this meeting, it will be important to present findings sensitively and to emphasise the potential benefit to the nursing profession of exploring and perhaps re-evaluating the dominant discourse of resilience within their area. Within such discussions it would be useful to explore why resilience is described in terms of coping, why this might be problematic, how this might contribute to binary judgements, and why this might be damaging and disempowering for children's nurses.

Children's nurses within the relevant trust might be encouraged to question what the role of the wider organisation should be in providing access to resources that could reduce endemic pressures and decrease the requirement for constant coping. Consequently, this might place more responsibility on local trusts to listen and act to address endemic challenges rather than relying on staff to "just work that bit harder".

QNs also need to understand the important role they play in modelling resilience to the SN population. While QN participants generally stated that they did not expect resilience of their students and were committed to providing opportunities for students to develop resilience, it was evident that the SN population perceived that resilience was expected of them. In part this was due to the judgments SNs witnessed staff making about themselves and others who were deemed to lack resilience. This study evidences how SNs internalised this and worried about not being "tough enough" to be a children's nurse. This internalised narrative was then repeated with potentially damaging consequences for both SNs and QNs.

Within this thesis, I argue that the phenomenon of resilience must be viewed within the context and demands of the profession. Furthermore, nurses and student nurses should be educated to understand that failure to cope with constantly increasing workplace demands does not constitute a failure of personal resilience and does not constitute a "weakness" in themselves or others. Instead, increased focus should be placed on wider contextual stressors and QNs and SNs should be empowered to challenge unreasonable demands and request support to reduce endemic challenges to their resilience.

As identified at the end of the previous section, this study may have wider applicability across fields of nursing and other institutions nationally. Consequently, a longer-term goal is to dissemination my research findings more widely and strengthen the knowledge in this important area. The next section will briefly detail plans for wider dissemination.

## 6.6 Dissemination of findings

To disseminate my findings more widely to the Nurse education community I intend to present at the Children and Young People's Nurse Academics UK forum (CYPNAUK), Centre for Children and Young People's Health Research Group (CYP-HR), and finally to the wider education and nurse education community via conferences such as EDULEARN.

CYPNAUK provides a forum for like-minded children's nurse academics to lobby, empower, and influence children's nursing. The forums aim to share good practice & innovation, influence new standards, contribute to the evidence base for the child nursing workforce, and drive nurse education policy.

CPY-HR is a research centre located within our institution and led by nationally recognised Professors. Research conducted within this group has national and global reach and impact. The initial stages of this study have already presented at this group and the findings are due to be presented imminently.

EDULEARN is an international conference on education and new Learning Technologies. It aims to stimulate thought-provoking discussions and bring together people from all over the world with a common interest in sharing knowledge about the sphere of education, inclusive of nurse education. An abstract will be submitted to this conference for consideration at the July 2024 conference. Furthermore, opportunities to publish this work will be sought within relevant academic, peer reviewed journals, for example Nurse Education Today.

To disseminate my findings more widely to the Children's nursing community and the nursing community more generally I will aim to secure opportunities to present at conferences such as the RCN nurses in management and leadership conference, which focusses on enhancing leadership skills, management

strategies, and team resilience; or the Royal College of Nursing (RCN) congress which provides an opportunity for nurses to network, learn, and share nursing practice.

Opportunities to publish in relevant nursing journals will also be sought. While this would include publishing in high quality peer-reviewed research journals, it would also be important to publish in professional journals such as the Nursing Times or Nursing Children and Young People as this would probably be a better channel for knowledge exchange with the wider professional nursing population.

## 6.7 Limitations

Finally, it is important to consider some of the limitations of this research. One limitation, already identified within the Methods Chapter (page 48-49), is that this study took place within the local trust and educational institution I currently work within. This decision was taken for two reasons, firstly practical reasons in terms of sample access, as the original intention was to conduct interviews face to face. Secondly, my role as a nurse educator resulted in a desire, in the first instance, to explore experiences and perceptions of resilience pertinent to students I was responsible for teaching. I deemed this to be an important starting point in this research journey. While this led to some additional ethical considerations, these were carefully considered, particularly in relation to informed consent, self-determination, and harm minimisation (pages 59 – 60) and included in my ethics application.

The next limitation relates to the small sample size. Only 18 participants were included within this study which limits the scale of the claims that can be made. Despite this, it should be remembered that the aim of this study was not to arrive at a universal definition, or a statistically generalisable measure, of the

phenomenon of resilience but rather to gain a deeper understanding of how it is understood by children's nurses and how this influenced everyday experiences.

Within interpretive phenomenology, lived experience must be understood before it can be interpreted and shared. This called for a subjective ontological stance, and an interpretive epistemology that enabled access to participants ideas and experiences. Hence one could argue that the study has been successful in this sense. While it is not possible to say that all children's nurses would answer in the same manner if asked the same questions, common themes did emerge between and across the participant groups. Furthermore, these themes are supported by emergent literature within nursing but also other professional fields such as education or social care, which may add credibility to the findings.

This study contributes a detailed account of 18 QN and SN participants experiences of resilience within one organisation, further research to identify commonalities and to study a larger population of nurses from all fields of practice may help to strengthen the findings further.

The third limitation is that nurse educators were not included as a participant group within this study. In part this is because the original aim was to explore how children's nurses and student nurses, experience and understand resilience within their daily lives within clinical practice. While some nurse educators retain clinical roles alongside their academic roles many do not and so nurse educators were not included in the original study design. Similarly, while challenges to resilience within the educational setting for students was a consideration within this study the initial focus remained upon student voice. As the data analysis progressed, and the analysis developed, the role of the nurse educator became more prominent. To further strengthen the study findings and subsequent

contribution to knowledge it would be beneficial to repeat this study with nurse educators.

The fourth limitation pertained to the homogeneity of the QN nurse participant group. The recruitment approach meant that the QNs who volunteered to take part were all relatively senior in terms of nursing experience. This means that there is a gap in the knowledge in relation to how more junior nurses may have answered the questions. QN participants, also tended to hold specialist nurse roles. Such nurses typically do not work in general ward settings and may not spend as much of their time supporting student nurses. Thus, it would be beneficial to repeat this study with junior qualified nurse participants working in more generalised acute paediatric settings.

Similarly, the sample strategy for this study focussed on qualified nurses within the local acute paediatric hospital trust and so did not include nurses working in community settings such as health visitors, or school nurses. In part this decision was taken to keep the sample size manageable and enable some comparisons between QN responses to be made. While the pressures and working environment within acute and community settings are undoubtedly different, literature cited within the discussion chapter e.g. p142 highlight similar pressures in terms of excessive workload. Consequently, it may be beneficial to repeat this study to include nurses working in community paediatric settings. Nevertheless, while further research into these areas would undoubtedly be valuable, it seems highly likely that even with different participants and settings the findings would be similar. This is based on the convergence of findings in this study and wider nursing literature as already explicated in the preceding chapters.

As interpretive research focusses on the collection of detailed reflective descriptions, interpretation, and making meaning, analytical generalisable is possible from smaller samples. Thus, I contend that the findings of this study can be deemed to add to an emergent body of knowledge that might point to a maladaptive discourse of resilience within children's nursing and perhaps nursing more widely.

## 6.8 Concluding remarks

The current discourse of resilience within children's nursing practice and education has the potential to do qualified and student nurses a disservice as it does not adequately account for the wider contextual challenges faced daily. There is a need to rethink and challenge definitions of resilience to understand that resilience resides in everyone but is manifested in different ways.

The phenomenon of resilience should be viewed within the context and demands of the profession and nurses and student nurses should be educated to understand that failure to cope with constantly increasing workplace demands does not constitute a failure of resilience in themselves or others. Instead, increased focus should be placed on wider contextual stressors and QNs and SNs should be empowered to challenge unreasonable demands.

Once this is understood, it may be possible to move away from unhelpful binary conceptualisations of resilience and counter the blame culture that is evident when nurses or students struggle to cope with workplace demands. There might also be a need to reconceptualise the act of leaving the profession as an act of personal resilience in certain situations.

# 7. References


Aburn, G., Gott, M., Hoare, K. (2016) What is resilience? An integrative review of the empirical literature**.** ***Journal of Advanced Nursing***. 75 (5), 980-1000.

Adam, D., Taylor, R., 2014. Compassionate care: empowering students through nursing education. ***Nurse Education Today***. 34 (9), 1242–1245.

Aldwin, C.M. (2007) **Stress, Coping and Development** (2nd edition). The Guilford Press, London.

Aldwin, C., Igarashi, H. (2012) An Ecological Model of Resilience in Late Life. ***Annual Review of Gerontology and Geriatrics*****.** 32 (1), 115-130.

Al-Jubouri, M. B. (2021). Debate as a teaching strategy in nursing. **The Journal of Continuing Education in Nursing.** 52 (6), 263-265.

Amsrud, K.E., Lyberg, A. and Severinsson, E. (2019) Development of resilience in nursing students: A systematic qualitative review and thematic synthesis. ***Nurse education in practice***. 41, pp 102621.

Anthony, E.J., Cohler, B.J. (1987) **The Invulnerable child**. The Guilford Press, New York.

Antonovsky, A. (1987) **Unravelling the mystery of health: How people manage stress and stay well**. Jossey-Bass Publishers, San Francisco.

Apker, J., & Eggly, S. (2004). Communicating Professional Identity in Medical Socialization: Considering the Ideological Discourse of Morning Report. ***Qualitative Health Research.*** 14 (3), 411–429.

Appleton, J.V. (1995) Analysing qualitative interview data: addressing issues of validity and reliability. ***Journal of Advanced Nursing***. 22, pp 993-997.

Aytekin, A., Yilmaz, F., and Kuguoglu, S. (2013) Burnout levels in neonatal intensive care nurses and its effect on their quality of life. ***Australian Journal of Advanced Nursing***. 31 (2), 39-47.

Balls, P. (2009) Phenomenology in nursing research: methodology, interviewing and transcribing. ***Nursing Times***. 105 (32), 30 – 33.

Barratt, C. (2018) Developing resilience: the role of nurses, healthcare teams and organisations. ***Nursing Standard***. 33 (7), 43-49.

Berger, R. (2015) Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. ***Qualitative Research.*** 15 (2), 219–234.

Berger, J., Polivka, B., Smoot, E.A., Owens, H. (2015) Compassion fatigue in pediatric nurses. ***Journal of Pediatric Nursing***. 30, pp e11-e17.

Berglund, M., Sjögren, R. and Margaretha, E. (2012) Reflect and learn together – when two supervisors interact in the learning support process of nurse education. ***Journal of Nursing Management*****.** 20. (2), 152-158.

Binnie, G. (2016) ***Struggling students are not 'lacking resilience' – they need more support****.* [Online] Available at: https://www.theguardian.com/higher-education-network/2016/aug/18/struggling-students-are-not-lacking-resilience-they-need-more-support [last accessed 07/07/23].

Block, J.H., Block, J. (1980) The role of ego control and ego resiliency in the organisation of behaviour. In Collins, W.A. (Eds) ***Minnesota Symposium on Child Psychology***. (p 39-101). Hillsdale, NJ: Erlbaum.

Bong, H.E. (2019). Understanding moral distress: How to decrease turnover rates of new graduate pediatric nurses. ***Pediatric Nursing***. 45 (3), 109-114.

Bonnano, G.A. (2005) Resilience in the face of potential trauma. ***Current Directions in Psychological Science***. 14 (3), 135-138.

Borhani, F., Abbaszadeh, A., Nakhaee, N., Roshanzadeh, M. (2014). The relationship between moral distress, professional stress, and intent to stay in the nursing profession. ***Journal of Medical Ethics and History of Medicine.*** 7 (3), 1-3.

Boyden, J., Cooper, E. (2007) "Questioning the power of resilience: **Are children up to the task of disrupting the transmission of poverty?"** CPRC Working Paper 73, Chronic Poverty Research Centre, Oxford.

Braun, V., Clarke, V. (2006) Using Thematic Analysis in Psychology. ***Qualitative Research in Psychology***. 3, pp 77-101.

Brewer, M.L., Kessel, G., Van., Sanderson, B., Naumann, F., Lane, M., Reubenson, A., Carter, A. (2019) Resilience in higher education students: a scoping review. **Higher *Education Research & Development***. 38 (6), 1105–1120.

Brint, S. (2017) Obligated to care. A personal narrative of compassion fatigue in an oncology nurse. ***Journal of Holistic Nursing***. 35 (3), 296–309.

Brito, R., Joseph, S., Sellman, E. (2022) From Instrumental to Integral Mindfulness: Toward a More Holistic and Transformative Approach in Schools. ***Studies in Philosophy and Education*** 41, pp 91–109.

British Educational Research Association - ***BERA (2018) Ethical guidelines for Educational Research (fourth edition)*.** British Educational Research Association, London.

Brody, J.L. (1997) Participants understanding of the process of psychological research: informed consent. ***Ethics and Behaviour***. 7 (4), 285-298.

Busher, H., James, N. (2015) In pursuit of ethical research: Studying hybrid communities using online and face-to-face communications***. Educational Research and Evaluation***. 21 (2), 168-181.

Caballero, K., 2009. Construcción y desarrollo de la identidad profesional del profesorado universitario (The construction and development of professional identity among university teachers). (Doctoral Dissertation), Universidad de Granada (Retrieved from http://0-hera.ugr.es.adrastea.ugr.es/tesisugr/17922471.pdf). In Marañón, A.A., Pera, P.I. (2015) Theory and practice in the construction of professional identity in nursing students: A qualitative study. ***Nurse Education Today***. 35, pp 859 – 863.

Card, A.J. (2018) Physician burnout: resilience training is only part of the solution***. Annuals of Family Medicine.*** 16 (3), 267 – 270.

Carinanos-Ayala, S., Arrue, M., Zarandona, J., & Labaka, A. (2021). The use of structured debate as a teaching strategy among undergraduate nursing students: A systematic review. ***Nurse Education Today***. 98. doi: 10.1016/j.nedt.2021.104766

Carver, N., Clibbens, N., Ashmore, R. and Sheldon, J. (2014) Mental health pre-registration nursing students' experiences of group clinical supervision: a UK longitudinal qualitative study. ***Nurse Education in Practice***. 14 (2), 123-129.

Chamorro-Premuzic, T., Lusk, D. (2017) ***The dark side of resilience***. [Online] Available at: https://hbr.org/2017/08/the-dark-side-of-resilience [last accessed 07/07/23].

Chandler, D., Reid, J. (2016) ***The neoliberal subject: Resilience, adaptation, and vulnerability***. Rowman and Littlefield: London/ New York.

Chinn, T. (MBE) (2018) Please don't call me resilient. ***Nursing in Practice***. [online] Available at: https://www.nursinginpractice.com/professional/please-dont-call-me-resilient/ [last accessed 06/09/22].

Clark, E., McCann, T. (2005) Researching students: An ethical dilemma. ***Nurse researcher***. 12 (3), 42-51.

Clarke, K., Iphofen, R. (2006) Issues in phenomenological nursing research: the combined use of pain diaries and interviewing. ***Nurse Researcher***. 13 (3), 62-74.

Cohen, L., Manion, L., Morrison, K. (2011) ***Research methods in education. 7th edition***. Routledge: London.

Cole-King, A. (2015) ***Doctors under pressure need resilience, not mental toughness***. [Online] available at: https://gmcuk.wordpress.com/2015/07/15/doctors-under-pressure-need-resilience-not-mental-toughness/ [last accessed 07/07/23].

Cope, V., Jones, B., Hendricks, J. (2014) Why nurses chose to remain in the workforce: Portraits of resilience***. Collegian***. [Online] Available at: http://www.collegianjournal.com/article/S1322-7696(14)00115-2/fulltext [Last accessed 07/07/23].

Connor, K.M, Davidson, R.T. (2003) Development of a new resilience scale: the Connor Davidson resilience scale (CD-RISC). ***Depression and Anxiety***. 18, pp 76-82.

Council of Deans of Health (2023) ***CoDH response to UCAS application data 2023***. [Online] Available at: https://www.councilofdeans.org.uk/2023/02/codh-response-to-ucas-application-data-2023/ [last accessed 07/07/23].

Coyle, D., Edwards, D., Hannigan, B., Fothergill, A., Burnard, P. (2005) A systematic review of stress among mental health social workers. **International Social Work**. 48, (2), 201-211.

Crist, J.D., Tanner, C.A. (2003) Interpretation/ analysis methods in hermeneutic interpretive phenomenology. ***Nursing Research***. 52 (3), 202-205.

Crotty, M. (1996) ***Phenomenology and nursing research***. Churchill Livingstone, South Melbourne.

Crouch, M., McKenzie, H. (2006) The logic of small samples in interview-based qualitative research. ***Social Science Information***. 45 (5), 483-499.

Cusack, L., Smith, M., Hegney, D. Rees, C.S., Breen, L.J., Witt, R.R., Rogers, C., Williams, A., Cross, W., Cheung, K. (2016) Exploring environmental factors in nursing workplaces That promote psychological resilience. Constructing a unified model. ***Frontiers in Psychology***. 7, Article 600.

Cuthill,F. (2016) Political representation for social justice in nursing lessons learned from participant research with destitute asylum seekers in the UK. ***Nursing Inquiry***. 23 (3), 211-222.

Czaja, A.S., Moss, M., and Mealer, M. (2012) Symptoms of posttraumatic stress disorder among pediatric acute care nurses. ***Journal of Pediatric Nursing***. 27, pp 357-365.

Davis, F. (1975) Professional socialisation of a subjective experience: the process of doctrinal conversion among student nurses. In cox, C., Mead, A. (Eds) ***A sociology of Medical Practice***. Collier-Macmillan, London pp 116-131.

Davis, S., Lind, B.K., and Sorensen, C. (2013) A comparison of burnout among oncology nurses working in adult and pediatric inpatient and outpatient settings. ***Oncology Nursing Forum***. 40, (4), E303-E311.

