

Aim: To explore how adult, child, mental health nursing and midwifery students describe their 'values journey' after completing their second year following exposure to the clinical practice environment.

Background: Where student nurses and midwives are selected using multiple mini interviews, in a values based recruitment process, the conservancy and or development of their personal values remains unclear.

Design: A hermeneutic, cross-professional longitudinal study was commenced at one university in England in 2016 with data collection points at the end of years one (DC1), two (DC2) and three (DC3). From the 42 participants recruited in year one, 28 went on to participate in data collection at DC2 (3 adult, 6 child, 3 mental health nurses and 16 midwifery students).

Methods: Four semi-structured focus groups were conducted. Data analysis incorporated inductive and deductive approaches in a hybrid synthesis.

Findings: Participants did not feel their values had changed fundamentally since year one. However, the prioritisation of their values and how they were 'put into practice' had changed. Key themes identified were: 'changed sense of self as a healthcare practitioner'; 'influences on values in practice' and 'reflection on values'.

Conclusion: Reframing of personal values is an integral part of learning across clinical and academic settings. Critical reflective practice should be integrated into pre-registration health education programmes to support student nurses and midwives sustain their learning around values; to maintain 'good' values in the face of observed 'bad' values.

Key Words:

Focus groups, midwifery students, nursing students, multiple mini interviews, values, values based recruitment, hermeneutic

1. INTRODUCTION

It is no surprise that the provision of high quality nursing and midwifery care continues to be prioritised by the World Health Organisation (WHO) in their vision for health services (WHO, 2016, 2018). In this respect, 'experience' of care is once again being positioned as a critical aspect of service provision and not just complementary to routine clinical practices (WHO, 2018). The national Values Based Recruitment (VBR) Programme in England (Health Education England, HEE, 2014) is consistent with this vision where all healthcare staff and students are recruited according to defined compassionate, 'patient-centred' values (Great Britain, DoH, 2013). Multiple mini interviews (MMIs) (Eva et al, 2004,) are one approach to VBR endorsed by HEE (2014, Patterson et al, 2014). This study focuses on the challenges and developments to personal values explained by nursing and midwifery students, reported as a 'journey' in the context of VBR.

Organisational pressures, financial constraints, rising population numbers, life expectancy and multiple co-morbidities have meant that health services are struggling to keep up with demand (Allan et al, 2017, Hojat et al, 2009, Paley, 2014, Zimmerman et al, 2005). Serious lapses in care have been identified (Francis, 2013, Keogh, 2013, OECD, 2013, Kirkup, 2015, Toth, 2015, Jones et al, 2015, Hutchinson, 2016, Bloche, 2016). Situations of 'missed care' (Bagnasco et al, 2017) or 'care left undone' (Ball et al, 2016) are described as well as 'compassion fatigue' (Joinson, 1992), 'erosion' of healthcare professionals' personal values (Maben et al, 2009, Jack, 2017) and 'care erosion' (de Vries & Timmins, 2017). Intrinsic to these reported observations are progressive inconsistencies between the values of healthcare, at staff and organisational levels, and actual care provided in clinical environments. These may be emergent disparities but may also represent a change in caring practices none-the-less. Rather than see values as unchanging over time, we have conceptualised students' expression of change in their personal values as a 'values journey' (XXXX et al, 2017) experienced with increasing exposure to clinical practice. We see this values journey as integral to, and an opportunity for, learning in pre-registration education programmes. Drawing on data from a longitudinal study first reported in 2017 (XXXX et al, 2017) with student nurses and midwives' selected using MMIs, we now explore these students' 'values journeys' at the end of their second year of study.

2. BACKGROUND

We acknowledge the complexity of defining personal and professional values in a health service context (XXXX et al, 2018). Values hold differing degrees of significance and relevance to individuals (Schwartz, 2012); they transcend different situations and can be prioritised by perceived importance when two or more are in conflict. Personal values shape behaviour and can be influenced by internal and external factors. Examples are motivation and economic pressures (Parks and Guay, 2009) as well as historical and cultural consciousness (Palmer, 1969). Drawing on Gadamer's (1989) theory of 'horizons of understanding', XXXX et al (2017) suggest that, as individuals exist in a state of flux, so students are continually refining their value priorities through interactions with others in a fluid state of knowledge acquisition.