Day, C., Gu, Q. (2010) ***The new lives of teachers***. Routledge, London.

Day, C., Chi-Kin Lee, J. (2011). Emotions and Educational Change: Five Key Questions. In Day, C., Chi-Kin-Lee, J. (Eds.) (2011) ***New Understandings of Teacher's Work - Emotions and Educational Change***. Springer, London/ New York.

Deary, I.J., Watson, R., Hogston, R. (2003) A longitudinal cohort study of burnout and attrition in nursing students***. Journal of Advanced Nursing***. 43, pp 71-81.

Delgado, C., Upton, D., Ranse, K., Furness, T., Foster, K. (2017) Nurses resilience and the emotional labour of nursing work: an integrative review of empirical literature. ***International Journal of Nursing Studies***. 70, pp71-88.

Denzin, N. (1984) ***On understanding emotion***. Jossey-Bass: San Francisco.

Diprose, K. (2015) Resilience is futile. ***Soundings***. 58 (58), 44-56.

Dodgson, J.E. (2019) Reflexivity in Qualitative Research. ***Journal of Human Lactation***. 35 (2), 220-222.

Dowling, M. (2006) Approaches to reflexivity in qualitative research. ***Nurse Researcher***. 13 (3), 7-21.

Drury, V., Craigie, M., Francis, K., Aoun, S., Hegney, D. (2014) Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: Phase 2 results*. **Journal of Nursing Management***. 22, pp 519-531.

Duckworth, A. (2016) ***Grit: the power of passion and perseverance***. Harper Collins: Toronto.

Dudovskiy, J. (2016) ***The ultimate guide to writing a dissertation in business studies: A step by step assistance.*** [online] Available at: http://research-methodology.net/sampling-in-primary-data-collection/purposive-sampling/ [Last accessed 07/07/23].

Fletcher, D., Sarker, M. (2013) Psychological resilience: a review and critique of definitions concepts and theory. ***European Psychologist***. 18 (1), 12-23.

Flood, A. (2010) Understanding phenomenology. ***Nurse Researcher***. 17 (2), 7 – 15.

Folkman, S., Moskowitz, J.T. (2004) Coping: pitfalls and promise. ***Annual Review of Psychology.*** 55, pp745–74.

Froneman, K., Du Plessis, K., Koen, M.P., 2016. Effective educator-student relationships in nursing education to strengthen nursing student's resilience. ***Curationis***. 39 (1), 1–9.

Garmezy, N. (1974). The study of competence in children at risk for severe psychopathology. In E. J. Anthony & C. Koupernik (Eds.), ***The child in his family: Children at psychiatric risk*** (Vol. 3, pp. 77–97). New York: Wiley.

Garmezy, N. (1985). Stress-resistant children: The search for protective factors. In A. Davids (Ed.), ***Recent research in developmental psychopathology*** (pp. 213–233). Elmsford, NY: Pergamon

Gee, J.P. (2010) **An Introduction to Discourse Analysis**. Routledge: London.

Glaser, B.G., Strauss, A.L. (1967) The discovery of grounded theory: Strategies for qualitative research. Aldine de Gruyter: New York.

Grant, L., Kinman, G. (2013) **The importance of emotional resilience for staff and students in the 'helping' professions: Developing an emotional curriculum**. Higher Education Academy: York.

Goldenberg, D., Iwasiw, C. (1993) Professional socialisation of nursing students as an outcome of senior clinical preceptorship experience. ***Nurse Education Today***. 13 (1), 3-15.

Guba, E. G., Lincoln, Y. S. (1981). **Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches**. Jossey-Bass, California.

Guba, E., Lincoln, Y. (1994) Competing paradigms in qualitative research. In Denzin, N., Lincoln, Y (Eds.) (1994) ***Handbook of Qualitative Research*** pp 105-117. SAGE: Thousand Oaks-California.

Guo, Y.F., Luo, Y.H., Lam, I., Cross, W., Plummer, V., Zhang, J.P. (2018) Burnout and its association with resilience in nurss: cross sectional study. ***Journal of Clinical Nursing.*** 27 (1-2), 441-449.

Gustafsson, T., Hember, J. (2022) Compassion fatigue as bruises in the soul: A qualitative study on nurses. ***Nursing Ethics***. 29 (1), 157 – 170.

Haggerty, R., Sherrod, L., Garmezy, N., et al (1994) **Stress, risk and resilience in children and adolescence**. Cambridge University Press, Cambridge.

Hallwood, J. (2023) ***Universities will be at the heart of the NHS workforce plan's success***. [Online] Available at: Universities will be at the heart of the NHS workforce plan's success | Wonkhe [last accessed 07/07/23].

Hart, P.L., Brannan, J.D., DeChesnay, M. (2012) Resilience in nurses: an integrative review. ***Journal of Nursing Management***. 22 (6), 720 – 734.

Healey, K. (2005) Social Work Theories in Context: Creating Frameworks for Practice. Palgrave MacMillan: Basingstoke.

Health and Safety Executive (2019) **Health and safety statistics.** [Online] Available at: https://www.hse.gov.uk/statistics/index.htm [last accessed] 04/12/23]

Health Education England (2018) ***Reducing Pre-Registration Attrition and Improving Retention (RePAIR) Report***. Health Education England: London. [Online] Available at: https://www.hee.nhs.uk/our-work/reducing-pre-registration-attrition-improving-retention [last accessed 06/07/23].

Health Foundation (2018). In Perry, S. (2018) ***One in four student nurses drop out of their degrees before graduation*** [Online] Available at: https://www.health.org.uk/news-and-comment/news/one-in-four-student-nurses-drop-out-of-their-degrees-before-graduation [last accessed 07/07/23].

Health Foundation (2019) **How many nursing students are leaving or suspending their degrees before graduation** [Online] Available at: https://www.health.org.uk/news-and-comment/charts-and-infographics/how-many-nursing-students-are-leaving-or-suspending-their-degrees [last accessed 04/12/23].

Health Research Authority (2018) ***HRA Approval*** [Online] Available at: https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ [last accessed 30/04/19].

Hecktman, H.M. (2012) Stress in Pediatric oncology Nurses. ***Journal of Pediatric Oncology Nursing***. 29 (6), 356-361.

Heidegger, M. (1962). ***Being and Time***. Translated by John Macquarrie & Edward Robinson. S.C.M. Press: London.

Hendry, L.B. (1975) Survival in a Marginal Role: The Professional Identity of the Physical Education Teacher. ***The British Journal of Sociology***. 26 (4), 465-476.

Hennink, M., Hutter, Bailey, A. (Eds.) (2011) ***Qualitative Research Methods***. SAGE: London.

Hesselgrave, J. (2014) Coping with compassion fatigue in pediatric oncology nursing. ***Oncology Times***. 36 (15), 2-3.

Higgs, J., Trede, F. (2010) Philosophical frameworks and research communities. In Higgs, J., Cherry, N., Macklin, R. et al (Eds) 2010**. *Researching practice: A discourse on qualitative methodologies***. Sense Publishers, Rotterdam.

Hinkle, R.C. (1961) Howard Becker's Approach to the Study of Social Change. **The Sociological Quarterly**. 2, (3), 155-180.

Institute of Health Visiting (2021) **Survey confirms babies, young children and families' needs are increasing in the postcode lottery of support**. [Online] Available at: https://ihv.org.uk/news-and-views/news/survey-confirms-babies-young-children-and-families-needs-are-increasing-in-the-postcode-lottery-of-support/ [last accessed 04/12/23].

Jack, G., Donnellan, H. (2010) Recognising the person within the developing professional: Tracking the early careers of newly qualified childcare social workers in three Local Authorities in England. ***Social Work Education***. 29 (3), 305-318.

Jack, K., Hamshire, C., Chambers, A. (2017) The influence of role models in undergraduate nurse education. ***Journal of Clinical Nursing***. (23-24), pp 4707-4715.

Jackson, D., Firtko, A., Edenborough, M. (2007) Personal resilience as a strategy for surviving and thriving in the face of workplace adversity; a literature review**.** ***Journal of Advanced Nursing***. 60 (1), 1-9.

Jackson, J., Vandall-Walker, V., Vanderspank-Wright, B., Wishart, P., Moore, S.L. (2018) Burnout and resilience in critical care nurses: A grounded theory of managing exposure. ***Intensive Care and critical care Nursing***. 48, pp 28-35.

Jacobs, L.M., Nawaz, M.K., Hood, J.L., Bae, S. (2012) Burnout among workers in a pediatric health care system. ***Workplace Health and Safety***. 60 (8), 335–44.

Jasper, M.A. (1994) Issues in phenomenology for researchers of nursing. ***Journal of Advanced Nursing***. 19 (2), 309-314.

Johnson, M. (1987) **The body in the mind: The bodily basis of meaning, imagination and reason**. University Chicago Press, Chicago.

Johnson, M., Cowin, L.S., Wilson, I., Young, H. (2012) Professional identity and nursing: contemporary theoretical developments and future nursing challenges. ***International Nursing Review***. 59 (4), 562-9.

King, N. (2004) Using Interviews in Qualitative Research. In Cassell, C., Symon, G. (Eds.) (2004) ***Essential Guide to Qualitative Methods in Organizational Research***. SAGE: London.

Kings Fund (2023) **The King's Fund responds to NHS England's workforce plan**. [Online] Available at: The King's Fund responds to NHS England's workforce plan | The King's Fund (kingsfund.org.uk) [last accessed 07/07/23].

Kings Fund (2023b) **The NHS Staff Survey 2022: what do the results tell us?** [Online] Available at: https://www.kingsfund.org.uk/blog/2023/04/nhs-staff-survey-2022-what-do-results-tell-us [last accessed 04/12/23].

Kirkwood, T., Bond, J., May, C., McKeith, I. (2010) ***The M foresight mental capital and well-being project. Mental capacity through life: future challenges*** [online] available at: http://www.foresight.gov.uk/mental%20capital/mental_capital_through_life.pdf [02/02/17]

Kobassa, S. (1979) Stressful life events, personality, and health: an inquiry into hardiness. **Journal of personality and social psychology**, 37, pp. 1-11.

Koch, T., Harrington, A. (1998) Reconceptualising rigour. The case for reflexivity. ***Journal of Advanced Nursing***. 28, pp 882-890.

Kvale, S. (1996) **Interviews: An introduction to qualitative research interviewing**. Sage Publications: Thousand Oaks CA.

Lambert, C., Jomeen, J., McSherry, W. (2010) Reflexivity: A review of the literature in the context of midwifery research. ***British Journal of Midwifery***. 18 (5), 321-326.

Lee, E., Gagne, J.C. (2022) The impact of resilience on turnover among newly graduated nurses: A 1 year follow up study. ***Journal of Nursing Management***. 30 (5), 1295-1302.

Leipold, B., Greve, W. (2009). Resilience: A conceptual bridge between coping and development. **European Psychologist**. 14, (1), 40–45.

Leitch, A.M., Bohensky, E. (2014) Return to 'a new normal': Discourses of resilience to natural disasters in Australian newspaper 2006-2010. **Global Environmental Change**. 26, pp14-26.

Li, Z., Hasson, F. (2020) Resilience, stress, and psychological well-being in nursing students: a systematic review**. *Nurse Education Today***. 90, [Online] Available at: https://doi.org/10.1016/j.nedt.2020.104440 [last accessed 06/07/23].

Liersch-Sumskis, S. (2013) A phenomenological examination of the meaning of resilience as described by people who experience schizophrenia. **University of Wollongong Thesis Collection** 1954-2016, University of Wollongong.

Lopez, K. A., Willis, D. G. (2004). Descriptive Versus Interpretive Phenomenology: Their Contributions to Nursing Knowledge. ***Qualitative Health Research***. 14 (5), 726–735.

Luthans, F., Vogelgesang, G.R., Lester, P.B. (2006) Developing the psychological capital of resiliency. ***Human Resource Development Review***. 5 (1), 25-44.

Luthar, S. S. (2006). Resilience in development: A synthesis of research across five decades. In Cicchetti, Cohen, D.J. (Eds.), **Developmental psychopathology: Risk, disorder, and adaptation** (pp. 739–795).

Luthar, S.S., Cicchetti, D., Becker, B. (2000) The construct of resilience: A critical evaluation and guidelines for future work. ***Child Development***. 71 (3), 543-562.

Luthar, S., Zelazo, L.B. (2003) Research on resilience: an integrative review, in Luthar, S. Resilience and Vulnerability: ***Adaption on the context of childhood adversities***. Cambridge University Press; Cambridge/ New York.

Lysaker, P., Buck, K. and Lintner, J. (2009) Addressing recovery from severe mental illness: in clinical supervision of advanced students**. *Journal of Psychosocial Nursing and Mental Health Services***. 47. (4), 36-42.

Mahdiani, H., Ungar, M. (2021) The Dark Side of Resilience. ***Adversity and Resilience Science***. 2, pp 147-155.

Marañón, A., Pera, I. (2015) Theory and practice in the construction of professional identity in nursing students: a qualitative study. ***Nurse Education Today***. 35 (7), 859-63.

Mason, J. (2002) Qualitative Researching. 2nd edition. SAGE: London.

Mason, M. (2010) 'Sample size and saturation in PhD studies using qualitative interviews'. ***Forum: Qualitative Social Research***. 11 (3), Article 8.

Masten, A.S. (2001) Ordinary magic: resilience processes in development. ***American Psychology***. 56, pp 227-238.

Masten, A., Powell, J. (2003) A resilience framework for research, policy and practice. In ***Resilience and Vulnerability: Adaption in the context of childhood adversities*** (Ed. Luthar, S.) Columbia University Press; New York.

Maybin, J., Charles, A., Honeyman, M. (2016) **Understanding quality in district nursing services Learning from patients, carers and staff**. [Online] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/quality_district_nursing_aug_2016.pdf [last accessed 04/12/23].

McAllister, M., McKinnon, J. (2009) The importance of teaching and learning resilience in health disciplines: A critical review of the literature. **Nurse Education Today**. 29, (4), 371-379.

McAllister, M. (2013) Resilience: A personal attribute, social process and key professional resource for the enhancement of the nursing role. ***Professioni infermieristiche*** 66 (1), 55-62.

McCann, C.M., Beddoe, E., McCormick, K., Huggard, P., Kedge, S., Adamson, C., Huggard, J. (2013) Resilience in the health professions: A review of recent literature. ***InternationaL Journal of Wellbeing***. 3 (1), P60-81.

McComiell-Hemy, T., Chapman, Y., Francis, K. (2009) Husserl and Heidegger, exploring the disparity'. ***International Journal of Nursing Practice***. 15 (I), 7-15.

McDonald, G., Jackson, D., Vickers, M.H., Wilkes, L. (2015) Surviving workplace adversity: a qualitative study of nurses and midwives and their strategies to increase personal resilience**. *Nursing Management***. 24 (1), 123-131.

McGowan, J.E., Murray, K. (2016) Exploring resilience in nursing and midwifery students: a systematic review. ***Journal of Advanced Nursing***. 72 (10), 2272-2283.

McGrath, D. and Higgins, A. (2006) Implementing and evaluating reflective practice group sessions. ***Nurse Education in Practice***. 6. (3), 175-181.

Mcloskey, S., and Taggart, L. (2010) How much compassion have I left? An exploration of occupational stress among children's palliative care nurses. ***International Journal of Palliative Nursing***. 16 (5), 233-240.

Miles, M.B., Huberman, A.M. (1994) ***Qualitative data analysis (2nd Edition)***. SAGE: Thousand Oaks, CA.

Mohaupt, S. (2008) Review article: Resilience and Social Exclusion. ***Social Policy and Society***. 8 (1), 63-71.

Monat, A. and Lazarus, R.S. (eds) (1985) ***Stress and Coping – An Anthology 2nd edn***. Columbia University Press, New York.

Morris, J., Fisher, E. (2022) **Growing problems, in depth: The impact of Covid-19 on health care for children and young people in England**. [Online] Available at: https://www.nuffieldtrust.org.uk/resource/growing-problems-in-detail-covid-19-s-impact-on-health-care-for-children-and-young-people-in-england [last accessed 04/12/23].

Morse, J.M., Kent-Marvick, J., Barry, L.A., Harvey, J., Okang, E.N., Rudd, E.A., Wang, C.Y., Williams, M.R., et al (2021). Developing the Resilience Framework for Nursing and Healthcare. ***Global Qualitative Nursing Research***. 8. [Online] Available at: https://journals.sagepub.com/doi/epub/10.1177/23333936211005475 [last accessed 16/05/23]

National Health and Medical Research Council (2002) ***Human Research Ethics Handbook***. Canberra: Commonwealth of Australia.

NHS Digital (2020) **NHS Digital Annual Report and Accounts 2019-20**. [Online] Available at: https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/nhs-digital-s-annual-reports-and-accounts/nhs-digital-annual-report-and-accounts-2019-20/annual-report-and-accounts [last accessed 04/12/23].

NHS Digital (2022) ***NHS vacancy statistics England April 2015 – June 2022. Experimental Statistics***. [Online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---june-2022-experimental-statistics [last access 15/05/23].

NHS England (2019) **2019 National NHS Staff Survey**. [Online] Available at: https://www.england.nhs.uk/statistics/2020/02/18/2019-national-nhs-staff-survey/#:~:text=Over%20one%20million%20staff%20across,of%2045.7%25%20in%202018) [last accessed 04/12/23].

NHS England (2023) ***Record recruitment and reform to boost patient care under first NHS Long Term Workforce Plan***. [Online] Available at: https://www.england.nhs.uk/2023/06/record-recruitment-and-reform-to-boost-patient-care-under-first-nhs-long-term-workforce-plan/ [last accessed 07/07/23].

Norlyk, A., Harder, I. (2010) 'What makes a phenomenological study phenomenological? An analysis of peer-reviewed empirical nursing studies. ***Qualitative Health Research***. 20, (3), 420-431.

Nursing and Midwifery Council. (2017**) *The NMC Register: 2012/13-2016/17*** [online] available at: www.nmc.org.uk/globalassets/sitedocuments/other-publications/nmc-register-2013-2017.pdf [Last accessed 02/03/19].

Nursing and Midwifery Council (2018a) ***Future nurse: Standards of proficiency for registered nurses.*** [Online] Available at: https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf [last accessed 07/07/23].

Nursing and Midwifery Council (2018b) ***Realising professionalism: Standards for education and training Part 3: Standards for pre-registration nursing programmes*** [Online] Available at: https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/standards-for-pre-registration-nursing-programmes/programme-standards-nursing.pdf [last accessed 21/07/22].

Nursing and Midwifery Council (2022) ***The NMC register 1 April 2021 – 31 March 2022***. [Online] Available at: https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/march-2022/nmc-register-march-2022.pdf [Last accessed 15/05/23]

Nursing and Midwifery Council – NMC (2023) ***NMC responds to the NHS England's Long Term Workforce Plan***. [Online] Available at: NMC responds to the NHS England's Long Term Workforce Plan - The Nursing and Midwifery Council [last accessed 07/07/23].

Oakley, A. (1981) 'Interviewing Women: A Contradiction in Terms', in H. Roberts (ed.) ***Doing Feminist Research***. Routledge: New York.

Olsson, P., V. Galaz., Boonstra, W.J. (2014) Sustainability transformations: A resilience perspective. ***Ecol. Soc***. 19, pp1.

Olsson, L., Jerneck, A., Thoren, H., Persson, J., O'Byrne, D. (2015) ***Why resilience is unappealing to social science: Theoretical and empirical investigations of the scientific use of resilience***. [Online] Available at: http://advances.sciencemag.org/content/1/4/e1400217.full [last accessed 07/07/23]

Ong, A.D., Bergeman, C.S., Bisconti, T.L., Wallace, K.A. (2006) Psychological resilience, positive emotions and successful adaption to stress in later life. ***Journal of Personality and Social Psychology***. 91, pp 730-749.

Oshio, A., Taku, K., Hirano, M., Saeed, G. (2018) Resilience and Big Five personality traits: A meta-analysis. ***Personality and Individual Differences***. 127, pp 54-60.

Palys, T. (2008) ***Purposive sampling***. [Online] Available at: https://www.sfu.ca/~palys/Purposive%20sampling.pdf [Last accessed 07/07/23].

Parameswaran, U. D., Ozawa-Kirk, J. L., & Latendresse, G. (2020). To live (code) or to not: A new method for coding in qualitative research. ***Qualitative Social Work***. 19 (4), 630–644.

Pardo, P. (2011) Psychological support for nurses on paediatric intensive care units. ***Nursing Children and Young People***. 23 (8), 27-29.

Patton, M.Q. (1990) Qualitative evaluation and research methods. 2nd edition. SAGE: Newbury Park – California.

Pearlin, L.I. and Schooler, C. (1978) The structure of coping. ***Journal of Health and Social Behaviour.*** 19, pp 2-21.

Pereira, H.R. (2012) Rigour in phenomenological research: reflections of a novice nurse researcher. ***Nurse Researcher***. 19 (3), 16.

Perry, B. (2009) Role modelling excellence in clinical nursing practice. ***Nurse Education in Practice***. 9, pp 36-44.

Polit, D.F., Beck, C.T. (2012) ***Nursing Research: Generating and assessing evidence for nursing practice***. Lippincott Williams and Wilkins: Philadelphia.

Polit, D.F., Hungler, B.P. (1999) ***Nursing Research principles and methods. 6th edition***. Lippincott: Philadelphia.

Polivy, J., Herman, C.P. (2000) The false hope syndrome: Unfulfilled expectations of self-change. ***Current Directions on Psychological Science***. 9, pp 128-131.

Pradas-Hernández, l., Ariza, T., Gómez-Urquiza, J.L., Albendín-García, L., Emilia I. De la Fuente, E.I., Cañadas-De la Fuente, G.A. (2018) ***Prevalence of burnout in paediatric nurses: A systematic review and meta-analysis***. PLoS ONE ,13 (4) [Online] Available at: https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0195039&type=printable [last accessed 15/05/23]

Price, A., Mansfield, C., McConney, A. (2012) Considering 'teacher resilience' from critical discourse and labour process theory perspectives. ***British Journal of Sociology of Education***. 33 (1), 81-95.

Renzetti, C.M., Lee, R.M. (1993) ***Researching sensitive topics***. SAGE: Newbury Park – California.

Rice, V., Baoxia, L. (2016) Personal resilience and coping with implications for work. Part 1: A review. ***Work*****.** 54, pp 325-333.

Robinson, O.C. (2014) Sampling in interview-based qualitative research: A theoretical and practical guide. ***Qualitative Research in Psychology***. 11 (2), 25-41.

Robins, P.M., Meltzer, L., Zelikovsky, N. (2009) The experience of secondary traumatic stress upon care providers working within a children's hospital**.** ***Journal of Pediatric Nursing***. 24, pp 270-279.

Roslan, N.S., Yusoff, M.S.B., Morgan, K., Ab Razak, A., Ahmad Shauki, N.I. (2022) Evolution of resilience construct, its distinction with hardiness, mental toughness, work engagement and grit, and implications to future healthcare research. ***Education in Medicine Journal***. 14 (1), 99–114.

Roth, M., van Collani, G. (2007) a head-to-head comparison of big five types and traits in the prediction of social attitudes: Further evidence for a five-cluster typology. ***Journal of Individual Differences***. 28, pp 138-149.

Royal College of Nursing – RCN. (2019) **RCN Employment Survey 2019**. [Online] Available at: https://www.rcn.org.uk/Professional-Development/publications/pub-007927 [last accessed 04/12/23].

Royal College of Nursing – RCN (2021). **RCN Employment Survey 2021**. [Online] Available at: https://www.rcn.org.uk/Professional-Development/publications/employment-survey-2021-uk-pub-010-075 [last accessed 04/12/23].

Royal College of Nursing -RCN (2023a) ***Royal College of Nursing responds to UCAS data showing nursing applications drop by almost a fifth in England*** [Online] Available at: https://www.rcn.org.uk/news-and-events/Press-Releases/rcn-responds-to-ucas-data-showing-nursing-applications-drop-by-almost-a-fifth-in-england [last accessed 07/07/23].

Royal College of Nursing – RCN (2023b) ***RCN responds to NHS Long Term Plan***. [Online] available at: RCN responds to NHS Long Term Plan | Royal College of Nursing [Last accessed 07/07/23].

Rutter, M. (1981) Stress, coping and development: some issues and some questions***. Journal of Child Psychology and Psychiatry and Allied Disciplines***. 22, pp 323-356.

Rutter, M. (1985) Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. ***British Journal of Psychiatry***. 147, pp 598-611.

Rutter, M. (1987) Psychosocial resilience and protective mechanisms. ***American Journal of Orthopsychiatry***. 57, pp 316-331.

Rutter, M. (2012) Resilience as a dynamic concept. ***Development and Psychopathology***. 24, pp335-344.

Saldaña, J. (2021) **The Coding Manual for Qualitative Researchers** (4th edition). SAGE publications: London.

Scammell, J. (2016) Should I stay or should I go? Stress, burnout and nurse retention**. British Journal of Nursing**. 25, (17), 990.

Schubert, S., Buus, N., Monrouxe, L.V., Hunt, C. (2023) The development of professional identity in clinical psychologists: A scoping review**. *Medical Education***. 57 (7), 612- 626.

Sekol, M.A., and Kim, S.C. (2014) Job satisfaction, burnout, and stress among pediatric nurses in various specialty units in an acute care hospital*. **Journal of Nursing Education and Practice***. 4, (12), 115-124.

Sellman, E.M., Buttarazzi, G.F. (2020) Adding lemon juice to poison – Raising critical questions about the oxymoronic nature of mindfulness in education and it's future direction. ***British Journal of Educational Studies*.** 68 (1), 61–78.

Silverman, D. (2013). **Doing Qualitative Research: A Practical Handbook**. Sage Publications: London.

Sinha R, Aramburo A, Deep A, Bould EJ, Buckley HL, Draper ES, Feltbower R, Mitting R, Mahoney S, Alexander J, Playfor S, Chan-Dominy A, Nadel S, Suntharalingam G, Fraser J, Ramnarayan P. (2021) Caring for critically ill adults in paediatric intensive care units in England during the COVID-19 pandemic: planning, implementation and lessons for the future. ***Archives of Disease in Childhood***. 106 (6), 548-557.

Smith, L., Drower, S.J. (2008) Promoting resilience and coping in social workers: Learning from perceptions about resilience and coping among South African social work students. In Liebenbers, L., Ungar, M. (Eds.) ***Resilience in Action: Working with youth across cultures and contexts***. University of Toronto: Toronto p. 137-164.

Stacey, A. (2022) Student attrition: what's happening with the Covid-19 cohort*?* ***Nursing Standard***. 37 (10), 10 -12.

Stacey, G., Aubeeluck, A., Cook, G., Dutta, S. (2017) A case study exploring the

experience of resilience-based clinical supervision and its influence on care towards self and others among student nurses. ***International Practice Development Journal*****.** 7 (2), 1-16.

Stacey, G., Cook, G. (2019) A scoping review exploring how the conceptualisation of resilience in nursing influences interventions aimed at increasing resilience. ***International Practice Development Journal*****.** 9 (1), Article 9.

Steinhardt, M., Dolbier, C. (2008) Evaluation of a resilience intervention to enhance coping strategies and protective factors and decrease symptomatology. **Journal of *American College Health***. 56 (4), 445–53.

Stamm, B.H. (2010). **The Concise ProQOL Manual**, 2nd Ed. Pocatello, ID: ProQOL.org.

Stephens, T. (2013) Nursing student resilience: A concept clarification. ***Nursing Forum***. 48, pp 125-133.

Stoffel, J.M., Cain, J. (2018) Review of grit and resilience literature within health professions education. ***American Journal Pharmaceutical Education***. 82 (2), 124–34.

Sun, L., Gao, Y., Yang, J., Zang, X.J., Wang, Y.G. (2015) The impact of professional identity on role stress in nursing students: A cross-sectional study. ***International Journal of Nursing Studies***. 63, pp 1-8.

Sutherland, L., Howard, S., Markauskaite, L. (2010) Professional identity creation: examining the development of preservice teachers' understanding of their work as teachers. ***Teaching and Teacher Education*****.** 263, pp455–465.

Taylor, R. (2019) Contemporary issues: Resilience training alone is an incomplete intervention. **Nurse Education Today,** 78, pp 10-13.

Teddlie, C., yu, F. (2007) Mixed methods sampling: A typology with examples. ***Journal of Mixed Methods Research***. 1, pp 77-100.

Teh, Y. Y., Lek, E. (2018) Culture and reflexivity: Systemic journeys with a British Chinese family. ***Journal of Family Therapy***. 40, 520–536.

Thomas, L.J., Hunter-Revell, S. (2016) Resilience in nursing students: An integrative review. **Nurse Education Today**. 36, pp. 457-462.

Thomas, J., Jinks, A., Jack, B. (2015) Finessing incivility: The professional socialisation experiences of student nurses' first clinical placement, a grounded theory. ***Nurse Education Today***. 35, pp e4–e9.

Thompson, J.L. (1990) Hermeneutic inquiry. In Moody, L.E. (Ed) 1990) ***Advancing Nursing Science Through Research***. SAGE Publications: Newbury Park CA.

Traynor, M., Buus, N. (2016) Professional Identity in nursing: UK students' explanations for poor standards of care. ***Social Science and Medicine***. 166, pp 186-194.

Tuohy, D., Cooney, A., Dowling, M., Murphy, K., Sixsmith, J. (2013) An overview of interpretive phenomenology as a research methodology. ***Nurse Research***. 20 (6), 17-20.

Turner, D. (2016) **Designing a semi-structured interview guide for qualitative interviews** [Online] Available at: https://www.quirkos.com/blog/post/semi-structured-interview-guide-qualitative-interviews/ [last accessed 19/04/24].

Turner, S.B. (2014) The Resilient Nurse: An Emerging Concept. **Nurse Leader**. 12, (6), 90.

Tusaei, K., Dyer, J. (2004) Resilience: a historical review of the construct. ***Holistic Nursing Practice***. 18 (1), 3-10.

University and College Admissions Service - **UCAS (2023) *2023 Cycle Applicant Figures – 25 January Deadline*** [Online] Available at: https://www.ucas.com/data-and-analysis/undergraduate-statistics-and-reports/ucas-undergraduate-releases/ucas-undergraduate-applicant-releases-2023-cycle/2023-cycle-applicant-figures-25-january-deadline [last accessed 07/07/23].

University of Nottingham (2016) **Code of Research Conduct and Research Ethics**. [Online] Available at: http://workspace.nottingham.ac.uk/display/ResEth/Code+of+Research+Conduct+and+Research+Ethics?preview=/123507321/267923166/Code%20of%20Research%20Conduct%20and%20Research%20Ethics%20(Version%206%202016).pdf [Last accessed 31/07/17].

UNDP (2014) Human Development Report 2014—Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience, Human Development Reports - United Nations Development Program, New York.

Ungar, M. (2001) Constructing narratives of resilience with high risk youth. ***Journal of Systemic Therapies***. 20 (2), 58-73.

Ungar, M. (2004) A Constructionist Discourse on Resilience: Multiple contexts, multiple realities among at-risk children and youth. ***Youth and Society***. 35 (3), 341-365.

Ungar, M. (Ed.) (2005) **Handbook to working with children and youth: Pathways to resilience across cultures and contexts**. SAGE: Thousand Oaks, CA.

Ungar, M. (2019) Change Your World: **The Science of Resilience and the True Path to Success**. Sutherland House: Toronto.

Ungar, M., Brown, M., Liebenberg, L., Othman, R. (2007) Unique Pathways to Resilience across Cultures. ***Adolescence***. 42 (166), 287-310.

van Manen, M. (1997) From meaning to method. ***Qualitative Health Research***. 7 (3), 345-369.

van Manen, M. (2007) Phenomenology of practice. ***Phenomenology & Practice***. 1 (1), 11-30.

van Rijnsoever, F.J. (2017) (I Can't Get No) Saturation: A simulation and guidelines for sample sizes in ***Qualitative Research***. *PLoS ONE* 12 (7).

Virkstis, K., Herleth, A., and Langr, M. (2018) Cracks in the Foundation of the Care Environment Undermine Nurse Resilience. ***Journal of Nursing Administration (JORN).*** 48 (12), 597-599.

von Bertalanffy, L. (1968). **General System Theory: Foundations, Development, Applications**. George Braziller: New York.

Wagnild, G., Young, H.M. (1990) Resilience among older women. ***Journal of Nursing Scholarship***. 22, pp 252-255.

Weisman, A.D., and Worden, J. W. (1976) The existential plight in cancer significance of the first 100 days. ***International Journal of Psychiatry In Medicine***. 7, pp 1-15.

Werner, E. (1989) HIGH-RISK CHILDREN IN YOUNG ADULTHOOD: A Longitudinal Study from Birth to 32 Years. ***American Journal or Orthopsychiatry***. 59 (1), 72-81.

White, S. (2001) Auto-ethnography as reflexive enquiry: The research act of self-surveillance. In Shaw, I., Gould, N. (eds) (2001) ***Qualitative Research in social work***. SAGE: London.

Williams, M., Moser, T. (2019) The Art of Coding and Thematic Exploration in Qualitative Research. ***International Management Review***. 15 (1), 45-55.

Williamson, G.R., Health, V., Proctor-Childs, T. (2013) Vocation, friendship, and resilience: A study exploring nursing student and staff views on retention and attrition. ***The Open Nursing Journal***. 7, pp 149-156.

Wilson, A. (2014) Being a practitioner: an application of Heidegger's phenomenology. ***Nurse Researcher***. 21 (6), 28-33.

Windle, G. (2011) What is resilience? A review and concept analysis. ***Reviews in Clinical Gerontology***. 21, pp 152-169.

Wolcott, H.F. (1994) **Transforming Qualitative Data: Description, Analysis and Interpretation**. SAGE: Thousand Oaks, CA.

World Health Organization (2020) ***State of the world's nursing 2020: investing in education, jobs, and leadership***. [Online] Available at: 9789240003279-eng.pdf [last accessed 06/07/23].

Xu, J. H. (2016). Toolbox of teaching strategies in nurse education**. *Chinese Nursing Research***. 3 (2), 54–57.

Yellin, E.M., Quinn, M.M., Hoffman, C.C. (1998*).* Heavy mettle: Stories of transition for delinquent youth***. Reaching Today's Youth***. Summer 408.

Zander, M., Hutton, A., King, L. (2013) Exploring resilience in paediatric oncology nurses*.* ***Collegian***. 20, pp 17-25.

# 8. Appendices

## 8.1 Exemplar recruitment email

For reminder – same email sent out three weeks later

**From:** Louise Clarke <ntzlc4@exmail.nottingham.ac.uk>
**Sent:** 11 June 2019 20:59
**To:** Louise Clarke <ntzlc4@exmail.nottingham.ac.uk>
**Subject:** Invitation to take part in a research study focusing on resilience in children's nursing

Dear XXXXX

I would like to invite you to take part in a research study which aims to improve our knowledge of how children's nurses and child field student nurses understand and experience resilience in their professional lives.

I am interested in exploring a number of issues including:

- How children's nurses/ student nurses describe resilience.
- How children's nurses/ student nurses experience resilience in their professional lives.
- How resilience is incorporated into the identity of a children's nurse/ student nurse.

There is currently a lack of literature relating to resilience in children's nurses, an increasing focus on resilience within undergraduate nursing curricula, and increasing pressure for nurses to demonstrate resilience in their daily lives. In view of this, a more sophisticated understanding of this phenomena, as it is experienced by children's nurses and student nurses, is needed so your opinions are deemed to be extremely important.