During nurses and midwives' programmes, movement or change in value priorities is influenced by clinical practice and education (Evans et al, 2010). How individuals perceive, validate and process their experiences can be transformative (Mezirow, 1978). Informed by the constructivist assumption that 'meaning is individualistic and found inside ourselves' (Kitchenham, 2008), new perspectives are fostered through learning from critical reflection. Mezirow (1978) describes four types of learning (Table 1) relevant in a healthcare context. Critical reflection facilitates self-correction to maintain personal and professional values and reduces chances of care erosion (de Vries & Timmins, 2017). Issues arise when healthcare professionals feel unable to provide the standard of care they aspire to due to external organisational, structural or economic pressures. To manage the resulting personal conflict they may employ a 'smoke screen' (de Vries & Timmins, 2016). This 'smoke screen' can take the form of avoiding reflection, focusing on something else, trivialising events or making excuses. It remains unclear if and how healthcare students, recruited using values-based approaches, maintain and develop their values and what supportive strategies might be needed when facing challenges in clinical practice.

2.1 Study aim

To explore how adult, child, mental health nursing and midwifery students describe their 'values journey' after completing their second year following exposure to the clinical practice environment.

3. DESIGN

This hermeneutic (Palmer, 1969) cross-professional longitudinal study was commenced at one university in England in 2016. The study was designed to explore healthcare students' articulation of their 'values journey' at the end of each year of their programme. This paper reports year two findings which are discussed in the context of those previously published from year one (XXXX et al, 2017).

3.1 Participants

All September 2015 entry adult, child, mental health nursing and midwifery students were invited to participate using non-probability, consecutive sampling. Exclusion criteria applied to any student who had undertaken any prior health education programme. Notably, the midwifery students were 'direct entry' i.e. they did not have any prior nursing qualifications which might have influenced their perspectives. In year one, students were initially contacted via email and then followed up one week later when they attended university for lectures. Forty-two individuals agreed to participate at the end of their first year: eight adult, eight child, nine mental health and seventeen midwifery students (XXXX et al, 2017). At the end of year two the volunteers were emailed again asking if they would take part in a second focus group. Twenty-eight students volunteered (three adult, six child, three mental health and 16 midwifery) out of the original sample of 42 from year one. It was not possible to follow up those who declined to take part in year two data collection due to ethical restrictions.

3.2 Data collection

Four semi-structured focus groups were held on 6th October 2017 lasting between 37 and 48 minutes. This was during the first week of the September 2015 cohorts' third year while they were in university for lectures. This approach reflected that taken in year one where a university setting was considered preferable to avoid distraction and influences from the clinical practice environment (Creswell, 2013). To ensure consistency with year one data collection, those who participated remained in the same profession-specific focus groups and the same questions were asked (XXXX, 2017).

Focus groups foster iterative, fluid dialogue between participants (Wilkinson et al, 2004). They have been the subject of critique in relation to how such interactions might 'contaminate' participants' descriptions of experiences (Webb & Kevern, 2001). Consistent with the theoretical position of this study, Bradbury-Jones et al (2009) argue that such group

interviews are beneficial because of the stimulation of discussion, reflection and opening up of new perspectives (Mezirow, 1978).

3.3 Ethical issues

This study received a favourable opinion from the University Research Ethics Committee in May 2016 (UEC/2016/022/FHMS). Students were advised that their participation/non-participation in the study would have no consequence to their programme progression and they were free to withdraw at any time.

3.4 Analysis

Focus groups were audio-recorded and transcribed verbatim. NVivo (version 11) was employed for in-depth text analysis and cross-referencing between year one and year two data sets, (Woods et al, 2015) initially by the second author; subsequently checked by the first author.