If you are interested in taking part you will be asked to undertake one interview which will be conducted by the Principle Investigator Louise Clarke. At present it is planned that this will take place virtually via Microsoft Teams or via telephone. However if COVID regulations allow face to face interviews in person in the future – this option will also be available. The interview will cover questions such as:

- What does it mean to be resilient?

- Is there a pressure to be resilient?
- How easy is it to be resilient on a day to day basis?
- What are the implications if one deems themselves or others not to be resilient?
- What things help us to be more resilient?

It is anticipated that this interview take no longer than an hour of your time and this can be arranged at a time that would be convenient for you.

Before deciding whether or not to take part please take some time to read the attached Participant Information Sheet.

If you would like to take part, please email the Principle Investigator Louise Clarke louise.cook@nottingham.ac.uk Louise Clarke will then contact you to discuss further and, if you are happy to proceed, arrange for a convenient date and time to conduct the interview.

If you have any questions please do not hesitate to get in touch with me via email of phone (details on the Participant Information Sheet).

Best wishes,

Louise

Louise Clarke
BA (Joint Honours), RN Child, PGCHE, FHEA.
Assistant Professor – Child Health, School of Health Sciences
University of Nottingham
Room B312, B floor, Medical School Block,
Queen's Medical Centre Campus
Nottingham, NG7 2UH, UK
**t direct line:** +44 (0) 115 82 30912

**e-mail direct:** louise.cook@nottingham.ac.uk

## 8.2 Exemplar participant information leaflet exemplar – SN version

Louise Clarke
Assistant Professor
School of Health Sciences
University of Nottingham
Room B312, B floor, Medical School Block,
Queen's Medical Centre Campus
Nottingham, NG7 2UH, UK
Tel: direct line: +44 (0) 115 82 30912
e-mail direct: louise.cook@nottingham.ac.uk

Participant Information Sheet 1 (NURSING STUDENTS)
(FINAL Version 1.2: 13/08/20)

IRAS Project ID: 268988

Title of Study: Understanding and Challenging Resilience in Children's Nursing

Name of Chief Investigator: Professor Andy Townsend
Local Researcher(s): Louise Clarke

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

**What is the purpose of the study?**

The purpose of this study is to improve our knowledge of how children's nurses and child field student nurses understand and experience resilience in their professional lives. This will include a consideration of whether such understandings influence the development of professional identity in children's nurses/ student nurses.

This study is important because nurses are faced with many stressful situations on a daily basis which range from excessive workload, staff shortages, time

pressures and frequent exposure to human pain and distress. One potential strategy that is increasingly viewed as a way to protect against the negative consequences of stress is the concept of resilience and thus the ability to display resilience is increasingly being seen as an asset that should be promoted within the nursing profession. There is however, a lack of literature which focusses upon resilience within children's nursing. When considering the role of a children's nurse, there is emerging evidence that nurses who work with children may experience higher levels of stress than colleagues in other fields of nursing due to the unique nature of their role. Currently there is an increased focus on resilience within undergraduate nursing curricula, and seemingly an increasing pressure for nurses and student nurses to demonstrate resilience in their daily lives, therefore a more sophisticated understanding of this phenomena, as it is experienced by children's nurses/ student nurses, is needed.

It is important to stress that this project does not aim to build resilience; rather it deliberately focuses upon meaning and therefore aims to improve our understanding of how children's nurses/ student nurses understand resilience. As such the primary objectives are to:

- Explore how children's nurses describe resilience
- Explore how children's nurses experience resilience in their professional lives
- Explore how resilience is incorporated into the identity of a children's nurse.

(* Please note where the term children's nurses is used here it refers to qualified children's nurses but also student nurses training to become children's nurses)

**Why have I been invited?**

You are being invited to take part because you are currently a student nurse who is registered on a child field programme of study within the School of Health Sciences at the University of Nottingham. Caring for a child who is sick or dying is argued to be particularly stressful, especially when one considers the value society places on protecting and caring for children. Furthermore, it is argued that such stressors challenge the way that children's nurses practice which can in turn, test fundamental assumptions of what it is to be a children's nurse resulting in disillusionment, discontent, issues with professional identity and an increase in staff attrition. In view of the increasing emphasis on resilience, the lack of literature in relation to resilience within children's nursing and the fact that you will become the future generation of children's nurses, your voices are deemed to be extremely important. Interpretive studies of this nature have the potential to contribute to knowledge that is practically relevant to nursing practice and therefore we need to hear your views. We are inviting 10 participants like you to take part and are keen to hear from student nurses at various stages of training, specifically students in Year/part 1 and Year/ Part 3 of their nursing studies.

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights, employment or study.

**What will happen to me if I take part?**

If after reading the participant information sheet you volunteer and consent to take part in this study you will be asked to undertake one interview which will be conducted by the local investigator (Louise Clarke). At present it is planned that this will take place virtually via Microsoft Teams or via telephone. However if COVID regulations allow face to face interviews in person in the future – this option will also be available. It is anticipated that the interview will last for approximately 30 minutes to one hour. In this interview you will be asked a number of questions relating to your views on resilience for example: you might be asked to explain what the term resilience means to you, or you might be asked about how easy or indeed difficult it is to be resilient on a day to day basis? We are very aware of the demands on your time so all efforts will be made to ensure that any interview is scheduled to take place at a time that is most convenient for you. If face to face interviews are allowed in the future it is anticipated that they will take place in a private tutorial room within the School of Health Sciences.

The interview will be audio recorded and once the interview has finished the local investigator will produce a word for word transcript of the interview. At the end of the interview you will be asked whether you would like the local investigator to email you a copy of the completed interview transcript so that you can check it for accuracy. There is not obligation for you to do this, if however you agree it is anticipated that checking through it and providing any feedback will take no longer that 2 hours.

Finally you will be asked if you would like to receive a summary (via email) of the findings of the study following the data analysis stage. There is no obligation to agree to this but if you choose to agree you will be welcome to email the local investigator Louise Clarke with any comments you may have.

**Expenses and payments**

Participants will not be paid to participate in the study and travel expenses cannot be reimbursed so as identified above all efforts will be made to ensure that interviews take place at a time and place that is convenient for you.

**What are the possible disadvantages and risks of taking part?**

Completion of the interview will require some of your time to complete (this is not anticipated to take longer than 1 hour). The interview is a one off activity and if you do not wish to check the transcript of your interview – no further demands on your time will be made. If you do wish to check the transcript this will be emailed to you at your preferred email address and it is anticipated that this will take no longer than two hours to complete. Finally while it is not the intention of the local investigator to elicit sensitive information from you, some

questions may elicit sensitive answers. However any answers you give will be completely within your control and if you feel you do not wish to answer a question or do not wish to continue with an answer, this will be respected at all times.

**What are the possible benefits of taking part?**

We cannot promise the study will help you but the information we get from this study may help contribute to knowledge that is practically relevant to nursing practice. While this study may have limited benefits to participants in the short term, this study could lay the foundations for future studies which aim to build or enhance resilience in a more meaningful and practically applicable way. It may also enhance understanding of the potential role of 'resilience' within the nursing profession and contribute to a nursing culture which better understands both the potential advantages, and limitations of resilience as a means to cope with the pressures inherent in a career within children's nursing.

**What happens when the research study stops?**

Your study participation ceases once you have completed the interview unless you wish to check the transcript of your interview. If this is the case your participation will end once you have checked the transcript and provided feedback in relation to the accuracy of it. Interviews will be transcribed as soon as possible after the interview has occurred. You will receive one email reminder two weeks after you have received the transcript for review. If you have not provided feedback 6 weeks after receiving the transcript we will presume that you no longer wish to review this and provide feedback. Your contact information will be kept by the University of Nottingham for 12 months after the end of the study and until the results of the study have been written up. This is so we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted).

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the local Investigator who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. Some of the questions within the interview may be sensitive in nature if you wish to talk to someone regarding this please contact the Student Welfare Team on 0115 82 31455, the University student Counselling service on 0115 951 3695, Nightline on 0115 95 14985, Samaritans on 0115 941 1111 or your personal tutor If you remain unhappy and wish to complain formally, you can do this by contacting the School of education ethics committee educationresearchethics@nottingham.ac.uk

**Will my taking part in the study be kept confidential?**

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. Some information e.g. interview recordings, may be commissioned out to a professional transcription service. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Your contact information will be kept by the University of Nottingham for no longer than necessary after the end of the study but will be retained until the data analysis phase has been completed (approximately 12 months after the end of the study). This is so we are able to contact you if we have any queries about your interview transcript/ inform you of any findings (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other research data will be kept securely for 7 years post publication in an appropriate Journal. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

**What will happen if I don't want to carry on with the study?**

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible.

**What will happen to the results of the research study?**

The results of the study will be available after it finishes and will be reported within a final 60,000 word thesis which will be submitted as part of the requirements for successful completion of an educational qualification the Taught Doctorate in Education (EdD). It is anticipated that the thesis will be completed by the end of September 2021. Additionally throughout the course of the data collection and analysis phase and in line with the School of Health Sciences vision to build the profile of children's nursing research there may be an expectation to publish findings in a peer-reviewed healthcare journal and/or to present be at a scientific conference. The data will be anonymous and none of the participants involved in the study will be identified in any report or publication. Due to the qualitative nature of the study, participant quotes will be reported in the thesis and any future publications. These will however, be carefully selected to ensure participant anonymity is retained. We aim to inform all participants about the results of this study. Should you wish to see the results, or the publication, please contact the study team.

**Who is organising and funding the research?**

This research is being organised by the University of Nottingham and is being funded by both the School of Health Sciences (50% contribution) and the local investigator (50% contribution).

**Who has reviewed the study?**

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by

- The School of Education Research Ethics Committee.
- In addition all research conducted within the NHS is looked at by an independent group of people called The Health Research Authority (HRA) to protect your safety, rights, well-being and dignity. This study has been reviewed and given a favourable opinion by the Health Research Authority [IRAS ID: 268988].
- The study has also been reviewed and approved by the Research & Innovation department of Nottingham University Hospitals NHS Trust.

**Further information and contact details**

You are encouraged to ask any questions you wish, before, during or after the study. If you require any further information or have any concerns while taking part in the study please contact:

**Investigator**
Louise Clarke
Assistant Professor
School of Health Sciences
University of Nottingham
Room B312, B floor, Medical School Block,
Queen's Medical Centre Campus
Nottingham, NG7 2UH, UK
Telephone: +44 (0) 115 82 30912
e-mail: louise.cook@nottingham.ac.uk

**Chief Investigator**
Professor Andy Townsend
School of Education
University of Nottingham
Jubilee Campus,
Wollaton Road,
Nottingham, NG8 1BB
Telephone: +44 (0) 115 8467043
e-mail: ttzajt@exmail.nottingham.ac.uk

## 8.3 Consent forms - QN and SN participants

**CONSENT FORM**
**(FINAL Version 2.0: 12/10/20)**

Title of Study: Understanding and Challenging Resilience in Children's Nursing

**IRAS Project ID: 268988**

**Name of Researcher**: Louise Clarke

**Name of Participant:**

**Please initial**

1. I confirm that I have read and understand the information sheet version number 1.2 dated 13/08/20 for the above study and have had the opportunity to ask questions. I understand the purpose of the research project and my involvement in it. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my employment, study or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

5.I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research. ☐

6.I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐

7. I agree to take part in the above study. ☐

| _____ | _____ | _____ |
|---|---|---|
| Name of Participant | Date | Signature |
| _____ | _____ | _____ |
| Name of Person taking consent | Date | Signature |

2 copies: 1 for participant, 1 for the project notes

## 8.4 Interview guides exemplar – SN version

**Resilience in children's nursing Interview Schedule/topic guide - STUDENTS**

Researcher name:
Louise Clarke

Participant Initials:

Date of interview:

**Opening:**

Thank the participant for agreeing to take part

Reassure and reiterate that participation is voluntary thus the participant can ask to stop the interview at any time for any or no reason. This will not be questioned and no pressure will be exerted for the participant to continue with the interview.

Advise the participant that I am going to ask a series of questions regarding resilience in children's nursing. Remind that the interview will be audio-recorded and that a few field notes may be taken as the interview progresses.

Ascertain that the participant is happy to start the interview.

**Resilience - general views:**

- What do you understand by the term resilience?
  - What does the term mean to you?
  - What does it mean to be resilient?
- Is this a term that is referred to often either in practice or in the university setting?
  - Who uses this term?
  - In what way is it used?
- Who do you think of when you picture a resilient person?/ Is there a person you can picture when you think of a resilient person?
  - Why do you consider this person to be resilient?
- People often have different views about what resilience is can you give me an example of a situation where you witnessed resilience?

**Resilience – in children's nursing:**

- When you think of your role as a student nurse, are there times when it has been difficult to be resilient? (pre and post Covid)

    - What made it difficult? (Pre and post covid)
    - Can you give me an example?
    - Are there any other unrelated factors that made the situation more difficult?
- Are there times when it has been easy to be resilient?
    - What made it easy?
- Do you feel like you have ever been judged by others in relation to your own levels of resilience?
    - Who judged you?
    - What did this feel like?
    - Have you ever judged yourself?
- Have you ever judged others based on how resilient you think they are?
    - How did that feel?

**Professional Identity:**

- How important do you think it is to be resilient as a student nurse? (pre and post covid)
    - Why is it important?
- How important do you think it is to be resilient as a children's nurse?
- What is it about the role of a children's nurse that makes resilience so important?
- Do you consider yourself to be a resilient person?
- Have you always been resilient or is this something you have learnt?
    - If learnt: How have you learnt to be resilient?
        - Who did you learn from?
    - If not learnt: Do you think you can learn to be resilient?
- Do you think there is a pressure to be resilient as a student nurse/ children's nurse?
    - Where does this pressure come from?
    - How does this make you feel?
- If someone is not deemed to be resilient, how are they viewed by others?
    - How are they thought of?
    - Do you worry about being seen as 'Not resilient'?
    - Are there any implications?
    - Can you give me an example?
- Why do you think people stay in/ leave the nursing profession?
    - Does resilience have any role in this?

**Enhancement of resilience:**

I would like to focus a little more now on things that help you to be resilient.

- Can you tell me about a situation where you feel you demonstrated resilience?
    - What helped you to be resilient?
- Can you suggest anything that might make it easier for you or your colleagues to be resilient on a daily basis?
    - If you could ask the School of Health Sciences to make changes what would they be?
    - If you could ask the ward manager to make any changes what would they be?
    - If you could ask the trust to make any changes what would they be?
    - If you could ask the government to make any changes what would they be?

**Closing Questions:**

- Thank you, there are no further questions I would like to ask. Is there anything else you would like to say?
- Is there anything else you feel should have been covered in the interview?

**Closing:**

Thank you very much for taking part in this study

Explain that the interview will be transcribed word for word.

**Ascertain: Does the participant want the interview transcript to be emailed so they can check for accuracy?**

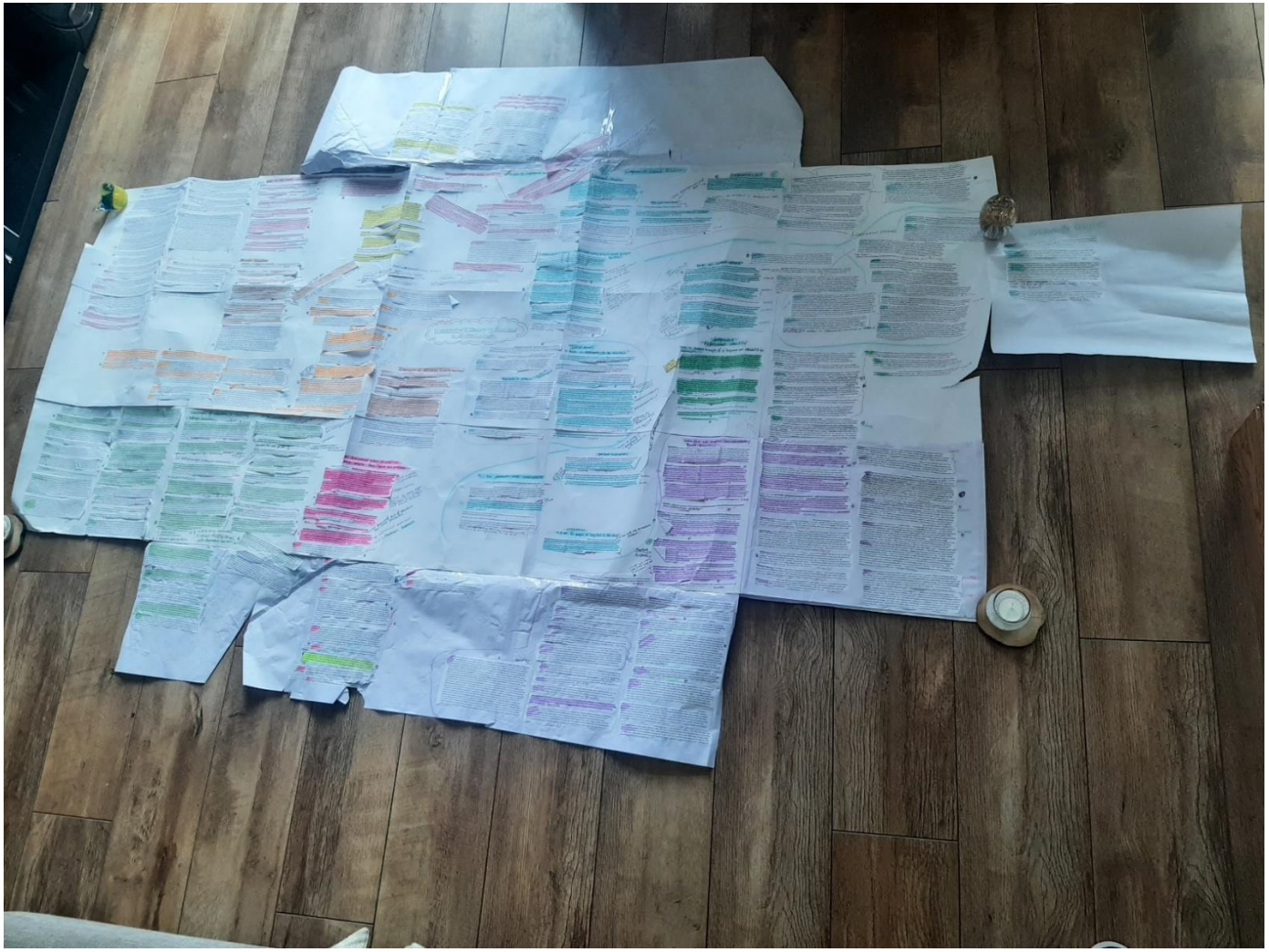
Tick if yes ☐ Reiterate this is optional, there is no obligation to agree. Also of the participant does agree at interview they can change their mind at a later date and after receiving the transcript

Explain the findings will be reported in my doctoral thesis which will be available to view if they wish once completed/ published on the -Thesis library

Do participants have any further questions?

Thank participants again for taking part and close interview.

## 8.5 Concept map exemplar – QN nurses



## 8.6 Additional participant information leaflet detailing professional support agencies

**Participant Information Sheet 2**
(FINAL Version 1.0: 03/09/19)
IRAS Project ID: 268988

**Title of Study: Understanding and Challenging Resilience in Children's Nursing**

Name of Chief Investigator: Dr Andy Townsend
Local Researcher(s): Louise Clarke

While it is not the intention of this research to elicit any sensitive information from you, some of the questions within the interview may be sensitive in nature. Please remember that any answers you give will be completely within your control and if you feel you do not wish to answer a question or do not wish to continue with an answer, this will be respected at all times. If after the interview however you feel you wish to talk to someone regarding any of the topics raised within the interview there are a few potential contact numbers listed below:

**For Nursing Staff:**

**Confidential NUH Employee Helpline** on: 0800 783 2808. Further information regarding this service is available at: https://www.nuh.nhs.uk/staff-helpline/

**Samaritans** on 0115 941 1111

**For Student Nurses:**

**SoHS Student Welfare Team** on 0115 82 31455 **OR**
email: SS-Welfare-QMC@exmail.nottingham.ac.uk

**University of Nottingham Student Counselling service** on 0115 951 3695 **OR**
email: counselling.service@nottingham.ac.uk

**Nightline** – nottinghamnightline.co.uk on: 0115 95 14985 (open 7pm – 8am during term time) **OR**
email: nightlineanon@nottingham.ac.uk (email open 365 days)

**Samaritans** on 0115 941 1111

Or you can speak to your personal tutor.

## Further information and contact details

You are encouraged to ask any questions you wish, before, during or after the study. If you require any further information or have any concerns while taking part in the study please contact:

**Louise Clarke**
Assistant Professor
School of Health Sciences
University of Nottingham
Room B312, B floor, Medical School Block,
Queen's Medical Centre Campus
Nottingham, NG7 2UH, UK
Telephone: direct line: +44 (0) 115 82 30912

**e-mail direct: louise.cook@nottingham.ac.uk**

# 8.7 ethical approval documentation – School of Education

## 8.7.1 Ethics application

**The blue cells on this sheet must all be completed to provide your details and to respond to the appropriate questions asked. Please note that some cells will ask you to use a drop-down box to supply your answer and others will expand to accommodate your answer.**
**Please note there is a section at the bottom about the GDPR.**
Once you have answered all the questions you should submit this spreadsheet by email to **educationresearchethics@nottingham.ac.uk** with the other ethics documents required for the submission (see Tab 2). You need to ensure your submission is copied to your supervisor/host.

| | |
|---|---|
| **Period of time for fieldwork/research (e.g. 2019 - 2021)** | 2019-2021 |

| | | |
|---|---|---|
| **1** | Your name | Louise Clarke |
| | Student/staff status | EdD Student |
| | Supervisor(s)/host | Dr Andy Townsend/ Professor Joanne Lymn (School of Health Sciences) |
| | Student ID | 4283906 |
| | Your contact email | louise.clarke@nottingham.ac.uk |
| | Project Title | Understanding and Challenging Resilience in children's nursing |
| | Where will your research take place? | Within the UK |

| | | | |
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| | If any of your research is to be conducted outside of the UK you will need to follow local ethical requirements. Use this space to confirm your understanding of local requirements. | N/A | |
| | A DBS check is required if your research will involve the researcher being left alone with children and/or vulnerable adults. Does this project need a DBS check to be carried out? | No | |
| | What is your DBS number? | N/A | |
| | Is there external funding for this research? | No | |
| | If this research is funded by external sources please indicate the funder and project code | N/A | |
| | ***For students and visiting scholars only:*** | | |
| | Your main supervisor/host needs to be involved in the preparation of and approve this ethics submission. Use this space to advise how this has been done. | I have received regular face to face supervision sessions with my main supervisor/ second supervisor. These have included detailed discussions surrounding my ethics submission. My supervisors have also reviewed all documentation pertinent to my ethics submission. | |

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| **2** | **1a** | Is the research with non-vulnerable adults in private interactions? | Yes |
| | **1b** | Is the research concerned with a non-sensitive topic? | No |
| | **1c** | Is the research of completely anonymous participants (with no identifying information recorded)? | No |

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| | **1d** | Is the research taking place in a public physical or virtual space where participants might reasonably expect that their behaviour is observed (eg web presence that is not restricted access in any way)? | No |
| | **1e** | Is the research involving openly available secondary data (eg government archives)? | No |
| | Confirm whether each of the following statements *in their entirety* is accurate: | | |
| | **2a** | There is *no* gatekeeper involved. | Disagree |
| | **2b** | There *is* a gatekeeper involved but I am assured no pressure will be placed on potential participants to be involved. | Agree |
| | **3a** | I do *not* have a current or prior relationship with participants. | Disagree |
| | **3b** | I *do* have a current or prior relationship with participants but the decision whether or not to participate will have no bearing on their relationship with me. They will be informed about the research. They will be informed they can refuse to take part. They will be informed they can withdraw from participation at any point until the date shown on the consent form provided. | Agree |
| | **4** | Participants *are* students I teach or with whom I have a prior or existing relationship. They will be informed about the research. They will be informed they can refuse to take part with no negative consequences for their studies and relationship with me. They will be informed they can withdraw from participation at any point until the date shown on the consent form provided. | Agree |
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| **3** | **1** | Does the study involve children described as 'typically developing children in mainstream settings' (ESRC, 2015: 8) | No |
| | **2** | Does the study involve personal data, for example relating to age, gender, ethnicity, religious affiliation, sexuality? | Yes |
| | **3** | Does the data involve discussion of sensitive issues such as mental health issues or sexual activity? | Yes |
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| **4** | **1** | Does the study involve vulnerable participants? (vulnerable children, people with learning difficulties, people with mental health issues) | No |

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| | **2** | Does the research involve participants not providing consent, deception or covert observation in any form? | No |
| | **3** | Might the study generate a level of stress of anxiety above that which might be expected from normal social interactions? | No |
| | **4** | Does the study involve the discussion of any of the following: sensitive issues (such as sexual activity, substance abuse or professional misconduct); *or* participants' involvement in illegal activities; *or* participants' involvement in activities likely to cause harm to themselves or others? | No |
| | **5** | Does the study involve the public use of data that might result in participant identification? (e.g. audio or video data that is used for purposes beyond basic data analysis by the research team) | No |

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| **5** | **1** | Please provide a description of the project and its aims | This study will explore children's nurses understanding of and encounters with the concept of resilience; which will include a consideration of how this relates to personal and professional identity. This will be an interpretive study which will explore personal and professional life experiences, and consider how these might contribute to an individual's understanding of resilience. This will include an exploration of how children's nurses describe resilience, what they believe constitutes an act of resilience, how they experience resilience in their day to day lives and whether this phenomenon influences personal and professional identity within children's nursing. (* Please note where the term children's nurses is used it refers to qualified children's nurses but also student nurses training to become children's nurses.)<br><br>Research purpose and aims:<br>While resilience is increasingly being advocated as a potential measure to reduce stress and burnout within the nursing profession, little is known about how children's nurses understand or experience resilience within their daily lives. There is also a growing concern over the uncritical use of the term 'resilience'. With this in mind, this research will address one main research statement which is supported by three sub-questions.<br><br>Research questions<br>Main Research aim/ statement:<br>Understanding and challenging resilience in children's nursing.<br><br>Research sub-questions:<br>1. How do children's nurses describe resilience?<br>2. How do children's nurses experience resilience in their professional | |

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| | | | lives?<br>3. How is resilience incorporated into the identity of a children's nurse? | |

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| | **2** | Please identify the intended participants (how many? and who they are?) indicating how they will be selected and approached. | Intended participants:<br>The sample Universe for this study includes:<br>- Paediatric student nurses in one local HE setting (UoN)<br>- Junior paediatric nurses in one local children's hospital Nottingham University Hospital Trust Children's Hospital)<br>- Senior paediatric nurses in one local children's hospital (NUH Children's Hospital)<br><br>Inclusion Criteria:<br>- Paediatric nursing students enrolled on nursing course in chosen higher education institute.<br>- Junior and senior Paediatric nurses in local children's hospital.<br><br>Number of participants<br>I propose an initial sample size of 20 participants:<br>5 x Year 1 Undergraduate nursing students,<br>5 x Year 3 Undergraduate nursing students,<br>5 x newly qualified nurses – up to 18 months post qualification (Band 5 nurses),<br>5 x senior nurses – Post 18 months qualification (includes band 5, 6 and 7 nurses).<br>This sample size is not considered to be fixed at this point and I propose that data collection should continue until/ cease when the point of saturation is reached<br><br>Selection of participants<br>In view of the aims of the study a stratified sampling technique will be employed. As such I have identified participants who should be purposively included in the final sample. The sample has then been | |

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| | | | stratified into the four categories identified above. Qualified nurses have been included alongside student nurses because the role of the qualified nurse mentor, within the practice setting, is seen as pivotal to the development of resilience and professional identity in nursing students.<br><br>Recruitment of participants<br>Qualified Nursing participants will be recruited from any ward within the Nottingham University Hospital Trust Children's Hospital (for qualified Children's nurses) and the School of Health Sciences UoN for child field student nurses. This is to ensure that children's nurses with a range of practice experience can be recruited along with student nurses who are training within the clinical area. For participants within the Children's Hospital the initial approach will be from a gatekeeper (this is a requirement of undertaking research within the NHS). The gatekeeper is yet to be identified but is it anticipated that this will be a member of administrative staff based within the Nottingham Children's Hospital. Recruitment will be via a recruitment email which will be emailed to staff email addresses throughout the children's hospital. If nurses/ students are interested in taking part they will be asked to contact me directly either via email or phone. I will then provide further information, email a copy of the participant information sheet and then, if participants are still happy to proceed, arrange a time and date for the interview to take place. One further reminder email will be sent to all staff three weeks after the initial email (exemplar attached to this application). As stated the gatekeeper's role will be purely administrative. No further involvement is required from the gatekeeper. For student nurses the initial approach will be from the PI and will also be via a recruitment email (exemplar attached to this application). One reminder email will be sent three weeks after the initial email. | |

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| | **3** | What types of data will be collected and what methods of data collection will be used? | Types and Methods of data collection<br>1) Only personal/ demographic data pertinent to the study aims will be collected. This will include:<br>• Age<br>• Nursing course<br>• Status as either student or qualified member of staff<br>• For students - year of study<br>• For staff - years of experience post qualification and professional grade<br>• Any experience prior to commencing nurse training<br>This information will be collected through the course of the interview process.<br><br>2) Qualitative interview data will be collected via semi-structured interviews which also include a narrative element:<br>• Interviews will be conducted on a face to face basis where possible (phone interview will be considered but face to face is preferred).<br>•All interviews will be conducted by myself as the primary investigator.<br>•Interviews will take place at a time and place that is most convenient for the participant. For qualified nurse participants interviews may take place within the clinical ward setting but it will be important to secure a private room in which there will be no interruptions. Due to the nature of ward work it may be preferable for participants to be interviewed away from the work setting. In this case this could be undertaken within the School of Health Sciences (SoHS) or another private venue of the participants choice e.g. their homes. If this is the case strict adherence to the lone worker policy will be required. For student nurse participants it is anticipated that these will take place within a private room within the SoHS.<br>• Interviews will be audio recorded and then transcribed verbatim.<br>• Interview transcripts and audio recordings will be anonymised and | |

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| | | | pseudonyms will be used.<br>• No identifying participant information will be included upon either the interview transcripts or the audio recordings.<br>• Audio recordings will only be listened to by myself – no other researcher will have access to the interview audio recording.<br>• Interview transcripts will only be viewed by myself and the supervisors if necessary. Participants will however have an opportunity to check their own transcripts for accuracy.<br>• To assist in structuring the interview, an interview guide has been developed. This lists the topic areas to be covered and potential probes which may be used in order to obtain greater detail from participants (interview schedule for qualified nurses and separate interview schedule for student nurses is attached to this application). The interview guides are based upon my knowledge and prior experience (fore-structure) thus in line with Heideggerian principles, reflexivity will be essential throughout the data collection stage so as to ensure the interview schedule is not applied too strictly which could impact on the balance between direction and flexibility.<br>• I will undertake to test this interview schedule through the use of a pilot interview. This will enable me to ensure that my questions are appropriate whilst also allowing me to explore and reflect upon my own influence and potential impact upon the interview process.<br>• Two participant information sheets have been developed (one for qualified nursing staff and one for student nurses). These clearly inform participants of the purpose of the study but also clearly advise participants of their right to refuse to take part/ withdraw from the study at any point until the date shown on the consent form provided. Please note that as a condition of gaining access to undertake my research within the NHS, Health Research Authority (HRA) Approval is required in addition to University of Nottingham Sponsorship. To gain | |

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| | | | this it is mandatory that certain forms are used within my ethics application – see below extract from the research Governance Co-ordinator - Research and Innovation, Jubilee campus. "Protocol, information sheet and consent forms – it is mandatory requirement that where University of Nottingham is acting as sponsor that our templates are used for all research conducted which requires HRA review and approval". One further information sheet has been developed for both staff and students which identifies professional agencies that could provide support should participants feel this would be beneficial after undertaking the interview (attached).<br>• Finally participants will be asked to sign a consent form and will be provided with a privacy notice. (Please see attached forms) | |

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| | **4** | How will data be stored and for how long? How will it be used? | How will data be stored and for how long?<br>• Identification code numbers will be used to correspond to research data in any research paperwork and computer files.<br>• Interview transcripts and audio recordings will be anonymised as above. No identifying personal data will be included upon either the interview transcripts or the audio recordings.<br>• Contact information will be kept for no longer than necessary after the end of the study but will be retained until the data analysis phase has been completed (approximately 12 months after the end of the study). This is so participants can be contacted if there are any queries about an interview transcript (unless the participant advises that they do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it.<br>• Personal data will not be kept with interview transcripts to ensure maintenance of confidentiality.<br>• Records of personal data relevant to the research, including year of study or year post qualification will not be kept for longer than necessary.<br>• Research data will be retained intact for a period of at least seven years from the date of any publication which is based upon them as per UoN guidance.<br>• Data will be stored in its original form – i.e. tapes/discs/ interview transcripts/ coded data analysis.<br>• All data including Audio recordings, paper copies of interview transcripts, data analysis and coding, consent forms, will be kept in a locked filing cabinet in my office in the School of Health Sciences.<br>• Electronic forms of data will be stored on my own UoN OneDrive which is password protected or on an encrypted memory stick and only kept for the amount of time stipulated by the university. | |

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| | | | • If stored on an encrypted memory stick this will also be stored in a locked filing cabinet in my office.<br>• Participant quotes referred to in the thesis or subsequent publications will be anonymised and pseudonyms will be used.<br><br>• Audio recordings will be kept by the PI and will be transferred from the interview to a secure location following the interview. If the interview takes place within the Hospital or School of Health Sciences the recording will be transferred immediately after the interview to the PI's office and kept within a secure locked cupboard until it has been securely uploaded onto a University of Nottingham password protected laptop. If the interview takes place away from the hospital or university setting the PI will transfer the recording to her home address where it will be stored in a secure pin protected safe (in the home environment). The recording will then be transferred, by the PI, at the earliest opportunity to the PI's office where it will be stored in a secure locked cupboard until secure upload of the interview recording (as above). Once secure upload has been completed (which will take place as soon as possible following the interview) the audio recording will be deleted from the recording device.<br><br>4. How will it be used?<br>• Personal/ demographic data will only be used to assist in the data analysis of the research data and to consider whether there are any relevant themes which emerge in relation to the demographic profile of the participants.<br>• No personal or identifying data will be included on raw research data or any subsequent publication of the study findings | |

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| | | | • Due to the qualitative nature of the study, anonymised participant quotes will be reported in my thesis and may be reported in future publications. These will however be carefully selected to ensure participant anonymity is retained<br>• Interview data will be analysed using thematic analysis in order to identify and analyse patterns of meaning within the qualitative data.<br>• Findings from the data analysis will be reported within the thesis which will be submitted as part of the requirements for successful completion of the EdD.<br>• Following completion of the data analysis, in an attempt to enhance the credibility of my work, I will provide a summary of the analysis and themes that have emerged and request feedback from participants on whether they find these to be representative and credible. Participation in this stage of the study will be identified to participants as optional. Consent will be sought to contact participants to send out summary data and participants will be able to opt out of this if they choose<br>• Finally as a university employee, the University's Open Access policy applies to me. This requires that all research papers (including journal articles, conference proceedings, book chapters and similar material), where copyright allows, should be made available in an open access form upon publication.<br>• Similarly all research papers (either in the form of the author's final manuscript or the formally-published version), where copyright allows, should be deposited in the Nottingham ePrints repository upon publication or as soon as possible thereafter. | |