The very limited published literature exploring healthcare students 'values journey' necessitated a three stage hybrid approach to data analysis (Fereday & Muir-Cochrane, 2006). As in year one, initial deductive coding was undertaken with each focus group using a codebook (Crabtree & Millar, 1992; Miles & Huberman, 1994) developed *a priori* from the focus group questions (Stage 1). These codes were entered as 'mother nodes' into NVivo. In Stage 2, coding took place semi-inductively: the predetermined codebook was used as guidance for categorising the data, but, at this stage, new, additional codes, based on the data, were recorded and entered into NVivo as 'child nodes'. In the final stage an inductive, data driven approach, using the 'child nodes', elicited new, unanticipated insights which would not have been otherwise possible (Boyantzis, 1998).

3.5 Study rigour

Focus groups were facilitated by two female researchers (one PhD student and one Lecturer) who were not directly involved in participants' education programmes. This avoided potential conflict of interest especially as a number of the PI's personal students had volunteered to take part. Both interviewers were experienced in focus group facilitation, fully conversant with the study design and involved in recruitment. Interviewers explained their role in the study to participants. Ground rules for the conduct of the focus groups were established prior to

commencement and over seen by the PI. The interview pro forma used in year two data collection replicated that in year one. Audio-recordings of the focus groups discussions were transcribed verbatim by a research assistant. Secondary data checking of 20% of the transcripts was undertaken and found to be over 95% accurate and complete.

4. FINDINGS

Twenty-eight volunteers agreed to take part, 4 male and 24 female aged between 18-42 years.

Initial deductive coding was undertaken based on the focus group questions. Codes at this stage were:

- Changes to 2015 values
- Influence on values and care practice
- Meaning of 'values journey'
- Students' awareness of organisational and financial constraints

Stage 2 of the analysis elicited additional data-driven sub-codes, Table 2.

Analysis in Stage 3 focused on looking for items that were similar, or linked to each other, in order to synthesise new themes and subthemes. For example, the sub-code 'increased confidence' and 'increased knowledge and skill' under the code 'changes to 2015 values', and the sub-code 'being more competent' under the code 'meaning of values journey' could all be related to a change in self-perception regarding the professional role. Three main themes, with different subthemes became clear during this final stage of the analysis, Table 3.

Theme 1. Changes in sense of self as a healthcare practitioner

Students' perceptions of themselves as professionals and their role within the clinical placement environment appeared to have changed compared to year one.

Students explained that, compared to year one (XXXX et al, 2017) they felt a greater level of confidence. They related this to an increase in knowledge and skills regarding guidelines and procedures, as well as feeling more included within the professional team. Students argued that their enhanced confidence positively influenced their initiative-taking and courage. From the year one data, students describe courage as the ability to practise according to one's

values, related to, for instance, integrity and patient advocacy (XXXX et al, 2017). The manner in which students conceptualised courage appeared to be unchanged in year two.

Both child nursing and midwifery students progressively felt part of, and able to make useful contributions to – the healthcare team, as opposed to in year one, when they were ‘seen as an inconvenience’.

“You become to feel like more of the team which, obviously... enhances how you work, because... you don’t just feel like you’re following somebody around, you feel like you can contribute (...) So, I definitely noticed that over this last year.” – Student midwife

Students suggested that their position as second years within the team enabled them to question and challenge suboptimal practice, as hierarchy issues were less likely to get in the way. For example, compared to year one, students were able to name more situations in which they had actively ‘spoken out’ against what they saw as poor practice.

“Having worked with district nurses, I was on a hospital ward... and there was a woman there who had an open wound, and they were just putting a plaster over. And (...) I felt confident and able to say ‘you’re not doing that right... That needs to be treated like this, you need to be doing this with the wound’.” – Adult nursing student

Additionally, midwifery students explained that feeling like part of the team enhanced their values in general, as it made them experience a greater willingness to contribute to the workplace, rather than place their focus solely on working towards their degree.

“They’re becoming my colleagues, rather than me being... the student [...] Which is really nice. And you can start to see your placement as somewhere that you would like to work... as well. Rather than it just being Uni.” – Student midwife.