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| | **5** | Based on responses to questions in Sections 3 to 5, please identify potential risks associated with this research and the steps taken to mitigate these risks. Risks relate to participants, researchers (including lone working) and the storage of data. | Risks to Participants<br>1. Familiarity<br>I have frequent contact with the paediatric student nurse population as well as clinical nursing staff up to Band 7. While this may make it easier to recruit certain participants, I must bear in mind the potential for this to influence a participant's ability to provide valid informed consent and must ensure that they do not feel any pressure or obligation to consent to participate within the study.<br><br>2. Involvement of students as participants:<br>A further issue pertains to my role as a nurse academic and the proposed inclusion of student nurses within my target sample. This centres on the power differential between a student and their lecturer and can lead to issues relating to abuse of power, coercion, lack of meaningful informed consent and problems with confidentiality. Therefore it is essential, when recruiting student participants, to ensure they are clear about their right to refuse or withdraw without any penalty.<br><br>Measures to mitigate risks of familiarity/ involvement of students:<br>One measure I intend to take to mitigate these risks is that I will endeavour to narrow the sample universe to students I do not teach frequently and nursing staff I have knowledge of, but less close professional links to. However this will be influenced to some extent by the participants who volunteer to take part in the study.<br><br>3. Informed consent:<br>It is vital to ensure that all potential participants are able to provide valid informed consent prior to taking part in the study: | |

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| | | | Actions to mitigate risks relating to informed consent:<br>• To secure a participants voluntary informed consent prior to engagement in the research process it is vital to provide clear information which avoids any deception or subterfuge. This must include clear communication of a participant's right to withdraw from the research project at any time and for any or no reason.<br><br>• To ensure that all participants are able to provide valid informed consent two detailed information sheets have been developed (one for qualified nurses and one for student nurses) These provide clear information on the purpose of the research study, the process participants will be asked to undertake, why their participation is deemed necessary, how information will be collected and ultimately how and to whom it will be reported. Participants will be informed about retention, sharing and any possible secondary uses of the research data along with their right to have access to any personal data that is stored, and which relates to them. Participants will also be advised of their right to withdraw from the study at any time, for any or not reason, and without any penalty.<br><br>I must also accept that participants have a right to withdraw from and not continue with an interview at any point if they wish. Should this happen it will be important to examine my own behaviour to evaluate whether my actions have contributed to a participants decision to withdraw.<br><br>• Each participant will also be asked to provide written consent prior to any research activity taking place. | |

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| | | | 4. Disclosure of poor practice<br>• It is possible that, in the course of the interview, students or qualified staff may disclose incidences or poor practice. While it is important to maintain the anonymity and confidentiality of participants there is also a requirement to protect patient/ public/ staff safety. If it were deemed that the disclosure presented a risk to patient/ public/ staff/ student safety then it may be necessary to escalate the issue via appropriate routes.<br><br>For Qualified nursing staff it was deemed that patient/public/staff safety has been compromised then this should be reported to the senior staff member in the appropriate area.<br><br>For students, or staff reporting the poor practice of students, if there is deemed to be a safety issue, this should be reported to the course lead for the relevant education programme of study.<br><br>• It is difficult to mitigate against this risk however a statement will be included within the patient information leaflet. This will clearly identify that, while we treat what a participant says to as confidential, should they disclose anything which is deemed to put them or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.<br><br>5. Unintentional harm<br>• As my research will involve asking participants to discuss their views on/ experiences of resilience, it is possible that that this may cause participants to revisit painful memories or events. While it is not my intention to elicit painful personal memories; I have a responsibility to ensure that I am prepared to respond with empathy and sensitivity if | |

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| | | | such situations arise. I must also be fully aware of the availability of further professional support if necessary.<br><br>Actions to mitigate the risks of unintentional harm to participants:<br>• A measure which could assist with this potential risk are my own personal skills. As a qualified children's nurse I have well developed communication skills and a sustained history of the ability to develop and maintain therapeutic relationships. This includes the ability to disengage professionally from therapeutic relationships. Furthermore, as an experienced university lecturer who has a long history of involvement in the pastoral support of students, I have extensive experience of dealing with students who are in emotional crisis. I also have extensive knowledge of the support services that are available to students both within the School of Health Sciences and the wider University.<br><br>• I have developed an information sheet for participants which details the professional support agencies and organisations which could be accessed should they feel this would be of benefit if painful memories arise. (Information sheet is attached to this ethics submission)<br><br>6. Anonymity and confidentiality<br>A standard measure to protect participants and minimise harm is to guarantee confidentiality and anonymity. Confidentiality is arguably harder to achieve in qualitative research as there is often a need for researchers to include quotations from participants within their reports. This is a consideration within my study as the majority of participants will be recruited from one children's hospital/ School of Nursing which increases the likelihood of participants knowing one another.<br>To mitigate this risk the careful selection of quotations and strict | |

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| | | | adherence to principles of anonymity will be of increased importance. Consequently, when reporting findings and selecting suitable supporting quotations, careful deliberation will be required to ensure that participants remain anonymous.<br><br>Risks to the Researcher:<br>1. Research wellbeing<br>I must acknowledge that there is also a potential risk to my own emotional wellbeing by acting as the main researcher in this study. This could result from the need to listen to participants stories particularly if they reveal upsetting stories. To mitigate this risk I intend to arrange for regular clinical supervision for myself to ensure that I have support to deal with any unforeseen issue that may arise as a result of conducting this study.<br><br>2. Possibility of Lone working<br>Interviews will take place at a time and place that is most convenient for the participant. For qualified nurse participants, interviews may take place within the clinical ward but it will be important to secure a private room in which there will be no interruptions. Due to the nature of ward work it may be preferable for participants to be interviewed away from the work setting. In such cases this could be undertaken within the SoHS or another private venue of the participants choice e.g. their homes. If interviews are to take place in a participant's home I will adhere strictly to the lone worker policy. In these circumstances a risk assessment will be completed and appropriate safeguards taken e.g. the implementation of appropriate contact arrangements which would be documented as part of the risk assessment. I will also undertake any relevant training to familiarise myself with the lone working policy in particular appendix 4 | |

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| | | | which identifies personal security guidance for staff, students and visitors.<br><br>Risks pertaining to Storage of data<br>Personal and research data will be stored as identified in 5.4.<br>Interview transcripts and audio recordings will be anonymised and pseudonyms will be used for both participants and the institutions they are affiliated to.<br><br>1. Access to personal interview data:<br>• Participant's personal information will not be shared with any other individual or internal/ external party.<br><br>• Audio recordings will only be listened to by myself – no other researcher or internal/external party will have access to the interview audio recordings. Interview transcripts will only be viewed by myself and my supervisors if necessary. Participants will however, be provided with the opportunity to check their own interview transcripts for accuracy.<br><br>• Any subsequent publications which utilise the research data will maintain the anonymity of the research participants through the use of pseudonyms and the careful selection of participant quotes. No personal information that could identify participants or relevant institutions will subsequently be published.<br><br>2. Sensitive data<br>While it is not the intention to collect participant information that could be classified as sensitive data, it is acknowledged that in the course of asking individuals to speak about resilience it is possible that this may raise sensitive issue for the individual. As such participant confidentiality | |

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| | | | is essential. Thus participants will be informed that individual participant personal information obtained as a result of research is to be considered confidential thus disclosure to third parties is prohibited with the exception of statutory notification as applicable to the particular research. As previously identified Participant confidentiality will be ensured by utilising identification code numbers to correspond to research data in any research paperwork and computer files. | |

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| On the basis of the answers you have provided your ethics submission is indicated to be: | **Above minimal risk** |
| | **High risk. Include instruments with your submission** |

| **GDPR (update to Data Protection Act 1998)** | |
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| **All research carried out at the University of Nottingham must comply with the EU GDPR. Please confirm that you have familiarised yourself with GDPR (see link on intranet) and explain how you will implement this in your research design. If you are a PGR student or visiting scholar, your supervisor will be able to advise on this. Please also see the Useful forms section on the student intranet for privacy notices for tailoring. These are also available to staff here.** | I confirm that I have familiarised myself with GDPR requirements.<br><br>These requirements will be implemented into my research design as already explicated in sections 3-5.<br><br>Additionally I will ensure that all participants are given a copy of the GDPR participant privacy notice along with all other relevant forms and information. |

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07/11/2019

Our Ref: 2019/45

Dear Louise Clarke

Thank you for your resubmitted research ethics application for your project:

*Understanding and Challenging Resilience in children's nursing*

I am pleased to confirm that we give you full ethical approval to your research. We have noted that it also complies with the sponsor's and IRAS recommendations.

We wish you well with your research.

8.7.2 minor amendments application

### 8.7.3 HRA ethics approval

Hard copies available to examiners on request

## 8.8 Exemplar lesson plan

**Lesson Plan – Resilience in Children's nursing Facilitated session.**

Prior to this session students would be asked to access an online presentation or perhaps an interactive package that introduces them to some of the main theories of resilience e.g. trait/ dynamic process/ ecological model/ social constructionist model of resilience. They would be asked to access this in advance of the seminar to assist them with preparing for the debate.

| **Room Set up** | **Room to set up with four tables and students will be asked to spread themselves evenly between the tables 5 – 6 students per group.** | | **Resources Flip charts and pens iPad for independent/ group research** |
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| **Method** | **Content** | **Duration** | **Resources** |
| **Introduction** | • Brief introduction to the aims and objectives of the session<br>• Brief introduction of some background content | 5 mins | Facilitator led |
| **Individual activity** | • Ask students to spend 5 minutes reflecting on what resilience means to them, how would they define it.<br>• Ask students to write their own personal definition of resilience.<br>• Ask students to share their definitions with the whole group | 15 minutes max | Personal reflection followed by whole group discussion. |
| **Facilitator led discussion.** | • Introduce common definitions of resilience.<br>• Discuss the perceived importance of resilience to nursing | 10 minutes | Facilitator led |
| **Preparation for Debate** | Use the fours tables as a natural way to split the whole group into four smaller groups 1 -4<br><br>Give groups 1 and 2 the first statement:<br>**Nurses and student nurses need to be more resilient.**<br>Group 1 should construct an argument that supports this statement and group 2 an | 30 minutes | Group work |

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| | argument that challenges this statement.<br><br>Give groups 3 and 4 the following statement:<br>**Resilient people are strong. People who lack resilience are weak.**<br>Group 3 should construct an argument that supports this statement, group 3 an argument that challenges this statement.<br><br>Allow all groups up to 30 minutes to discuss and prepare their arguments. They can base this on the experiences they have had, what they have seen in practice and literature if they wish – iPad available if students wish to use these.<br><br>Students will have 10 minutes each to present their arguments, | | |
| **Comfort break – 30 minutes** | | | |
| **Debate** | Students will have up to 10 minutes each to present their arguments.<br><br>Once groups 1 and 2 have presented their arguments, students in groups 3 and 4 will vote on who has presented the most convincing argument – then vice versa.<br><br>There will be a small prize for each winning group | 40 minutes | Debate |
| **Debrief** | • How did that feel?<br>• What are your thoughts about the statement you were given<br>• Do you agree with the stance you were given?<br>• Has your opinion changed?<br>• If so what changed it? | 10 minutes | Whole group discussion and debrief – facilitator led |
| **Facilitator led presentation** | Presentation of some of the main findings from the study in relation to how nurses tend to conceptualise resilience/ link to coping/ how student learn about resilience. | 20 minutes | Facilitator led. |

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| **Whole group debrief and discussion** | Finally consider some of the following questions as a general discussion<br>• Is resilience always a positive thing?<br>• Can you have too much resilience?<br>• Is there a maladaptive discourse of resilience in nursing?<br>• What could be done about this?<br>• What resources might help people maintain their resilience?<br>• How easy is it to access these resources in the university/ practice setting?<br>• What might help you to negotiate access to such resources how might the university/ trusts be able to help? | 25 minutes | Whole group discussion |
| **Final questions** | Opportunity to ask any final questions or make any final comments. | | Student led |
| | Total Sessional length | **180 minutes** | |

## 8.9 Details of the initial scoping review undertaken at conceptualisation of this study

**1. Search strategy:**

This literature review takes the form of a scoping review; this type of review tends to be undertaken at the start of doctoral research with the aim being to document what is already known about a subject before focusing in on potential gaps, niches, or blind spots (Thomson, 2013a). This review was conducted at the start of my doctoral journey in 2018. This started with a search of Google Scholar because it holds a broad repertoire of resources from academic publishers, professional bodies, and online university repositories (Weetman DaCosta, 2012), before the search was repeated using four further electronic databases namely NUsearch, CINAHL, SCOPUS and EMBASE. NUsearch is the University of Nottingham's library collections discovery tool; it was chosen because it enables searches of the universities extensive collection of books, eBooks, journals, and e-journals. CINAHL was chosen as it is the authoritative resource for nursing and allied health professionals (University of Nottingham, 2017). SCOPUS was chosen because it covers a broad range of disciplines and includes high quality research. EMBASE was chosen because it is a medical research database that includes high quality research and additionally includes all research available within MEDLINE. Furthermore, all databases have advanced search functions so allow a more focussed search of the literature to be undertaken.

***1.1 Key words, limiters, and inclusion/ exclusion criteria***

After deciding upon the databases, key search terms (keywords) were selected. These were devised with the main aims of the literature review in mind (to discover what was known about resilience in children's nursing, and to expose potential gaps in that knowledge). Aveyard (2014) states that keywords should be identified which "capture the essence" (p83) of the question to be reviewed; as there were two main aims for this

literature review, key terms were identified across a range of related concepts, please see Table 1.

| **Key search terms** |
| --- |
| Emotional resilience |
| Paediatric (alternative words paediatric OR pediatric OR child OR children OR children's used in NUsearch, CINAHL. EMBASE, and SCOPUS) |
| Nursing (truncation symbol (Nurs* used in NUsearch, CINAHL, EMBASE and SCOPUS) |
| Stress |
| Compassion fatigue |
| Burnout |
| Vicarious traumatisation |

*Table 1: Key search terms*

While I acknowledge that terms like stress, burnout, compassion fatigue, vicarious traumatisation and resilience are all separate concepts, they are often discussed together within the literature. Stress is seen as a risk factor for the development of vicarious traumatisation and compassion fatigue, which if sustained is thought to increase the risk of burnout; resilience is seen as one possible measure to ameliorate stress, CF, and BO (Hesselgrave, 2014), thus I deemed these key terms to be relevant to this review. Furthermore, I wanted to keep the search terms relatively broad as, in line with a scoping review, I wanted to try to find out what had been written already about the topic whilst also searching for potential gaps in the body of knowledge. All five databases were searched with various combinations of the key search terms to further focus the results. Truncation was employed within NUsearch, CINAHL, SCOPUS, and EMBASE for the search term 'nurs*' to retrieve results that included the terms nurse, nurses, and nursing. Additional search terms were used for the key search term 'paediatric' to ensure articles including the term 'pediatric, child, and children's' were also included.  Key search terms were combined within NUsearch, CINAHL, SCOPUS, and

EMBASE with the Boolean operator 'AND' to further focus the search (EBSCO, 2017). Several limiters were also set as follows to further refine the search results.

| Data Base | Limiters | Results |
|---|---|---|
| **Google Scholar** | Limited to the last 10 years<br>Displayed by relevance | 17,400 |
| **NUsearch** | Full text<br>English<br>Peer reviewed<br>Last 10 years<br>Displayed by relevance | 649 |
| **CINAHL** | Full text<br>English<br>Peer reviewed<br>Last 10 years<br>Displayed by relevance | 629 |
| **SCOPUS** | English<br>Journal<br>Last 10 years | 9 |
| **EMBASE** | Full text<br>English<br>Last 10 years | 0 |

*Table 2: Table of limiters*

While there is some debate about limiting literature searches to most recent works due to the requirement of a researcher to locate their work within the field so demonstrating that they understand the historical context and progression of their field of study; it is also important for a researcher to situate and identify the contribution they are going to make (Thomson, 2013b). As one of the general aims for this literature review was to identify potential gaps in current research, I reasoned that it was acceptable to limit my search to the most recent literature.

When looking at the number of hits within Google Scholar it was not possible to read through the title and abstract of all articles found. The database was set to display literature based on relevance to the key search terms and so I took the decision to check through the articles displayed until I was confident that no further relevant articles were being uncovered. I arbitrarily determined that I would stop at a point where no relevant articles had been identified within the last 10 screens of results (100 papers). This decision was based loosely on an approach described by Pat Thomson (2012) in one of her Patter blogs in which she reported checking through the first 15 screens of results during a review that had revealed an extensive number of hits. I also determined my own set of inclusion criteria to make decisions about which articles to include within the review and which to exclude.

| **Inclusion considerations** |
| --- |
| • The literature must focus on paediatric nurses.<br>• The literature should focus on resilience or closely related phenomena such as stress, vicarious traumatisation, compassion fatigue, burnout, emotional burden.<br>• The literature should focus on stressors evident with the paediatric nursing setting.<br>• The literature should focus upon the development/ presence of resilience or closely related factors (as above) within paediatric nurses.<br>• The literature may focus upon strategies to enhance the development of resilience in the paediatric nursing population |

*Table 3: Inclusion Criteria*

The results of the literature search and a record of decisions regarding inclusion or exclusion of literature have been represented in pictorial form in the following section.