Where, in year one, students used their inexperience and lack of training as an excuse for the debasing of their values in practice (XXXX et al, 2017), they had apparently ceased to make such excuses by year two. Child nursing students spoke about the increased responsibility that they experienced in relation to patient care. Equally, student midwives expressed a conscious awareness that, within a year, they would be responsible for patients as qualified practitioners. Interestingly, in this context, they spoke about the greater emphasis they now placed on clinical skills as opposed to other aspects of responsibility:

“[...] about clinical skills, I don’t think I ever really put any... not emphasis on it, but I didn’t worry about it, but now... you know, in a few months, that’s going to be your responsibility... you know, this time next year, we are literally... responsible. On our own.” – Student midwife

A dichotomy between focusing on skills and values was mentioned by student midwives in year one (XXXX et al, 2017). In year two, different narratives appeared to exist regarding this dichotomy. On the one hand, it was argued that different skills and values can co-exist, without compromising each other:

“[...] it doesn’t... mean that... the compassion’s less... any less important. It’s still... at the same level it always was. I think the... just because other things become important, it doesn’t take it away...” – Student midwife.

On the other hand, it was mentioned that an emphasis on clinical skills may compromise the provision of compassionate care:

“You know, I feel like the compassionate stuff is just there (...) I like to think you wouldn’t come into this sort of career if it wasn’t something... intrinsic within you, but the clinical stuff is the stuff you learn... and it just becomes... sometimes it overtakes the compassion, because you’re kind of concentrating on what you’re supposed to be doing [...] There’s just so much going on. You kind of lose focus on having a conversation with the woman, because... you just can’t...” – Student midwife.

In addition to experiencing a greater degree of responsibility for patient care, both student midwives and child nursing students felt increasingly responsible for their work environments and interactions with colleagues:

“A supportive environment does make a huge difference, but also, you can make the environment around you supportive.” – Child nursing student.

Theme 2. Influences on values in practice

Overall, students did not feel that their values had changed since the start of their programme. Compassion, empathy, courage, communication, and competence were still deemed important. However, students across groups believed that the prioritisation of values, and how they put them into practice had changed. Although in year one, students’

experience of time and organisational pressures shaped their values journeys (XXXX, et al, 2017) it was one they could mediate. By year two, these pressures had increased, due to the greater level of responsibility that students were now given.

They argued that this could compromise their values, including their ability to show empathy.

“Especially after last year, when they started putting more and more emphasis on the fact that, okay, you’re second year now ... it’s not that you care any less about your women, you don’t want to be any less compassionate to them, but at the same time, you want to get the job done... as well.” – Student midwife.

Child nursing students mentioned that, in the face of time pressures and short staffing levels, they were charged with more tasks and responsibilities than they were supposed to take on, based on their level of experience. This posed a values challenge for them: If the students would *not* take on the extra responsibilities, patients would miss out on care. However, the *quality* of patient care could be impaired due to the fact that they were taking on responsibilities that they were not qualified for. Fears of poor patient care were mixed with fears of their own careers being jeopardised.

“So, I ran the paediatric assessment unit, while [the mentor] dealt with the rest of the ward. But then, I went home that day, (...) I questioned, I was running back to her, like, ‘what about this, what about this’... she’s not physically... seeing any of these... and, you’re thinking... am I jeopardising a kid, and my own career if I miss something right now’, because it’s not just going to go back on her, it’s also going back on me. Because they’re short-staffed you find that, as student nurses you take on sometimes bigger roles...” – Child nursing student

More so than in year one, students mentioned instances in which they had witnessed practice that challenged their values. For example, nursing students across groups spoke about the lack of respect and discrimination of mental health patients by nursing staff.

“It’s funny though, because... in that... house... they work so closely together with doctors and all these professionals and specialist nurses and stuff like that... How can you let your nurse speak about a... client in a way that is really xxxx... that separates them from another group of patients?” – Mental health nursing student.

Both nursing and midwifery students had come encountered qualified colleagues who claimed to be working only 'for the money', colleagues who had become 'conditioned' to adopt a non-investigative attitude, and colleagues who failed to show compassion and empathy when working with patients. Across all professional groups, students' narratives about their colleagues were more negative in year two. Students did not fully understand how and why 'cynicism' among healthcare professionals could emerge, but suggested that this could be a result of constantly having to compromise one's values due to organisational pressures, and subsequent burnout. These factors were also discussed in year one (XXXX et al, 2017). However, in contrast to year one, some students had now started to ascribe the bitterness of their colleagues to personality traits:

"[...] this chap [nurse] doesn't really like people. That's why they are not able to... show that compassion. That's why they're not able to empathise with this patient, because... they are not a people person." – Mental health nursing student

"She's not a nice person [midwife]. Actually, having... spoken to some parents on the special care unit who had her... as their midwife for their delivery... they said 'she was cold, she didn't actually talk to us...'" – Student midwife.

Compared to year one, students appeared to make fewer excuses for nurses or midwives that displayed behaviour that was not in line with their values. In year one, students mentioned that they were 'picking and choosing' good aspects from mentors and other colleagues that they had worked with to include in their own practice. However, in year two, they argued that they were now also actively choosing to dismiss certain things:

"And I just looked at her [nurse] and I... I thought, I don't want to be like you in some ways, because you're... you know what you're doing, and you can make decisions like this, and it's usually the right thing, but I don't want to have that... attitude, I don't want to become... jaded like that [...]" – Adult nursing student

Students acknowledged that the negative values of mentors and other staff members could 'ruin' or 'kill' their values. They emphasised the importance of working with good mentors, in a supportive environment.

“And... she’s mentoring students, and you think, ‘God, all that negativity and you’re newly qualified...’ Bloody hell. You know, that is really having an influence on new students (...) you think ‘God... don’t... don’t ruin them... by saying those things’”. – Student midwife.

Student midwives mentioned that universities should have an active role in selecting mentors, arguing that, as mentors shape students, they need to have ‘the right values’ too.

“The University should interview for mentors.” – Student midwife

“I think, just like you [other student] said about interviewing... the mentors have such a big influence on our practice, and our values... that actually... getting those right people is almost as important, if not more important than getting the right students.”

– Student midwife

Students were able to name a variety of positive experiences with patients. Situations in which patients (and their relatives) showed appreciation regarding the care they received reinforced their values, as was seen in year one. Nevertheless, students had experienced adverse situations with patients, which challenged their values. Mental health nursing students spoke, for instance, about experiencing racial discrimination from patients, and encountering patients who did not want the help they were offering.

“I’ve been told to go back to my country. I’ve been racially abused left, right and centre...” – Mental health nursing student.

Nursing students across groups spoke about experiencing aggression and resistant behaviour from patients. In most situations, students were able to see such incidents as useful learning moments. They explained that they were often able to reflect on and understand patients’ behaviour, and therefore develop their tolerance. Experiencing difficult patient situations also reinforced students’ belief that, sometimes, small gestures of compassion can make a big difference. However, mental health nursing students in particular mentioned how their idealism was tempered by adverse patient behaviour:

“[...] especially verbal or... physical aggression, takes you back. Because ... my vision is to help. And when you’re doing all of these things and suddenly you are being told ‘you’re like this,

you're like that, you're like this' ... it actually does take you back a bit." – Mental health nursing student

The tempering of students', perhaps naïve, idealism as a response to being confronted with the reality of the clinical practice environment appeared to be a central topic. In comparison to Year One, students across professional groups expressed, to a greater extent, a realisation that providing care to the standard that they wish is not always possible:

"Yeah, you always do it to your best, but you... sometimes you go home, and you didn't get gold, you got bronze. 'I should have done... I should have done more', but you have done as much as you can, you have gone for gold, but... you just haven't quite achieved it." – Child nursing student

Theme 3. Reflection on values

Students across professional groups displayed an ability to reflect on their values in relation to those of other staff members and patients. Using specific examples, they showed an understanding that these values do not always align, and that it is important to listen to others and be open to their opinions. In year one, students mentioned the importance of being 'non-judgemental' (XXXX et al, 2017). The reflective insights expressed in year two may point towards further development in this respect.