## 2. Results of Literature search

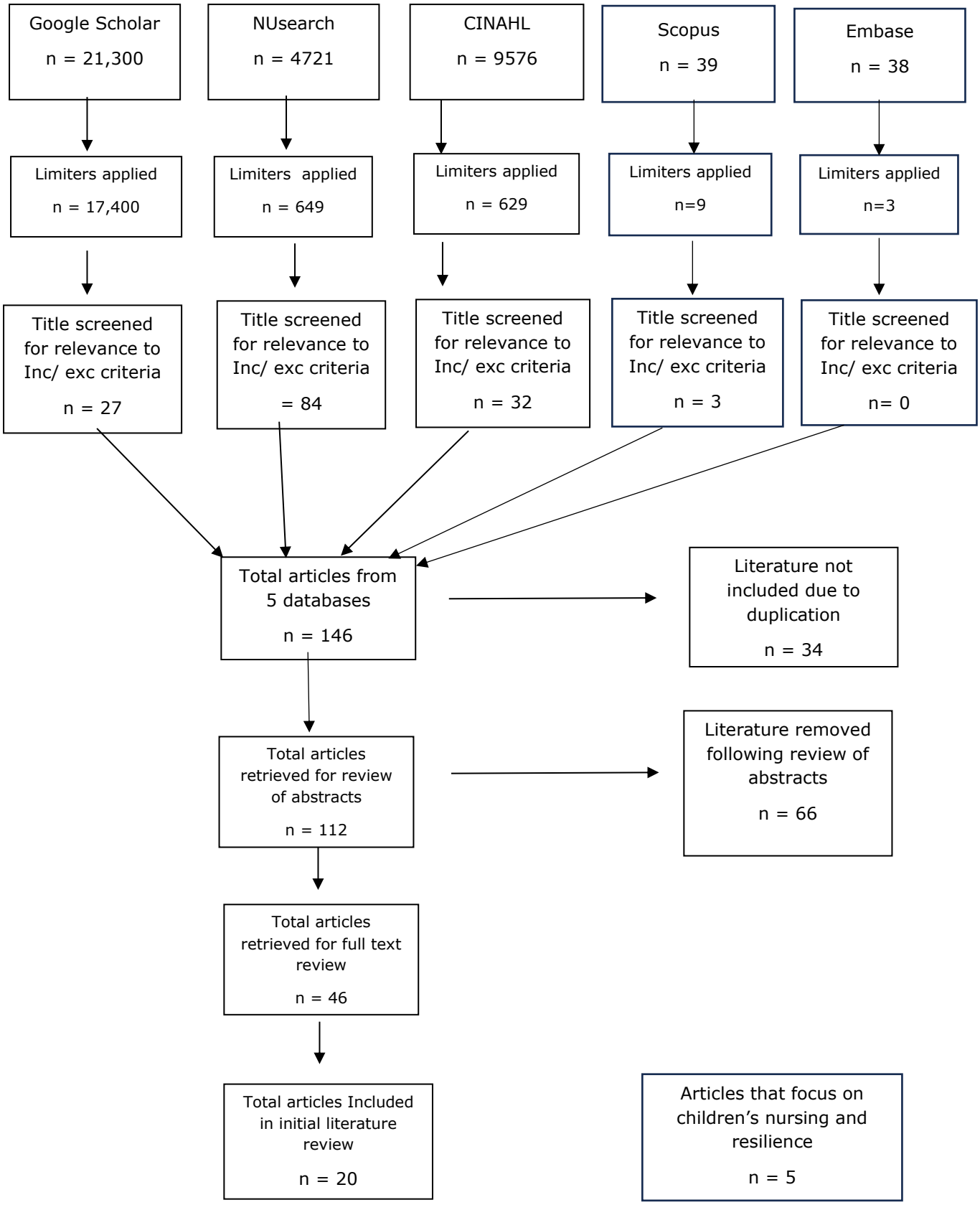



*Figure 1: Based on PRISMA flowchart (Liberati, Altman, Tetzlaff , et al, 2009)*

### 2.1 Summary of literature

The papers were mainly empirical research papers (14 of the 20) of these 10 were quantitative in nature and 4 were qualitative. For the remaining papers, 2 literature reviews were included along with 4 practice papers which mainly took the form of discussion papers written by experienced clinical staff. In terms of origin of the papers 10 papers originated from the USA, 3 from Australia, 3 from the UK and 2 from Turkey (see Table 4). Finally, as shown in the table below, while 20 papers were included in the initial scoping review, only 5 had a stated focus on resilience within children's nursing and no papers were found that focussed on resilience within students studying to become children's nurses.

| **Summary of literature – type, location, and focus** | | | |
|---|---|---|---|
| **Quantitative** | **Qualitative** | **Literature Review** | **Practice paper** |
| Akman et al (2016)<br>**Turkey**<br>**Focus: Burnout** | Aburn et al (2018)<br>**New Zealand**<br>**Focus: Resilience** | Hecktman (2012)<br>**USA**<br>**Focus: Stress** | Hesselgrave (2014)<br>**USA**<br>**Focus: Compassion Fatigue** |
| Aytekin et al (2013)<br>**Turkey**<br>**Focus: Burnout** | Cook et al (2012)<br>**USA**<br>**Focus: Coping** | Zander et al (2010)<br>**Australia**<br>**Focus: Resilience** | Howard et al (2012)<br>**UK**<br>**Focus: Emotional Labour** |
| Berger, et al (2015)<br>**USA**<br>**Focus: Compassion fatigue** | Mcloskey et al (2010)<br>**Ireland (UK)**<br>**Focus: Compassion fatigue** | | Morgan (2009)<br>**USA**<br>**Focus: Emotional labour** |
| Czaja et al (2012)<br>**USA**<br>**Focus: Stress** | Zander et al (2013)<br>**Australia**<br>**Focus: Resilience** | | Pardo (2011)<br>**UK**<br>**Focus: Psychological support** |
| Davis et al (2013)<br>**USA**<br>**Focus: compassion and burnout** | | | |
| Lee et al (2015)<br>**USA**<br>**Focus: Resilience** | | | |
| McGarry et al (2013)<br>**Australia**<br>**Focus: Resilience** | | | |
| Meyer et al (2013)<br>**USA**<br>**Focus: Compassion Fatigue** | | | |
| Robins et al (2009)<br>**USA**<br>**Focus: Stress** | | | |
| Sekol et al (2014)<br>**USA**<br>**Focus: Burnout and Stress** | | | |

*Table 4: Summary of literature*

## 3. Full list of references relevant to the literature review extract

Aburn, G.E., Hoare, K., Gott, M. (2018) Reflecting on a journey of resilience in children's blood cancer nursing. **Reflective Practice**. 9, (2), p250-266.

Akman, O., Ozturk, C., Bektas, M., Ayar, D., and Armstrong, M.A. (2016) Job satisfaction and burnout among paediatric nurses. **Journal of Nursing Management**. 24, (7), p923-933.

Aveyard, H. (2014) **Doing a literature review in health and social care**. Open University Press: Berkshire.

Aytekin, A., Yilmaz, F., and Kuguoglu, S. (2013) Burnout levels in neonatal intensive care nurses and its effect on their quality of life. **Australian Journal of Advanced Nursing**. 31, (2), p39-47.

Berger, J., Polivka, B., Smoot, E.A., Owens, H. (2015) Compassion fatigue in pediatric nurses. **Journal of Pediatric Nursing**, 30, pp e11-e17.

Cook, K.A., Mott, S., Lawrence, P.,Jablonski, J., Grady, M.R., Norton, D., Liner, K.P., Cioffi, J., Hickey, P., Reidy, S., Connor, J.A. (2012) Coping while caring for the dying child: Nurses' experiences in an acute care setting. **Journal of Pediatric Nursing**, 27, pp e11-e21.

Czaja, A.S., Moss, M., and Mealer, M. (2012) Symptoms of posttraumatic stress disorder among pediatric acute care nurses. **Journal of Pediatric Nursing**. 27, p357-365.

Davis, S., Lind, B.K., and Sorensen, C. (2013) A comparison of burnout among oncology nurses working in adult and pediatric inpatient and outpatient settings. **Oncology Nursing Forum**. 40, (4), pE303-E311.

EBSCO (2017) **Searching with Boolean operators** [online] Available at: https://help.ebsco.com/interfaces/EBSCO_Guides/EBSCO_Interfaces_User_Guide/Searching_with_Boolean_Operators [last accessed 08/11/17]

Hecktman, H.M. (2012) Stress in Pediatric oncology Nurses. **Journal of Pediatric Oncology Nursing**, 29, (6) pp 356-361.

Hesselgrave, J. (2014) Coping with compassion fatigue in pediatric oncology nursing. **Oncology Times**. 36, (15), p2-3.

Howard, A., Timmons, S. (2012) Emotional Labour: The challenges of working with children and cancer. **Nursing Children and Young People**, 24, (5), pp 14-18.

Lee, K,J., Forbes, M, L., Lukasiewicz, G.J., Williams, T., Sheets, A., Fischer, K., Niedner, M.F. (2015) Promoting Staff Resilience in the Pediatric Intensive Care Unit. **American Journal of Critical Care**, 24, (5) pp 422 – 430

Liberati A, Altman DG, Tetzlaff J, Mulrow C, Gøtzsche PC, et al. (2009) The PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses of Studies That Evaluate Health Care Interventions: Explanation and Elaboration. **Ann Intern Med** 151(4).

McGarry, S., Girdler, S., McDonald, A., Valentine, J., Shew-Lee, L., Blair, E., Wood, F., Elliott, C. (2013) Paediatric health-care professionals: Relationships between psychological distress, resilience and coping skills. **Journal of Paediatrics and Child Health**, 49, pp725-732.

Mcloskey, S., and Taggart, L. (2010) How much compassion have I left? An exploration of occupational stress among children's palliative care nurses**. International Journal of Palliative Nursing**. 16, (5), p233-240.

Meyer, R.M.L., Li, A., Klaristenfeld, J., Gold, J.I. (2013) Pediatric novice nurses: Examining compassion fatigue as a mediator between stress exposure and compassion satisfaction, burnout and job satisfaction. **Journal of Pediatric Nursing**, 30, pp174-183.

Morgan, D. (2009) Caring for dying children: assessing the needs of the pediatric palliative care nurse. **Pediatric Nursing**. 35, (2), p86-90.

Pardo, P. (2011) Psychological support for nurses on paediatric intensive care units. **Nursing Children and Young People**. 23, (8), p27-29.

Robins, P.M., Meltzer, L., Zelikovsky, N. (2009) The experience of secondary traumatic stress upon care providers working within a children's hospital. **Journal of Pediatric Nursing**, 24, pp 270-279.

Sekol, M.A., and Kim, S.C. (2014) Job satisfaction, burnout, and stress among pediatric nurses in various specialty units in an acute care hospital. **Journal of Nursing Education and Practice**. 4, (12), p115-124.

Thomas, L.J., Hunter-Revell, S. (2016) Resilience in nursing students: An integrative review. **Nurse Education Today**. 36: p 457-462.

Thomson, P. (2012) **Mapping the literatures, step two. #acwrimo work in progress** [Online] available at: https://patthomson.net/?s=mapping+the+literatures [last accessed 13/11/17].

Thomson, P. (2013a) **Not all literature reviews are the same** [Online] available at: https://patthomson.net/?s=not+all+literature+reviews+are+the+same [last accessed 13/11/7].

Thomson, P. (2013b) **The literature review – how old are the sources?** [Online] available at: https://patthomson.net/?s=the+literature+review+how+old+are+the+sources [last accessed 13/11/17].

University of Nottingham (2017) **NUsearch FAQ's** [online] Available at: http://www.nottingham.ac.uk/library/collections/nusearchfaqs.aspx [Last accessed 08/11/17].

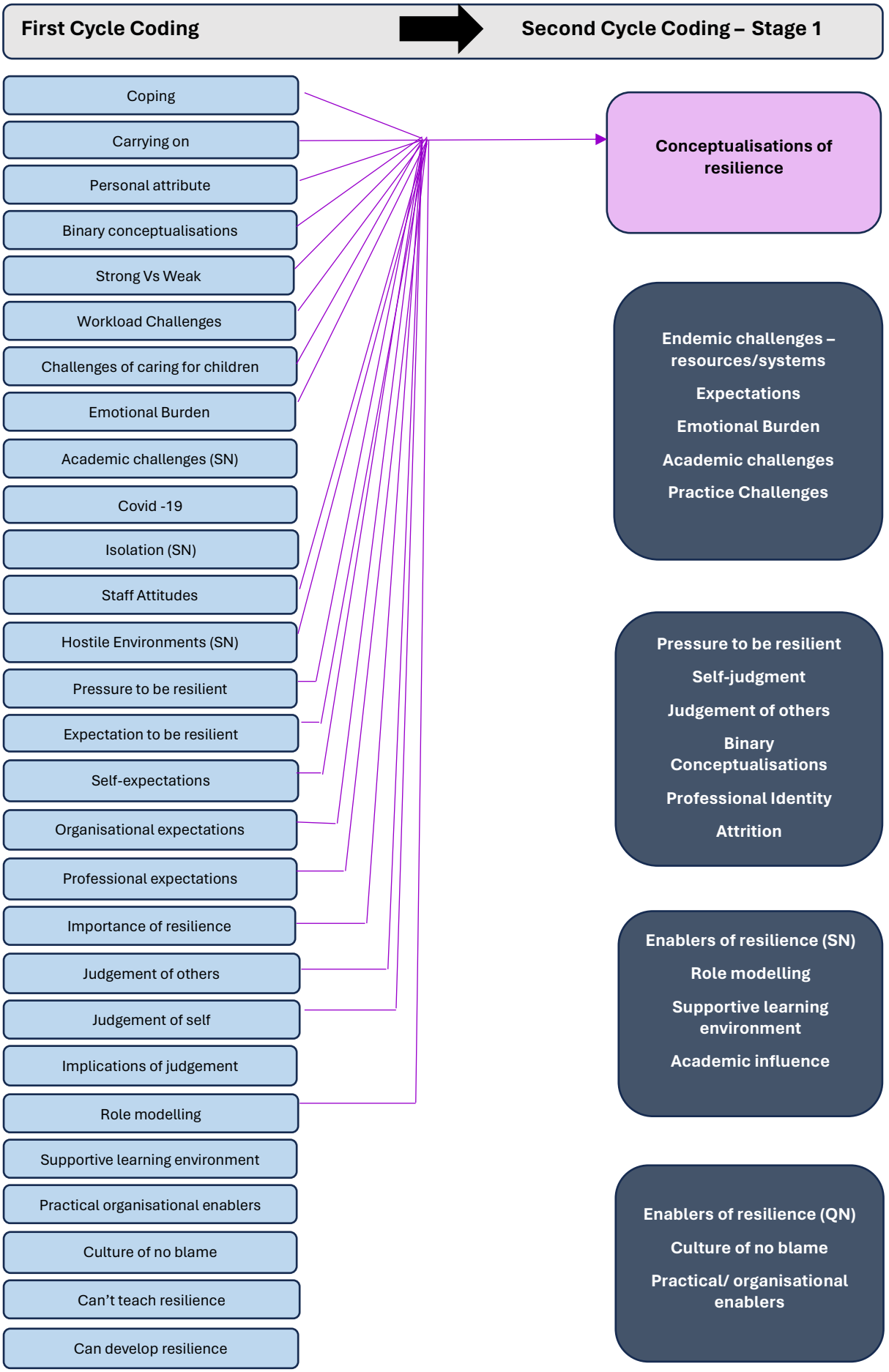
Weetman DaCosta, J. (2012) reviewing educational Literature in Briggs, A.R.J., Coleman, M., Morrison, M. (Eds.) **Research Methods in educational leadership and Management**. SAGE: London.

Zander, M., Hutton, A., King, L. (2010) Coping and resilience factors in paediatric oncology nurses. **Journal of Pediatric Oncology Nursing**, 27, (2) pp 94-108.