Similar to in year one (XXXX et al, 2017), the importance of reflection on values (by oneself, and with mentors, tutors and peers) was mentioned by students. Student midwives believed that reflecting on both positive and negative situations could be helpful with regard to the development of values. However, they experienced a lack of reflective time in clinical practice environments. One mental health nursing student spoke about the benefits of an opportunity for reflection that he had experienced during a hospital placement, in the form of a weekly group with other students and a psychologist, where incidents that had happened on the ward were discussed. The student argued that this caused him to gain a better understanding of why patients with mental health issues could sometimes behave in an aggressive or offensive way, and that it helped him to remain compassionate.

Midwifery students discussed the gap between theory and practice, and argued that more reflective practice in relation to clinical placements should be encouraged by universities. In this context they, yet again, spoke about the vital role the mentor can have:

“It [reflection] does help change your values, because if you can get someone to validate your feelings... or even say: ‘it’s really normal to feel that way. Please just give it a bit of time, and you’ll feel better’. It... it’s that support that helps keeping you going.

– Student midwife

More so than in year one, students across professional groups were outspoken about the fact that they wanted to hold on to their values. Where, in year one, they described that they had started to act like the staff they were working with (XXXX et al, 2017), in year two, they were adamant that they did not want to be, or become, like the negative role models that they had encountered on their placements. Student midwives in one focus group spoke about being ‘resilient’ or ‘stiff’ with their values, and argued that such resilience is what universities should be recruiting for. Although they were aware of the possibility of losing their values, these students felt empowered to effect change within the profession:

“I look around (at other students) and I think... some people here are going to be the band sevens, or coordinators that I would be so happy to work under. And some people are going to be practice development midwives, and some people are going to be lecturers, and... you think... it’s really exciting, all of you... You know, it won’t take long. And we are going to be the people who... like... not going to be downtrodden [...]”

– Student midwife

This contrasts with the feelings of powerlessness that were apparent across professional groups in year one (XXXX et al, 2017). However, this renewed feeling of empowerment was specific only to one focus group of student midwives, and was not clearly observed in the other groups.

5. DISCUSSION

This paper builds on first year data reported in 2017 (XXXX et al) regarding students’ expression of their ‘values journey’; how and what has impacted on their values as they progressed to completion of their second year.

Findings suggest that participants had experienced an altered sense of self as a healthcare practitioner. Greater confidence associated with length of time in clinical practice appeared to enhance courage and initiative-taking. Increased courage meant that students felt more prepared to question sub-optimal care. Conversely however, students described the need to place greater emphasis on clinical skills in year two to the detriment of the provision of compassionate care in some instances. Participants reported feeling that increased organisational pressures could also compromise their values. Values choices are complex and can be influenced by personal factors as well as external pressures. Students suggested that organisational pressures and the mentors they worked with challenged and influenced their personal values. This could negatively impact on care provision and was more significant in year two due to greater levels of responsibility.

A potential dissonance is inferred between the inevitable increase in clinical skills and responsibility associated with seniority and the care students aspired to provide. Indeed, rather than 'not wanting to' or 'not being willing to' provide care, students explained that, at times, it was not possible. Students at this stage in their programme did not appear prepared or ready to 'delegate' tasks to, for example, healthcare assistants (HCAs). But we suggest students were aware that some shift was necessary to resolve the conflict in their values. They showed a preparedness to learn through re-contextualising their values (Mezirow, 1978) in relation to the prioritisation of care as XXXX et al (2014) have shown happens in other areas of the curriculum. Raising awareness of role transitions likely to be experienced by student nurses and midwives in their education programmes might enable them to better manage their own and others' expectations to enhance safe and effective patient care and outcomes.

De Vries (2017) suggests clinical staff can become complicit in inadequate care when exposed to others' sub-optimal practice including poor role models as mentors. Paley (2014) and De Vries (2017) describe social cognition or individuals' need to understand their strengths and limitations through critical self-reflection (Mezirow, 1978). Compared to year one, participants felt abler to 'speak out' against what they considered to be poor practice. They appeared to be reflective of their self-perception of courage, understanding the need to maintain their personal values by addressing care deficits to restore optimal care (Bagnasco et al, 2017). These heartening insights concur with seminal critical pedagogical theory which espouses that individuals can deal critically with reality and discover how to transform their

world (Mezirow, 1978, Freire, 2009). Opportunities are suggested for healthcare education programmes to actively encourage, facilitate and foster reflective practice techniques to ensure self-correction of values when threats to values have raised internal conflict.

One approach to facilitating more formal 'reflective moments' is through Schwartz rounds (Robert et al, 2017). Schwartz rounds provide a structured forum where staff can come together at regular meetings to discuss sensitive cases and related emotional and social aspects of working in healthcare (Robert et al, 2017). This principle was captured by one mental health student in the study who explained how he valued the opportunity to take part in weekly group sessions designed to discuss incidents that had occurred in the clinical area. Schwartz rounds are a contemporary intervention with the potential to coalesce Mezirow's (1978) four types of learning (Table X) by creating spaces and places for healthcare staff to discuss issues they face in providing care. Compassion for patients is only sustainable where there is compassion for staff (Seed, 1994, NHSE, 2012) and this is missing in many areas (O'Driscoll et al, 2018). Interventions like Schwartz rounds can increase empathy and compassion for both colleagues and patients; reduce feelings of isolation; and improve teamwork and communication (Maben et al, 2018).

De Vries (2017) proposes the need for critical self-reflection to redress imbalances of inner conflict and turmoil which care deficits and dilemmas might cause. Our data suggests students in the study were mindful of the need for reflection both in relation to positive and negative situations. The phrasing 'critical reflection' can have negative connotations with a subconscious focus on situations which could be improved (Kemp, 2014). We suggest a renewed emphasis on self-affirmations to both positive and negative situations and a recognition that reflection leads to new knowledge (in this case about values) which positively influences individuals' development as independent practitioners and critical thinkers. Self-affirmations (Steele, 1988) aim to restore individuals' perceptions of themselves as 'adequate' by making small, positive responses to stressful situations. This can be informally embedded in education programmes through mentorship and personal tuition. In this regard, we draw attention to the revised Standards for Student Supervision and Assessment (Nursing and Midwifery Council, NMC, 2018) and urge education institutions to foster supported learning of students in line with their scope of practice. Furthermore, we question whether

the attributes/value domains being assessed by MMIs in a values based approach to student selection are 'fit for purpose' (XXXX et al, 2018).

6. CONCLUSION

This paper explores nursing and midwifery students' expression of their 'values journey' having completed two years of their education programme in a UK context. These findings have widespread relevance due to the burgeoning pressures faced by healthcare services internationally.

The students who took part did not feel their values had changed fundamentally since they commenced their programme but that the prioritisation of their values and how they were 'put into practice' had changed. This learning had taken place in the face of conflict around values in clinical practice more than their values being eroded. This, we argue, may be understood as learning through re-contextualising knowledge in a transformational process (Mezirow, 1978) using critical self-reflection. Factors that influence values choices include external organisational pressures, which are unlikely to be alleviated in the foreseeable future, and seniority associated with increased clinical practice experience. Education programmes have the responsibility to incorporate facilitative teaching and learning strategies to foster conservancy and development of values and support complex values choices. Focused attention should be placed on the integration of critical self-reflection into education contexts perhaps through incorporating validated approaches like Schwartz rounds.

6.1 Limitations and recommendations

Data saturation may not be assured due to the attrition of participants between years one and two and the unknown reasons for this. Furthermore, the numbers of participants from different professional groups differed between years which may have had an impact on the data recorded. Continuance of this study is recommended; it is anticipated that year three findings will be submitted for publication later in 2018 and, subject to funding, the participants will be followed up once they begin work as registered practitioners in 2018.

ACKNOWLEDGEMENTS

Grateful thanks are extended to the students who are taking part in this longitudinal study.

CONFLICT OF INTEREST: none

Author contributions: All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE <http://.icmje.org/recommendations/>):

- Substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- Drafting the article or revising it critically for important intellectual content.

Funding:

- This research received a XXXX Faculty of Health and Medical Sciences Pump-Priming award.

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