Zander, M., Hutton, A., King, L. (2013) Exploring resilience in paediatric oncology nurses. **Collegian**, 20, pp 17-25

## 8.10 Diagrams to show how first cycle codes informed initial second cycle codes.

(please see following pages)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Challenges of caring for children
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Covid -19
Isolation (SN)
Staff Attitudes
Hostile Environments (SN)
Pressure to be resilient
Expectation to be resilient
Self-expectations
Organisational expectations
Professional expectations
Importance of resilience
Judgement of others
Judgement of self
Implications of judgement
Role modelling
Supportive learning environment
Practical organisational enablers
Culture of no blame
Can't teach resilience
Can develop resilience
Conceptualisations of resilience
Endemic challenges – resources/systems
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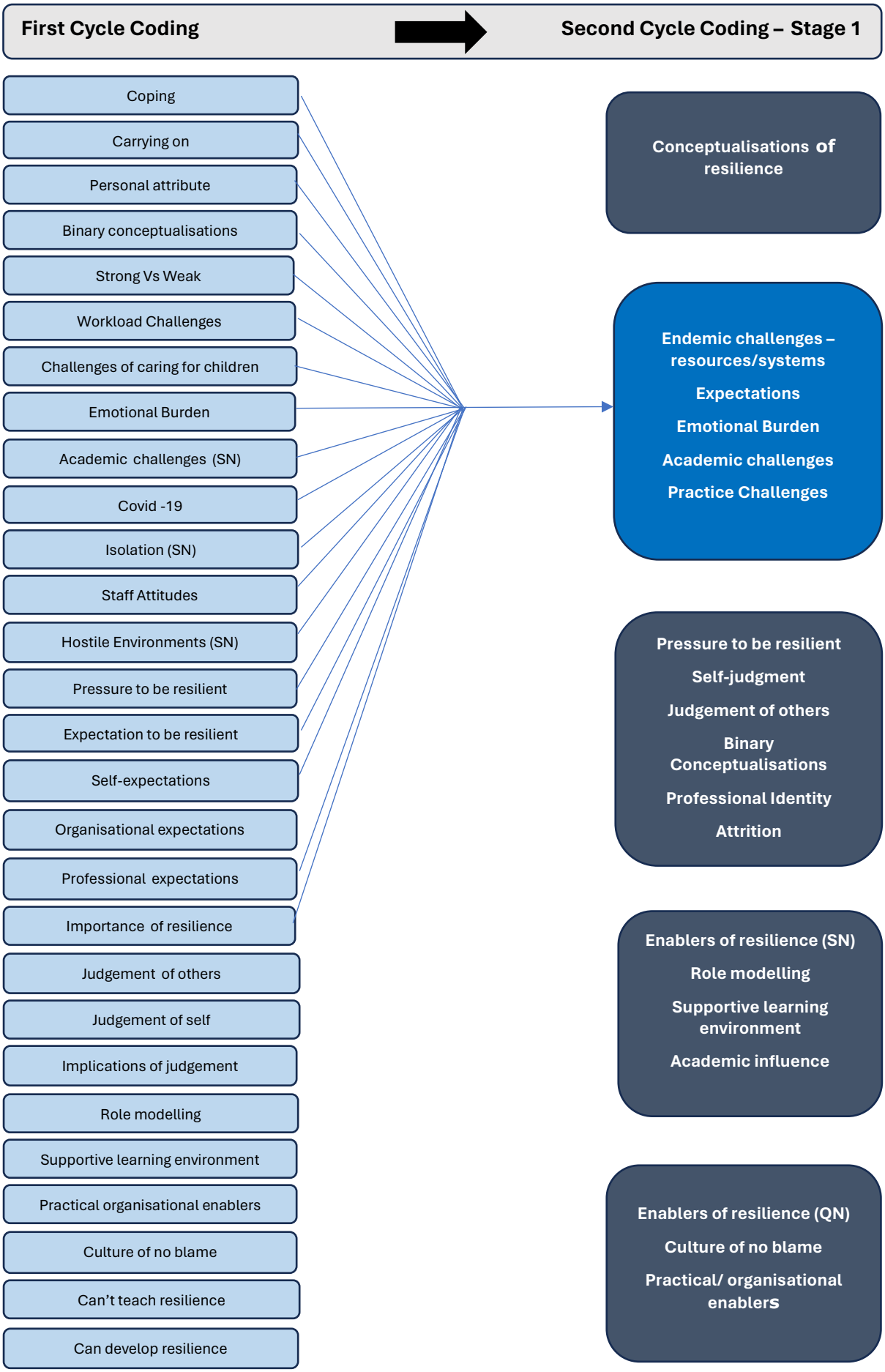
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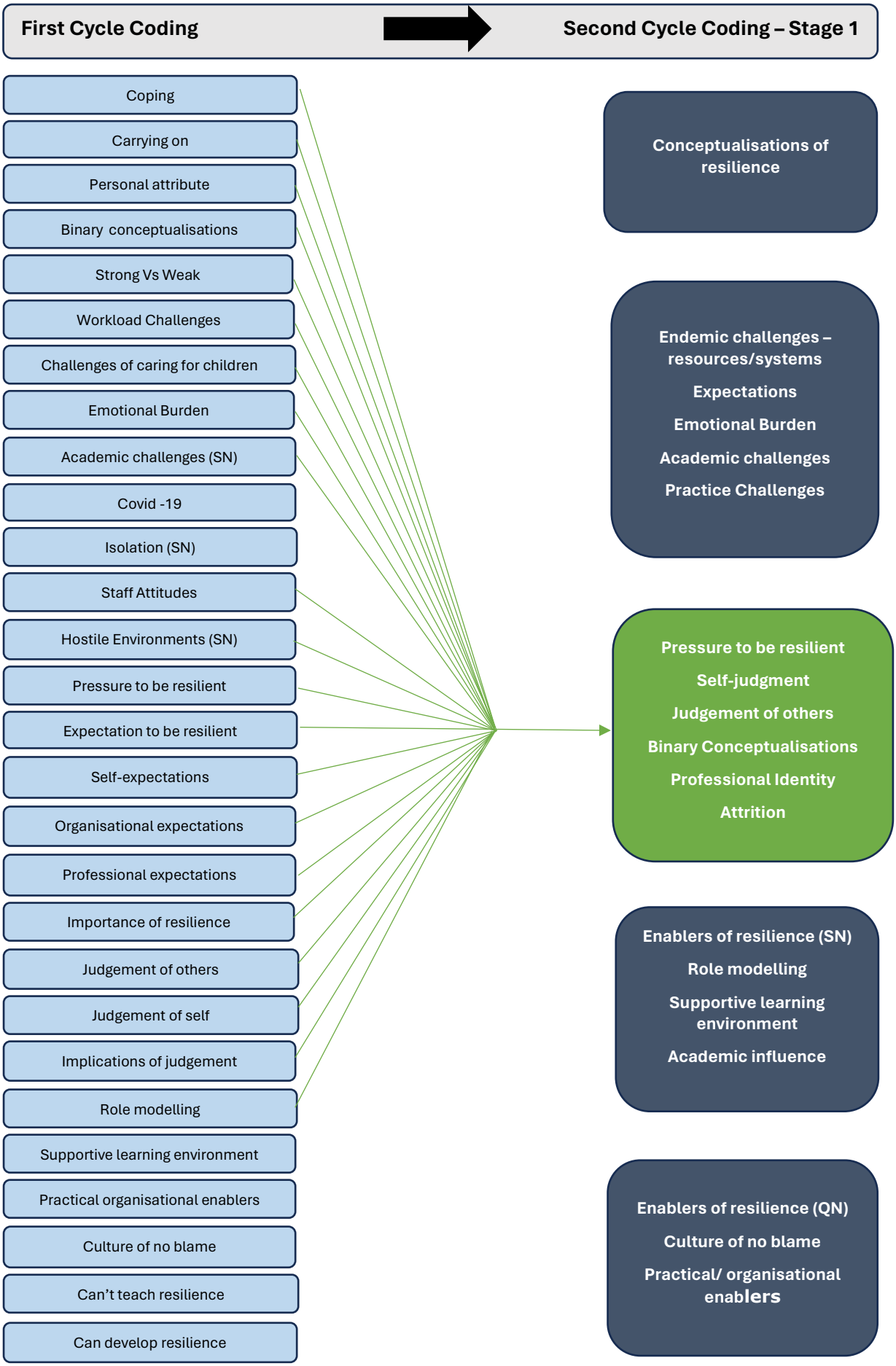
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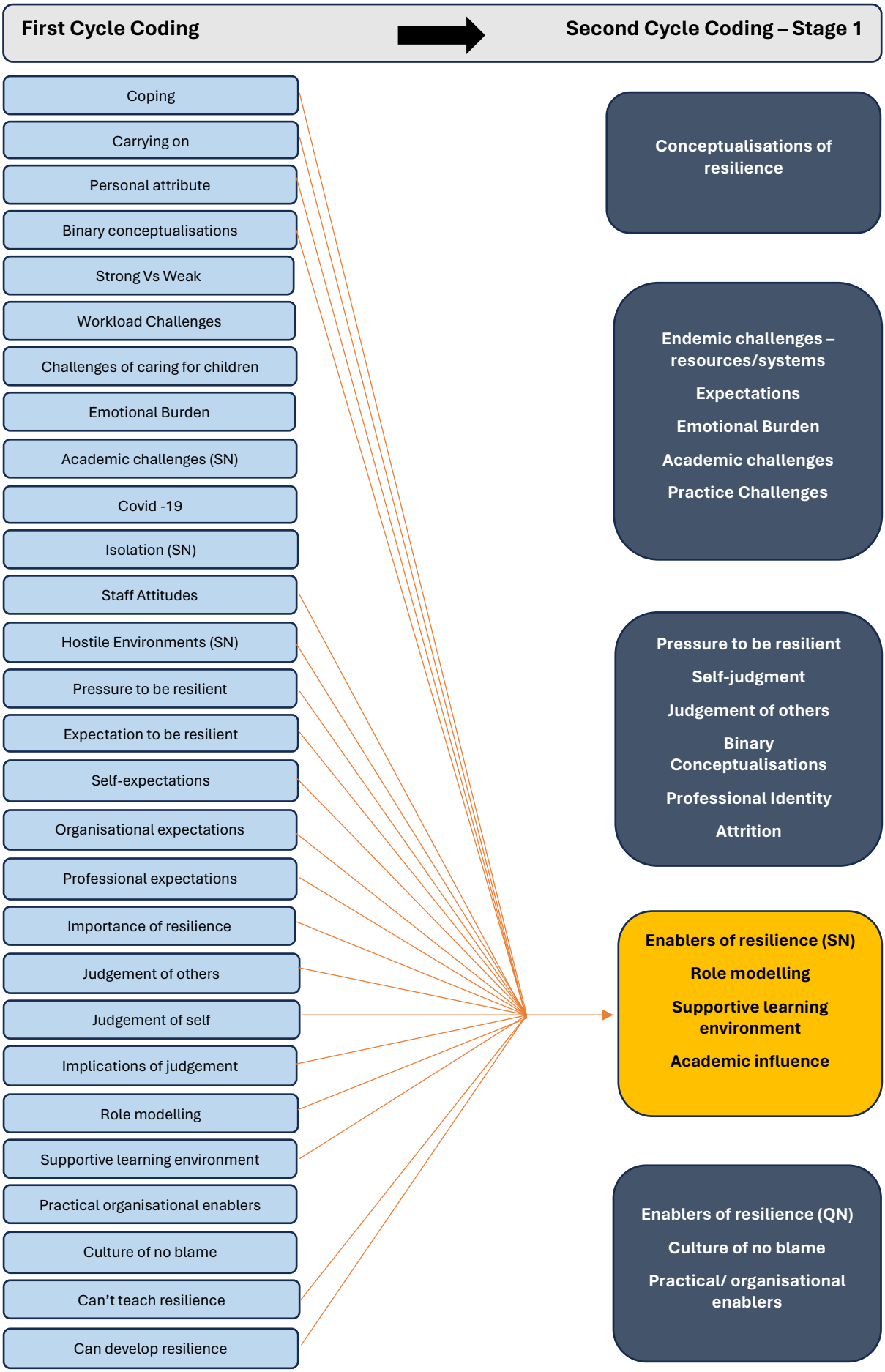
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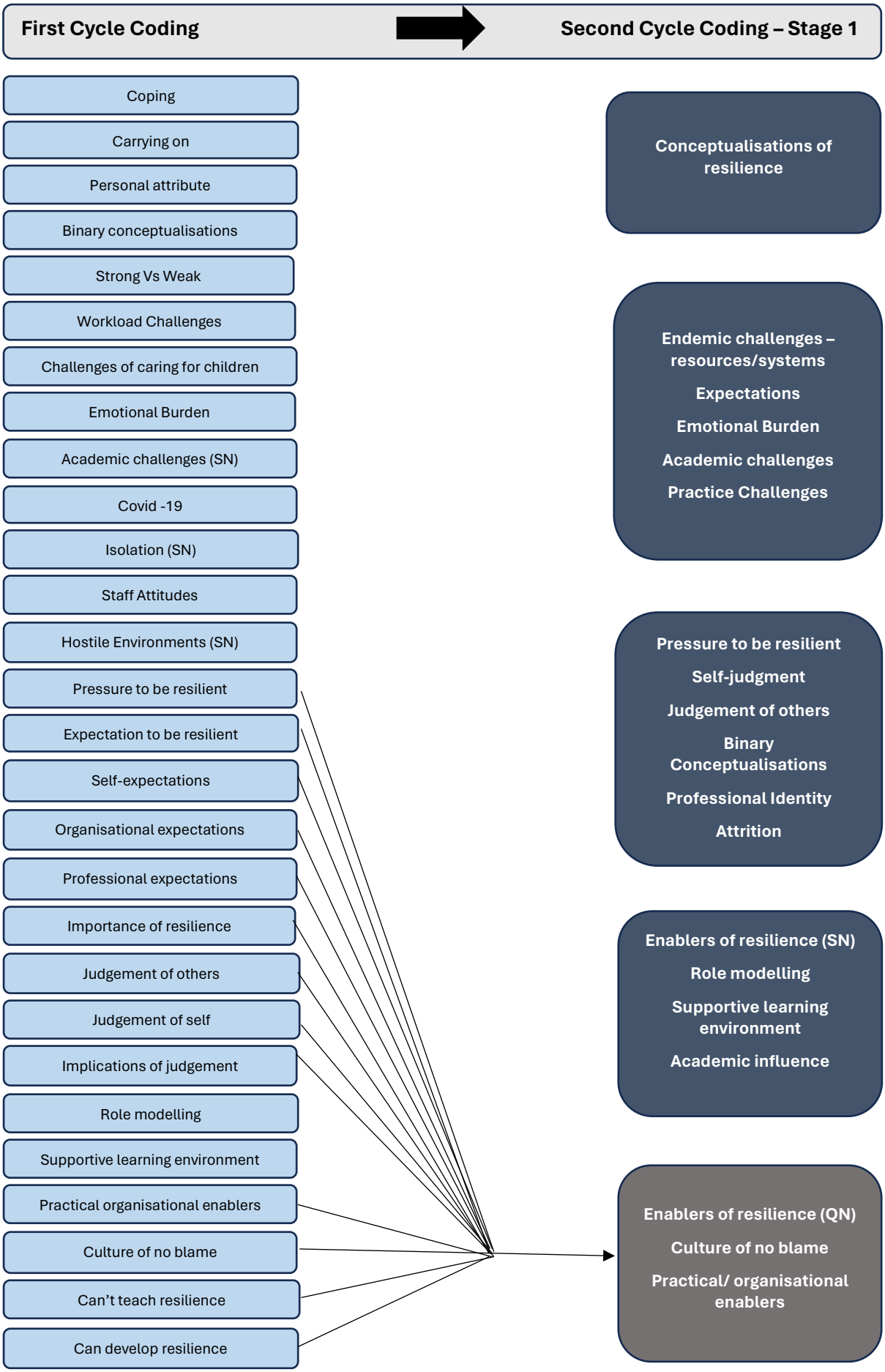
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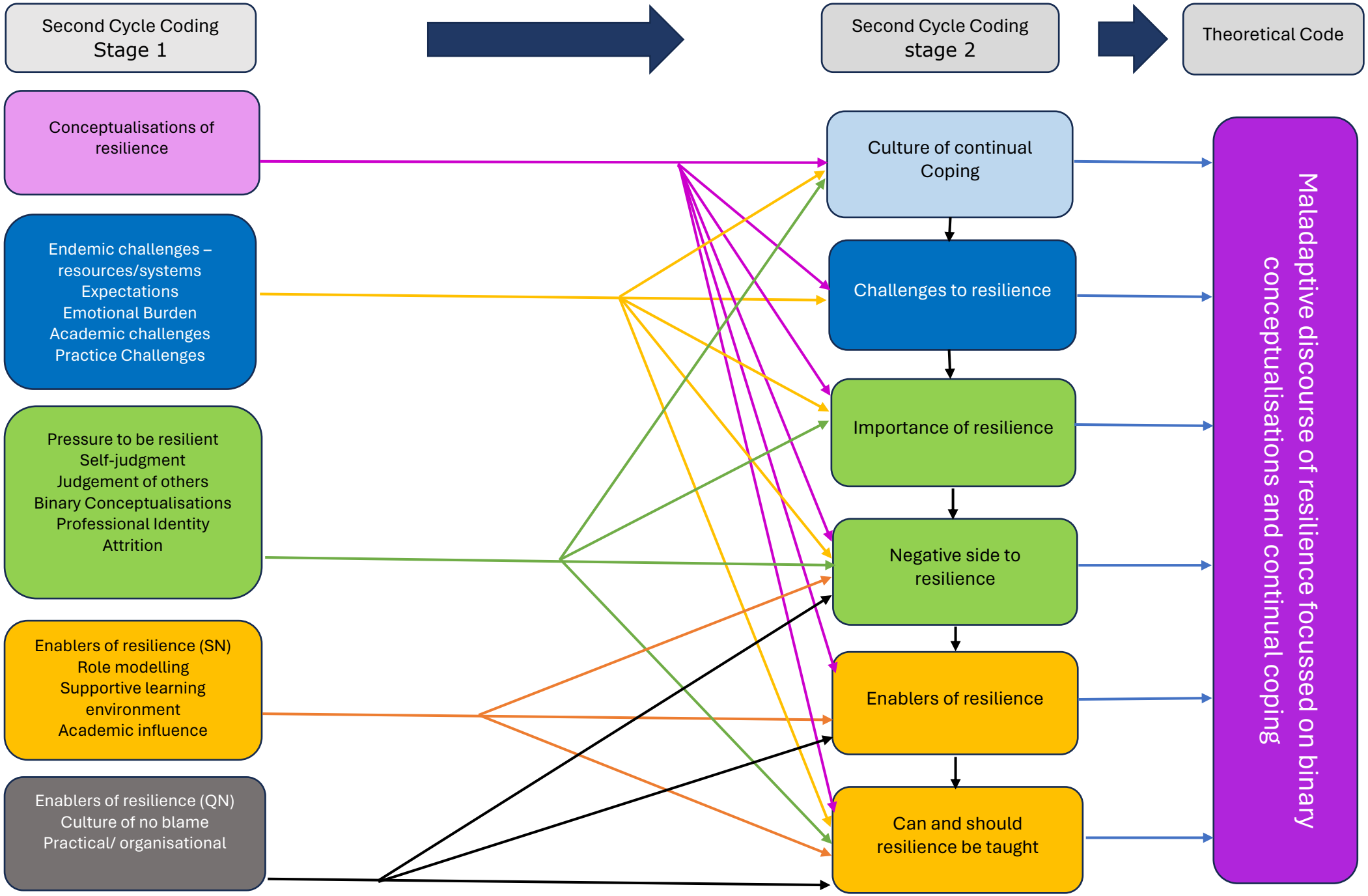
## 8.11 Diagrams to show how first cycle codes informed initial second cycle codes.

Diagram 1: Stage 1 second cycle coded to stage 2 second cycle codes.

Diagram 2: link between stage 2 second cycle codes to research questions.

(Please see following pages).

Louise Clarke (4283906)



Louise Clarke (4283906)